SB

377

(File #)

BILL CONTACT/ACTION

DATE	CONTACT/ACTION
4/1	notified Kelly & Zhavoff of 4/2
	hearing
4/4	Becky Beaw (2504) (2720) — DC&FD
	Kelly
	Zhavoff → all notified of d/c hearing
4/9	notified Zhavoff & Becky Beaw
4/11	notified Becky Beaw & Zhavoff
4/16	" " "

A Citizen's Guide to Tort Reform

Dear Concerned Citizen:

We have all seen the recent increase in the number of lawsuits in America, as well as the tendency of our courts to hand out more and ever-larger awards. We all know that America is considered to be the most litigious society in the world. As a result, we all are beginning to sense that something is wrong with our legal system.

As chief executive of a large insurance company, I am frequently asked about tort reform, especially about how we can restore the system to one that better matches our common sense notions of fairness and balance—one that provides prompt, just and full compensation to injured victims at a reasonable cost, without so weakening the test of liability that every productive and creative individual in society becomes a potential victim.

For most citizens, the major stumbling block to understanding tort issues is the fact that the issues are technical and complex. For that reason, and in response to requests from a number of consumer organizations, we have undertaken to explain the issues in clear, concise language. We believe that tort reform is a societal issue and that citizens of this country have a stake in—and a need to understand—these issues. The purpose of this guide is to educate rather than persuade; therefore, no recommendations are provided. Instead, we encourage you to look at the facts and judge for yourself what, if any, actions should be taken.

The following pages detail the major legal doctrines and issues which govern our tort litigation system. While there are many more doctrines, the areas outlined in this guide are the most important and the most frequently cited as in need of reform. Each doctrine is outlined in an historical context.

In addition, public policy questions which have been raised are put forth. The final section of this guide highlights proven methods of making your voice known at the legislative level.

Of course, Fireman's Fund does have a position on what reforms might be undertaken. Quite simply, we believe the laws governing tort litigation in America should be tightly defined. This may be best achieved by moving back toward the basic principles still employed in other common law countries and which worked well in the United States until erosion began in the 1960s.

Our position was put forth in my recent speech titled, "The American Tort System: A Time to Rebalance the Scales of Justice." If you would like a copy of this speech, please write to me at Fireman's Fund, 777 San Marin Drive, Novato, California 94998.

Sincerely,

William M. McCormick
Chairman & CEO
Fireman's Fund Insurance Companies

A Citizen's Guide to Tort Reform

An Overview

The legal framework for compensating personal injury in the U.S. is the tort reparations system. Like the rest of the United States legal system, the tort reparations system is adversarial: After hiring an attorney, the injured person—called the plaintiff—files a lawsuit. The defendants named in the lawsuit also retain attorneys who respond to the allegations. The theory behind the adversarial system is that, with both sides represented by lawyers arguing for their clients' best interest, the truth will emerge.

The trial court must decide the facts of the dispute and correctly apply the law. A party disagreeing with the legal basis for the trial court's decision may appeal to a higher court. These higher, appellate courts exist primarily to correct errors in applying the law.

In deciding appeals, appellate courts often must clarify, modify or explain legal rules. Their decisions become legal precedents which are supposed to be followed by other courts in their jurisdiction. These decisions are published in legal reports so lawyers and trial courts can determine what legal rules should be applied in the next case.

About 95 percent of the cases filed are settled or dismissed before trial. Only a small proportion of the lawsuits filed actually result in a trial and verdict. Many of those verdicts are not appealed.

Although most cases are settled out of court, the legal rules applied by courts and the expense of going to court largely determine whether—and for how much—the parties in the lawsuit are willing to settle. If legal precedents make it easier to recover for the specific injury, eliminate defenses that might prevent a finding of liability and/or increase the amount of potential damage awards, the amounts settled in out-of-court situations tend to increase.

Historical Evolution

Tort law is primarily judge-made law. When the United States declared independence, it continued to apply principles from the pre-existing body of English court decisions. These were amplified, explained and altered by later American courts in the tradition of common law, which allows the gradual evolution and change of legal doctrines.

United States tort law varies from state to state but, because state courts tend to regard other states' decisions as persuasive authority, the general trend has been the same almost everywhere in the country: Courts have increasingly eliminated many of the restraints to assigning liability present in the common law of England and in the common law applied in the United States through the 1950s.

The 1960s saw a dramatic increase in the pace of legal change. In the 25 years since then, there has been a fundamental alteration in many of the common law tort doctrines and in the basic balance of the tort reparations system.

The tendency has been to extend the definition of liability, resulting in an expensive and unpredictable tort liability system. Those most impacted by today's system are those who provide important products and services—such as doctors, manufacturers and municipalities—who are now at much greater risk of being sued.

Court Costs—The American Rule

Greenwood Village, Colorado, boasts a population of less than 6,000. To date, the town has run up a legal bill of $700,000 in attorneys' fees and court costs to defend itself from suits brought by landowners who object to commercial development.

The Greenwood Village taxpayers are responsible for paying their legal bills—whether the town wins, loses or settles.[1]

Description

Under the American rule, all litigants pay their own costs. Unlike other common law countries, if a plaintiff brings a lawsuit and loses, the defendant is still responsible for his own court costs and attorneys' fees.

Original Justification

The American rule was created to allow all persons full access to the courts.

Subsequent Developments and Operation Today

As discovery and defense costs have risen, and as it has become more difficult to dismiss tort suits at preliminary stages, it is extremely expensive to take cases to court.

Conversely, the cost to the plaintiff is relatively low. Under the traditional contingency fee arrangement, the plaintiff pays no attorney fees if the suit is unsuccessful. The plaintiff is, therefore, only responsible for the filing fees, which are a fraction of the total litigation costs. The result is that it is often cheaper for a defendant to settle even a meritless case out of court than it is to win the case after a jury trial.

Public Policy Questions

- Should the American rule doctrine be eliminated, requiring the losing party to pay all court and defense costs, as is done in other countries?
- Should the American rule be revised to apply only to certain types of cases, such as those in which the plaintiff is insolvent?
- Should the American rule not be applied in cases that are appealed after initial, non-binding arbitration?

Joint and Several Liability

The brakes on a boy's bicycle failed, causing him to cross over onto the wrong side of the street. The child ran head-on into an automobile and was seriously injured. Both the seller and manufacturer of the bicycle were sued. In addition, the City of Los Angeles was named as a defendant because it was alleged that plants growing on private property, over which the city had an easement for possible future street widening, had partially obstructed the view of the cyclist and the driver.

Because the bicycle seller and manufacturer settled their share of the lawsuit for substantially less, the City of Los Angeles was held liable for the entire remaining award of $1.7 million. The case is currently on appeal.[2]

Description

If more than one defendant is found partly responsible for an injury, many states hold them "jointly and severably" liable for all damages. This means that if one defendant is unable to pay his share of the award, the other defendants must pay the amount—in addition to their own share.

Original Justification

The courts believed that if one defendant was insolvent, the burden should fall on the other defendants who bore some responsibility for the accident, rather than on an innocent plaintiff.

Subsequent Developments and Operation Today

The doctrine of joint and several liability creates large liability exposures for such defendants as cities and insured businesses, which undertake many activities and have enough assets to attract lawsuits. This problem is compounded by the greater availability of pain and suffering awards and a general trend toward larger damage verdicts. Such defendants now

have an incentive to spend large amounts of money on attorneys' fees and expert witnesses to avoid a finding of even one percent liability.

Public Policy Question

▸ Does the "deep pocket" philosophy unfairly penalize such defendants as municipalities and insured businesses by holding them accountable for awards beyond their own responsibility?

Comparative Negligence

A New York man was seriously injured when he attempted suicide by jumping in front of an oncoming subway train. He filed a lawsuit claiming that the train engineer should have stopped the train faster. The man recovered $650,000 from the New York Transit Authority.[3]

Description

Comparative negligence allows a plaintiff to recover damages—even if his own negligence or misconduct contributed to the injury. This is a modern doctrine which, in many states, replaces the traditional rule of contributory negligence.

Currently, states adhere to one of three rules:

1. *Contributory negligence:* The plaintiff cannot recover if his negligence contributed in any way to the injury, unless the defendant had the last clear chance to avoid the injury;

2. *Pure comparative negligence:* The plaintiff can recover despite his own negligence, but the amount of recovery is diminished in direct proportion to his own negligence;

3. *Modified comparative negligence:* The plaintiff may recover an amount even if he is partially negligent, but only if he was no more negligent than the other party.

Original Justification

The traditional doctrine of contributory negligence was developed with the belief that the legal system existed to enable fault-free plaintiffs to recover from defendants who were at fault, and that the system should discourage self-injuring behavior.

The more liberal rules of comparative or modified comparative negligence were later developed with the belief that a slight degree of fault on the part of the plaintiff should not prevent all recovery.

Subsequent Developments and Operation Today

Liberalization of the comparative negligence doctrine has made it difficult for judges to dismiss lawsuits at an early stage on the grounds that the plaintiff was clearly responsible for his own injury.

Public Policy Question

▸ Should a plaintiff who is partially at fault for his own injuries be allowed to recover? If so, should there be limits on the amount he can recover?

Punitive Damages

A couple whose car had been rear-ended claimed they were entitled to $17,000 from their auto insurer. The insurance company estimated damages at $4,500. The couple sued. The court, finding in favor of the couple, ordered the insurance company to pay $7.4 million in punitive damages for failure to settle a claim in good faith.[4]

Description

Punitive damages are awarded in addition to the amount necessary to compensate the plaintiff for actual damages. They are assessed to punish the defendant and deter future similar behavior. Under the legal doctrine of vicarious liability, individuals and companies may be held liable for punitive awards based on the conduct of their employees or agents—even if that conduct is unknown to supervisors.

Original Justification

Despite the general notion that civil law was to recompense injury rather than punish wrongdoers, the following rationale was advanced to support punitive awards under English common law:

First, the punitive damage award allowed juries to help compensate for such factors as anguish and embarrassment, which the courts were reluctant to compensate during the formative stages of common law.

Second, this doctrine was developed at a time when there was a shortage of public prosecutors and many cases of outrageous conduct were not covered by criminal law. Punitive damages filled a void: They provided individuals with an economic incentive to litigate for personal injury in cases where the defendant should be deterred from future willful and wanton misconduct.

The American Tort System: A Time to Rebalance the Scales of Justice

William M. McCormick
Chairman & CEO
Fireman's Fund Insurance Companies

Delivered to
Commonwealth North
Anchorage, Alaska
January 7, 1986

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William M. McCormick, 45, is Chairman and Chief Executive Officer of Fireman's Fund Insurance Companies, a position he has held since 1983. He is also President of Fireman's Fund Corporation. Prior to joining Fireman's Fund, Mr. McCormick held various positions within American Express Company, where he rose to President of American Express Travel Related Services Company, Inc. He began his business career as a management consultant with McKinsey & Company, Inc. Mr. McCormick, who holds a Master's Degree in nuclear physics, served in the U.S. Navy as a lieutenant on the Atomic Energy Commission staff of Admiral H.G. Rickover.



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The American Tort System: A Time to Rebalance the Scales of Justice

The American Tort System: A Time to Rebalance the Scales of Justice

George Bernard Shaw once wrote, "The road to hell is paved with good intentions." Probably no statement better describes the state of our tort system in this country.

With the best of intentions, the scales of a system designed to render justice have been tipped. The balance has moved so far toward the desire to compensate all injuries and all losses that the overall cost to society has become too high. We have reached a point where exposure to liability is becoming almost limitless and incalculable, making everyone — governments, businesses and individuals — a victim.

Now, even people whom common sense would judge innocent are found liable by our courts.

In making these observations, I want to make it clear that I am doing it as a citizen, not as an insurance expert or as a lawyer. As chief executive of a major insurance company, I find myself in the middle of the current debate on our tort system. I have had the opportunity to examine the issues firsthand, and I don't mind telling you that I have become very concerned about the societal cost and fairness of litigation in this country.

To put the tort problem into perspective, let's look at a few recent suits and their outcomes:

- A little league player was injured when a fly ball hit him on the head. His parents sued the coaches on the theory that they were negligent in putting their son in the outfield. The parents recovered a settlement. As a result, the athletic league may have to disband because it cannot afford liability insurance. And coaches everywhere are beginning to worry about whether their contribution of time is worth the new risk.[1]
- A man was hurt when a drunk driver crashed into the phone booth he was using. The California Supreme Court held that the manufacturer of the phone booth could be held liable for the man's injuries.[2]

• A burglar accidentally fell through a painted-over skylight while he was stealing lights from the roof of a public school. He sued the school district and recovered $260,000 in damages plus a continuing income.[3]

• In New York City, a man attempted suicide by jumping in front of a subway train. The man was injured but did not die; he sued, claiming the driver should have put the brakes on faster. The New York Transit Authority paid $650,000.[4]

• A man sued for emotional damages after seeing a leopard kill a neighbor's child at the circus. He was awarded more than $1 million. The child's parents, who had not witnessed the accident firsthand, received $120,000.[5]

These few cases — and believe me, there are many more — do make you wonder where we are heading. Something is wrong when parents get paid damages because their child can't catch. Something is wrong when a manufacturer is liable because its telephone booths don't withstand sidewalk attacks from speeding autos. Something is wrong when a burglar can recover from the taxpayers because a public school wasn't safe to break into. Something is wrong when a person can sue because he was injured while trying to kill himself. Something is wrong when someone is paid $1 million for observing an accident, however tragic.

Decisions such as these are beginning to outrage our common sense notions of justice. Why is this happening? The fact is, the justice system as we long knew it no longer exists. The system no longer provides a clear definition of the law. It encourages plaintiffs to sue, hampers defense, makes incredible awards, and has stretched the line that defines responsibility from "true negligence" to what almost amounts to "innocent bystander." And as a result, the system is overloaded and fails to provide prompt, just and full compensation to injured victims at a reasonable cost.

1800s–1960s: Historical Stability

A little historical perspective is needed to understand how we got to where we are.

There are two broad areas of the law: criminal and civil. Tort law falls under the civil category and includes everything from slip and fall cases to automobile accidents to libel suits.

The rules in tort law center on what kinds of injuries can be compensated and what has to be proved to win the lawsuit. We inherited these rules from English common law. In the past, changes in these rules evolved slowly, largely from court decisions, not from statutes.

In America, we have 50 different state court systems and hundreds of federal courts that must interpret and apply these laws. There is often a difference between the rule in one place and the rule applied in another. Overall, however, most court decisions on tort law have followed the same general trend.

Surprisingly enough, even with all the minor adjustments and additions made through nearly 200 years of American court decisions, the balance struck by English common law remained essentially the same from the early 1800s until the 1960s.

With limited exception, a person suing could recover only if he proved that the defendant was at fault — that the defendant's negligence caused the injury. If the plaintiff — the person bringing the lawsuit — was the primary cause of his own injury through negligence or deliberate conduct, he could not recover.

Plaintiffs could usually get damages for intangible pain and suffering only if there was an accompanying physical injury. And punitive damages — punishment awards over and above compensation for injury — were available only for truly outrageous conduct. In other words, tort laws were defined in such a manner that one only obtained redress for cases of true negligence, not for the personal risks of everyday life.

1960s–Today: The Erosion of Justice

The tort system we have today — only 25 years later — is vastly different. Our generation has overturned 200 years of legal tradition.

To illustrate recent changes, let's look at just a few of the important decisions of the last 25 years in California. I have chosen California because its lead has often been followed by other states.

In 1961, California rejected the common law doctrine of sovereign immunity, which for centuries had protected cities and states from lawsuits. In fiscal 1984, California cities — that's California taxpayers — paid out more than $19 million in claims, up from $5 million just three years ago.

In 1962, the concept of fault was tossed aside in the area of product liability. Now, an injured person doesn't have to prove any negligence — just that the injury might have been prevented by a different product design. That's how you get lawsuits against telephone booth manufacturers for not making their product crashproof.

In 1968, the California Supreme Court changed the standard of care owed by landowners, extending the duty of "utmost care" to even criminal trespassers. You can now see why a burglar robbing a school can successfully sue for injuries.

In 1975, California replaced the doctrine of "contributory negligence" with "comparative negligence." Comparative negligence allows an injured party to recover if he is partly — or even primarily — at fault for an accident.

Not only has legal doctrine been substantially altered, the dollar value of awards has ballooned. The tort system today has more million dollar winners than a state lottery. You may think that the high awards you read about are aberrations, but in 1984 the average product liability verdict was over a million dollars. The average medical malpractice award was $950,000.[5]

Courts today also have become more liberal in awarding punitive damages. Recently, an insurance company disputed the proper settlement

amount with a couple whose car was rear-en ed. The insurance company offered $4,500; the couple believed they were entitled to $17,000. They sued, claiming the insurance co..pany had failed to settle their claim in good faith, and recovered $7.4 million in punitive damages. Regardless of who was right or wrong, the punitive damages awarded were totally out of proportion to the claim at hand.

And courts in many states are handing out extraordinary awards even where there is no physical injury, just the mental trauma caused by watching an injury happen to someone else, or the worry brought on by fear that an injury might occur in the future. That is why the man who saw the boy killed at the circus sued and why people are now suing for fear of contracting AIDS.

Huge damage awards are a recent phenomenon. The first million-dollar tort verdict was awarded in 1961. In 1983 alone, this country settled 360 cases for $1 million or more. By comparison, in the entire judicial history of Canada, there have been only six $1 million tort cases — and three of those cases, applying Canadian law, were decided by U.S. courts. No other country pays these huge amounts.

The financial cost of our tort reparations system is staggering: In 1984, the tort system was estimated to cost 37 times as much as it did in 1950. Commercial liability insurers alone spent $2.9 billion defending suits in 1983; and legal defense costs had risen to 25 cents per premium dollar, compared with 5 cents per dollar in the 1950s.

The System Today: Expensive and Unpredictable

But while these statistics point out some of the dimensions of what has happened to our legal system in the past 25 years, there is another aspect that is harder to quantify and that is the cost of uncertainty as to what the law is. Just over a hundred years ago, U.S. Supreme Court

Justice Oliver Wendell Holmes wrote: "The tendency of the law must always be to narrow the field of uncertainty."

That tendency hasn't been very apparent lately. Certainty and predictability have been two casualties of the developments of the last 25 years. Without certainty and predictability, plaintiffs sue, defendants don't know how to protect themselves and we in the insurance industry can't price, and in some cases can't accept, risks.

And do not forget, there is enormous leverage on these recent court cases. Decided cases are only the tip of the iceberg; they directly affect the thousands of other cases that get settled before going to court, not to mention acting as a stimulant for ever more lawsuits.

Defendants often pay huge settlements just to avoid the uncertainty of court judgments. One particularly successful plaintiff attorney in Los Angeles recently bragged to a journalist that defendants "are so afraid of going before the jury . . . that they are ready to settle a $10,000 claim for $100,000."[2]

The impulse to find someone else to blame, and thus get compensated — and compensated highly — for every injury, has serious economic and behavioral repercussions. America has the most litigious and expensive legal system in the world, with the number of lawsuits and amount of damages growing at an unprecedented rate.

We now have three times as many lawyers per capita as England, and more than 20 times as many per capita as Japan. Can you believe that one out of every 12 adult Americans will be involved in a lawsuit this year?

Runaway tort litigation means we all pay higher prices for everything, whether it's in product prices, insurance rates or in municipal, state and federal taxes.

For example, the City of New York, which is large enough to be self-insured, pays claims itself. In 1983, New York City paid claims totaling $78 million. That was $78 million the city could

have spent on police protection, subway improvements or road repair. By the year 2000, New York City expects to pay more to settle lawsuits than it pays to provide fire protection.

Even the federal government faces high liability costs: There are now 40,000 civil cases pending against the United States, with damage claims of over $138 billion.

But the biggest dollar cost imposed by our tort reparations system is the invisible tax we pay on almost every product and service we buy. When you purchase a stepladder, for example, one-fifth of the price tag goes to cover the manufacturer's liability protection. The product liability component of a GM car now costs more than the steel that goes into it.

The Societal Cost of Litigation

But money is just money. If everything gets more expensive because we decide to maintain our current tort liability system, somehow we will all muddle through. Our standard of living will go down a bit, we'll be a little less competitive in international markets, and a number of small companies will go out of business. What is more frightening, however, is that soon there may be some necessary products and services that are no longer available at any price.

Day care centers all across the country are closing their doors. We have all read about instances of misconduct. But in addition, there is an attitude that if Susie hits Johnny with a building block, it's grounds for a suit claiming inadequate supervision and demanding punitive damages. The result is that many day care centers simply can't afford — or get — insurance.

Non-profit organizations and local government boards are now having trouble finding anyone willing to serve because they cannot afford insurance to protect their board members from lawsuits. Community service is rewarding, but for most of us it's not so rewarding that we would

risk our homes and savings in a lawsuit — just for the privilege of volunteering personal time.

And some manufacturers of life-saving products have quit because the threat of product liability suits is so overwhelming. In the last few years, seven companies have withdrawn from the business of making anesthesia machines; only two are left. Johnson & Johnson recently withdrew a drug designed to prevent sudden infant death syndrome — crib death. The reason wasn't that the drug didn't work: It does. But because it is given to high-risk infants, some of whom would die of crib death regardless of whether or not they took the drug, the company did not feel it could expose itself to the inevitable product liability suits.

And American vaccine makers are being driven out of the business as well. There is only one maker of whooping cough vaccine in the United States, and they are talking about getting out of the business. Why? Because the vaccine, which saves thousands of lives every year, is not perfectly safe: It causes unavoidable injury in three out of every one million children. As a result, the manufacturer has attracted more than 100 lawsuits over the last three years, amounting to almost $2 billion in claims. The entire U.S. market for all vaccines amounts to only $250 million.[9]

Where is the next vaccine or wonder drug going to come from if the companies can't even distribute the life-saving products that they have already developed?

What we are facing is an issue that is very important and that affects all of society. The pendulum of the American tort system has swung too far. The desire to hugely reward every claimant is creating too great a price. The belief that the world owes us a living has come full circle — back to us. Each of us now lives in almost mortal fear of being sued, particularly if we have — or through insurance have access to — money. We can no longer count on being protected by the law; we can now be attacked by it.

What Is the Problem?

Part of the problem is the inherent difficulty of balancing the competing objectives in any tort law system. As society has become more complex over the centuries, the task of delicately balancing competing social goals — each of which has a place, and none of which can be totally neglected — is more difficult. How does one balance the tradeoffs among:

- Full compensation for injured parties;
- Deterrence of negligence or punishment of outrageous behavior;
- Deterrence of self-injuring behavior;
- Maintenance of an efficient court system for dispute resolution; and
- Avoidance of limitless or incalculable liability in order to encourage the productive elements of society and avoid disincentives for economic development and innovation?

Part of the problem is the fact that the enormous changes in legal doctrine made over the past 25 years have been, for the most part, invisible. Courts have expanded the law on a case-by-case basis without much public debate or even notice.

Each change has been a well-intentioned attempt to compensate someone for some injury. But the revolution in legal philosophy that occurred with the best of intentions affects all of society. Yet it was done by courts based on what they perceived to be changes in prevailing values without the benefit, or crucible, of public debate and legislative mandate.

Part of the problem is that most business people, most consumers and even some legislators think that tort reform is an area for the experts. They hear trial lawyers argue with insurance executives over the impact of the collateral source rule or the doctrine of joint and several liability, and their eyes glaze over. They figure the experts deserve each other.

There are no doubt even more parts to the problem. The result, however, is clear: We in America have the most unpredictable, expensive

and litigious tort system in the world. This is no longer a problem just for lawyers, for the insurance industry or for the courts. The time for leaving decisions to narrow categories of experts is over. The costs — both economic and societal — are too great.

What Is the Solution?

We can't look to the lawyers to solve the problem. Abraham Lincoln, a lawyer himself, once said that the highest duty of an attorney was to discourage litigation. While I certainly support his view, it is a tough standard. It's like asking doctors to discourage medicine or ad agencies to discourage advertising. In fact, just the opposite is happening as lawyers increasingly advertise for tort clients.

We can't look to insurance companies to solve the problem. As middlemen, insurers are in the business of spreading risks in a society, not picking up the tab for them. Insurance is unusual in that it must price its product to cover the cost of lawsuits today and many years into the future. As long as the courts define the rules, the policies will be competitively priced to reflect those rules. If the liabilities are undefined, the insurance cannot, or should not, be written.

Finally, we can't look to the courts alone to solve the problem. Courts are focused institutions which decide narrow cases involving the parties before them. Only occasionally do they see repercussions beyond the immediate case. If they did, they would probably not have set many of these recent precedents.

It took 25 years of case-made changes in doctrine to create our most litigious society in the world; but we do not have 25 years to correct it. The stakes are simply too high. So, if we can't look to the lawyers, and we can't look to the insurance companies, and we can't look to the courts to solve the problem, who can we look to? Well, look around.

Citizens Must Act

The answer lies with us as citizens and with the legislature. But the legislature will not act until the voters make their voices known. Everyone must get involved because everyone is paying the price — municipalities, businesses, citizens and even the trial lawyers, who are themselves having trouble getting liability insurance.

It is time for all of us to step back and readdress some basic questions:

- Is fault still important?
- Where do we draw the line on defining and assigning liability?
- Should there be limits on financial damages?
- When does ease of suit cripple the productive elements of society?

These questions — and others — are big, important and complex. They must be thoroughly analyzed and debated at the local, state and national levels by everybody, not just the experts. We must understand the issues. We must talk to one another. We must involve our legislators. Only then will the system begin to change.

The key is to become involved. When citizens are involved, legislative change happens. Last fall in California, Lee Phelps, a retired Marine, founded a lobbying group to protect property owners from being sued by criminal trespassers who injure themselves on their property. To overrule the California Supreme Court case that held otherwise, Lee Phelps raised and spent $5,000. He faced opposition from the California Trial Lawyers Association, which had contributed over half a million dollars to candidates last year. But he got the measure passed.[10] So something can be done.

The following are some solutions we might consider:

Put some *limits on liability*, whether that's limits on types of claims or on the size of damages awarded. For example:

- Product liability when there is no negligence on the part of the manufacturer and where the

injured parties' own negligence contributed to the problem;

- Pain and suffering awards, particularly when there's no physical injury or when the injury occurred to someone else;
- Size of awards where the impact of taxes, expenses and collateral sources are significant.

A second area in need of reform is *punitive damages*. The original justification for punitive damages was to deter outrageous behavior, willful and wanton misconduct. In recent years, this good standard has been diluted to the point of capriciousness.

Third, we must reexamine the concept of *comparative negligence*. This doctrine allows plaintiffs to recover large damages even if they are more responsible for the injury than the defendant. That's what allows people who throw themselves in front of subway trains to recover hundreds of thousands of dollars from the taxpayers. It should be possible for judges to dismiss lawsuits at an early stage if the plaintiffs are clearly responsible.

Fourth, we must eliminate *joint and several liability*. The defendant should be financially responsible only for his own fault in the incident, and not for someone else's fault if that person can't pay.

Fifth, we should limit the *contingency fee system*, which encourages frivolous lawsuits and provides an irresistible incentive to extend the line on defining liability.

Sixth, we should seriously consider establishing a mechanism for mandatory, *non-binding arbitration* of smaller claims, which make up the bulk of tort cases. If a plaintiff then carries his case on to the courts, he should pay defense costs if he does not prevail.

But the specific details of one tort reform proposal or another aren't important yet. What matters is that we as a society make some comprehensive and fundamental changes to put our tort system back in balance. Tort law is an

integrated system and piecemeal solutions will not do.

Someone once said that people get the kind of government they deserve. In a democracy, it's also true that we get the kind of civil justice system we deserve.

I think we deserve a system that is predictable. A system that provides prompt, just and full compensation to injured victims at a reasonable cost. A system that does not make each of us a potential target for lawsuits arising from someone else's accidents. A system, in other words, that does not outrage our common sense notions of justice.

But if that's the kind of system we want, then we must work to get it. We do not have it now.

Footnotes

[1]Associated Press, July 10, 1985.
[2]*Wall Street Journal*, December 3, 1985.
[3]*Business Week*, August 26, 1985.
[4]*Underwriter's Report*, November 7, 1985.
[5]*Journal of Commerce*, December 5, 1985.
[6]*Forbes*, July 15, 1985.
[7]United Press International, May 11, 1985.
[8]*New York Times*, May 8, 1985.
[9]*Forbes*, November 18, 1985.
[10]*San Francisco Chronicle*, December 8, 1985.

For further information please refer to *A Citizen's Guide to Tort Reform*, which may be obtained by writing:

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FIREMANS FUND
INSURANCE COMPANIES

Subsequent Developments and Operation Today

Today, the courts generally award pain and suffering and mental anguish damages without resorting to the category of punitive damages. In addition, there has been a dramatic change in the climate of legal regulation: A well-developed criminal law and extensive framework of government regulation act to deter invasions of personal rights.

While the original justification for punitive damages has grown less persuasive, these damages have become increasingly larger and easier to obtain. Today, instead of demanding an injury be "willful and wanton," or that the defendant's conduct be wrongdoing of an outrageous character, many states now permit punitive awards when the defendant's conduct amounts to the equivalent of gross negligence.

Unlike compensation for actual injury, punitive damages are unpredictable, making it difficult for both sides to agree on a reasonable settlement. Often, plaintiffs are encouraged to bring lawsuits involving only minor injuries because of the potential for a large punitive award.

Public Policy Questions

- Who should be held accountable for the payment of punitive damages: the defendant's insurance company or the specific defendant deemed to be responsible for the conduct?
- Should punitive damages be paid to the plaintiff, who has already been economically compensated for his injury, or should they accrue to a general fund established and administered by the state?
- Should caps be placed on punitive damages—either dollar limits or ratios of economic awards—in order to allow for some predictability and certainty within the system?

Contract Interpretation

In California, a man's homeowner's insurance policy specifically excluded coverage for earthquakes. The man did not purchase special earthquake insurance coverage. When an earthquake damaged his home, the man filed a lawsuit demanding that his insurer pay for the repairs.

The man argued that the construction of the house affected the way it was damaged in the earthquake. Since construction errors were covered by the insurance policy the insurer was ordered to pay $47,000 in repair costs, along with $1 million in punitive damages for failing to settle the claim earlier.[5]

Description

When one of the defendants in a lawsuit has an insurance policy, there is sometimes the question of whether the defendant is covered by the terms of the policy. To resolve the question, the courts generally apply the rule that if the contract is ambiguous it should be interpreted to provide coverage.

Original Justification

Since the party drafting the contract is in the best position to protect itself by making the wording clear, courts resolve ambiguities in favor of the other party. Insurance companies generally write the terms of insurance policies, so courts construe ambiguities against them.

Subsequent Developments and Operation Today

Many courts have gone beyond this general rule to find insurance companies responsible—even in some policies which clearly exclude the damage being sued for. In some states, insurers have a duty to make good faith settlements. They may be held liable for huge punitive damage awards for failing to settle, even when the policy

excludes the claimant's claim. Therefore, more dubious claims are paid, resulting in a higher cost being passed on to consumers.

Public Policy Question

▸ If coverage is specifically and clearly excluded in a policy, should the insurer be required to pay?

Strict Liability

An overweight man with a history of heart disease suffered a heart attack while he was trying to start a Sears lawnmower. He sued Sears, charging that the mower's pull rope required too much force. A Pennsylvania jury awarded the man $1.2 million, plus an additional $550,000 in punitive damages because Sears did not promptly settle the claim.[6]

Description

The strict liability doctrine allows courts to hold a defendant liable for an injury—even if the defendant was not negligent. The plaintiff simply must prove that he was injured while using the product the way it was intended and that the injury might have been prevented if the product had been designed or manufactured differently.

Original Justification

Strict liability doctrines in English common law grew partially out of purely technical pleading rules and partially from property law concepts. The strict liability standard for extremely hazardous activities, such as blasting, grew out of the belief that some activities were so dangerous that, even when carried out with the utmost care, anyone who undertook them could be held liable for causing injuries.

The justification for strict liability for product-caused injuries was that manufacturers were in the best position to discover and prevent hidden defects and that if a product was dangerous the cost of that danger should be assessed through the tort liability system.

Subsequent Developments and Operation Today

Because strict liability was not based on negligence, American courts were initially hostile to the adoption of this doctrine. In some states,

strict liability was considered a violation of the state constitutional requirement that defendants be given due process of law.

By the mid-1900s, however, American courts were applying the strict liability doctrine in two areas: (1) those engaging in ultrahazardous activities were held strictly liable for injuries they caused, regardless of how careful or prudent they had been, and (2) in a certain number of cases involving adulterated foods and beverages, defendants who made and packaged the products were held liable without a requirement of showing negligence.

Beginning in the early 1960s, a number of state courts adopted strict liability as the standard for all manufactured products. If a customer is injured while using the product in the way it was intended, he can sue. It is now no longer a defense to argue that the product was designed and manufactured in a reasonably prudent manner.

While strict liability for manufacturers initially applied only to hidden dangers or product defects, some states have extended the doctrine to apply to products even where the danger was obvious.

Greater availability of large punitive and pain and suffering awards, coupled with the doctrine of joint and several liability, has meant that manufacturers are now faced with the prospect of enormous liabilities—regardless of the extent of care used when manufacturing a product.

Public Policy Questions

- Should products which are unavoidably dangerous, yet socially desirable (such as drugs and vaccines), be exempt from the strict liability standard as long as prescribed, protected procedures are followed?
- Should obvious negligence on the part of a plaintiff release a manufacturer from his responsibility for an injury?

Proximate Cause

A New York doctor left his car with an attendant in a parking lot. While moving the car, the parking attendant hit a security guard. The guard sued. The New York Court of Appeals held that the guard could recover $75,000 from the doctor and his auto insurance company, even though the doctor's sole involvement in the accident was to leave his car in the lot.[7]

Description

Proximate cause is a doctrine which originally limited the liability of a person to the relatively direct and foreseeable effects of his actions. The defendant was only held liable if his negligent act or omission was an immediate cause of injury and not superseded by someone else's later unforeseen negligent act or omission which more directly caused the injury.

Original Justification

The doctrine of proximate cause was adopted to provide a common sense boundary for what otherwise might be limitless liability for relatively innocent acts.

The original doctrine of proximate cause took into account that an almost limitless number of events can contribute to an accident or injury. For example, an alarm clock which fails to go off could make a man late for work and the fact that his car takes an unusually long time to warm up could make him even later. These events could conceivably combine to make the man so nervous about being late that he drives recklessly and strikes a pedestrian as he careens around a corner.

Those who formulated the common law recognized that not every act which indirectly contributes to an accident is a basis for liability. In the example cited above, a case could be made that if the alarm clock had not malfunctioned and if the car had started more promptly, the accident

might not have occurred. The original doctrine of proximate cause would have held that the reckless driver should be held liable for the injury.

Subsequent Developments and Operation Today

The doctrine of proximate cause has always been a somewhat flexible one, and the courts have steadily expanded the scope of liability. In addition, statutes or judicial decisions in many states now make bartenders liable for injuries caused by drunk drivers.

Some area courts have gone so far as to drop the requirement of showing actual causation, holding that where the plaintiff is unable to prove which of several possible defendants' products injured him, the defendants can be held liable in proportion to their market share.

Public Policy Question

▸ Should courts return to traditional proximate cause analysis, requiring plaintiffs to prove that the defendant's acts directly contributed to their injury?

Pain and Suffering/Mental Distress

A New Jersey man took a neighbor's child to the circus. While there, a leopard mauled and killed the child. The man recovered $1 million for the emotional trauma caused by witnessing the incident. By comparison, the boy's parents, who were not present at the circus, recovered $120,000 for the death of their child.[8]

Description

In addition to compensating for economic loss such as medical expenses, the courts now award general damages for pain and suffering to cover physical pain, mental anguish, emotional distress, etc.

Original Justification

English common law severely limited the availability of general damages for pain and suffering. It was thought that emotional injuries without accompanying physical injuries were too difficult to evaluate, too easy to fabricate and often too trivial to justify compensation.

Subsequent Developments and Operation Today

The awards for pain and suffering that accompany other injuries have become increasingly large. In addition, some courts now allow recovery for mental distress caused by seeing or hearing about injuries to others, as well as for a variety of emotional traumas that occur without physical injury.

Public Policy Questions

- Should pain and suffering awards be allowed only when there is an accompanying physical injury?
- Should there be limits on the amount and/or type of pain and suffering claim?

Additional Issues

Several other issues which are not doctrine-related may require further study. These issues include:

Contingency Fee Arrangements

Plaintiff attorneys today can earn upwards of 40 percent of a total award verdict. No other profession in the world can command an agent fee which is this high. We might want to consider placing limits on attorneys' contingencies, based on how the case is settled (settlement, arbitration or judgment) or on the size of the award or settlement, or on costs.

Nuisance Lawsuits

Each year, thousands of groundless lawsuits are filed with the hope of coercing an easy settlement. The high costs of defense frequently make it cheaper to settle a lawsuit than to win it.

Courts are becoming more receptive to the idea of imposing costs and attorneys' fees upon litigants who bring frivolous suits. Although there is obvious difficulty in determining when a lawsuit is "frivolous," many have proposed increased use of these sanctions to deter the use of frivolous suits which clog the court system and coerce settlements.

Alternate Dispute Resolutions

Tort litigation is time consuming and expensive. Alternative dispute resolutions (ADRs), such as negotiation, arbitration and mediation, have been suggested as a method to ease the expense and back-up in our tort reparations system. ADRs might be deemed mandatory and binding for claims falling under a pre-set limit, thus allowing the judicial system to free itself to deal with cases involving larger claims in a more timely fashion. If the case were appealed to a trial court, then the losing party would be required to pay litigation costs. The same rule would also

apply if the plaintiff appealed and received an identical or lesser award compared to that achieved in ADR.

Jury Verdict Responsibility

Any consumer knows how difficult it is to establish a budget. Juries today are asked to determine an award to an injured victim simply by guessing how that victim should be fairly compensated. Some have suggested requiring juries to itemize awards in the same way any budget is itemized in order to more accurately reflect the costs of the injury. These awards might be itemized to reflect specific medical expenses incurred to date, future estimated medical losses, days lost from work, etc.

Caps on Damages

Many have suggested placing limits on damages, specifically non-economic damages, such as pain and suffering or punitive damages. Recommendations include placing top dollar limits on specific types of non-economic damages or limiting these awards to a certain ratio of the economic damage award.

Apportionment of Damages

Joint and several liability, coupled with comparative negligence, can require a defendant to pay for the total cost of an injury, even if he is only slightly responsible. Some have recommended that the judge or jury determine the extent (percentage) to which each defendant would be held financially responsible for payment of an award. Those who support apportionment of damages believe this would allow for more flexibility within the system, without eliminating the ability of an innocent victim to be fairly and justly compensated for an injury.

Tort Reform: What You Can Do

In America, it is our right—some would argue our obligation—to make our voices heard. That's what makes democracy work.

There are various steps you can take to directly impact tort reform in your state:

- Write your legislator and request his/her opinion regarding tort reform in your state.
- Respond to the letter, indicating your support for or opposition to your legislator's stance.
- Use the media: When you see a story about tort reform in a newspaper or magazine, write a letter expressing your opinion on the subject. (This is one of the most effective methods of speaking directly to legislators.)
- Get involved in a grassroots organization which supports your stance on tort reform. Your local state representative should be able to help direct you to an appropriate group. If no such organization exists, consider starting one with others who share your opinions.

William M. McCormick recently presented a speech, titled "The American Tort System: A Time to Rebalance the Scales of Justice," in which he urged reform of the American tort system. Mr. McCormick, 45, is Chairman and Chief Executive Officer of Fireman's Fund Insurance Companies, a position he has held since 1983. He is also President of Fireman's Fund Corporation. Prior to joining Fireman's Fund, Mr. McCormick held various positions within American Express Company, where he rose to President of American Express Travel Related Services Company, Inc. He began his business career as a management consultant with McKinsey & Company, Inc. Mr. McCormick, who holds a Master's Degree in nuclear physics, served in the U.S. Navy as a lieutenant on the Atomic Energy Commission staff of Admiral H.G. Rickover.

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FIREMAN'S FUND
INSURANCE COMPANIES

ISSUES FOR DISCUSSION WITH RESPECT TO
CSSB 377 (JUDICIARY)

I. OVERVIEW OF JUDICIARY CS

Section 1. Includes "purpose" language explaining the motivation behind the legislation. The language was taken from the state of Washington's recent tort reform legislation.

Sec. 09.17.010. Non-economic damages. Explains what type of damages constitute non-economic damages.

Sec. 09.17.020. Punitive damages. Allows for an award of punitive damages with half of the award going to the plaintiff and half to the state's general fund. Attorney's fee awards will be based upon the entire punitive award.

Sec. 09.17.025. Damages incurred while intoxicated or committing a felony cannot be recovered by a plaintiff more than 50% responsible for his injuries.

Sec. 09.17.030. Itemized verdicts. Provides for the factfinder's itemization of damage awards. Apportions the total amoun between non-economic and economic categories, with furthe break-down in the economic category.

Sec. 09.17.040. Verification of claims. Either the party or his attorney must sign the complaint, counter-claim, cross-claim or answer submitted in an action and verify the truth of the allegations.

Sec. 09.17.050. Contributory fault. Codifies existing law regarding comparative fault.

Sec. 09.17.055. Collateral benefits. Provides that after a damage award, the defendant may provide the factfinder with evidence of the claimant's compensation for his injury from collateral sources lacking a right of subrogation. The claimant may then provide evidence of the amount of his attorney's fees and the premiums paid for the collateral source insurance coverage. The court will offset the excess collateral source income from the damage award.

Sec. 09.17.060. Apportionment of damages. Modifies the current common law rule of joint and several liability to limit a defendant's exposure to no more than twice the percentage of fault allocated to that party if he is less than 50% responsible for the total damage.

Sec. 09.17.070. Releases. Reduces any damage award by the amount a plaintiff receives from a settling defendant.

Sec 09.17.900. Definition. Defines the term "fault."

Section 3. Mandatory arbitration. Requires arbitration of tort claims seeking less than $75,000 in damages.

Section 4. Offers of judgement. Modifies prejudgment interest rules to provide for a 5% increase or decrease in the interest rate on a damage award if an offeree rejects a settlement offer and receives a less favorable judgment at trial.

Section 5. Prejudgment interest. Interest runs from date of accrual of the cause of action.

Section 6. Confirmation of award. Modifies the existing rule to account for the new arbitration requirement.

Section 7. Appeal of arbitration award. Provides the mechanism for appealing an arbitration award.

Section 8. Awards. Repeals existing collateral source rules and structured settlement rules.

Section 9. Review of attorney's fees. Provides for judicial review of a party's attorney's fees

Section 10. Attorneys' fees for arbitration awards. Provides for the award of attorney's fees for an appeal of an arbitration award if the prevailing party improves his award position by more than 10 percent.

Section 11. Superior Court jurisdiction. Provides superior court jurisdiction for appeals of arbitration awards.

Section 12. District court jurisdiction. Provides District Court jurisdiction for appeals of arbitration awards of less than $25,000.

Section 13. Right of contribution. Repeals existing law with respect to contribution among joint tortfeasors.

Sections 14 - 18. Rules of Civil Procedure. These sections amend the rules of civil procedure affected by the proposed legislation.

Section 19. Applicability. Specifies that all causes of action accruing on or after the Act's effective date are subject to sections 1 - 13 of the Act.

Section 20. Effective date. The Act takes effect immediately.

II. ISSUES UP FOR CONSIDERATION

A. Alternative dispute resolution.

1. Use of a "private judge" hired by the parties to resolve their dispute. Patterned after the California procedure.

2. Requirement of either mandatory arbitration or adjudication in small claims court of claims involving less than $75,000 in damages prior to initiating a court action. A trial de novo in District Court or Superior Court would be be available following the arbitration or small claims proceeding.

a. Modification of Rule 82. A party seeking a trial de novo would pay his opponent's attorney's fees and costs if he did not improve his position by more than 10% over the award in the initial proceeding.

2. Mandatory arbitration of contribution claims. Proposal to require defendants to arbitrate claims of contribution.

B. Collateral Sources.

1. Should this information be provided to the factfinder prior to the damage award?

2. Should all evidence of collateral source income be excluded from consideration by the factfinder in order to encourage responsible behavior such as self-insurance?

III. INSURANCE REFORM

1. eaningful tort reform can only be accomplished if comprehensive insurance reform is simultaneously undertaken.

a. Should a tort reform bill be passed in the absence of insurance reform?

2. Potential areas of reform.

a. Disclosure on a closed claim basis of all claims paid or settlements made with respect to the insurance of Alaska risks.

b. Insurance premiums based on the insured's claim history. Proposal that premiums should be higher for those with a history of

successful claims than for those who never seek payment on claims.

c. Notice of cancellation of policy. Proposal to extend notice period to 60 days prior to cancellation with immediate return of unused premiums.

d. Caps on increase in premiums. Proposal to limit the amount by which premiums may be increased in a given time period.

3. Alternatives to Traditional Insurance Coverage.

a. Should the state actively pursue alternative forms of risk management, e.g., the use of reciprocals and pooling arrangements?

- Should the legislature loan reciprocals funds to establish their required reserves initially?

b. Comprehensive state reinsurance program.

- CSHB 589 (L&C) proposes the establishment of state disability insurance.

SCOTT WETZEL SERVICES:

OUTSTANDING REHABILITATION CASES:
TOTAL CASES: 19

1981	1982	1983	1984	1985
2	1	2	9	5

AVERAGE COST PER CLAIMANT: $ 7,740 *

ALYESKA PIPELINE:

1984 & 1985 CASES
TOTAL CASES: 6

1984	1985
4	2

Average Cost 1984 =$3,250 Average Cost 1985 =$5,473.50

DIVISION OF WORKERS' COMPENSATION:

ALL REPORTED CASES

TOTALS	1982	1983	1984	1985
	270	224	94	10
AVERAGE COST	$3,804	$3,595	$2,907	$1,384

	Ending In 1982	Ending In 1983	Ending In 1984	Ending In 1985	Incomplete
1982 CASES Total = 270	16	87	63	39	65
	6%	32%	23%	14%	24%

	1983	1984	1985	
1983 CASES Total = 224	15	90	49	70
	7%	40%	22%	31%

	1984	1985	
1984 CASES Total = 94	17	33	44
	18%	35%	47%

	1985	
1985 CASES Total = 10	8	2
	80%	20%

SUCCESSFUL?

SCOTT WETZEL SERVICES:

NO.		PERCENTAGE
4	Successfuls	21%
7	Possibly Successfuls	
8	Unsuccessfuls	

ALYESKA PIPELINE:

All Cases Unsuccessful

DIV. OF WORKERS' COMPENSATION: **

NO.		PERCENTAGE
46	1982	17%
62	1983	28%
26	1984	28%

*SWS Manager reports rehab. cases running an average between $3,000 and $5,000.
**Based on "Returned to Work" and "Released for Work" codes.

CONSUMER ORGANIZATION

FOR IMMEDIATE RELEASE
August 15, 1985

For further information, contact:
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INSURANCE COMPANIES "ON STRIKE"
NADER/NICO CHARGE:
FEDERAL SOLUTION SOUGHT

Washington, DC, August 15 - Ralph Nader today charged the insurance industry with "going on strike to extort excessive rates from the public." Nader also said that states were "failing to adequately protect consumers and stop the hemorrhaging." He called for federal action to make insurance available when insurers "abdicate their responsibilities."

Nader was joined by ex-Federal Insurance Administrator Robert Hunter, President of the National Insurance Consumer Organization (NICO). Hunter, an actuary, released a major NICO study of insurer profitability, stating that: "While insurer profits were low last year, a modest rate adjustment of about five percent was all that was needed to gain an acceptable profit level. Instead, we see massive cancellations and price increases of up to 1000% for day care centers, municipalities, environmental clean-up firms, fishing fleets, transit authorities, nurse-midwives and others. This is an unjustified raid on peoples' pocketbooks and the states are letting them get away with it," Hunter charged.

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Good morning! I am Bob Hunter, President of NICO.

We are here this morning to discuss a mounting crisis in America, a crisis which involves every man, woman and child: the nation is losing its liability insurance. (See chart of headlines.) Day care centers are losing their insurance and are being forced to close, perhaps driving second breadwinners out of work or creating new latchkey children. Nurse-midwives are losing their insurance and the lower cost birthing centers are shutting down. Doctors are marching on state capitals because insurance is unavailable or costs have skyrocketed. Cities, Transit authorities, even whole states are losing their liability insurance. One of the leading auto insurers in the District of Columbia has pulled out. The list goes on and on.

And prices have skyrocketed. As this chart shows, the cost of insuring an auto in America has gone up at 9.1% for the first 6 months of 1985, exceeding the rate of change for all of 1984. 1/ The annualized rate of change is 18.2%

What is going on here? Are these practices of insurers justified?

The answer is "NO!" What we are witnessing is a manufactured crisis intended to bloat insurer profits and reduce victim's rights.

Property-Casualty insurance has a cyclical profitability, as this chart shows. 2/ In 1984, if you accept the insurer's whopping reserve increases as valid (quite a large leap of faith), they earned a 3% rate of return on net worth (equity). That is too low. It would indicate that their premiums were about 5% short. If their premiums had been 5% higher, they would have earned a rate of return on net worth of about 15%, more than enough for an industry of the low to average riskiness of Property/Casualty insurance. 3/

A five percent premium shortfall is not a crisis. Yet we see all of the cancellations and mammoth price increases such as:

- A 70% increase for OB/GYNs in Maryland (totally unjustified — per analysis, attached).
- 300% to 900% increases in lawyer and architect malpractice insurance premiums around the country.
- Increases of 200% to 500% for the day care centers who can get insurance. Many can't.
- 300% to 1000% increases for public transit authorities.

The statistics don't justify any of this!

What is going on?

If you look again at the cycle chart you will see that 1984 was a typical "bottom-of-the-cycle" year. The last time it happened was in the mid-1970's when I served as Federal Insurance Administrator. At that time, the country observed the twin crises of medical malpractice and product liability unavailability and skyrocketing premiums.

After insurers abandoned the medical and product manufacturer lines, the federal government reviewed the situation. I was fortunate to be part of the interagency working group that found that there was no justification for the insurer actions. 4/ We concluded that the insurers had just panicked from lack of data.

But look at what happened; their profits skyrocketed to all time record levels. They learned that the state regulators would, during the panic, give away the store in rate increases. They also learned that state legislators would act to reduce victims' rights in the wake of the panic (over half the states did so 5/).

They are applying the lessons they learned in the mid-1970's very well today -- to day care centers, to nurse-midwives, to doctors, to product manufacturers, and so on. They are petitioning Congress for product liability tort law changes and the states for changes in other tort systems.

Some property/casualty officials have made statements in the public record that; "It is right for the industry to withdraw and let the pressures for reform build in the courts and in the state legislatures." (Journal of Commerce, 6/18/85) Reinsurance, a critical aspect of maintaining available and affordable insurance rates may not be available from overseas because syndicates would "simply not write reinsurance for the American casualty industry" in 1986. A representative of that overseas market was recently reported to have said that if a new policy form is not adopted by state regulators, reinsurance wouldn't be provided to American liability underwriters.

Wall Street knows what is going on. This chart shows that the property/casualty stocks have soared to record highs more than doubling the Dow Jones Industrial Average rise in 1985. 6/ Wall Street expects state regulators to allow excessive rate increases; Wall Street is right!

Insurers blame this crisis on the courts and the tort law and say the only way to fix it is to take away as many victims' rights as possible. They can point to such statistics as these:

> Of 23 insurers riting liability insurar for day care centers in Maryland last year, 15 have left the market. Of the remaining 13, six will not write any new business. The last 7, those who will write new business, all have excluded child abuse from their policies. The Maryland Commissioner of Insurance has termed the pull out "hysteria" since no data supports it. 7/

Insurers will say this points to the need for tort reform, 8/ while admitting that data don't justify the action. 9/ I believe it shows joint action intend to create an atmosphere where rates can be put too high and legislators will be intimidated into action designed to take away victims' rights. Further, at the top of the cycle a few years ago, the now-dreaded liability insurance prices were being slashed wildly and even being sold after the insured event happened, such as in the case of the MGM Grand Hotel fire where liability coverage was written months after the fire. 10/ If tort reform was so desperately needed in 1974 and 1975, why not in 1981? Why again today? The crisis is within the insurance industry, not in the courts.

Now, insurance premiums represent 11.1% of the disposable income in this country. 11/ It is the fourth leading purchase Americans make (behind food, housing and federal income taxes, although we expect it to pass federal taxes this year).

In 1944, the Supreme Court found that insurance was interstate commerce and, thus, subject to anti-trust and other federal statutes. In 1945, under heavy insurer pressure, Congress passed the McCarran-Ferguson Act which uniquely exempts insurance from the federal anti-trust laws (except should intimidation, coercion or boycott occur). Congress delegated the authority to regulate insurance to the states with no standards for regulatory excellence and no ongoing congressional oversight. Indeed, the FTC cannot even study insurance under current law 12/ unless Congress specifically authorizes it in advance. (Their power was revoked because they had the audacity to point out that whole life insurance was not a wise purchase for most Americans. The fact that the FTC was right did not alter their fate.)

The immensely important McCarran-Ferguson Act was adopted by Congress without benefit of a hearing. The legislative history makes it clear that President Roosevelt wanted only a short, two or three-year moritorium after which anti-trust laws would fully apply. 13/ That is, in fact, what both houses of Congress adopted but their language was somewhat different, requiring a conference. Mysteriously, the conference committee reported back a bill that continues in effect today.

Every independent study of insurance concludes that the states have failed mysteriously in their attempts to regulate this giant industry. 14/

The states have allowed this crisis to happen. Had they been equipped to keep prices to statutory standards (all states require that the rates be "not excessive, not inadequate, not unfairly discriminatory") we would not be in the mess we are in today with clearly excessive prices going into effect routinely around the nation and unfair cancellations rampant.

What Should We Do?

(1) We call today upon Congress to review the McCarran-Ferguson Act to determine if it is working to protect America. The quality of state regulation is documented to be inadequate; the insolvency funds are a "Maryland S&L Crisis Waiting to Happen." Congress should act now.

(2) NICO also believes that the approach enacted at a previous bottom, 1968/9 is worthy of consideration by the Congress: The Urban Property Protection and Reinsurance Act of 1968 was a response to the unavailability of insurance in the inner cities in the wake of the riot situation of the late 60's. 15/

To be sure, the predicate for the withdrawal of riot insurance was strong, given the very serious situation extant in the country at the time. But the finding of the President's Panel on the Insurance Crisis is just as valid for the day care provider community today as it was for the inner city communities of the late 60's: "Communities without insurance are communities without hope." 16/ Providers will have to shut down, possibly forcing spouses to decide among themselves which one will have to stop working, or the latchkey situation will be exacerbated, or other undesirable results will be forced on parents. Some families may even have to give up a home for loss of the second income, situations not unlike the loss of mortgage following loss of insurance in inner city areas plagued by riot almost two decades ago.

The federal government agreed to reinsure (insure the insurance companies — a sort of lay-off bookie arrangement) the insurers against the specified peril of riot and civil commotion in return for a reinsurance premium and a commitment to participate in a pool to make sure insurance is available to all residents whose homes met reasonable standards of insurability.

The federal government made $125 million writing this reinsurance!

The cities were saved from the sure death that no insurance brings in twentieth century America!

The program worked well.

I think that a program of stand-by authority should be prepared to take care of the day care and nurse-midwives current problem (and, perhaps some of the others). The authority should be granted to cover future crises as well, to stabilize the insurance profit cycle's harsh symptoms.

When a line of insurance became severely distressed, representatives of those purchasers could appeal to the agency given authority to reinsure. The agency would make a finding as to the extent and cause of the dislocation. If a distressed situation is certified, then the agency could offer reinsurance to insurers who would agree to make a market in the line. Following meetings with the insurers, the agency head would determine what the cause of distress was and would offer only to reinsure that cause (e.g., only reinsure the peril of child abuse for day care liability if that is the finding). Insurers would pay a reinsurance premium designed to be self-sufficient.

Insurers, the administrator of the program and representatives of the distressed industry would meet to set standards for insurability under which those who qualify are assured of an insurance market.

Studies will be undertaken to determine if other longer range action (risk management, tort reform, etc.) is also needed to resolve underlying problems.

Funding for this program would come from reinsurance premiums. I also envision a small surcharge, perhaps one-quarter of one percent of premiums written by all p/c insurers, to back up the program. This is in case premiums are insufficient over a short period or if it is determined by Congress that some short term subsidy is required to stabilize a distressed line sometime in the future.

The one-quarter of one percent surcharge would cost only 81 cents on the average private passenger car premium but would yield over$300 million this year. Over a ten year cycle, with a 10% growth in premiums and a 10% interest rate, $7 billion would flow into the Treasury. I would envision these funds being used in the general revenue area, but carefully accounted for to be available to the agency head when needed.

(3) Finally, NICO has today asked the Department of Justice to review the evidence to see if a conspiracy to boycott insureds has occurred in Day Care insurance and other lines, the intent of which is to intimidate state regulation into granting excessive rate increases and to intimidate state and federal legislators into passing unjustified tort law modifications which will maximize insurer profit levels.

Such boycotts and intimidations are not exempt from federal review under the provisions of the McCarran-Ferguson Act.

Conclusion

America deserves a better deal on its insurance. The federal government cannot sit idly by and let the insurance industry hold day care providers hostage in a large game beyond the providers' control. The terrorist tactics of insurers every 10 years at cycle bottom must be dealt with in a systematic way that adds the stability to our economy that insurance is meant to deliver. It is time the Congress began to look at the delegation it made to the states in 1945 to see if we are, as a nation, getting the most we can out of that twelve percent of our disposable income we pay into insurance premiums. A good place to start is solving the day care crisis that exists only in the minds of a few underwriters on John Street in New York City.

FOOTNOTES

1/ CPI data on "auto insurance", Bureau of Labor Statistics.

2/ Source of data: Citybank Economics and Insurance Services Office.

3/ For a discussion of risk in the property/casualty insurance business, see Investment Income and Profitability in Property/Casualty Insurance Ratemaking, J.R. Hunter and J.W. Wilson, 1983, Chapter 5.

4/ Hearing on December 3, 1975, Subcommittee on Health of the Committee on Labor and Public Welfare, US Senate. Among the interesting data supplied by ISO at that hearing were exhibits that showed that the average claim cost ISO used for ratemaking significantly exceeded the limit of liability, clearly ratemaking that had run amok. That led to this exchange:

Sen. Laxalt: Is malpractice always a loser as far as carriers are concerned?

Mr. Hunter: If they charge these rates, they could not help but win. (Page 141.)

In John Guinther's book, The Malpractitioners, Anchor Press, 1978, Guinther cites this exchange at page 169 in a chapter entitled "They Could Not Help But Win." In the following chapter, called "They Won," Guinther reviewed the later experience.

Final Report, Prodt : Liability Task Force. eport on Product Liability Ratemaking, Product Liability and Accident Compensation Task Force, US Department of Commerce, 1980. At page ix the Report states that "overly subjective ratemaking practices were one of the principal causes of the product liability insurance problem."

5/ St. Louis Post Dispatch, Section B, P.3, 4/14/84.

6/ Source of data: Best's Property/Casualty Stock Index, A.M. Best and Company, Oldwick, NJ.

7/ "The day care facilities have been caught up in this availability crunch and are being deemed higher risk, not necessarily based on a claims experience but due more to an insurance hysteria . . ." Testimony of Edward J. Muhl, Insurance Commissioner of the State of Maryland, before the House Select Committee on Children, Youth and Families, July 30, 1985.

8/ "Any permanent solution (of the day care insurance crisis) will require significant changes in the tort system." Testimony of Frank Neuhauser, Vice-President and Actuary for AIG (a leading insurer of day care centers) before the House Select Committee on Children, Youth and Families, July 30, 1985.

9/ "The countrywide experience for those companies reporting premium and loss data to the Insurance Services Office . . . appears to conform with the current loss experience for the majority of commercial insurance lines . . . (these data) do not suggest that insurers should abandon the market." Testimony of James L. Kimble, Senior Counsel, American Insurance Association, before the House Select Committee on Children, Youth and Families, July 30, 1985. The testimony was also endorsed by the Alliance of American Insurers.

10/ See, for instance, the National Underwriter, 11/20/81, page 1, where it says:

> A large commercial umbrella (liability) risk came up for renewal and was rated at $105,000, about the same as the previous year. But the insured was not satisfied. Aware of the aggressive rate competition in the commercial lines market today, he decided to shop around. He approached a second agent, who submitted the very same risk to a different company, which offered to write it for just $20,000.
> But the insured was still not happy. He continued shopping and eventually the original company, which originally wanted $105,000 came back and took the business for $5,000. That's right, $5,000. (Emphasis added.)

11/

Item	1984 Amount Spent in Billions a/	Column (1) - 1984 Disposable Income of $2,578.1 Billion a/
Food	444.3	17.2%
Housing	397.8	15.4
Personal Income Taxes	302.6	11.7
INSURANCE b/	287.1	11.1

a/ Source: US Department of Commerce, Bureau of Economic Analysis.
b/ Source: Bests Management Reports, December 31, 1984, page 1.
Life Insurance Fact Book, page 56.
Blue Cross Association, Telephone call of 1/25/85.

12/ The law was euphemistically entitled the "FTC Improvements Act of 1979."

13/ See Statement of Honorable Claude Pepper before the Subcommittee on Monopolies and Commercial Law on the Insurance Industry's Antitrust Exemption, April 11, 1984; found at page 5 of the Subcommittee's report, Competition in the Insurance Industry.

14/ See, for instance, Issues and Needed Improvements in State Regulation of the Insurance Business, General Accounting Office, 1979; Invisible Bankers, Andrew Tobias, Linden Press, 1982; The Life Insurance Game, Ronald Kessler, Holt, Rinehart and Winston, 1985; "Protection for Sale: The Insurance Industry," NBC-TV Nes, 1981; Risk, Reality and Reason, the Conference of Insurance Legislators, September, 1983.

One of the tests of state preparedness to deal with a crisis in availability and pricing of liability insurance is actuarial staff. Of the 52 states (including DC and Puerto Rico) NICO surveyed, we find that 26 have actuaries. So one-half of the states have no actuaries at all.
There are 62 actuaries employed by the states, of the 7,682 actuaries in the nation. It is well known in the industry that those best suited to deal with matters pertaining to liability insurance are those who have passed the examinations enabeling them to be "Fellows" in the Casualty Actuarial Society. State regulation has only 8 such persons. They are employed by only 5 states [Connecticut (1), Massachusetts (1), Michigan (1), New Jersey (1) and New York (4).]
Aetna Life and Casualty Insurance Company alone employs 126 actuaries. Travelers has 100.

Source of data: American Academy of Actuaries 1985 Yearbook and Directory of Members by Business Affiliation.

15/ Public Law 90-448, 82 Stat. 476; 12 U.S.C. 1749bbb, 42 U.S.C. 4011.

16/ Meeting the Insurance Crisis of Our Cities, A report of the President's National Advisory Panel on Insurance in Riot-Affected Areas, January, 1968, p. 1.

NATIONAL INSURANCE CONSUMER ORGANIZATION

5 Rocky Mt. States Lose Liability Cover

6/27/85

Midwives Facing Uphill Battle

Loss of Insurance

Insurance Premiums Sink Fishing Fleet

7/5/85

Transit System Faces Liability Shortage

7/4/85

The loss ratio for public transportation systems has remained constant, yet members are experiencing premium increases from 300 percent to 1,000 percent.

Fireworks Makers Face Loss of Insurance

7/2/85

Day Care Insurance Imperiled

Policies Canceled

House Hearing 'Is

Rate hikes, capacity crunch seen with July 1 renewals

7/1/85

THE 1985 INSURANCE CRISIS

WHAT'S GOING ON HERE?

Auto Insurer To Discontinu Service in D.C.

7/10/85

Risky Business

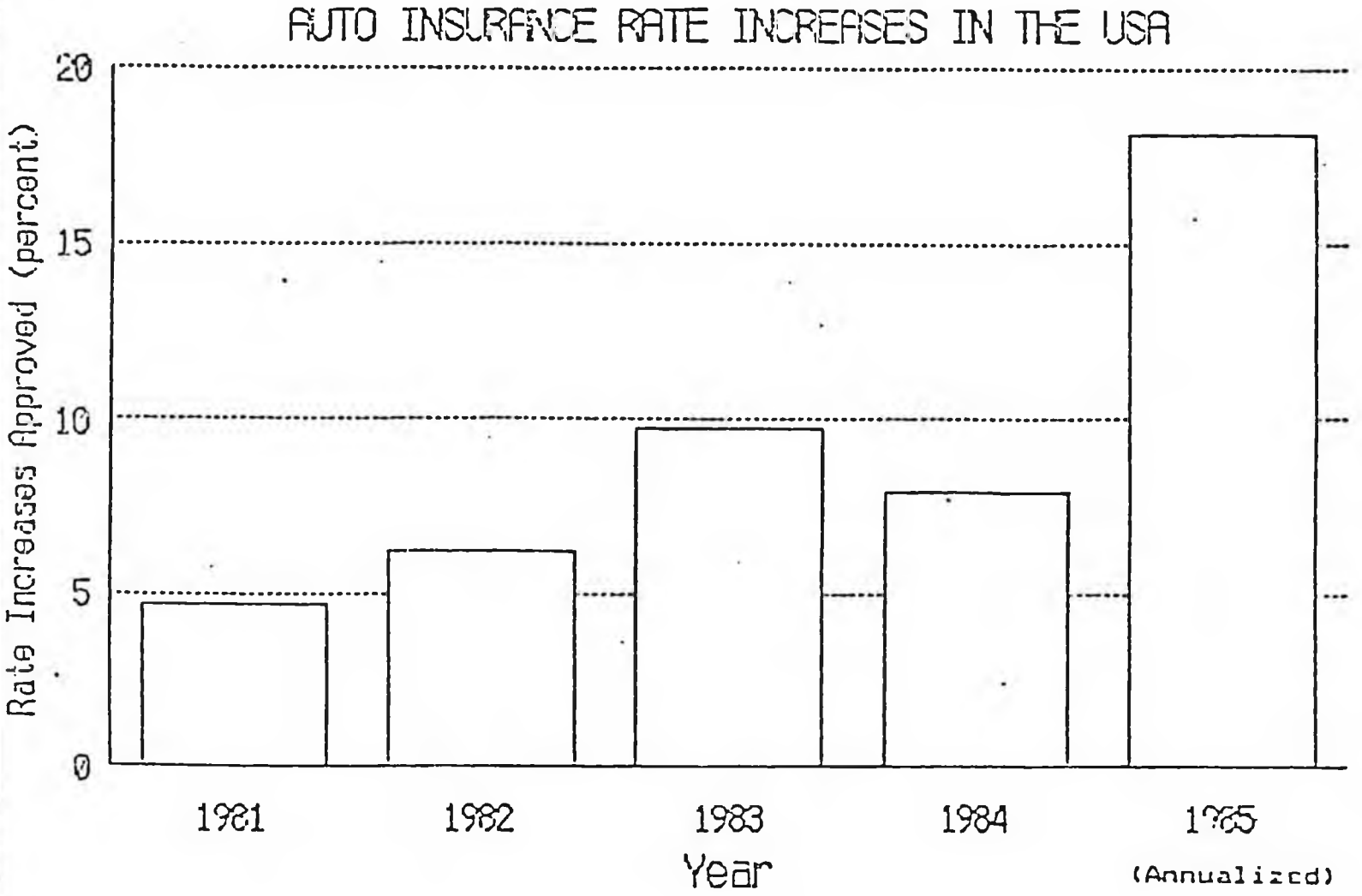
Liability Insurance Is Difficult to Find Now For Directors, Officers

7/10/85

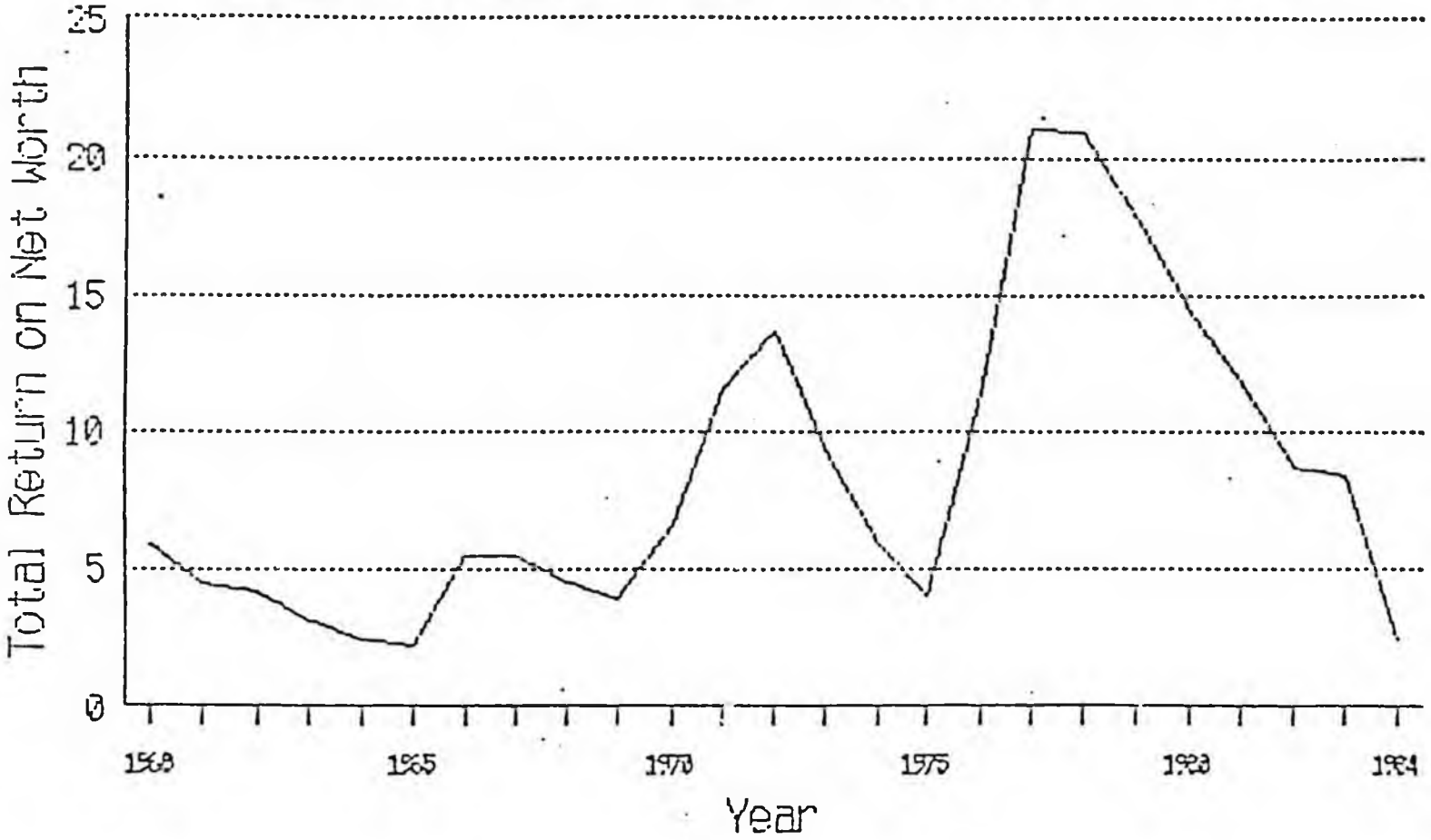
Suits by Shareholders Cause Premiums to Skyrocket.

The worst is yet to come, reinsurers, brokers predict

By DOUGLAS Hood 7/5/85


AUTO INSURANCE RATE INCREASES IN THE USA
Rate Increases Approved (percent)
20
15
10
5
0
1981
1982
1983
1984
1985
Year
(Annualized)

THE "CYCLE" AND CONSUMER ABUSE



CITIZENS COALITION ON TORT REFORM, INC.

One of the gravest problems facing individuals, governments and businesses in Alaska today is the dramatic rise in liability premiums. At the present time the problem is compounded by a variety of factors. While insurance premiums are being increased, many insurance companies are pulling back from servicing policies in Alaska. The risks, especially in the Bush, are too great. Legislative remedies are needed. Following is a summary of proposals from the CITIZENS COALITION ON TORT REFORM INC.

1. CAP NON-ECONOMIC AWARDS

Non-economic awards compensate a victim for pain and suffering, loss of consortium and other intangible losses. A cap will establish consistency and result in predictable insurance programs. We suggest a maximum award of $250,000.

A recent United States Supreme Court decision allowed California to impose a limit of $250,000.

BOLLIO V ELLIOT

2. MANDATE STRUCTURED SETTLEMENTS

Structured settlements provide future payments to the victim equal to the total award. The future payments are consistent with the victim's loss.

3. DISCLOSE COLLATERAL INCOME SOURCES

Juries currently are not allowed to know when a victim has insurance coverage and has already been compensated. Accordingly that coverage is ignored in Jury awards.

4. SET A SLIDING SCALE OF ATTORNEY'S CONTINGENT FEES

A sliding scale will increase the proportion to the victim as the amount of the award increases. Current practice allows an attorney a set percentage irrespective of the amount of the award.

The California sliding scale has been upheld as constitutional.

5. MODIFY JOINT AND SEVERAL LIABILITY

Several liability will apportion responsibility in accordance with degree of fault. Under current practice of Joint and Several liability, anyone at fault may be subject to the total liability.

6. REQUIRE ITEMIZATION OF ALL JURY AWARDS

The jury should make its award for damages with specific amounts. Damages will be itemized so as to reflect the monetary distribution among economic losses, non-economic loss, future losses, past expenses and other losses as applicable.

Similar legislation has been adopted by the State of Illinois in May of 1985.

7. ABOLISH RULE 82

This eliminates an additional expense. Current practice allows juries to make an award for damages which includes attorney's fees. Under Rule 82, the court can add up to 10% of the award for attorney's fees. (An attorney can claim and receive up to 10% of the settlement even if the case does not go to court.)

8. MODIFY PREJUDGEMENT INTEREST

Interest should accrue from the time of award or first offer of settlement. Current practice allows for interest to accrue from time of occurance. This will eliminate an unreasonable expense.

How Know Time of Filing?

9. REVISE WRONGFUL DEATH STATUTE

A cap on wrongful death awards where there are no legal dependents will eliminate unreasonable expenses. The maximum benefit payable for wrongful death, in instances of no surviving dependents, should be limited to $25,000.

Similar legislation exists in Montana.

10. PUNITIVE DAMAGES

Awards for punitive damages should accrue to the benefit of society as a whole, ie., the State of Alaska.

11. Statute of Limitations

The current statutes of limitation should be modified to insure that they are applicable to a reasonable time certain. Recent interpretations open the individual to liability to an indefinite time future. The result is total unpredictability and unlimited exposure is an uninsurable risk.

12. REQUIRE AN AFFIDAVIT OF MERIT

As a condition of filing a complaint, the plantiff's attorney; must certify there is reasonable and meritorious cause of filing the action. The plantiff's attorney must certify that he has consulted and reviewed the facts with a competent authority and has determined there is reasobnable and meritorious cause for filing the action.

Similar action has been adopted by the State of Illinois in May of 1985.

13. SPECIAL DAMAGES IN COUNTERCLAIMS

Eliminate the requirement to show special damages. This will require the plantiff's attorney to be held to the same standard of care principles required of other professionals.

14. EXPERT WITNESSES

Strict guidelines must be established for expert witness standards including current experience, substantial portion of his or her time currently involved in the practice and demonstration of a knowledge of the state of the art. Currently there are some expert witnesses whose sole practice is being an expert witness.

15. UNTRUE ALLEGATIONS

Legislation is needed to permit award of attorney's fees and payment of reasonable expenses from parties making untrue allegations without reasonable cause.

Currently there is no prohibition to plantiffs making allegations which are untrue. Similar legislation has been adopted by the State of Illinois in May of 1985.

16. MANDATORY ARBITRATION

Contracts shall provide for mandatory arbitration. The law should provide for judicial review of the arbitration hearings. In the event the mandatory arbitration is substantially upheld, the party requesting the judicial review shall assume all costs and fees related to the appeal.

OTHER SIGNIFICANT ISSUES

Provision for early dismissal of uninvolved parties by filing an Affidavit of Non-Involvement.

Require release of records prior to the institution of a suit.

Mandate advance notice of at least 60 days prior to the cancellation of insurance and provide for a timely return of unearned premiums.

Require disclosure of settlement information to licensing authority.

Provide reasonable immunity in anti-trust suits, except in the instance of malice and provide penalities for frivolous suits.

Make provision for review of professional activities by professional society.

Require all disciplinary actions by any professional group duly consistituted to be reported to licensing authority.

Limit application of strict liability.

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TESTIMONY OF

J. ROBERT HUNTER
PRESIDENT
NATIONAL INSURANCE CONSUMER ORGANIZATION

BEFORE THE
ALASKA LEGISLATIVE CONFERENCE

THE LIABILITY CRISIS IN INSURANCE

ANCHORAGE, ALASKA
DECEMBER 6, 1985

121 N. Payne Street
Alexandria, Virginia 22314
(703) 549-8050

OVERVIEW

We are here today to discuss a mounting crisis among small businesses and across America, a crisis which involves every man, woman and child: the nation is losing its liability insurance. Day care centers are losing their insurance and are being forced to close, perhaps driving second breadwinners out of work or creating new latchkey children. Nurse-midwives are losing their insurance and the lower cost birthing centers are shutting down. Doctors are marching on state capitals because insurance is unavailable or costs have skyrocketed. Cities, transit authorities, even whole states are losing their liability insurance. One of the leading auto insurers in the District of Columbia has pulled out. The list goes on and on.

And prices have skyrocketed. For example, the cost of insuring an automobile in America has gone up at a 9.1% rate for the first 6 months of 1985, exceeding the rate of change for all of 1984. 1/ The annualized rate of change is 18.2%, a record dollar change.

What is going on here? Are these practices of insurers justified?

The answer is "NO!" What we are witnessing is a manufactured crisis intended to bloat insurer profits and reduce victims' rights.

Property-Casualty insurance has a cyclical profitability, as Chart Number 1 shows. 2/ In 1984, if you accept the insurer's whopping reserve increases as valid (quite a large leap of faith), they earned about a 3% rate of return on net worth (equity). That is too low. 3/ It would indicate that their premiums were about 5% short. If their premiums had been 5% higher, they would have earned a rate of return on net worth of about 13%, more than enough for an industry of the low to average riskiness of Property/Casualty insurance. 4/

A five percent premium shortfall is not a crisis. Yet we see all of the cancellations and mammoth price increases such as:

- A 70% increase for OB/GYNs in Maryland (totally unjustified -- per analysis, attached as Exhibit I).
- 300% to 900% increases in lawyer and architect malpractice insurance premiums around the country.
- Increases of 200% to 500% for the day care centers who can get insurance. Many can't.

- 300% to 1000% increases for public transit authorities.

- One Northeastern state's liability insurance was $100,000 for $100 million of coverage last year. This year it's $400,000 for $3 million in coverage. Last year, it cost $1.00 per $1000 of coverage; this year it is $1.00 for $7.50 of cover.

The list goes on and on, but the statistics don't justify any of this!

What is going on?

THE LAST CYCLE BOTTOM - 1974/5

If you look again at the first chart you will see that 1984 was a typical "bottom-of-the-cycle" year. The last time it happened was in the mid-1970's when I served as Federal Insurance Administrator in the Ford Administration. At that time, the country observed the precise phenomena we see today. As a Washington Post editorial of November 3, 1976 put it:

> It is becoming increasingly apparent that liability insurance -- or the lack of it -- is becoming a national problem. . . . The rates charged those in professions other than medicine, most notably architects, are rising rapidly. Local governments are finding that it is increasingly difficult or expensive to buy insurance covering their police departments. And because of the price now placed on it, many small companies are dropping the product liability insurance they th ought they needed. . . .
>
> It is no doubt true that the increasing number and size of judgments against police departments for false arrest or mistreatment of prisoners have had some salutory effects on police behavior. Similarly, malpractice suits have provided an incentive for more careful medical care, and product liability suits have forced manufacturers to produce better and safer products. But there must be some limit to all this, and we suspect it has been passed. The real beneficiaries of this litigation explosion have been the lawyers. . . . There has to be a better way of compensating those to whom reparations are due than the clumsy and expensive mechanisms that exist today. The legal ingenuity that created the present problem is going to have to be used to solve it. Otherwise, the whole system of liability insurance and of personal liability for wrongdoing is going to collapse of its own weight.

After insurers abandoned the medical and product manufacturer lines, the federal government reviewed the situation. I was fortunate to be part of the interagency working groups that found that there were no justifications for the insurer actions. 5/ We concluded that the insurers had just panicked from lack of data.

But look at what happened; their profits skyrocketed to all time record levels. Insurers learned that the state regulators would, during the panic, give away the store in rate increases. Insurers also learned that state legislators would act to reduce victims' rights in the wake of the panic (over half the states did so 6/). The fact that insurers achieved much of their 1975 legislative agenda and now are back for a bigger bite from the apple is very significant. Now, medical professionals want caps on overall and non-economic damages and municipal governments (and especially insurers!) are seeking elimination of joint and severable libility and punitive damage awards. Where will this raid on victims' rights end?

They are applying the lessons they learned in the mid-1970's very well today -- to day care centers, to nurse-midwives, to doctors, to product manufacturers, and so on. They are petitioning Congress for product liability and medical malpractice tort law changes and the states for changes in other tort systems.

THE HEAT IS ON

Some property/casualty officials have made statements on the public record that; "It is right for the industry to withdraw and let the pressures for reform build in the courts and in the state legislatures." 7/ Reinsurance, a critical aspect of maintaining available and affordable insurance rates may not be available from overseas because syndicates would "simply not write reinsurance for the American casualty industry" in 1986. A representative of that overseas market (Lloyd's of London) was recently reported to have said that if a new policy form is not adopted by state regulators, reinsurance wouldn't be provided to American liability underwriters. When I recently testified before the Maryland Governor's Special Medical Malpractice Committee, a medical malpractice insurance company executive told the committee that higher rates for ob/gyns in Maryland were put into their filing because the reinsurer required it, not because the rates were actuarily justifiable (which they weren't).

Wall Street knows what is going on. Chart Number 2 shows that the property/casualty stocks have soared to record highs more than doubling the Dow Jones Industrial Average rise for 1985. Through November 20, 1985, the Best's Property/Casualty Stock Index was up by 44% compared with a 20% Dow Jones increase.8/ Wall Street expects state

regulators to allow excessive rate increases; Wall Street is right! At the end of the first six months of 1985, the surplus of insurers has skyrocketed by $8 billion, over the year earlier figure, a growth of 13.4%. 9/

Insurers blame this crisis on the courts and the tort law and say the only way to fix it is to take away as many victims' rights as possible. They can point to such statistics as these:

> Of 28 insurers writing liability insurance for day care centers in Maryland last year, 15 have left the market. Of the remaining 13, six will not write any new business. The last 7, those who will write new business, all have excluded child abuse from their policies. The Maryland Commissioner of Insurance has termed the pull out "hysteria" since no data supports it. 10/

Insurers will say this points to the need for tort reform, 11/ while admitting that data don't justify the pull out. 12/ In New Jersey, at a hearing where ISO requested the new claims made form, the ISO could not say how many million dollar CGL type claims there were in recent years, nor what percentage of claims paid were in suit last year. Iowa Insurance Commissioner and NAIC president, Bruce Foudree says that "regulators cannot trust annual statements and quarterly financial data. We [regulators] will therefore need to get tougher and spend more time looking over companies' shoulders. We cannot tolerate falsification or deception on annual statements." 13/

I do not believe that there is a tort crisis across the nation, I believe we are witnessing joint action by insurers intended to create an atmosphere where rates can be put too high and legislators will be intimidated into action designed to take away victims' rights and to allow wrongdoers to go unpunished. It was no accident that A.H. Robbins tried to piggyback onto federal tort "reform" to be excused from its misdeeds.

At the top of the cycle a few years ago, the now-dreaded liability insurance policy rates were being slashed wildly and even being sold after the insured event happened, such as in the case of the MGM Grand Hotel fire where liability coverage was written months after the fire. 14/ Chart #3, labeled the "National Insurance Strike," shows the effect of rate cutting during 1981 and 1982 upon the profit levels of insurers. As you can see, the insurers cut about $1.5 billion in premiums over this interval and the resulting impact upon insurers profits was vastly significant---they plummeted. Chart #4 shows the profit levels insurers would have enjoyed had insurers not cut their premiums, but only maintained them at 1981 levels. Chart #4 shows great disparity between actual profits and those able to have been

realized had insurers simply held the line on premiums. Obviously, if premiums were increased at the same level as, say, the Consumer Price Index, insurer profits could have been even higher than the levels indicated in Chart #4. The national problem of insurer profits is clearly and convincingly self-inflicted.

If tort reform was so desperately needed in 1974 and 1975, why not in 1981? Why again today? The crisis is within the insurance industry, not in the courts.

When insurance trade association representatives talk to legislators, they point their fingers at the tort system for all their financial ills. But, amongst themselves, insurance association representatives and insurance company executives are more honest and admit their culpability for the current capacity crunch. A recent report put out by the Insurance Services Office (ISO) and the National Association of Independent Insurers (NAII) concluded that:

> The property/casualty industry must accept the major responsibility for its current financial condition. But, the brutal price war of the last six years is over. The industry has finally realized that a business cannot indefinitely price its product below cost and expect to survive. 15/

Now, we are asked to take the insurance industry's word that there is a tort problem and that limits on pain and suffering or on overall damages must be imposed so that rates will go down. All the evidence so far indicates that such caps have no effect on rates whatsoever.

Virginia has had limits on medical malpratice damages for years, but I was still called to testify before the legislature this year about insurance problems. Pennsylvania enacted one of the most restrictive immunity acts on record for its political subdivisions in 1978. 16/ Yet, despite those limits, Pennsylvania has another "crisis" in municipal liability insurance. A recent national study of the impact of "reforms" after the last crisis showed that caps on pain and suffering in medical malpractice cases have had no statistically measurable impact upon premium increases. 17/

I have done a lot of work in North and South Carolina as a consultant to the state governments. I am convinced that the degree of litigeousness in the Carolinas is low, significantly below that of other states where I work, for example. Such actuarial calculations as the loss development and the ratio paid to incurred losses, which I use for investment income purposes, make it crystal clear that, if there is a tort problem in this nation, it has not manifested itself in these states.

Yet, South Carolina has had to issue emergency regulations requiring no mid-term cancellations and 30-day notice of non-renewal price increases. If the crisis were truly tort based, South Carolina would not have to undertake such action. The fact that South Carolina insureds are feeling the same "hit" as the other states is stong evidence that the law is not causing the crisis, but rather that it is a creation of insurers.

In plain English, what the insurers propose in so-called "tort reform" hasn't worked and won't work. The evidence points overwhelmingly to a substantial insurance problem, both in the regulation and management of the property/casualty industry.

Insurance premiums represent 11.1% of the disposable income in this country. 18/ Insurance is the fourth leading purchase Americans make (behind food, housing and federal income taxes, although we expect it to pass federal taxes this year). Insurance rates have grown at an 18% rate for the first six months of 1985. If we are to see any relief, specific steps will have to be taken at both the state and federal level to end this insurance company misbehavior.

ALASKA'S EXPERIENCE

As great as things have been over the last cycle for the property/casualty insurers nationally, it is greater in Alaska. Over the last cycle, the operating income of insurers in Alaska was more than double that of the nation as a whole. Think of it, the profits in the nation were excessive, leading to a stock market performance of about four times the Dow Jones, yet Alaska's profit was twice the nation's; three times in private passenger auto insurance.

Perhaps you should look into your Insurance Division instead of into the tort law. In the 1981 Private Passenger Auto and Homeowner's Insurance, A Statistical Analysis published by the Division of Insurance, there was a discussion of the fact that Alaska had the lowest loss ratio in the country, indicating the highest profits for insurers, the least competition and the least efficiency. The Analysis said:

> The fact that Alaska ***enjoyed*** this position ***for the past three years*** is indicative of a ***healthy trend, one we hope to see continue*** . . . ." (Emphasis added.)

How's that for consumer protection?

THE MCCARRAN-FERGUSON ACT

In 1944, the Supreme Court of the United States found that insurance was interstate commerce and, thus, subject to anti-trust and other federal statutes. In 1945, under heavy insurer pressure, Congress passed the McCarran-Ferguson Act which uniquely exempts insurance from the federal anti-trust laws (except should intimidation, coercion or boycott occur). Congress delegated the authority to regulate insurance to the states with no standards for regulatory excellence and no ongoing congressional oversight. Indeed, the Federal Trade Commission (FTC) cannot even study insurance under current law 19/ unless Congress specifically authorizes it in advance. (FTC's power was revoked because they had the audacity to point out that whole life insurance was not a wise purchase for most Americans. The fact that the FTC was right did not alter their fate.)

The immensely important McCarran-Ferguson Act was adopted by that earlier Congress without benefit of a hearing. The legislative history makes it clear that President Roosevelt wanted only a short, two or three-year moritorium after which anti-trust laws would fully apply. 20/ That is, in fact, what both houses of Congress adopted but their language was somewhat different, requiring a conference. Mysteriously, the conference committee reported back a bill that continues in effect today; an infinite moritorium.

Every independent study of insurance concludes that the states have failed miserably in their attempts to regulate this giant industry. 21/ The states have allowed this crisis to happen. Had regulators had the political will and been properly equipped to keep prices to statutory standards (all states require that the rates be "not excessive, not inadequate, not unfairly discriminatory") we would not be in the mess we are in today with clearly excessive prices going into effect routinely around the nation and unfair mid-term cancellations, coverage and price changes rampant.

WHAT SHOULD CONGRESS DO?

(1) NICO has called upon the Judiciary Committees of the US Senate and House to review the McCarran-Ferguson Act to determine if it is working to protect America. The quality of state regulation is documented to be inadequate; the insolvency funds are a "Maryland S&L Crisis Waiting to Happen." I do not call for the elimination of state regulation here as some insurers recently have. I believe that federal standards for state regulation, coupled with federal oversight on a continuing basis, are needed. Further, the federal government should take over the insolvency funds, making them an FDIC-type operation.

(2) NICO also believes that the approach enacted at a previous bottom, 1968/9 is worthy of consideration by Congress: The Urban Property Protection and Reinsurance Act of 1968 was a response to the unavailability of insurance in the inner cities in the wake of the riot situation of the late 60's.22/

To be sure, the predicate for the withdrawal of riot insurance was strong, given the very serious situation extant in the country at the time. But the finding of the President's Panel on the Insurance Crisis is just as valid for the day care provider community today and others losing coverage as it was for the inner city communities of the late 60's when the panel found that; "Communities without insurance are communities without hope." 23/

In the riot insurance crisis, the federal government agreed to reinsure (insure the insurance transactons of the insurance companies -- a sort of lay-off bookie arrangement) the insurers against the specified peril of riot and civil commotion in return for a reinsurance premium and a commitment to participate in a pool to make sure insurance is available to all residents whose homes met reasonable standards of insurability.

The federal government made $125 million writing this reinsurance!

The cities were saved from the sure death that being uninsured brings in twentieth century America!

I think that a program of stand-by authority should be prepared to take care of the day care and nurse-midwives current problem (and, perhaps, some of the others). The authority should be granted to cover future crises as well, to stabilize the insurance profit cycle's harsh symptoms. I have provided a copy of a draft bill to establish such a program to your staff.

Insurers, the administrator of the program and representatives of the distressed industry would meet to set standards for insurability under which those who qualify are assured of an insurance market.

Studies will be undertaken to determine if other longer range actions (risk management, insurance reform, etc.) are also needed to resolve underlying problems.

Funding for this program would come from reinsurance premiums. I also envision a small surcharge, perhaps one-quarter of one percent of premiums written by all property/casualty insurers, to back up the program. This is in case premiums are insufficient over a short period or if it is determined by Congress that some short term subsidy is

required to stabilize a distressed line sometime in the future.

(3) NICO has asked the Department of Justice to review the evidence to see if a conspiracy to boycott insureds has occurred in day care insurance and other lines, the intent of which is to intimidate state regulation into granting excessive rate increases and to intimidate state and federal legislators into passing unjustified tort law modifications which will maximize insurer profit levels. 24/ Such boycotts and intimidations are not exempt from federal review under the provisions of the McCarran-Ferguson Act. NICO has called upon the Congress to monitor activity upon this important request, which has prompted a preliminary investigation by the FTC.

(4) NICO has called upon the Congress to require federal licensing of alien insurers that are not licensed and meaningfully regulated by any state in this nation but who insure or reinsure here. If Lloyd's of London will use its economic clout to dictate our nation's policy forms, (it is Lloyd's which is pushing the claims made form down the throats of the primary carriers; it is Lloyd's which is forcing the defense costs inside the limit of liability) we think they should be subject to review by some authority here.

5) NICO proposes that the Congress modify the Product Liability Risk Retention Act of 1981 25/ to allow small businesses as defined by the Small Business Administration at 13 CFR 121 to form risk retention groups along the lines already authorized under the statute. Targeted assistance through the proposed reinsurance program can assist those small business insureds who are too few to form risk retention groups in a given state.

WHAT SHOULD STATES DO?

States must concentrate their major efforts on insurance reform and not tort "reforms."

1) States should encourage the federal government to seek a more pro-active role in the regulation of the insurance business. It is a sign of strength, not weakness, to ask for help when it is truly needed, and states surely need help in this area today.

2) The US General Accounting Office noted that the most critical deficiency in the regulation of insurance by the states was in the shortage of proper staff for adequate regulation. 26/ The GAO pointed out that this was a function of money and increased resources for targeted staff development for actuaries, accountants and lawyers will improve the quality and extent of state regulation of the

insurance business. Regulators need to develop staff in the critical areas outlined and must be given sufficient resources to do so.

3) State law must require disclosure of loss data on a line-by-line basis which would give regulators much better ability to discern whether rates are excessive, inadequate or unfairly discriminatory. Line-by-line reporting will allow for adjustments between personal and commercial lines. Companies' annual statements should be expanded to require detailed reporting of all general liability subline data, by subline.

4) To the maximum feasible extent, insurance rates must be made based upon experience. The failures of the regulators and the insurers to provide proper safety incentives lies chiefly in their unwillingness to rate commercial risks based upon individual experience. Admittedly some risks are hard to rate experentially, but over time the necessary data base can be developed to properly rate individuals and unusual risks. Experience rating will allow proper market messages to be sent to unsafe risks and reduce the costs for good risks currently paying to allow the continued operations of bad risks. No where is this more critically needed than in medical malpractice rates.

5) Tough conflict-of-interest statutes must be enacted in the states to prevent continuation of the "revolving door" found by the USGAO where 50% of regulators came from the industry and 50% went to it after being a regulator. 27/ An "arms length" relationship between regulators and the regulated industry must be established.

6) Insurance regulators need better data verification techniques either through conducting their own, more frequent audits or using outside auditors. Recent charges by the NAIC president that data has been falsified strikes at the core of state regulation of insurance. If we cannot trust the annual statements, then state regulation of insurance is a fraud and a sham.

7) Insurers must be required to fully disclose to regulators the total rates of return earned, including on investment income, so that full blown rate of return rate regulation can be utilized. The NAIC endorsed this approach at its June 1984 meeting. Texas, the first state to fully use the method in setting auto rates earlier this year, saw a 10 percent reduction in premiums required. This action saved Texas consumers $250 million over the proposed rates.

8) State Commissioners must be empowered by the legislatures to meaningfully regulate excess, surplus lines carriers and reinsurers, at least to the extent that the federal goverment does not. Abuses, such as withholding cover by these

carriers, have contributed significantly to the current capacity crunch.

9) States need to establish their own reinsurance programs modeled after NICO's federal proposal. A state reinsurance program with a risk management component requirement can bring meaningful safety considerations into insurance markets. Establishing models for risk management as a requirement for reinsurance through the state would provide a general market incentive and would ease availability and decrease risks faced by consumers and their primary carriers.

10) States need to examine their anti-group and anti-rebate statutes to see if they serve any public purpose. If these laws adversely impact upon availability and affordability of cover, then they should be scrapped.

11) State regulators should conduct financial, market conduct and trade practice examinations on a regular basis for all licensed insurers in states. Increased monitoring of insurer's practices and finances can only benefit consumers by curbing rating and other market abuses, as well as insolvencies.

12) Regulators must resist attempts by industry advocates to force proposed claims made forms, which include defense costs inside the limit of liability, upon consumers.

The proposed, and constantly modified, ISO claims made form means less coverage, more exclusions and less competition for insureds.

There is less coverage because of the timing of coverage involved in the policy and the proposed inclusion of defense costs inside the limit makes coverage illusory. If a buyer has a million dollar claim against it and a million dollars are spent by the insurer defending the suit from which the loss accrued, there is nothing to pay for the loss but the assets of the insured. That's not coverage, its an insurance defense lawyer income security plan! The proposed pollution exclusion is simply a refusal to write this risk until the tort law is changed to suit the industry. It is fascinating to note that ISO does not discount the claims made policy rate a whit for excluding "high cost" pollution coverage. ISO cannot have it both ways; either polluton cover costs a lot and the exlusion should cause a dramatic drop in price, or it costs little (nothing according to ISO) and the coverage should be contained within the policy. Consumers face captivity because of the exhorbitant levels of premium for extended tail coverage that can go as high as 200 percent of the last year's premium. The higher the tail coverage cost, the less likely you are to seek more competitive rates at another company.

Claims made poses a particular problem for the unsophisticated purchaser. Believing that they are getting the same coverage for less, many insureds will immediately purchase the new policy and suffer unanticipated losses. I think that if states adopt any form of the new claims made policy form that it should not be allowed to be sold to small business consumers at all. ISO admits that its "problems" are with only five percent of its larger accounts. It would be inappropriate for regulators to broadly restrict cover based upon scarce, potentially false, and small samples of data. In the alternative, if it can be shown that some small business consumers (again, as defined in 13 CFR 121) would be able to benefit from the new policy form, then that form should be made available to such consumers but only after a reasonable occurrence policy quote is given and a full and complete disclosure of the differences of cover is made by the seller. Disclosure forms could be promulgated by the regulators with input from consumers and the industry.

In any event, states should not approve this moving target, constantly amended form until the industry has had time enough to educate the agents and the consumer. Even if the latest amendments are the last, which I doubt, the form should not become effective before July 1, 1986 at the earliest.

13) States must allow greater consumer representation before the regulatory bodies. All too often the only parties to rate cases are the regulators and the insurer. States must give greater funding to or create Offices of Public Advocate to statutorily intervene in insurance rate cases. The New Jersey experience can serve as a good model, there the costs of intervention are billed back to the filing party and this causes minimal growth in appropriations expenditures while maximizing consumer protection from abusive insurance rates. A related program could be authorized by the federal government or the states to allow consumers to organize their own Citizen's Insurance Board to intervene on their own behalf as a complement to the efforts of the Public Advocates.

CONCLUSION

America deserves a better deal on its insurance. The federal and state governments cannot sit idly by and let the insurance industry hold day care providers, nurse-midwives, and others, hostage in a large game beyond the providers' control. The terrorist tactics of insurers every 10 years at cycle bottom must be dealt with in a systematic way that adds the stability to our economy that insurance is meant to deliver. Periodic price gouging must be stopped. It is time for the states, as well as the federal government, to act responsibly in the area of insurance regulation and take appropriate remedial action now.

FOOTNOTES

1/ CPI data on "auto insurance", Bureau of Labor Statistics.

2/ Source of data: Citibank Economics and Insurance Services Office.

3/ The ISO admits that the p/c industry had a positive return on net worth last year, conceding the point that the industry did not lose money last year. But, ISO's Mavis Walters disputes the level of that return, saying it was only two percent on net worth. Even at that level, the premium shortfall for last year was only 5.5 percent or so. (See, Statement of Mavis Walters, Senior Vice President, Insurance Services Office,Inc., before the House Energy and Commerce Subcommittee on Commerce, Transportation and Tourism hearings on the Liability Insurance Crisis of 1985, p.16 (Sept. 19, 1985)).

4/ For a discussion of risk in the property/casualty insurance business, see Investment Income and Profitability in Property/Casualty Insurance Ratemaking, J.R. Hunter and J.W. Wilson, 1983, Chapter 5.

5/ Hearing on December 3, 1975, Subcommittee on Health of the Committee on Labor and Public Welfare, US Senate. Among the interesting data supplied by ISO at that hearing were exhibits that showed that the average claim cost ISO used for ratemaking significantly exceeded the limit of liability, clearly ratemaking that had run amok. That led to this exchange:

Sen. Laxalt: Is malpractice always a loser as far as carriers are concerned?

Mr. Hunter: If they charge these rates, they could not help but win. (Page 141.)

In John Guinther's book, The Malpractitioners (Anchor Press, 1978), Guinther cites this exchange at page 169 in a chapter entitled "They Could Not Help But Win." In the following chapter, called "They Won," Guinther reviewed the later experience.

Final Report, Product Liability Task Force. Report on Product Liability Ratemaking, Product Liability and Accident Compensation Task Force, US Department of Commerce, 1980. At page ix the Report states that "overly subjective ratemaking practices were one of the principal causes of the product liability insurance problem."

6/ St. Louis Post Dispatch, Section B, P.3, 4/14/84. (See also, Sloan, infra, at note 17).

7/ Journal of Commerce, "Insurers Told: Exit Some Lines," p.8A, (June 18, 1985).

8/ Source of data: Best's Property/Casualty Stock Index, A.M. Best and Company, Oldwick, NJ. December 31, 1984 index = 416.30; November 20, 1985 index = 600.06. Dow Jones Industrial Average December 31, 1984 = 1211.57; November 20, 1985 = 1441.37.

9/ According to the Insurance Information Institute's Executive Letter of August 26, 1985, Policyholder surplus grew from $58.2 billion as of 6/30/84 to $66.0 billion as of 6/30/85.

10/ "The day care facilities have been caught up in this availability crunch and are being deemed higher risk, not necessarily based on a claims experience but due more to an insurance hysteria . . ." Testimony of Edward J. Muhl, Insurance Commissioner of the State of Maryland, before the House Select Committee on Children, Youth and Families, July 30, 1985.

11/ "Any permanent solution (of the day care insurance crisis) will require significant changes in the tort system." Testimony of Frank Neuhauser, Vice-President and Actuary for AIG (a leading insurer of day care centers) before the House Select Committee on Children, Youth and Families, July 30, 1985.

12/ "The countrywide experience for those companies reporting premium and loss data to the Insurance Services Office . . . appears to conform with the current loss experience for the majority of commercial insurance lines . (these data) do not suggest that insurers should abandon the market." Testimony of James L. Kimble, Senior Counsel, American Insurance Association, before the House Select Committee on Children, Youth and Families, July 30, 1985. The testimony was also endorsed by the Alliance of American Insurers.

13/ Journal of Commerce, "Tougher Insurance Rules Loom," p.1A, (Oct. 10, 1985).

14/ See, for instance, the National Underwriter, 11/20/81, page 1, where it says:

> A large commercial umbrella (liability) risk came up for renewal and was rated at $105,000, about the same as the previous year. But the insured was not satisfied. Aware of the aggressive rate competition in the commercial lines market today, he decided to shop around. He approached a second agent, who submitted the very same risk to a different company, which offered to write it for just $20,000.

But the insured was still not happy. He continued shopping and eventually the original company, which originally wanted $105,000 came back and took the business for $5,000. That's right, $5,000. (Emphasis added.)

15/ NAII and ISO, "1985: A Critical Year," p.30 (Spring 1985). This quote has been curiously lacking in any reference made to this document by insurers in previous testimonies. (See, Walters, supra.)

16/ Pennsylvania Political Subdivision Tort Claims Act, (42 Pa. CSA 8541 et. seq.)

17/ Sloan, Frank A., "State Responses to the Malpractice Insurance 'Crisis' of the 1970s: An Empirical Analysis," 9 Journal of Health Politics, Policy and Law, 629 (Winter 1985).

18/

Item	1984 Amount Spent in Billions a/	Column (1) - 1984 Disposable Income of $2,578.1 Billion a/
Food	444.3	17.2%
Housing	397.8	15.4
Personal Income Taxes	302.6	11.7
INSURANCE b/	287.1	11.1

a/ Source: US Department of Commerce, Bureau of Economic Analysis.
b/ Source: Bests Management Reports, December 31, 1984, page 1.
Life Insurance Fact Book, page 56.
Blue Cross Association, Telephone call of 1/25/85.

19/ The law was euphemistically entitled the "FTC Improvements Act of 1979."

20/ See Statement of the Honorable Claude Pepper before the Subcommittee on Monopolies and Commercial Law on the Insurance Industry's Antitrust Exemption, April 11, 1984; found at page 5 of the Subcommittee's report, Competition in the Insurance Industry (Serial No. 127).

21/ See, for instance, Issues and Needed Improvements in State Regulation of the Insurance Business, General Accounting Office (Oct. 9, 1979) (hereinafter, GAO Issues); The Invisible Bankers, Andrew Tobias (Linden Press, 1982); The Life Insurance Game, Ronald Kessler (Holt, Rinehart and Winston, 1985);"Protection for Sale: The Insurance Industry," NBC-TV News (1981); Risk, Reality and Reason, the Conference of Insurance Legislators (September 1983).
One of the tests of state preparedness to deal with a crisis in availability and pricing of liability insurance is actuarial staff. Of the 52 states (including DC and Puerto

Rico) NICO surveyed, we find that 26 have actuaries. So one-half of the states have no actuaries at all.
There are 62 actuaries employed by the states, of the 7,682 actuaries in the nation. It is well known in the industry that those best suited to deal with matters pertaining to liability insurance are those who have passed the examinations enabeling them to be "Fellows" in the Casualty Actuarial Society. State regulation has only 8 such persons. They are employed by only 5 states [Connecticut (1), Massachusetts (1), Michigan (1), New Jersey (1) and New York (4).]
Aetna Life and Casualty Insurance Company alone employs 126 actuaries. Travelers has 100.

Source of Data: American Academy of Actuaries 1985 Yearbook and Directory of Members by Business Affiliation.

22/ Public Law 90-448, 82 Stat. 476; 12 U.S.C. 1749bbb, 42 U.S.C. 4011.

23/ Meeting the Insurance Crisis of Our Cities, A report of the President's National Advisory Panel on Insurance in Riot-Affected Areas, January, 1968, p. 1.

24/ See Exhibit II for a copy of the letter to the Justice Department.

25/ 15 USC 3901 et. seq. and 1983 amendments.

26/ GAO Issues, p.35.

27/ Ibid., p.176

CHART #1

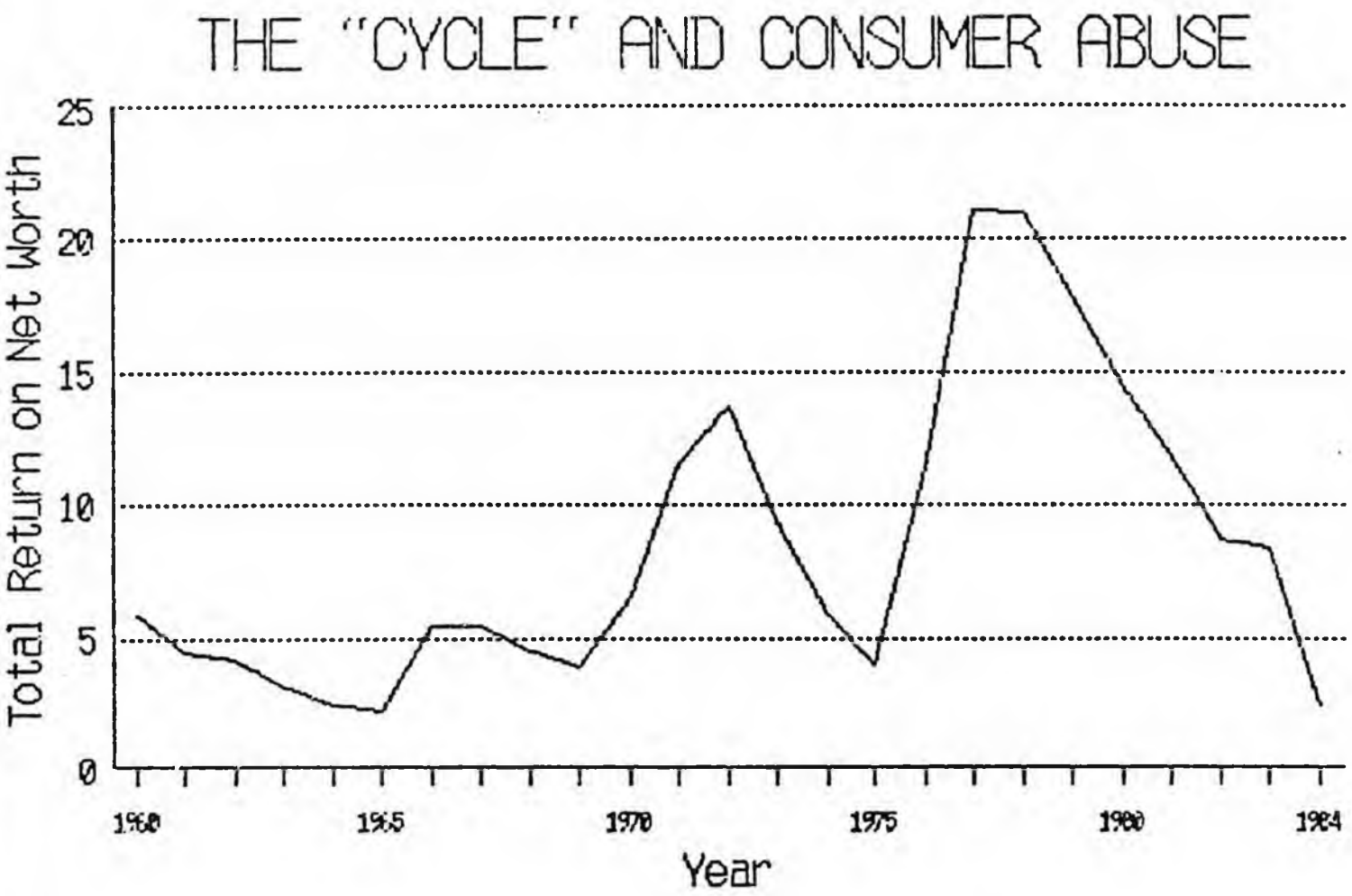

THE "CYCLE" AND CONSUMER ABUSE
Total Return on Net Worth
25
20
15
10
5
0
1960
1965
1970
1975
1980
1984
Year

CHART #2

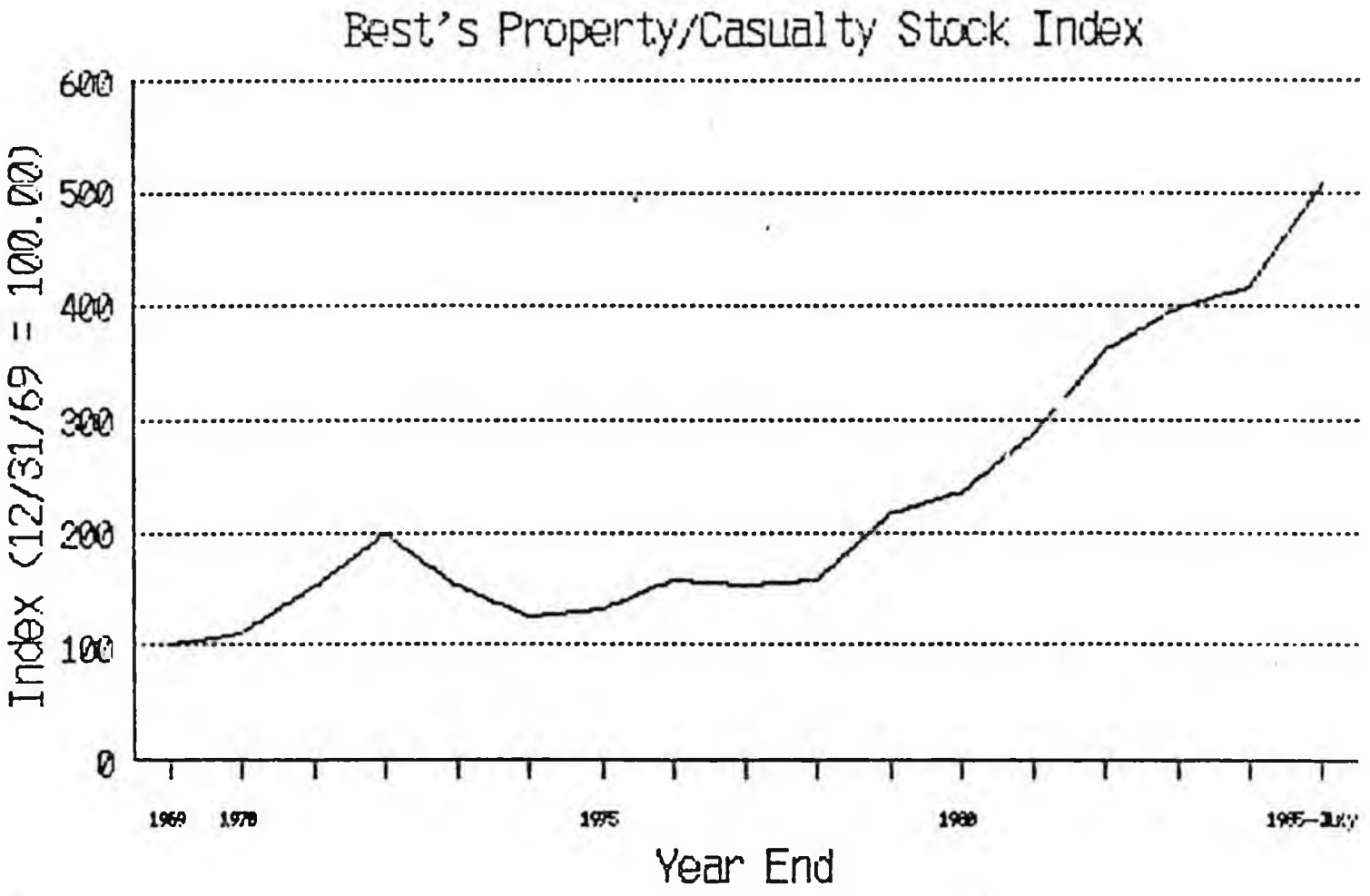
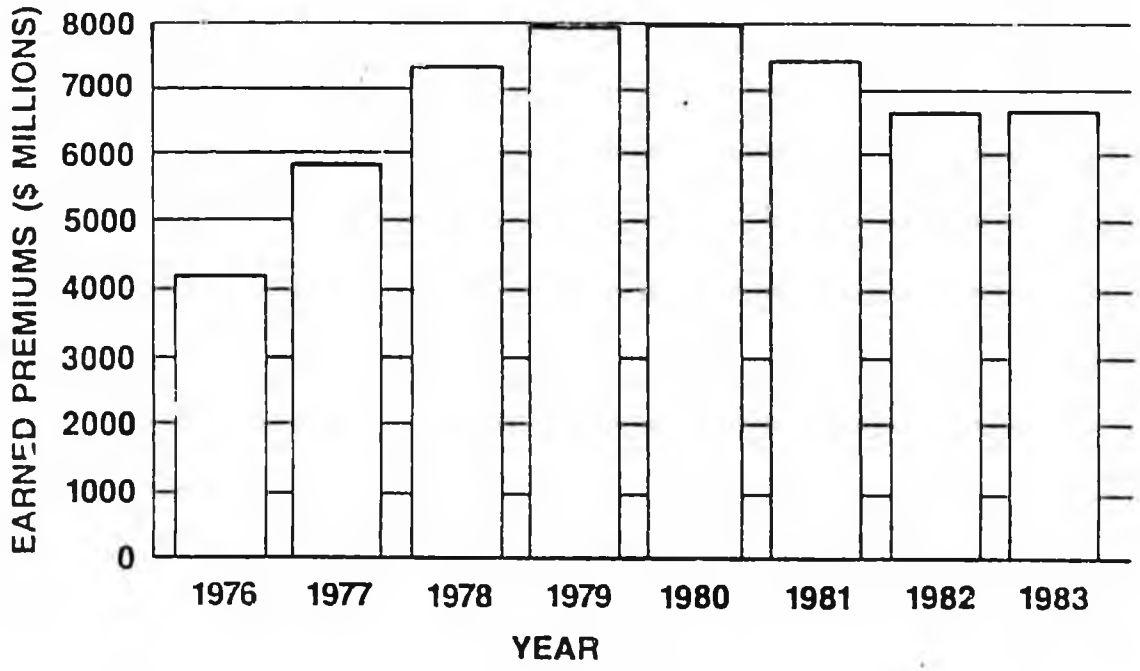

Best's Property/Casualty Stock Index
Index (12/31/69 = 100.00)
600
500
400
300
200
100
0
1969
1970
1975
1980
Year End

CHART 3

NATIONAL LIABILITY INSURANCE STRIKE



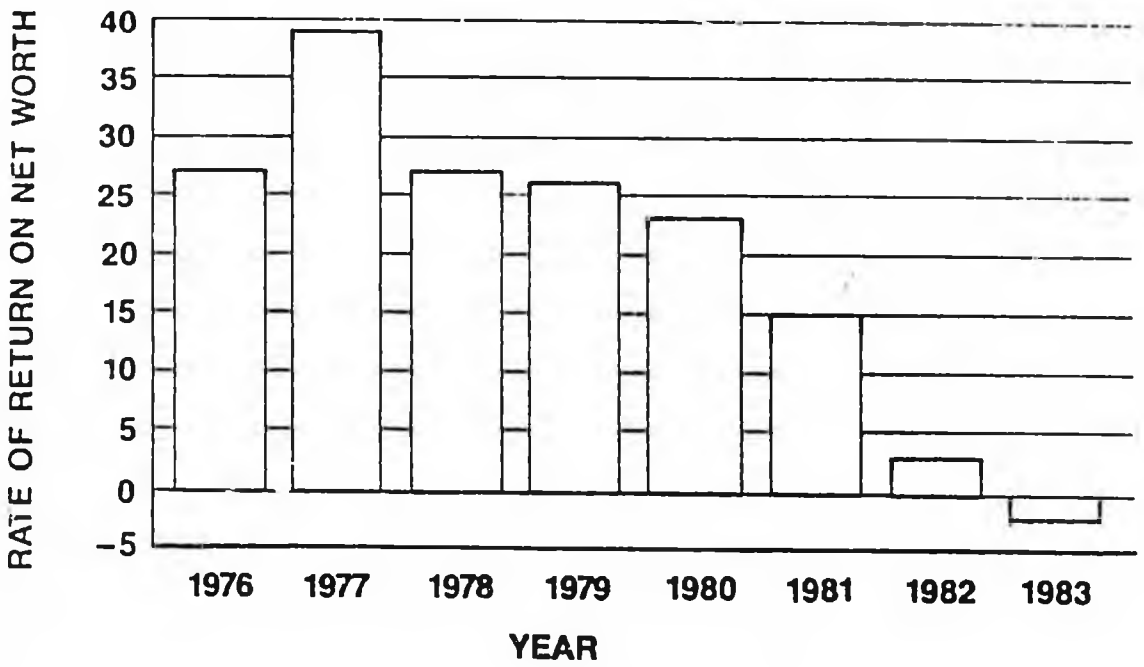
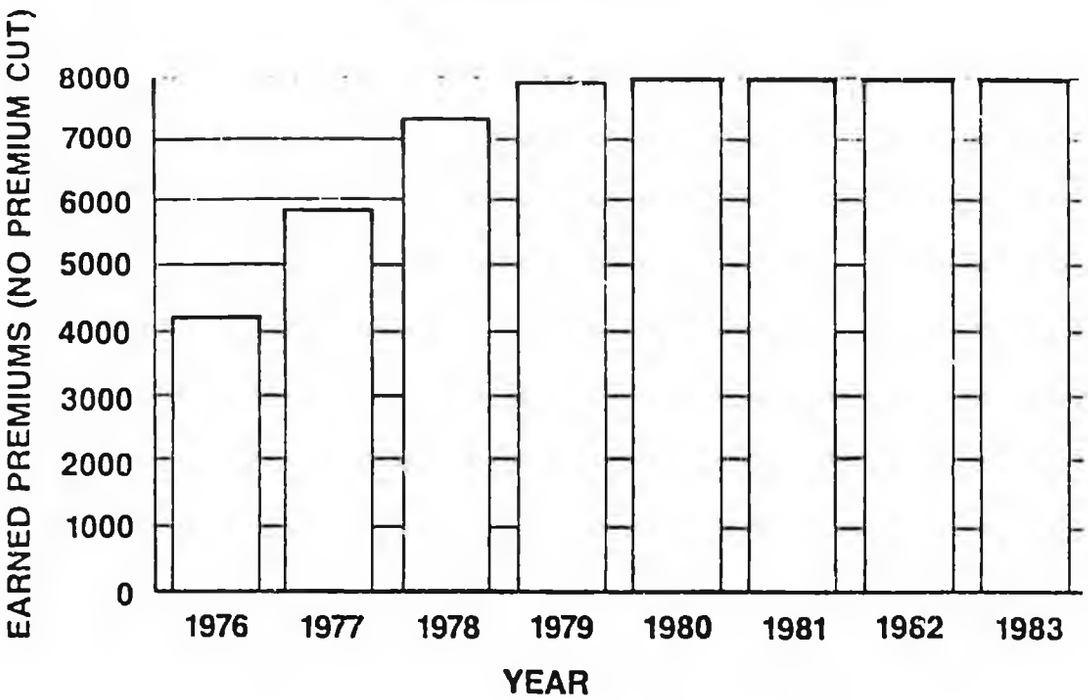
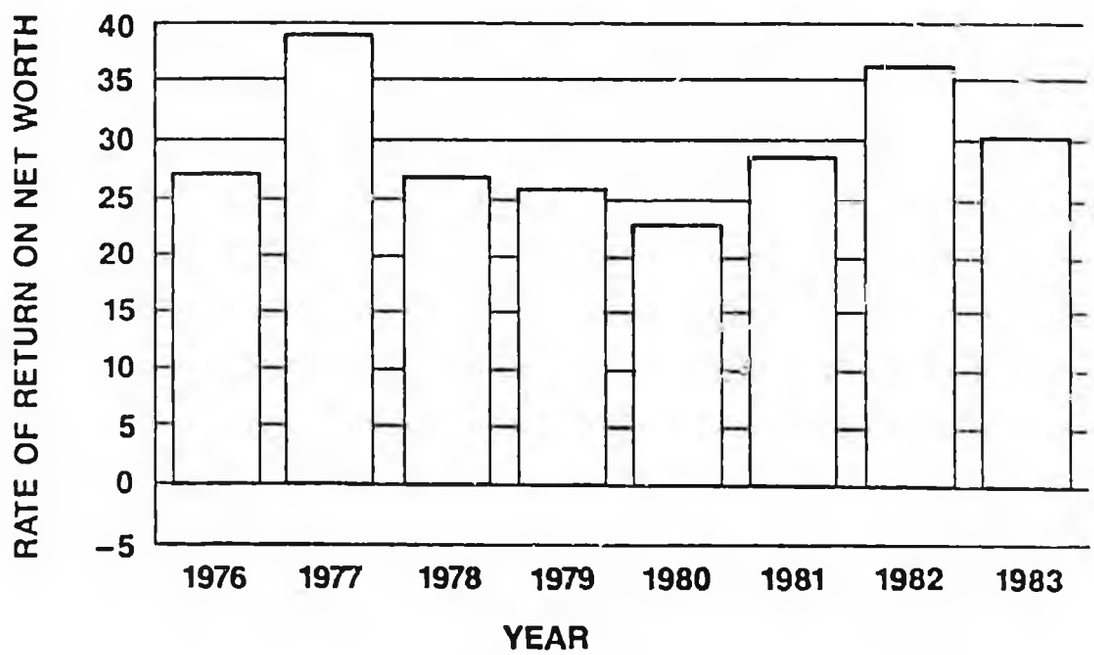


CHART 4

NATIONAL LIABILITY INSURANCE
STRIKE II





DATA UNDERLYING CHARTS 3 & 4

COMMERCIAL LIABILITY INSURANCE PROFITABILITY STATISTICS (1)
Rate of Return on Net Worth (2)

Year	Earned Premiums (Millions of $)	Actual ROR	All American Industry (3)
1976	$4160	27%	13.3%
1977	5[illegible]5	39	13.5
1978	7364	27	14.3
1979	7943	26	15.9
1980	7969	23	14.4
1981	7416	15	14.0
1982	6627	3	11.0
1983	6671	-2	11.5
Average		19%	13.5%

(1) Source: National Association of Insurance Commissioners Report on Profitability, By Line, By State.

(2) Rate of Return on net worth estimated from the NAIC Reported Insurance Operating Profit on Earned Premiums by converting to net worth by multiplying by a 2:1 Premium/Net Worth Ratio. Investment Income on Surplus is added at an assumed after tax yield as follows: 1976, 5.0%; 1977, 5.5%; 1978, 6.0%; 1979, 6.5%; 1980, 7.0%; 1981, 7.5%; 1982, 8.0%; 1983, 8.5%.

(3) Fortune 500, 1976-1980; Business Week, 1981-1983.

NOTE: Had the insurers not cut premiums after 1980 but held them constant, the Rate of Return on Net Worth would have been:

1981	29%
1982	37%
1983	31%
8-year average	30%

The problem is clearly rate cutting, nothing else!

Analysis of Rate Filing of

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

Filing Date: May 16, 1985 Effective: July 1, 1985

J. ROBERT HUNTER

Fellow, Casualty Actuarial Society
Member, American Academy of Actuaries
President, National Insurance Consumer Organization
Former Federal Insurance Administrator

BACKGROUND

On May 16, 1985, the Medical Mutual Liability Insurance Society of Maryland (MMLIS) filed for an increase in malpractice premiums of +29%. The filing also requested changes in the relativities between classes, the most notable of which was a one-third increase in Class 8 (OB/GYN Surgery). The total impact of the overall rate change of +29% and the class relativity change of +33.3% on OB/GYN surgeons was to increase their rates by 66.7%. For the highest rated territory, these doctors had their rates raised from $25,429 to $42,393. This did not please the OB/ GYN community.

WAS THE OVERALL 29% RATE INCREASE JUSTIFIED?

In my opinion, there was no justification for an overall rate increase of 29%. Indeed, I believe that the filing supports a reduction in premiums rather than an increase. Here's why:

- The filing incorrectly assumes that the yield on investments that the MMLIS will earn is 5%, an unrealistically low assumption, and

- The filing incorrectly assumes that inflation in the future will be at double-digit levels.

When proper assumptions are made on just these two items, even accepting other major assumptions (such as their reserves are accurate), a rate reduction of 10.5% is indicated.

HOW SHOULD INVESTMENT INCOME BE FACTORED IN?

To do the job properly, a full blown total return analysis should be undertaken. The National Association of Insurance Commissioners adopted the total return approach at their June, 1984 meeting, and issued a report detailing several approaches. Under a total return approach, all income is analyzed to determine what overall profit the company will make under a given set of rates and a comparison of that potential earning power to the needed margin to attract risk capital is undertaken. It is a sophisticated, highly desirable approach that should be used in Maryland, as the NAIC recommended for all regulated lines.

In that the filing was woefully short of the data needed to undertake total return analysis, I decided to accept, for review purposes, the MMLIS approach to discounting the cash flows (their Exhibit 5, my Exhibit "A", attached). On my exhibit, you will see the MMLIS approach as typed and mine in

handwriting. MMLIS discounted the losses based on a distribution of losses paid by time. Presumably this is based on their Maryland experience, the filing does not identify that.

The average claim takes a bit over 7 years to pay. This means that MMLIS holds the money in reserve for that long before they pay the average claim. Obviously this means that the reserves, which are fully funded today under statuatory accounting rules, will produce a significant amount of investment income.

The MMLIS approach assumes that they will earn 5% on their invested reserves. This is obviously too low. MMLIS has earned, according to their 1984 Annual Statement, the following yields on their total assets (including assets not invested or used for business--such as properties) the following:

1982	9.1%
1983	8.9%
1984	9.3%

Other filers recognize that the yield is not so absurdly low. For example, on May 17, 1985 the leading writer of medical malpractice insurance in the country, St. Paul submitted a filing in South Carolina in which it used a 10.5% yield to discount that state's cash flow. (see my Exhibit "B")

I have chosen to use a 10% discount rate, which is reasonable for the invested assets of MMLIS. That change is shown on Exhibit "A". It results in a discount for investment income of 43% rather than 26% based on the unjustified 5% yield assumption. If that change is carried through to the rate level itself, the rate filing would have been for a <u>reduction</u> in rates of 1.4% rather than an increase of 29%. The calculation of the reduction is found on Exhibit "C", attached.

TREND

MMLIS displayed its own Maryland data for trend on its Exhibit 4, my Exhibit "D". It carefully analyzed the data and concluded that the range of results were between an annual trend of +7.8% based on straight line projection, and +9.3% based on exponential line projection. The data are company specific and Maryland specific andthrough the most recent year, 1983.

For some reason, the filer then displays data for other insurers, for other states, that is old data. (See Exhibit

"E"). This experience is from a period of high inflation and is not relevant, in my opinion to the case at hand. For one thing, the federal government has reported that medical inflation rates in the nation are below 10%, certainly no where near the 16% figure that the irrelevant data produce. These data should not be given weight, in my estimation.

I selected a trend of 9% for the purposes of this review. It gives weight to the fact that the exponential line has a slightly better "fit" to the data and is within the range as calculated by MMLIS, but near the exponential side. I also chose to apply the trend exponentially (this gives a higher answer than using a straight line).

Looking again at Exhibit "C", the use of the amended trend, coupled with the 10% yield assumption produces an indicated rate level reduction of 10.5%

SENSITIVITY ANALYSIS

If we used a yield of only 9% (less than MMLIS earns, even on all assets including cash) and use a trend of 10% (which is more than that realized by MMLIS and more than that in the nation today) the indicated rate would be a reduction of 0.9%.

ANALYSIS OF CLASSIFICATION CHANGES

Incredibly, there is absoultely no justification for the changes in the classification differentials employed by MMLIS contained in the filing. The entire "justification" for the change is found on Exhibit "F", attached.

There are other, more minor changes made without a shread of evidence, such as the territorial relativity changes, and the increased limits changes.

BALANCE SHEET

MMLIS is as solid an insurer as there can be. Their 1984 balance sheet shows that the company enjoys a premium/surplus ratio of 1.2 to 1. This company appears to be over-capitalized. If the ratemaking has followed the current filing approach, it is no wonder.

Exhibit "A"

MEDICAL MUTUAL LIABLITY INSURANCE SOCIETY OF MARYLAND

1985 PROFESSIONAL LIABILITY RATE LEVEL REVIEW - OCCURRENCE COVERAGE

PRESENT VALUE OF PAID MEDICAL MALPRACTICE CLAIMS

(OCCURRENCE BASIS)

Time Interval	Cum. Paid	% Paid Losses By Interval	Years of Discount (n)	Vn (5%)	10%	Present Value	
Up to 12 mos.	0.0%	0.0	0.5	.976	.954	-	
24	2.0	2.0	1.5	.929	.867	1.858	1.73
36	7.0	5.0	2.5	.885	.788	4.425	3.94
48	19.0	12.0	3.5	.843	.716	10.116	8.59
60	35.0	16.0	4.5	.803	.651	12.848	10.42
72	53.0	18.0	5.5	.765	.592	13.770	10.65
84	68.0	15.0	6.5	.728	.538	10.920	8.07
96	79.0	11.0	7.5	.694	.489	7.634	5.38
108	87.0	8.0	8.5	.661	.445	5.288	3.55
120	92.0	5.0	9.5	.629	.404	3.145	2.02
132	95.0	3.0	10.5	.599	.368	1.797	1.10
144	97.0	2.0	11.5	.571	.334	1.142	.669
156	99.0	2.0	12.5	.543	.304	1.086	.609
168	100.0	1.0	13.5	.518	.276	.518	.27
						74.547%	

Ave 7.1 yrs

57.1

CONCLUSION

This filing is not justified. An overall [illegible] level decrease of 10.5% is needed, not a 29% increase. The class changes which so sharply impact the OB/GYN surgeon group is not justified in the filing, although their may be experience somewhere that supports that change. The filing should have been disapproved. It is particularly abusive to observe a 66.7% increase for OB/GYN surgeons with no justification. On the basis of the filing, the OB/GYN rate should have been decreased by 10.5%. This means that the OB/GYN surgeons in Maryland may be paying about 85% too much.

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

Exhibit "B"

Exhibit C
Loss and Loss Expense
Payout Patterns

Year	Cumulative Annual Payout	Incremental Annual Payout	Present Value*
1	.061	.061	.059
2	.275	.214	.187
3	.496	.221	.175
4	.668	.172	.124
5	.786	.118	.076
6	.869	.083	.049
7	.910	.041	.022
8	.952	.042	.020
9	.976	.024	.011
10	1.000	.024	.009
		1.000	.732

* Discounted claims payments at 10.5% pre-tax.

EXHIBIT "C"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 Professional Liability Rate Level Review - Occurrence Coverage

Total Limits Rate Level Indication -- $000's

(1) Calendar/ Accident Year	(2) E. P. at Current Rate Level (Exh. 3)	(3) Ultimate Incurred Loss & ALAE (Exh. 2)	(4) Trend Factor to 7/1/86 at 11%	9%	(5) Losses Trended to 7/1/86 (3)x(4)		(6) Loss Ratio at Current Rate Level (5)/(2)	
1979	33,395	24,688	1.826	2.076	51,255	45130	1.535	1.351
1980	35,732	25,235	1.677	1.870	47,200	42319	1.321	1.184
1981	33,872	25,904	1.539	1.685	43,649	38,866	1.289	1.177
1982	28,984	25,414	1.412	1.518	38,580	35,885	1.331	1.238
1983	18,203	18,854	1.295	1.368	25,785	24,416	1.417	1.341
	150,185				206,470		1.375	
					187,816		1.249	

Annual Trend Factor: 11.0%
(Exhibit 4)

a)	Five year loss ratio at current rate level:	1.249	1.375	
b)	Discount for investment income at 5.0%: (10%) (Exhibit 5)	.570	0.745	.570
c)	Discounted loss and ALAE ratio (a) x (b):	.712	1.024	.784
d)	Provision for Unallocated LAE (Exhibit 6)	1.05	1.050	
e)	Discounted loss and LAE ratio (c) x (d):	.748	1.075	.823
f)	Permissible discounted loss and LAE ratio: (Exhibit 6)	.835	0.835	
g)	Indicated rate level increase (e) / (f):	-10.5	1.288	-1.4%
h)	Selected rate level increase		1.290	

INVESTMENT INCOME AND TREND CHANGE

ONLY INVESTMENT INCOME CHANGE.

Exhibit "D"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 RATE LEVEL REVIEW - PROFESSIONAL LIABILITY - OCCURRENCE COVERAGE

TREND IN TOTAL LIMITS LOSS RATIOS AT CURRENT RATES

($000'S)

(1) Calendar/ Accident Year	(2) Earned Premium at Current Rate Level	(3) Ultimate Incurred Loss and ALAE	(4) Loss Ratio at Current Rates	(5) Linear Fit	(6) Exponential Fit
1979	33,395	24,688	.739	.672	.683
1980	35,732	25,235	.706	.748	.747
1981	33,872	25,904	.765	.825	.816
1982	28,984	25,414	.877	.901	.893
1983	18,203	18,854	1.036	.978	.976
			Average Annual Trend:	+ 7.8%	+ 9.3%
			r :	.899	.906

(2) Exhibit 3

(3) Exhibit 2

(4) (3) / (2)

ISO COUNTRYWIDE TREND (Exh. 4A): 16%

Selected Trend Factor: 11%

Irrelevant

I'd use 9.0%

EXHIBIT "C"

INSURANCE SERVICES OFFICE

EXHIBIT 4A

COUNTRYWIDE#

Professional Liability Insurance
Calculation of Annual Trend Factor
Based on Basic Limits Loss Ratios at Present Rates

PHYSICIANS, SURGEONS AND DENTISTS

Basic Limits

(1) Policy Year Ending	(2) $100,000 Basic Limits Incurred Losses*	(3) Premium At Present Rates	(4) (2)÷(3) Actual	Average Loss Ratio at Present Rates (5) Exponential Curve of Best Fit
12/31/75	$167,810,058	$615,020,250	.273	.232
12/31/76	139,176,608	524,225,859	.265	.271
12/31/77◆	181,630,098	638,830,853	.284	.316
12/31/78◆	251,848,210	700,894,098	.359	.369
12/31/79◆	280,590,219	717,382,127	.391	.430
12/31/80◆	332,612,672	705,726,416	.474	.502
12/31/81◆	426,038,352	684,461,050	.622	.585
12/31/82◆	497,532,513	666,499,516	.746	.683

Average Annual Loss Ratio at Present Rates Trend.....16.6%

Excluding Texas and Massachusetts

* Losses include allocated loss adjustment expense and are developed to an ultimate settlement basis.

◆ Includes Claims Made Data.

Selected Annual Trend 16.0%

TS-PR-84-11
12/20/84

Exhibit 5

Exhibit "F"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 PROFESSIONAL LIABILITY RATE LEVEL REVIEW

Effect of Proposed Classification Changes

Specialty	Description	Distribution Of Total Limits Premium	Present Relativity	Proposed Relativity
80240	Forensic Medicine	0.0 %	.75	.65
80232	Hypnosis	0.0	.75	.65
80248	Nutrition	0.0	.75	.65
80263	Ophthalmology-No Surgery	0.2	.75	.65
80235	Physiatry and Physical Medicine	0.2	.75	.65
80249	Psychiatry	0.3	1.00	.65
80250	Psychoanalysis	0.0	1.00	.65
80251	Psychosomatic Medicine	0.0	1.00	.65
80266	Pathology-No Surgery	0.5	1.00	.65
80261	Neurology-No Surgery	0.8	1.00	1.20
80253	Radiology-Diagnostic-No Surgery	0.5	1.20	1.80
80280	Radiology-Diagnostic-Minor Surgery	0.1	2.10	2.80
80145	Surgery-Urology	3.0	3.00	3.60
80155	Surgery-Plastic-Otorhinolaryngology	1.5	6.00	5.00
80156	Surgery-Plastic-N.O.C.	2.5	6.00	5.00
80141	Surgery-Cardiac	0.0	5.00	6.50
80150	Surgery-Cardiovascular	0.0	6.00	6.50
80153	Surgery-Obstetrics/Gynecology	8.0	9.00	12.00
80168	Surgery-Obstetrics	0.1	9.00	12.00
	All Other	82.3		
		100.0%		

Effect: +2.8%

Current Average Relativity: 2.15

Projected Average Relativity: 2.21

LANDSMAN & LASTER

1503 21ST STREET, N.W.
WASHINGTON, D.C. 20036

(202) 331-0800

JOHN L. LASTER
RON M. LANDSMAN

August 14, 1985

Hon. Rick Rule
Acting Assistant Attorney General
Antitrust Division
United States Department of Justice
Tenth and Constitution Avenues, N.W.
Washington, D.C. 20530

Dear Mr. Rule:

I am writing on behalf of the National Insurance Consumer Organization to bring to your attention evidence of concerted anticompetitive conduct within the property casualty insurance industry that is not exempt under the McCarran-Ferguson Act.

The industry is now going through one of its periodic capacity scares. As in previous incidents, the public suffers severe and economically debilitating dislocations. After a period of glut, when premiums drop to a fraction of their prior fixed-price levels, underwriting tightens like a vise and important major manufacturing and service industries find themselves unable to purchase insurance protection at any price from any company.

To be sure, much of this pattern may reflect nothing more than the operation of the business cycle in an industry not under reasonable and effective regulatory oversight at the national level. The extremely aggressive price competition in commercial property/casualty lines in the late 1970s, and perhaps the subsequent price increases as well, appears to reflect such market forces. Some of the industry's responses may also reflect the mindless herd instinct which so distinctively marks the insurance industry. This is perhaps to be expected in an industry with a long history of price-fixing and other cooperative anticompetitive arrangements under state regulation that from the consumers' perspective ranges from lax to impotent, but so be it.

But the response of the industry to recent developments in their customer industries -- and the statements of industry leaders explaining their conduct -- suggest that something more is occurring.

Spokesmen for the reinsurance industry have told state regulators that they plan to withdraw en masse if they -- the regulators -- do not approve new insurance policy forms jointly developed by the reinsurers and the industry price-fixing agency (Insurance Services Office, Inc.). These new policy forms severely

narrow the protection provided to the insurers' commercial customers, changes about which they are, to say the least, extremely unhappy. See Attachment A. Along the same lines, a well-known insurance company executive has justified the mass departure of insurers from medical, toxic waste, and directors' and officers' liability lines by "the social good" in "let[ting] the pressures build in the courts and the state legislatures" to change laws respecting their customers' -- and the insurers' -- liability. See Attachment B.

There is, finally, irrational market conduct that goes beyond even this industry's herd instinct. They have withdrawn from lines for risks with experience ranging from good to excellent and which even the insurers admit could and should be written. See Attachment C.

Boycotts to force action by state and federal officials, be they judges, legislators, or regulators, are illegal. The McCarran-Ferguson Act specifically does not exempt boycotts from federal antitrust enforcement. In St. Paul Fire and Marine Insurance Co. v. Barry, 438 U.S. 531 (1978), the Supreme Court held that the term boycott was broadly applicable to joint action to deny coverage to customers. Nor is there protection to be had under any of the familiar non-statutory exemptions. The Noerr-Pennington doctrine does not exempt "an express or implied agreement ... that the participants will jointly give up their trade freedom, or help one another to take away the trade freedom of others through ... boycotts ... ." Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127, 136 (1961). And Parker v. Brown, 317 U.S. 341 (1943), does not exempt joint product-fixing absent state statutes authorizing such joint action. The debates on the McCarran-Ferguson Act reflect absolutely no consideration of agreements respecting products, and the state laws enacted in response to it by and large do not adopt such joint action as state policy. Southern Motor Carriers Rate Conference v. United States, --- U.S. ---, 53 U.S.L.W. 4422 (March 27, 1985).

Property/casualty insurance industry conduct, as explained by industry leaders themselves, may be but a prelude to a larger campaign to force major industries, from the chemical and drug manufacturers to physicians and others, to bend to the interests and will of insurers. If their means include non-exempt joint anticompetitive action, however, then you may hold the key to important public protection. I urge you to investigate to ascertain whether the federal antitrust laws are being violated.

Yours truly,

Ron M. Landsman

Ron M. Landsman
Counsel, National Insurance
Consumer Organization

RML/kd

Appendix A

JCC 6/18/85

Insurers Told: Exit Some Lines

By JAMES NOLAN
Journal of Commerce Staff

WOODBRIDGE, N.J. — The insurance industry should quit covering doctors, chemical manufacturers and corporate officers and directors. And the sooner the industry quits such lines of business, the sooner it will free itself from its bondage to a court system "that has run amok."

This was the message delivered to a meeting of actuaries here Monday by John J. Byrne, chairman and chief executive officer of Geico Corp., the Washington-based personal lines insurance company.

Mr. Byrne said that the single thread running through such lines of business for underwriters was that they have fallen under the sway of the courts.

"There will be no problem with insuring homeowners or autos in the coming years," he said. "But anyone who puts his private capital behind lines such as malpractice is putting himself in the hands of a zany judge or jury out in California. To my mind, he is absolutely stupid."

Mr. Byrne's comments came in the midst of a discussion at a meeting of the Casualty Actuaries of New York about what kinds of insurance products might be available in the future.

The touchstone for the discussion was a presentation by the Insurance Services Office Inc., an industry-rating and data-gathering service. The ISO estimates that in the next few years the insurance industry will suffer a $82 billion shortfall in capacity. This means that corporate America will not be able to buy all the insurance it needs because insurers ability to cover them will fall short by that amount.

'Anyone who puts his private capital behind lines such as malpractice is putting himself in the hands of a zany judge or jury out in California.'

Mr. Byrne said the industry was responding to these losses in precisely the right way by refusing to cover lines of business that are hostage to court interpretations. "It will be best for the social good to let society know that the problem is not one for the insurance industry but for society as a whole. It is right for the industry to withdraw and let the pressures for reform build in the courts and in the state legislatures," Mr. Byrne said.

He said he saw little hope for reform in such things as the federal program for Superfund, a toxic waste cleanup measure. He said the vast amount of money thus far spent by Superfund was to "educate lawyers on how to refine their suits brought on the part of plaintiffs against industry."

"Anybody who leaves his private capital where the courts can grab it has not done the right thing for his owners," Mr. Byrne said.

On a related score, Thomas A. Greene, president of his reinsurance brokerage firm in New York, said that still more pressure would be brought to bear on the American property and casualty industry by underwriters at Lloyd's of London. Mr. Greene said that beginning in 1986, Lloyd's syndicates would "simply not write reinsurance for the American casualty industry, especially in the lines mentioned by Mr. Byrne." He said further that reinsurance underwriters would virtually dictate to the ISO about a proposed commercial general liability form. He said the domestic reinsurance industry will not write treaties unless the industry adopts the new CGL form.

As to the stability of the insurance companies suffering through this trying period, at least one of the actuaries said that current measures of company solvency used by the National Association of Insurance Commissioners were less than adequate.

Kevin M. Ryan of the National Council of Compensation Insurance urged the actuaries to model industry solvency judgments on a study done by the Aetna Life & Casualty Co. a few years ago.

Aetna studied the financial data of companies that had actually failed and the resultant ratios were absolutely realistic, Mr. Ryan said.

(1)

EPA Chief Deems It Necessary To Keep Toxic Liability Powers

JCC 7/21/85

By LEAH R. YOUNG
Journal of Commerce Staff

WASHINGTON -- The Environmental Protection Agency must keep the authority allowing it a wide choice of whom to sue for cleaning up toxic waste sites, Administrator Lee M. Thomas said.

While acknowledging that the market for all kinds of environmental insurance is drying up, Mr. Thomas insisted in an interview that the EPA cannot give up the "strict, joint and several liability" powers that courts have given it.

The insurance industry has been saying that it cannot insure and collect premiums from individual companies when a court can require one or a few companies to pay all the costs of cleaning up a site.

That is especially true, insurers say, when many of the policies being interpreted by state courts never were intended to pay for hazardous waste cleanup.

But Mr. Thomas pointed out that EPA is responsible for getting such sites cleaned up while ensuring to the extent possible that the polluter, rather than the federal government, bears the costs.

The insurance industry would like to provide liability so that its clients are held responsible only for their share of damage, but the EPA finds that in most Superfund waste cleanups hazardous substances are mixed and records are poor.

Then the EPA tried to apportion responsibility -- an approach that is surfacing again among some congressmen at the behest of the insurance industry -- it became "just as controversial among the private parties as utilization of joint and several" liability, Mr. Thomas said.

The EPA tried to base responsibility on the volume of waste, he said, but the companies fell into long debates over whose waste was more toxic.

However, as adamant as he is that strict, joint and several liability must be part of any Superfund program, Mr. Thomas opposes attempts by House Energy and Commerce Subcommittee Chairman James Florio, D-N.J., to write it into the pending Superfund bill.

"We don't think it should be specifically mandated," Mr. Thomas said. "Trying to get language in the statute has the potential of opening up the whole issue again to litigation."

But Rep. Florio argues that while he is "heartened" by the district court rulings to date, "this principle could be gutted by a specific district court or by the Justice Department."

He wants to make sure that industry cannot convince the administration to abandon this unwritten interpretation.

Rep. Florio lost a battle in his subcommittee on the issue to a group headed by Energy and Commerce Committee Chairman John Dingell, D-Mich.

In spite of the setback, Rep. Florio has vowed to continue his fight on the issue, and for other provisions the subcommittee rejected, in the full committee and on the House floor.

His rejection in subcommittee is no reason for rejoicing by the insurance industry. Many who opposed Rep. Florio support the views of Mr. Thomas.

Rep. Jim Slattery, D-Kan., explained that injecting joint and several liability into the legislation could lead to a situation in which the provision was either stricken or filibustered in the Senate.

That would create legislative history that might convince state courts that such liability is not part of Superfund.

While Mr. Thomas is determined to keep joint and several liability in spite of evidence of growing insurance problems, Mr. Thomas does not have any recommendations to alleviate the burden on the insurance industry.

He pointed out that a lot of the problems are not related just to Superfund, but rather to the general economic situation in the property-casualty insurance industry.

He noted that the European reinsurance market is drying up for environmental policies. There has been poor experience with asbestos, and a general desire to "establish a less risky base of insurance."

Under such circumstances, he said, he has been unable to win from the insurance industry any assurances that particular steps taken on the federal level will result in a return to the environment market.

Instead, insurance industry spokesmen will only say that if some steps are not taken "there is a chance we won't get back in the market," Mr. Thomas said.

It is possible that there is a need for federal involvement in the environmental liability field, but the debate has not reached the point where he thinks he can draw any conclusions.

In the meantime, EPA recognizes that many hazardous waste sites being licensed under the Resource Conservation and Recovery Act may not prove financial responsibility on Nov. 8 as required.

Without insurance, some facilities may use their own net worth, Mr. Thomas said, but others may just be forced out of business.

Fewer facilities will require companies that are generating wastes to modify their procedures to incinerate or otherwise minimize waste that until now was cheaper to send to land disposal facilities.

It is too soon to analyze the impact of this scenario, he said, in light of the congressional decision to encourage companies to move away from land disposal.

The only thing he is at all sure of now is that solving the problems of insuring hazardous waste facilities would not solve the entire insurance dilemma.

The House subcommittee did vote against one provision that disturbed the insurance industry. Congressmen rejected an amendment to permit citizens to sue private parties if they perceived a dangerous situation being ignored by the Environmental Protection Agency.

Only one Florio amendment was attached to the Superfund bill that goes to the full Commerce Committee.

That provision requests that the House Ways and Means Committee devise as part of the taxing scheme an import fee to reduce the share of general federal revenues envisioned in the bill from $250 million to $110 million.

The idea is to tax imported feedstock derivatives equally with domestic feedstock components in order not to give an advantage to foreign derivatives.

Mr. Thomas said the administration still opposes new Superfund taxes.

In Day-Care Crisis Cited

Official Criticizes Insurance Firms

By Sandra Sugawara
Washington Post Staff Writer

Maryland Insurance Commissioner Edward J. Muhl said yesterday that "hysteria" had caused insurance companies to discontinue coverage of day-care centers and that Maryland officials had blocked an attempt by one California firm to cancel 242 day-care policies.

Muhl also said that state officials were studying a wide variety of options, including the creation of a mutual liability insurance fund in Maryland similar to the one created in 1974 by the General Assembly to help physicians hit by an insurance malpractice crisis.

Muhl testified yesterday before the House Select Committee on Children, Youth and Families, which is holding hearings on the nationwide insurance crisis in the day-care industry. Muhl, who appeared on behalf of the National Association of Insurance Commissioners, critized insurance companies for wholesale cancellation of day-care policies, saying the insurance industry was overreacting to news accounts of sexual abuse and court suits involving some day-care centers.

Muhl said a California insurance carrier canceled policies at 242 Maryland day-care centers before they were to expire. He said he recently ordered that firm to revoke the midterm cancellations, although he said the company does not have to renew the policies.

Muhl said he was sympathetic to the plight of the insurance industry, which had its worst year ever in 1984. He said the Association of Insurance Commissioners expects the industry to sell $67 billion less in insurance this year than last year.

Muhl said he has signed 20 notices of insolvency for Maryland insurance firms this year. Those firms have gone out of business or must stop writing policies because of financial problems.

Insurance industry executives testified yesterday that the industry was in a slump and urged Congress to allow the industry to voluntarily



EDWARD J. MUHL
... testifies before House committee

gress would be forced to get involved if the insurance industry failed to take immediate action to prevent the closing of thousands of day-care centers.

Insurance industry representatives have said the financial slump was caused by excessively low rates that companies charged during the late 1970s, when they were trying to increase business. They tried to make up the losses through investments, but were hurt by falling interest rates, according to Marvis A. Walter, senior vice president of Insurance Services Offices Inc., which compiles statistics and rate information for the industry.

Because of the financial problems, insurance firms began dropping high-risk industries, and they place the blame on the high awards given in liability cases.

"The potential for multimillion-dollar judgments exists even though no such award has yet been paid in a child-abuse case, said Frank Neuhauser Jr., vice president of AIG Risk Management Inc., an insurance group based in New York. "Many of us believe we are living under a tort system that is completely out of control."

But J. Robert Hunter, former head of the Federal Insurance Administration during the Ford and Carter administrations, said that the insurance industry is using the courts "as a scapegoat."

"It's a self-inflicted problem, and to take it out on day-care centers is wrong," said Hunter.

Mike Causey is on vacation. The Federal Diary will

(3)

Appendix B

DOC 6/18/85

Insurers Told: Exit Some Lines

By JAMES NOLAN
Journal of Commerce Staff

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(1)

Insurers Urge Adoption Of New Policy

By JAMES NOLAN
Journal of Commerce Staff

CHICAGO — The very fate of the American liability insurance industry hangs on state regulatory approval of new liability insurance forms.

An array of insurance industry spokesmen argued this position in public hearings Thursday before a panel of insurance regulators from 18 states.

The industry representatives predicted further that American business and industry in all likelihood would go unprotected by insurance against liability claims on their assets unless the regulators approve a proposed uniform commercial general liability form for use by Jan. 1, 1986.

The hearings were organized by Illinois, New York and Texas insurance commissioners after a meeting of the National Association of Insurance Commissioners in Kansas City in June.

The commissioners at that time said they felt they wanted to hear from the industry in a single presentation, rather than taking testimony on a state-by-state basis as is usually the case when insurers seek approval for a new policy form.

Illinois Insurance Director John E. Washburn, chairman of the regulator panel, grouped supporters of the new policy in the morning and afternoon session.

Opponents, such as the Risk and Insurance Management Society, the voice of corporate insurance buyers, were to present their case later in the day and continue this morning.

Speaking in support of the new policy John C. Morrison, a senior vice president at Cigna Corp., said the use of the new commercial general liability policy drafted by the Insurance Services Office, an industry policy-making group, "will help to forestall a very serious threat to the financial solvency of some members of our industry.

"Without approval of the new ISO program, there will likely be an unacceptable number of insurer insolvencies — and this problem could have disastrous consequences for the general public."

The ISO in a statement said the industry's existing "occurrence" policy would be replaced by a "claims-made" version.

An occurence policy covers the insured for injury and property damage that happen during the policy contract year.

The claims-made policy covers the insured only if a claim is made for the damage during the year the policy is in force.

Christopher C. Mansfield, vice president and general counsel, Liberty Mutual Insurance Co. said that "unless we act positively, our industry may not be able to provide the risk shifting and loss distribution capacity which our customers require and society demands."

Fred R. Marcon, ISO executive vice president and chief operating officer, said, "There has been a complete breakdown in confidence on the part of risk takers: confidence in the predictability of loss, the efficacy of the underwriting process and the ability of insurers to control their own financial destinies."

Supporters of the new policy were united in placing the major share of the blame for the crisis on the judiciary system.

Industry officials say almost with one voice that it is the courts redefinition of policy contract language that has led to awards in pollution liability, product liability and medical malpractice that are bankrupting liability underwriters.

Gerald Wakefield, chief executive, North American reinsurance division of C.T. Bowring & Co., presented the views of Lloyd's of London reinsurers, vigorous supporters of the new policy.

Mr. Wakefield conceded that Lloyd's cannot dictate to American regulators on policy approval, but he wryly said that if the new form is not approved, Lloyd's will not reinsure American liability underwriters.

"Worldwide reinsurance capacity at this juncture is so short that further erosion could cause a fundamental change in the fabric of the U.S. insurance industry's mode of operation." He concluded: "ISO's proposed new claims-made form certainly goes a long way toward the retention of such reinsurance market support which currently looks so tenuous."

The industry spokesmen returned to the hearing table later in the day for questioning by the insurance commissioners.

Vs. Occurrence

Journal of Commerce Staff

CHICAGO — The casualty insurance industry and its biggest customers, corporate America, are having problems with words.

Three words in particular.

The words occurrence and claims made refer to that most important facet of the insurance business, the payment of claims and the question of who will make the payment.

To put it as simply as is possible, no small thing in a sea of policy language complexity, when you buy an occurrence insurance policy, your claim is good for damages you sustained in the period for which you paid the premium; usually one year.

You may not discover the damage until years later, but still your claim is valid and the underwriter who sold you that occurrence policy must pay the claim.

If you bought a claims made policy, your claim is good only if you file the claim during the year in which the policy contract

So if you are a doctor or make your living by making anything from cookie tins to insect spray, you most assuredly want that occurrence coverage. Who knows what you did 10 years ago to lay yourself open to a claim?

Now we get to the sticky part.

It is the occurrence policy and the way law courts are defining the words therein that is bleeding the casualty industry white, industry leaders say.

The insurance industry, therefore, wants to sell only claims made coverage beginning in January 1986.

In the process, the coverage afforded by the occurrence policy as it is understood by the corporations who buy it would be no more.

Understandly, then, the Risk and Insurance Management Society, the voice of insurance buyers for America's corporations, is, to a

Liability

JAMES NOLAN
...rce Staff ...

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Lloyd's has had a substantial position for generations in supporting American primary underwriters with reinsurance for product liability, pollution and environmental impairment coverages, directors and officers liability and medical and other professional malpractice coverages.

The industry forum was organized by commissioners from Illinois, Texas and New York. They were joined by commissioners and staff regulators from 14 other states after they found they were reacting in a piecemeal fashion to pleas from the industry, state by state, for permission to adopt the new system.

Although the commissioners protested that they were open minded about the issues, their questioning showed mounting skepticism.

For example, Peter Gilles, Connecticut commissioner, said that traditionally the industry position on a new policy filing has been that policy contract language is virtually cast in bronze and should not be changed.

"The purpose of this whole exercise is to avoid litigation. But aren't we going to just march lock step into court on this issue?" Mr. Gilles said.

"When the industry does not want us to approve something in a policy form the argument is made that if you change it, we will have to go and litigate. And you know what this means in the courts, so for God's sake, don't do that to us.

"Now you are asking us to approve a form which is going to make some very dramatic changes in a whole host of areas. How do you avoid the courts?" Mr. Gilles said.

Richard Savage of the ISO said that the danger of litigation was lessened because the new contracts were worded most carefully.

To put the kindest face possible on the matter, the response drew laughter from the regulator's table.

Later, Fred R. Marcon, ISO executive vice president, conceded that the possibility of new litigation had been much on the mind of those who shaped the new form. But, he added, the property/casualty industry has no other course if it is to survive.

At another point, Gerald H.C. Wakefield, chief executive, North American reinsurance division of C.T. Bowring at Lloyd's of London, employed an extended anecdote to explain the genesis of a legal liability principal.

He said that a British court had ruled in the days of Queen Victoria that if a householder was foolish enough to keep a tiger in the back garden, the householder was liable for damages the tiger did when he got out.

At a later moment in the proceedings, Mr. Wakefield sought permission to address the panel on a point.

"Fine," said James P. Corcoran, New York insurance superintendent, "but, please, no lions and tigers."

Outright hostility to the new policy forms was repeated at the meeting by a delegation from the Risk and Insurance Management Society, an organization of some 3,800 corporate insurance buyers.

William Blick Jr. of the Allen Group, a New York auto parts maker, and spokesmen for the society, said the group stood fast on the position it took in public hearings before the New York Insurance Department in May.

The society then accused the ISO of "an abuse of the antitrust exemption granted to insurers by the McCarran Ferguson Act," and that the new policy had been fashioned "with little or no concern as to the impact these changes will have on the insured or potential claimants."

OCC
9/22/85

APPENDIX C

STATEMENT OF THE AMERICAN INSURANCE ASSOCIATION

BEFORE THE

HOUSE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES

CONCERNING

CHILD CARE AND INSURANCE

JULY 30, 1985

American Insurance Association

The American Insurance Association is a national trade organization of casualty insurers.

The American Insurance Association (AIA) is a trade association which represents 172 property and casualty insurance companies. The member companies of the Association provide a majority of the commercial line insurance coverages written throughout the United States. Some of AIA's members provide general liability coverage to professional day care centers. Liability insurance is provided to some family day care homes through the application of the "business pursuits" endorsement which removes the business exclusion from the homeowner's policy.

Professional day care centers and family day care homes are currently experiencing a liability insurance availability and affordability problem. To the extent that state law mandates the acquisition of general liability insurance coverage as a prerequisite for doing business, the availability/affordability situation is exacerbated. Current insurance market conditions for professional day care centers suggest a market in transition rather than chaos. The countrywide experience for those companies reporting premium and loss data to the Insurance Services Office, Inc. (ISO) for advisory ratemaking purposes for day nurseries appears to conform with the current loss experience for the majority of commercial insurance lines. If expense factors are built into the loss and loss adjustment data for day care nurseries provided by ISO, the combined ratio approaches the aggregate general liability combined ratio of 152. Although these losses clearly indicate the need for increased rates, they do not suggest that insurers should abandon the market.

Insurance availability and affordability problems are not confined to the day care industry. Societal litigiousness and our legal system's movement

"The day care facilities have been caught up in this availability crunch and are being deemed higher risk, not necessarily based on a claims experience but due more to an insurance hysteria . . ." Testimony of Edward J. Muhl, Insurance Commissioner of the State of Maryland, before the House Select Committee on Children, Youth and Families, July 30, 1985. The Commissioner went on to point out these statistics for Maryland, remarkable action by many companies given the lack of statistical justification for such a move:

> Of 28 insurers writing liability insurance for day care centers in Maryland last year, 15 have left the market. Of the remaining 13, six will not write any new business. The last 7, those who will write new business, <u>all</u> have excluded child abuse from their policies. The Maryland Commissioner of Insurance has termed the pull out "hysteria" since no data supports it.

8611 Peck Avenue #4
Anchorage, AK 99504
907/333-9074

April 3, 1986

Senator Pat Rodey
Chair, Senate Judiciary
Pouch V
Juneau, AK 99811

Re: Tort Reform Legislation

Dear Senator Rodey:

I am writing to indicate my dismay over the proposed tort reform legislation now pending in the legislature.

It is my belief that although the current liability insurance crisis is a serious problem, it is too complex a problem to be resolved by passing the ill-advised tort reform package as it presently exists. The crisis, although exacerbated by the clogged civil court system, is a problem manufactured by the insurance industry because of their fiscal mismanagement. The truth is that the insurance companies are looking for a quick fix for investment losses caused by declining interest rates on their fiscal mistakes.

I believe it would be a travesty of justice to abridge the individual's right to personal redress through the court system. I say this as a "victim" in a products liability suit. I am one of the thousands of women who was injured through use of the Dalkon Shield intrauterine device. I was rendered sterile by that dangerous, untested device and am unable to ever have children. It is the single greatest loss of my life--the pain and disappointment I have experienced over this loss will be with me until the day I die. To this day, I have yet to be compensated, in any way, for the damages I have suffered, which include approximately $13,000.00 in medical expenses. It now appears that I may well never receive any remuneration for my loss, since A.H. Robins has filed bankruptcy.

Attorney's contingency fees are constantly brought up in the tort reform argument. I personally do not feel that a 1/3 fee is outrageous for an attorney to take when you consider that an attorney takes a risk in taking any case; there is certainly no guarantee that he will receive any award, let alone an amount to cover the billable hours he or she has in the case. People claim to be outraged that an attorney can collect his 1/3 fee from a sizable settlement or jury verdict, but I think those people should remember a few things regarding a large verdict:

1. That multi-million dollar verdicts generally come in cases of very severe injuries; e.g., an accident resulting in quadriplegia or injuries of an equally debilitating magnitude;

2. That many large verdicts are appealed by the loser and can be reduced by a higher court or are reduced by settlement between counsel during the appeal process;

3. That comparative negligence statutes exist in many states and thereby limit the percentage a plaintiff might recover; and

4. That an attorney puts in hundreds of hours in pretrial discovery and other legal procedures and, therefore, if he was billing at an hourly rate, the bill could well come to a comparable amount.

In addition, most attorneys advance costs to the client in contingency fee cases and these can easily run into several thousand dollars when expert witnesses and medical experts must be consulted for testimony.

Speaking from personal experience, I am quite happy to pay my attorney 1/3 of any settlement I may receive because he is the person who made the recovery possible in the first place by going out on a limb in accepting my case and proceeding to file suit.

Punitive damages are another bone of contention in the tort reform proposals. It is my belief that punitive damages are rarely awared and then only in cases of extreme abuse of the court system by the negligent party or its insurer.

Perhaps you can explain to me how it is that most of the 50 states dreamed up such severe tort reform proposals, all within the last year. I believe it is the result of a well-orchestrated lobbying effort by the insurance industry, aided and abetted by one of the country's most powerful professional lobbies--physicians. It has long been acknowledged that medical doctors have suffered under the malpractice surge and, prodded by the insurance industry, they have been quite an effective lobby for tort reform. The insurance industry is not regulated by the government, is not subject to anti-trust laws and is the third largest industry in the United States. They have assets of $319 billion and are adept at using the media for their own purposes.

In consideration of the above, I hope you will vote not to abridge the victim's right to recovery when he has been wronged by the negligence of an individual, corporation or other entity.

Thank you for taking the time to read this letter and to consider my opinion.

Sincerely,

Mary I. Peterson

File 01-07 (H)

J. W. WILSON & ASSOCIATES, INC.

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CHARLES E. JOHNSON
C. DAVID KIRBY
ERIC J. OLSON
CAROLINE M. SMITH
JOHN W. WILSON

UTILITY REGULATION
ANTITRUST ECONOMICS
TELECOMMUNICATIONS STUDIES
NATURAL GAS
TRANSPORTATION
INSURANCE RATES
REF:

March 7, 1986

RECEIVED
Department of Law
MAR 11 1986
AM 7 8 9 10 11 12 1 2 3 4 5 6 PM

Honorable Harold M. Brown
Attorney General of Alaska
Pouch K
State Capitol
Juneau, Alaska 99811

Dear Mr. Brown:

Dramatic insurance rate hikes and reduced coverage for many types of liability insurance in Alaska are disrupting key social sectors and creating crisis conditions in critical economic areas. Municipalities, school districts, medical and other professionals, nonprofit organizations, and even major industries are facing massive premium increases, insurance coverage restrictions, and, in some cases, non-renewals or cancellations. These insurance problems, in turn, are forcing curtailed public services, higher costs, and even closings for some important civic and business organizations.

The insurance industry blames our legal tort system for this situation. Law suits and rising damage verdicts, the insurance companies say, are forcing them to raise rates and limit coverages. But the actual evidence that insurance companies have presented is slim. In fact, the liability insurance claims data which are publicly available do not appear to support the insurance industry's crisis mentality. To be sure, some insurance companies have posted substantial underwriting losses during the past several years, due largely to their own rate cutting in a few highly competitive commercial insurance markets. But, those losses were generally not in the crisis liability lines, and they were substantially offset by equally large investment income profits (i.e., insurance companies operate like banks -- collecting premiums from policyholders in advance and investing these funds until they are ultimately "withdrawn" through the payment of claims).

Many insureds and public officials have responded to the insurance industry's arguments by questioning their reasoning and motives. Why should liability insurance premiums triple and coverages be cut in half for municipalities that have had no claims? Why do municipalities, churches, school districts and day care centers suddenly look like asbestos plants to insurance companies that have, up to now, profited from writing these coverages? Are key social areas being singled out by insurance companies to "soften up" public and regulatory resistance to insurance rate increases for all lines of coverage? Are insurers using their recent short-term profit reductions to promote statutory changes which would limit citizens' rights to compensation and thereby increase long-term insurance company profits? Are the special federal antitrust exemptions which permit insurance companies to operate collusively undermining effective independent competition in the insurance industry? Why is our legal tort system, which has played an increasingly key role in policing harmful actions by individuals and organizations now being singled out as the cause of the insurance crisis absent any conclusive supporting evidence?

Clearly, there is an insurance crisis. Any municipality, civic or professional organization, or business enterprise that has faced insurance renewals in the last year can attest to that. The cause, and therefore an appropriate response to the problem, is the only question. The importance of accurately identifying the cause of the insurance crisis and devising an appropriate solution can hardly be overstated. The insurance industry's hasty proposal to dismantle our legal tort system, which has evolved over the past two centuries to protect victims rights and shield the public from harmful products and actions, should be examined closely. If, as some have argued, a major cause of the crisis is actually traceable to the insurance industry's own cost excesses, rate increase strategies and antitrust exemptions, an entirely different solution is warranted.

That is the point of this letter -- to encourage the undertaking of a careful, independent, factual study of the causes and potential solutions to the mounting liability insurance crises in Alaska. J.W. Wilson & Associates, Inc., in cooperation with the National Insurance Consumer Organization (NICO), has actively researched issues in the insurance industry in recent years. Recommendations that we developed for the National Association of Insurance Commissioners (NAIC) on the importance of insurance company investment income in ratemaking were adopted by the NAIC and are now generally recognized in many states. We have also been actively involved (as advisors and consultants to state governments) in numerous insurance rate cases. In that capacity, we have gained detailed insights on insurance industry operations, costs, and rate increase strategies. We have undertaken research projects for State Insurance Departments and legislative committees dealing with insurance matters -- including, in recent months, examinations of the causes of and solutions to the liability insurance crisis.

Because of the knowledge that we have gained in these and related areas in recent years, we believe that the analysis that should be completed as a foundation for legislative or administrative action to resolve the liability insurance crisis in Alaska can be accomplished within several months and at a relatively modest cost, with appropriate legislative or administrative support in order to obtain necessary data and information from insurance companies.

In our opinion, the essential independent study that must be completed in order to devise an effective and publicly responsible solution to the liability insurance crisis involves two major focusses. First, a detailed and thorough examination of insurance company closed claims by line in Alaska should be completed. From such a closed claim study we will be able to identify:(a) the extent to which the legal system has or has not been the cause of dramatic liability insurance premium increases and coverage reductions in crisis lines in Alaska, (b) how victims are faring under the present system, and (c) what the various specific reform proposals

will actually accomplish. Second, a thorough examination should be made of insurance company financial operations, expenditures and profitability. This analysis will enable us to determine: (a) the extent to which dramatic liability insurance rate increases and coverage limitations in Alaska are or are not cost-justified, (b) what alternatives exist to limiting coverage and raising rates, and (c) the legislative and/or regulatory actions which may be undertaken to resolve the State's liability insurance crisis.

We would welcome the opportunity to discuss undertaking a project of this type in Alaska. We will, of course, be glad to supply examples of our past research and references from public officials who are familiar with our work in other states. Please call either of us at your convenience if you are interested in pursuing such a study.

Sincerely,

John W. Wilson, Ph.D., President
J.W. Wilson & Associates, Inc.
202-333-7442

Bob Hunter

J. Robert Hunter, FCAS, MAAA, President
National Insurance Consumer Organization
703-549-8050

ALASKA ACADEMY OF TRIAL LAWYERS
1015 W. 7th Ave.
Anchorage, AK 99501

FOR IMMEDIATE RELEASE
APRIL 4th, 1986

FOR MORE INFORMATION CALL:
AMES LUCE, 276-1191

ELEVEN STATE LEGISLATURES ADJOURN '86 SESSION REJECTING TORT CHANGES

Eleven states throughout the nation have rejected so called tort reform as a way of addressing the national insurance crisis. All eleven states have adjourned their business for the year.

"Legislators from these states have realized that changing the tort system will severely reduce their constituents' legal rights without a corresponding reduction in insurance rates," said Ames Luce, a local attorney and member of the Alaska Academy of Trial Lawyers. "Tort 'reform' does not mean lower rates, and insurance companies are refusing to make promises to that effect."

Six of the eleven states ended the session with no action on insurance issues. Both houses of the Georgia legislature had passed comprehensive tort change bills, but refused to compromise on a final version when the state's insurance industry, which spearheaded the tort effort, refused to guarantee that a rate

—more—

rollback would follow passage. Virginia empaneled an Interim Committee to study the issue.

Minnesota, Washington, and Idaho passed strict insurance reporting legislation requiring insurance companies to report on profits, investment income, reserves, and loss expenses for in-state operations for each type of insurance offered. Alaska requires each company to submit minimal information concerning its state operations.

West Virginia approved a $1,000,000 limit on pain and suffering in medical malpractice cases, but rejected an array of proposals. Likewise, Iowa simply passed a bill prohibiting frivolous lawsuits.

"Legislators in these states have seen the insurance industry campaign for what it is--a citizens rights reduction package," said Luce.

The Alaska Academy of Trial Lawyers is a statewide organization of personal injury and criminal defense attorneys. The Academy provides education and training for its members.

--END--

The Alaska Society of Professional Engineers

Address Reply To:
Vincent S. Haneman, Jr.
Dean, School of Engineering
539 Duckering Building
University of Alaska
Fairbanks, Alaska 99775

March 4, 1986

Senator Patrick Rodey
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Rodey:

The liability crisis and its impact upon the fabric of Alaskan life has become a major concern for everyone. It has hit full force across the United States at about the same time and is the subject of extensive study.

As president of the Alaska Society of Professional Engineers, I am involved in both the national effort and the Alaskan consideration. The impact upon Alaskan design professionals is far worse than on the country as a whole.

Insurance is either not available or is available with such restrictions that it is placing Alaskan firms at a disadvantage as compared to outside firms. The cost of premiums, when partial coverage is available, is extremely high. There are many reasons. An obvious one is the financial position of the insurance companies. Less obvious is the lack of predictability of awards, sizes of awards, and the cause or extent of liability.

The growing expectation of the average person to "make out" in litigation on liability; to "make out" far in excess of actual damages on cost to "restore to whole" is at the root of this problem.

The Alaska Society of Professional Engineers has joined the Citizens Coalition for Tort Reform. A strong thread throughout all the business ventures having trouble is that of establishing predictability for insurance. The Coalition has defined a primary set of areas which would reestablish some basis of logic and therefore assist in liability coverage. These items, in spite of comments from the bar, will not reduce recovery legitimately due the injured party for actual damages or limit the resources to "make whole".

The findings of the NSPE Liability Task Force and the NSPE/PEPP Professional Liability Committee are attached in the form of the NSPE White paper "The Liability Crisis". We feel this paper documents most of the items and, in turn, House Bill 532.

We, the Alaskan engineers, hope that you will support HB 532. If we can provide any information, please call.

Sincerely,

Vincent S. Haneman, Jr.
President, ASPE
Dean, School of Engineering, UAF

VSH/nes:300
Enclosure



a National Society of Professional Engineers

WHITE PAPER

THE LIABILITY CRISIS

published by the
Professional Engineers in Private Practice
and the
Legislative and Government Affairs Committee

This report was prepared by Milton F. Lunch, NSPE General Counsel, and reviewed for concept by the NSPE Liability Task Force and the NSPE/PEPP Professional Liability Committee. It is published for NSPE by the Professional Engineers in Private Practice, a semi-autonomous Practice Division of NSPE, and the NSPE Legislative and Government Affairs Committee.

Appreciation is expressed to Paul L. Genecki, Senior Vice President, Victor O. Schinnerer & Company, Inc., administrators of the NSPE/PEPP-endorsed liability insurance program, for reviewing the text and providing the insurance data.

It is intended that this report will serve as a basis for further cooperative programs with other professional societies and trade associations through the work of the Committee on the Liability Crisis of the Interprofessional Council on Environmental Design composed of The American Institute of Architects, American Society of Landscape Architects, American Society of Consulting Planners, American Society of Civil Engineers, American Institute of Certified Planners, American Consulting Engineers Council, and the National Society of Professional Engineers.

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1420 King Street, Alexandria, Virginia 22314

THE LIABILITY CRISIS

INTRODUCTION

At midnight on September 11, 1985 the town of Sykesville, Maryland (population 2200) went out of business.

At that hour the town's liability insurance expired and the town had been unable to find any replacement policy. The elected and appointed town officials resigned their positions and terminated all town services to the town's citizens. Their stated reason was the fear that they might be held individually liable for claims arising from the activities of the town or the services rendered by the town, ranging from street repair, water supply maintenance, enforcement of police laws, traffic control, and the host of other day-to-day functions which residents of towns and citizens routinely expect and hardly think about.

The Sykesville case is not unique or even special any longer. The loss of liability insurance because it is no longer available, or because the premiums are out of reach, has now extended to all elements of society. Child care centers are closing, school boards must close down schools with asbestos installed years ago, midwives are leaving the field, hospitals increasingly raise patient charges to cover ever-increasing premiums.

These concerns are not new to the professions. Engineers, architects, medical doctors, accountants, and now even lawyers (who are often blamed for the crisis) are feeling the pinch in terms of loss of coverage or substantial premium increases.

The purpose of this special report is not to assess blame, or to present solutions, as such. Rather, it is intended that it will be beneficial to members of NSPE, and others, to understand the background of how this all came about, what is the current situation in particular aspects of the problem, and what actions are underway or contemplated to deal with the many and varied issues which form the total crisis.

The emphasis of this report will naturally be on the implications of the problem for engineers, but not confined to those in private practice or any other single segment of the profession. Likewise, it discusses the relationship of the concerns of engineers with those of the other professions, but recognizing that there are major differences between the professions in light of their different forms of practice and liability exposure.

The liability crisis is not confined to the professions. It sweeps across virtually all elements of society. For some ten years the manufacturing industry has attempted to enact a federal law establishing a uniform standard for product liability. Despite extensive efforts and substantial financing the effort has not been successful. In addition to the arguments about the substance of the proposal which is intended to lessen the liability exposure for product cases, there has been strong opposition to the idea of "federalizing" what has always been a state function. Currently, a revised proposal to establish a voluntary "no fault" system for product liability has emerged, but there is no indication that Congress will move in that direction at this time. The justification for a national standard in product cases is that products are often produced in several states and are sold nationally in interstate commerce. That is not the case, however, with professional design and related services, which are almost always located within a particular state.

Engineering employees are sometimes concerned with the possibility of being named as defendants on an individual basis. While this is a rare occurrence, it is possible, particularly for those employed in industry, government, contracting or education, among others. Even those in consulting firms which do not carry professional liability insurance may be vulnerable. Employees in firms with such insurance policies are covered under the policy along with the firm, but there may be liability exposure for employees who leave the firm and go into non-consulting employment.

NSPE has attempted to provide for this potential exposure by a separate insurance program (jointly with ASCE) for individual employees. However, this undertaking did not generate enough support to justify its continuation from an insurance viewpoint. An effort to develop a new program for individual employees is continuing, but in the present state of the insurance industry there is no immediate prospect of success.

It is hoped that by this exploration of the problem, faced realistically from practical, economic, legal and ethical viewpoints, the engineering profession, working in concert with the other professions, may be able to play a constructive role in seeking remedies to a familiar, but now worsening situation; one which is heavily invested with an overriding public concern of health, safety and economic well-being of all citizens.

This report is presented in two basic parts. Part I is intended to deal with the current or immediate problems and to outline pending proposals to deal with practical approaches. These aspects of the problem reflect mainly the concerns of engineers in private practice and the efforts of the Professional Liability Committee of the Professional Engineers in Private Practice Section of NSPE. The Professional Liability Committee has worked extensively in recent months to monitor these fast-breaking developments, in-

cluding meetings with the insurance administrators and underwriters to press for the best possible language to limit the new policy exclusions discussed under the section on policy coverage.

Part II relates more to the long-term problems which are at the heart of the crisis, but which will require a much more detailed exploration of causes and possible remedies. This aspect, which in general is referred to as "tort reform", will require many years of effort if fundamental changes in our legal system are to be achieved. Of equal, if not more, importance will be a better public understanding of the nature of a legal system which in many respects has gone berserk in evaluating and balancing the rights of plaintiffs and defendants in injury cases.

THE LIABILITY CRISIS

PART I—The Immediate Crisis

The most evident change in the worsening liability picture has been the very high increases in premiums charged to practicing engineers in recent years.

For twenty-eight years NSPE and the American Institute of Architects have endorsed a professional liability insurance program underwritten by Continental Casualty Company, and administered by Victor O. Schinnerer & Co., Inc. It has been a fully collaborative program during all of those years, with regular review of development since its inception by committees of the two societies, and with full disclosure of all pertinent statistics as the basis for premium development.

In recent years the premium rate increases resulting from increased claims have averaged:

1981	17%
1982	9%
1983	9%
1984	15%
1985	35%

Historically, average premiums have been approximately 2-3 percent of gross billings of consulting firms. With the projected increases for the current policy period it is expected that they will average approximately 4-5 percent.

It should be emphasized that average rate increases or percentage of billings do not mean that each policyholder received or will receive the same increase. Premiums reflect a host of factors—size of the firm in terms of billings, type of practice, geographical location and loss experience. Thus, a firm with a substantial growth in billings may well have an increase above the average. Because firms which specialize in structural engineering have experienced the worst loss records in recent years their premium currently is in the highest range. Those firms which practice entirely, or mainly, in the field of structural engineering, and which have not heretofore been insured under the CNA program are finding it most difficult to find any source of liability insurance.

Another significant development in the worsening liability insurance picture is a trend toward higher deductibles required of the insured firms. This obviously means that in the event of a loss covered by insurance the firm will have to dig deeper into its own pocket to cover the first element of the loss.

All of this, compounded by the withdrawal or reduction in the availability of reinsurance, has resulted in a substantial lessening of insurance underwriters for A/E professional liability insurance. Only a few years ago there were some ten or a dozen insurance companies offering A/E liability insurance. Today there are only a handful or fewer insurance companies willing to offer such policies.

It would be erroneous, however, to conclude that the crisis is an insurance crisis. The state of the insurance market is basically a reflection and result of the liability crisis.

The reasons for insurance underwriters dropping out of the market are complex, but clear. The main reason, of course, is the heavy losses sustained by these companies in recent years. According to recent reports, the casualty insurance industry, overall, has lost $3.7 billion in the past year. In the A/E program alone, CNA, the largest of the remaining underwriters, reported an underwriting loss of $113,000,000 on the first $1,000,000 limit of liability between 1978-1983 with an accelerating loss trend. It has been observed by insurance authorities that insurance companies are not mainly interested in premium income; they look for their profit from cash flow—from investment of the premium income. This formula worked well during the years when interest rates were in the 20 percent, or better, range. The underwriters were then content to absorb the underwriting loss and make up for it from the investment income. In this regard it is worth noting that invested premium income generates income for a long period of time before claims are resolved and indemnity payments made. Now, however, with interest rates at a much reduced level the cash flow-investment formula fails to produce a sufficient return to compensate for the increased costs of claims handling, indemnity payments and overhead.

As an indication of the deteriorating A/E liability picture from the insurance underwriter's standpoint, in 1983 (the latest available complete statistics) claims frequency remained fairly steady at 44 claims per 100 firms per year. Paid claims frequency (claims in which there was an indemnity payment) was 9.5 per 100 firms. But, severity measured in terms of average indemnity payment was reported at $148,000, representing an increase since 1978 of approximately $40,000 per claim. Also, during the same time frame, average claims expenses have more than doubled on a per claim basis.

Policy Coverage

As serious as the premium increases have been, in some respects it is not the most serious concern. The firms required to pay these higher insurance costs must of course, pass them along to clients as part of the firm's overhead. It has been suggested in that connection that in billing a client the A/E may choose to add a line item to the bill to represent the liability insurance part of the bill. Thus, if a firm is paying 3 percent of its billings for liability insurance it would add 3 percent of the basic bill to the client. This is a dubious tactic, however, on several grounds. First, the line item for insurance would represent double billing if the same 3 percent were in the overhead part of the firm's charge to the client. Second, it may well be questioned whether it is wise in any event to spell out to clients the extent of the A/E's insurance, thereby perhaps giving the client the false idea that it may as well file a claim for some imagined deficiency in the plans and specifications "because the insurance company will pay it."

From its inception, the A/E insurance policy has included certain exclusions, such as certain types of more hazardous projects, guarantees by the A/E, nuclear facilities, etc. In the face of the emergence of pollution-related claims and enormous claims related to asbestos, the insurance industry as a whole has opted to now exclude those two categories from liability insurance coverage. Those two exclusions, to be written into every new policy and renewal policies read as follows:

Pollution

We will not defend or pay under this policy for "claim" and "claim expense" resulting from "professional services" performed by you and arising out of:

1. The actual, alleged or threatened discharge, dispersal, release or escape of "pollutants"; or
2. Any governmental or regulatory directive or request that "you" or anyone acting under your direction or control test for, monitor, clean up, remove contain, treat, detoxify or neutralize "pollutants".

This exclusion does not apply to "claim" or "claim expense" resulting from "professional services" performed by you in the design and construction of treatment facilities for:

a. domestic sewage including those receiving industrial waste but only if such industrial waste is pretreated in accordance with applicable governmental or regulatory standards,

b. potable water and

c. "storm water".

ADDITIONAL DEFINITIONS

"Pollutants" means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

"Storm water" means from rain, hail, snow or sleet.

It is noted that the exceptions to the basic exclusion were initially developed by extensive discussions between the NSPE/PEPP Professional Liability Committee and representatives of CNA and the Schinnerer firm. That initial language, later revised for a clearer understanding that the exclusions would not apply to "traditional" engineering activities, such as water supply facilities, drainage, wastewater facilities, street, roads and highways, municipal incinerators, power plants and domestic and non-manufacturing facilities, was not accepted by CNA, which had meanwhile filed the language quoted above with the state insurance authorities.

As the language now stands it does not meet the concerns of engineers in private practice, but there is an indication that the more extensive and explicit language will be considered for subsequent policies. The present language is, hopefully, only a first step in better defining the extent of the exclusion, but it will take more time to learn how the exclusion will be applied through a case-by-case experience. As explained by the CNA comment in transmitting the exclusion language to policyholders, the intent is to remove from coverage claims which rest upon damage from pollution, as defined, but to continue to cover the remedial costs in the project when it is deemed that the A/E had been negligent in the design of the particular part of the facility which failed.

Asbestos

To "claim" or "claim expense" alleged to or actually arising out of:

1. specification of a product, material or process containing asbestos
2. failure to detect the existence or proportion of asbestos in a product, material or process
3. the performance or failure to perform "professional services" in the abatement, replacement or removal of a product, material or process containing asbestos

whether by you or on your behalf.

Indemnification

Faced with a choice of taking on a project which may entail pollution or asbestos exposures, or declining the project because of the uninsurable risks, the engineer has little choice but to seek protection through an indemnification clause. For that purpose the PEPP committee has developed two indemnification clauses as follows:

Hazardous Waste—For services involving or relating to hazardous waste elements of this agreement, it is further agreed that the OWNER shall indemnify and hold harmless ENGINEER and their consultants, agents and employees from and against all claims, damages, losses and expenses, direct and indirect, or consequential damages, including but not limited to fees and charges of attorneys and court and arbitration costs, arising out of or resulting from the performance of the work by ENGINEER, or claims against ENGINEER arising from the work of others, related to hazardous waste.

The above indemnification provision extends to claims against ENGINEER which arise out of, are related to, or are based upon, the dispersal, discharge, escape, release or saturation of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids, gases or any other material, irritant, contaminant or pollutant in or into the atmosphere, or on, onto, upon, in or into the surface or subsurface (a) soil, (b) water or water-courses, (c) objects, or (d) any tangible or intangible matter, whether sudden or not.

Asbestos—For services involving or relating to the removal or encapsulation of asbestos as part of this agreement, it is further agreed that the OWNER shall indemnify and hold harmless ENGINEER and their consultants, agents and employees from and against all claims, damages, losses and expenses, direct and indirect, or consequential damages, including but not limited to fees and charges of attorneys and court and arbitration costs, arising out of or resulting from the performance of the work by ENGINEER, or claims against ENGINEER arising from the work of others, related to asbestos activities.

Already the question has been raised as to what action the engineer should take if a particular project does not indicate the likelihood of either a pollution or asbestos concern, but during the course of the work such a potential problem develops. It would be impractical in such an instance for the engineer to unilaterally terminate services. To do so, in fact, might well generate a claim for breach of contract. One suggestion to deal with this kind of potential problem is to add a clause in the owner-engineer agreement and in supplementary general conditions to the effect that when and if such conditions are observed the engineer or the contractor, as the case may be, shall cease all work related to the pollution or asbestos conditions and notify the owner of the circumstances. The owner will then be obligated to determine what course of action is to be taken, such as bringing in experts for advice on how to deal with the condition.

Toxic and Hazardous Waste—As this report was being prepared Congress was in the midst of deliberations on an extension and expansion of the federal Superfund program. This federal program designed to bring about the cleanup of toxic and hazardous waste sites around the country is expected to involve the expenditure of somewhere between $5 and $10 billion over the next five years. The key players in this national program will obviously be engineers and contractors. Yet neither will be able to play their role in such an undertaking without any protection from claims alleging damage as a result of cleanup operations in a highly sensitive area, and particularly as such claims may entail class action suits of enormous magnitude.

Fortunately, Congress appears to be receptive to the problem and is moving toward an indemnification program whereby the federal government will "hold harmless" engineers and contractors (referred to as "response action contractors") in the pending legislation.

The Senate has already passed its Superfund bill, which authorizes EPA to hold harmless and indemnify response action contractors "... against such claims to the extent not covered by available insurance and to the extent that any such damages awarded do not arise out of the gross negligence, recklessness, or intentional misconduct of the contracting or subcontracting party, so long as such indemnification is in the public interest."

Likewise, three House committees have adopted similar language in their bills, which are now being merged into one bill for House action. As explained by the report of the House Judiciary Committee:

> "At present, insurance availability for response action contractors is diminishing, limits of coverage are being reduced, and premium rates are increasing by more than 50-200 percent. Insurance industry sources estimate that only 10 percent of contractors' market needs are currently being met by insurers, and that by January, 1986, no insurance will be available. The present lack of insurance is already causing a reduction in the number of qualified contractors willing to participate in Superfund cleanups. As insurance becomes increasingly unobtainable over the next year, the availability of qualified contractors could diminish to the point of being acute, and the Superfund cleanup program could come to an abrupt halt."

Assuming final congressional approval of the Superfund bill, a remaining question will be the extent to which the EPA indemnification will apply. The House Judiciary Committee report recognizes that EPA may provide "appropriate limits", to represent amounts equivalent to, but not in excess of, adequate insurance coverage, and to include deductibles. The report also refers to payment by response action contractors of a premium for the ideminification coverage and to offer it only as a supplement to available insurance, if available insurance is not adequate. Thus, following enactment of the indemnification provision it will be necessary for engineers and contractors to engage in detailed discussions with EPA to define the basis upon which indemnification will be provided.

Final congressional action of an indemnification approach will open the way for similar legislative action at the state level to cover projects which are state-financed outside of the federal program. Some efforts have been initiated at the state level along similar lines, but it will take concerted action by the state societies to press for more vigorous action during the 1986 legislative sessions. The federal approach should serve as a model to spur state action.

Private cleanup operations will likewise call for an insistence upon indemnification provisions in the engineer-owner contract.

Other Approaches

Various other ideas have been advanced as possible means of dealing with the liability conditions which confront the design professions.

These include, for example, a firm establishing a separate corporation to handle the pollution and asbestos kinds of projects. The idea would be for the separate company to be alone liable for claims in those areas. This entails several important considerations. First, from a legal standpoint, for this approach to work it must be clearly established that the separate firm is truly independent of the parent company. This means separate stockholders, separate officers and personnel, and separate financial arrangements. Otherwise it may well be argued that the separate company is no more than a "shield" to avoid liability, much as the cases in which a husband-owner transfers his assets to his wife to protect himself from liability. The courts will most likely, in such cases, apply the legal doctrine of "piercing the corporate veil."

A second important consideration is whether, even if a company is created as a truly separate entity, prospective clients will be willing to enter into contracts with a firm which presumably would have limited assets and no liability insurance.

From time to time, some engineers have chosen to "go bare" on the theory that in the absence of liability insurance they may be less likely targets for liability suits. There is some theoretical basis for this philosophy in today's climate of plaintiffs' attorneys looking for the "deep pocket". Again, it is a question of the extent to which the engineer is a gambler and is willing to take the chance that his personal assets will be subject to claim. It may be contended that this approach might work if the assets of the firm alone are at risk, and not those of the individual officer or shareholder. However, in the case of professional services it is more likely than not that those who are in responsible charge of plans and specifications which are found to be negligent will be held personally liable. For that reason the present professional liability policy covers the individuals in the firm, as well as the firm itself.

This idea is closely akin to what is called "self- insurance" a term which actually means no insurance. True, a firm may set aside part of its revenue each year into a separate fund for liability claims only, but under present tax law such set-aside funds are after tax dollars. If a firm is lucky enough to not have serious liability claims for enough years to build the self-insurance fund to a substantial amount it may be a workable scheme, but how much is enough to pay potential losses is purely speculative.

Part II of this report will deal with the broader aspects of the liability crisis, including protective legislation against injured construction worker claims, joint and several liability laws, punitive damages, restrictions on contingent fees, frivolous suit claims, pre-trial panel requirements, statutes of limitation, a new "unified risk" insurance concept, and the need for long-range tort reform.

THE LIABILITY CRISIS

PART II—Remedial Actions

The commonly used phrase in discussion of what actions might be taken to help resolve the liability crisis is "tort reform". That refers broadly to the idea that much of the problem arises from laws and judicial procedures which tend to impose ever-higher responsibilities and costs upon defendants in liability cases. Another common reference to this situation is the use of the "deep pocket" in determining who should be held liable for damages in a given situation. It is said that whereas the lawyer representing a plaintiff traditionally would first ask, "who is at fault", now will first ask "who has the money?"

An equally important perception is the attitude of the general public in being excessively lenient in dealing with the claims of persons claiming the right of recovery for damages sustained in a given situation, with much less concern for whether a particular defendant was at fault. This is a reflection of the same "deep pocket" philosophy alluded to above, but here it is even more significant because it is the members of the general public who make up the juries. Since 1970 there have been approximately 220 verdicts of more than $1 million in injury cases. Even though many of these were later reduced by the courts as excessive, those kinds of numbers attract headlines and further implant the idea of tremendous awards in cases in which the sympathy of the jury is with the injured plaintiff.

The more difficult problem in trying to cope with these kinds of developments is that remedial action may be taken to bring about a fairer and more equitable system designed to protect the rights of those with a proper claim, while at the same time limiting the current atmosphere which drives juries to grant ever-higher awards on responsible defendants, and, even worse, drives a finding of liability when not justified.

This Part of the paper, therefore, deals with various and sundry current proposals and developments designed to achieve some degree of reform in the justice system. It should be emphasized that many of these items as discussed below flow from medical malpractice cases, and to a substantial degree are less relevant to cases involving design professionals. The reason for the distinction is that in medical malpractice situations there is virtually always a claim involving death or injury. In the design professions, however, approximately 80 percent of the cases involve property damage, broadly defined. Only about 20 percent of design professions cases relate to personal injury or death, and most of those occur in connection with accidents during the construction process.

Worker Compensation Laws

Turning, then, to the construction accident situations, a move has started in two states (Oklahoma and Kansas) which gives promise of alleviating a problem in which the design professional is unfairly a victim of claims for accidents completely outside the responsibility of the engineer. In a typical case, an unshored trench (in violation of safety laws) collapses and a construction workman is killed. The widow is entitled to the benefits provided under the state workers compensation law, which are generally relatively low. This exonerates the contractor-employer from any further liability. The widow in this case then files suit against the design engineer, alleging that in some fashion the collapse was caused by the negligence of the design firm in failing to properly monitor the construction as part of its services during the construction phase. Even if the defendant engineering firm is ultimately found to not be responsible, substantial legal costs are involved and to a large extent, if not totally, are paid by the firm out of its deductible under the liability insurance policy.

To deal with this kind of "no-win" problem, Oklahoma first enacted an amendment to its workers compensation law which provides that in such instances the design professional stands in the same shoes as those of the contractor; the firm is equally not subject to suit for damages over and above the amount paid under the worker compensation law system. The only exception is if it is determined that the collapse was due to the negligence of the engineer. While this exception may open the door to the filing of a suit in the kind of example stated above it should be relatively simple to quickly prove that the engineer under his contract had nothing to do with the trench. In that connection, it is exceedingly important that the engineer's contract with the owner, plus provisions in the general conditions, make it clear that the engineer during the construction phase is not responsible for contractor's means, methods and techniques.

A copy of the Oklahoma law is reproduced in Appendix A.

Frivolous Suits

Probably every engineer who has been sued has reacted that the suit was unjustified, groundless and without merit—a frivolous suit. While it is often true that the engineer is brought into a dispute between other parties on a "shotgun" basis, it does not follow that the engineer is a vic-

tim of a truly frivolous suit. A frivolous suit does not result because a party wins the case on the merits, or is dismissed prior to trial. While there are various definitions of what constitutes a frivolous suit, the most common characteristics are that the party alleging the suit was frivolous must first be dismissed from the case or win on the merits. But that is not enough. It must also be shown that the allegations were totally without merit, a showing of bad faith or other improper motives on the part of the plaintiff.

The leading case to illustrate the difficulty if maintaining a frivolous suit (sometimes called a counter suit) involving design professionals is **Bird v. Rothman**, 627 P.2d 1097 (Ariz. 1981). In that case an architect had designed a race track in 1963. In 1976 he was sued by a woman who was injured at the track when the grandstand glass was shattered by a rock. In 1977 the architects were dismissed from the case. In 1978 he sued the woman's attorney on the ground the attorney had been negligent in failing to investigate the facts and the law before bringing the case. In finding against the architect, the court noted that a balance must be struck between freedom of access to the court and discouraging unmeritorious litigation; that the courts must be open to litigating parties without fear of subsequent prosecution for calling upon the court to decide a contested issue; that an ulterior purpose alone cannot constitute abuse of legal process, concluding:

> "In summary, despite appellant's arguments that negligence suits, such as the underlying suit in this action, against architects and engineers have a significant impact on malpractice liability insurance rates and serve to impugn the reputation of conscientious professionals, we are persuaded that in the absence of proof of malicious prosecution on the part of the injured party or his attorney, the interest of freedom of access to the courts compels the conclusions we have reached."

A number of the state societies have tried over the years to enact frivolous suit statutes to define the circumstances in which a successful defendant might recover his legal costs in defending an unmeritorious case. In fact, however, most states have such provisions by law or by court rules, even though the wording varies considerably. For those still pursuing this type of legislation attention is called to the wording in Rule 11 of the federal rules of civil procedure, as amended in 1983, requiring that all pleadings and motions on behalf of a party shall be signed by the attorney of record, and further providing that:

> "The signature of an attorney or party constitutes a certificate by him that he has read the pleading, motion, or other paper; that to the best of his knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation. If a pleading, motion, or other paper is not signed, it shall be stricken unless it is signed promptly after the omission is called to the attention of the pleader or movant. If a pleading, motion, or other paper is signed in violation of this rule, the court, upon motion or upon its own initiative, shall impose upon the person who signed it, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee."
> (As amended Apr. 28, 1983, eff. Aug. 1, 1983).

While a rule of this type, or a statute along similar lines, is proper and desirable, based upon a review of the cases over the years it is not likely that a design professional who was involved to any degree in either the design or construction phase of the project will be held entitled to the benefits of a countersuit through a frivolous suit action except upon a showing of a malicious purpose on the part of the plaintiff, or a reckless failure of the plaintiff's attorney to make even a minimal investigation of the facts before naming the design professional as a defendant.

Pre-Trial Panels

A development of potential significance in recent years has been the enactment of laws to require that in malpractice cases the party bringing the action first submit it to a panel of those with ostensible experience in the area of practice involved for a hearing and subsequent rendering of an opinion on the merits of the case.

These kinds of statutes vary considerably in detail, ranging from the composition of the panel members, procedural hearing requirements, compensation for the panel members, and, most importantly, the extent to which the panel opinion is admissible in any subsequent court proceedings.

The theory behind this kind of procedure is that if the pros and cons of the case are presented to an unbiased but knowledgeable panel of persons with some degree of expertise in the subject matter the resulting opinion may bring about a result which is acceptable to either or both parties, and thus avoid full-scale litigation. In every such instance, however, the panel opinion is not binding on either party and either may then take the case to court in the normal manner.

Most of the experience in this type of operation has been in the medical field. A number of pertinent questions have resulted from that experience. First, in several states the courts have ruled that a requirement that the case be first submitted to the panel is unconstitutional because it has a "chilling" effect on the plaintiff. That is, the plaintiff is required to go through what may amount to two full-scale proceedings, involving repetition of witnesses, attorney fees and time spent in prosecuting the case. This objection is compounded when the statute allows the panel finding to be submitted to a jury in a subsequent trial because it may unduly influence the jury's judgment of the case. In other states, however, the courts have upheld the mandatory panel procedure in medical malpractice cases on the ground that such a procedure is designed to deal with the "medical crisis" in the state.

To what extent the constitutional issue will be resolved when the concept is applied to non-medical cases remains to be seen. To date only one state—Hawaii—has enacted a similar requirement for design professionals. The first Hawaii statute was enacted in 1981 and was subsequently determined to be lacking in several major respects, following which it was amended in 1985. The full statute is included as Appendix B.

The essential features of the Hawaii law are:

1. The panel is composed of a chairperson who is familiar with tort claims settlement processes, one attorney experienced in trial practice and one design professional appointed from a list submitted by the registration board.

2. The claimant and the design professional defendant must each deposit $450 with the director of regulatory agencies.

3. The panel is required to hear the case within 30 days after the date for filing a response, and no persons other than the parties, witnesses, consultants and attorneys may be present except with the permission of the chairperson.

4. The panel hearing is informal, but witnesses and consultants may be questioned by the panel members and legal counsel. The panel may subpoena witnesses and documents.

5. Following completion of the hearing, the panel shall file a written advisory opinion with the director of regulatory agencies, who shall mail copies to all parties in the case and the professional liability insurance carrier. The panel opinion is to decide the issue of liability and the amount of damages, if any, stipulating which part of the damages are for economic loss and non-economic loss, but the panel may not recommend punitive damages.

6. The claimant may institute litigation based upon the claim only after a party to the panel hearing rejects the decision of the panel. The opinion of the panel on the issue of liability or damages may not be admitted in evidence in any subsequent trial.

7. The section requiring cooperation on the part of all parties to the case also provides that the costs of the action may be assessed against a professional liability insurance carrier or a party for failure to cooperate, even though the insurance company is not a party to the proceeding.

8. The 1985 amendment added a section permitting a judge to avoid the panel procedure if the judge determines that the subject matter in dispute is unsuitable for the panel procedure.

9. The 1985 amendment also added a section calling upon the attorney for the claimant to obtain a qualified person's opinion that there is merit to the claim, but this requirement may be avoided if the attorney is not able to obtain such consultation from qualified persons.

It is too early since the 1985 amendments to determine to what degree the Hawaii procedure may be helpful in resolving disputes. Design professionals in Hawaii have reported a lack of success under the 1981 law, and more recent reports indicate divided opinion as to whether the amended law has been useful to date.

Dispute Resolution

The federal and state courts are literally drowning in the volume of civil cases filed each year. As reported in a recent special study of the Defense Research Institute, there were approximately 240,000 cases filed in 1984 in the federal courts alone, and there are now 10 million civil cases filed in all courts annually. That number suggests the reason for the lengthy delay in bringing a case to trial and judgment, often running into many years. It is only because a vast majority of these cases are ultimately dropped or settled that the judicial system works at all.

Meanwhile, there is renewed interest in finding means to resolve disputes short of formal trials, both in the interest of time and cost. In Hamlet's famous soliloquy he noted, among other of life's problems, "the law's delay", and as far back as 1759 Edmund Burke observed that, "The contending parties find themselves more effectively ruined by the delay than they could have been by the injustice of any decision." Warren Burger, Chief Justice of the United States, has led the way in calling for alternative dispute resolution techniques, observing:

> "We must remember that when a dispute arises there are options. I was trained with that generation of lawyers taught that the best service a lawyer could render a client was to keep the client out of court. The adversary litigation process is expensive and time-consuming; and it often leaves a trail of stress and frustration. Other alternatives represent a way to avoid litigation, yet they largely go unused."

Arbitration

The best known system of alternative dispute resolution is arbitration: a procedure which is particularly pertinent to disputes involving design professional and construction cases.

Arbitration of disputes has existed since time immemorial, going back to the story of King Solomon's resolution of a dispute between two women who claimed parentage of a baby. And it has long been used in commercial cases. But in 1966 the design professions undertook to establish a special set of rules and procedure for construction disputes under the aegis of the American Arbitration Association. NSPE and some dozen other societies now support and participate in the oversight of a special set of Construction Industry Arbitration Rules, administered by AAA through its 26 regional offices.The Rules and explanatory material about the program may be obtained from AAA, 140 West 51st Street, New York, NY 10020.

While there is little doubt that arbitration is faster and less expensive than full-blown litigation, there are some in the design professions and among their lawyers who find it unacceptable for a variety of reasons. There has been some confusion about the nature of arbitration by reference to it as "mandatory" arbitration. It is mandatory in the sense that if the parties agree by contract to arbitrate disputes which may arise either party may invoke the arbitration provisions. The resulting decision of the arbitrators is then binding and enforceable in the court. But the parties may likewise agree to not include an arbitration provision in their agreement, and in that case it is simply not an option for dispute settlement. Some critics favor a clause which says that the parties may agree to arbitrate when a dispute arises, but realistically the chances of the parties at that point agreeing to anything are almost nil, such as the procedure to select the arbitrators, the rules to be observed, payment of costs, and a host of other details spelled out in the AAA Rules.

Among the objections offered by opponents of arbitration are that it is an informal procedure; the rules of evidence do not apply, the decision is not subject to appeal to the courts on the merits of the dispute, there is no provision for discovery of information by the parties prior to the hearing, and that, according to some, arbitrators tend to "split the difference" in the decision. The other side of the coin, of course, in response to these arguments is that the lack of legal formalities is one of the factors that makes arbitration more expeditious and less expensive, that without the arbitration decision being final and binding the procedure would be fruitless if a party could retry the case in court at double expense. One of the advantages of arbitration is that it is private, whereas a court trial is public.

One of the strongest arguments for arbitration rather than a jury trial is that the arbitrators are selected on the basis of their technical expertise in dealing with often-complex cases in a construction setting. Under the AAA procedures, the parties have the choice of reviewing a list of suggested arbitrators and striking those not desired to the point that the arbitrators are then named from the lists acceptable to both parties. It is vitally important in cases involving technical issues that the arbitrators have an adequate technical background to fully understand the issues. Members of juries, on the other hand, and judges, for that matter, are most unlikely to have that kind of knowledge and expertise.

To deal as objectively as possible with these arguments and counter-arguments, NSPE and the other participating societies in the Engineers' Joint Contract Documents Committee have included an arbitration clause in the owner-engineer agreement and in the general conditions on a separate page which may be removed without affecting the rest of the document, thus leaving it to the parties to decide in advance which way they prefer to go in handling potential disputes. Also, the arbitration clause in the owner-engineer agreement is limited to claims and counterclaims not in excess of $200,000. This figure, however, based on AAA statistics, represents some 80 percent of all claims involving design professionals. Another important aspect of the arbitration clause is a stipulation that it may not be used to join the design professional not a party to the agreement; that is, in a dispute between an owner and contractor, or contractor and subcontractor, the engineer may not be required to participate in or be bound by the arbitration result without prior consent.

Mediation

An emerging form of alternative dispute resolution is the use of mediation. This is a process, sometimes confused with arbitration, which attempts to have the parties agree to bring in a neutral third party to act as a "go between", to try to encourage and induce the parties to reach a voluntary settlement. A mediator has no authority to render a binding decision. It has been suggested that in advance of the start of a project the parties agree to name a mediator in the event disputes arise. While this has not been tried to any degree in the construction area, it is somewhat questionable whether the formal anticipation of disputes might not, in fact, generate disputes which otherwise might be settled by the parties themselves.

Another aspect of this development has been the suggestion that two functions be combined; that is, an arrangement in which the mediator first attempts to induce the parties to reach a voluntary settlement, and if that effort fails to convert his status to that of an arbitrator, with authority to render a binding decision. That concept is flawed by the fact that because the two functions are so different in concept and procedure the same person cannot serve both purposes. A primary function of a mediator is to solicit from both

parties separately and confidentially their "bottom line" positions on each aspect of the dispute. If the parties know that such confidential information may be used against their interests if the mediator becomes an arbitrator the system itself will obviously fail.

The AAA has adopted "Construction Industry Mediation Rules" under the auspices of the Construction Industry Advisory Committee, including a contract clause for mediation. But this clause is not enforceable if either party refuses to mediate in good faith, in which case the clause becomes inoperative and the procedure turns to arbitration if the parties have also inserted the arbitration clause in their agreement.

Limitation of Liability

Another controversial idea in trying to deal with liability costs has been to write into the owner-engineer agreement a provision to the effect that the liability of the engineer will be limited to a stipulated amount or the amount of the engineer's fee, whichever is more. Although some engineers have indicated the acceptance of this idea by owners, it raises several difficult problems.

As noted in the Commentary accompanying the standard documents prepared by the Engineers' Joint Contract Documents Committee:

> "The Committee also feels strongly that it is undesirable and quite unprofessional to try by standard society-endorsed contract forms to relieve Engineers from liability for improperly performing those duties and responsibilities which their expertise and professional training qualifies them to perform and which, because of their being licensed to practice, they have a duty to the public to perform. In fact, such contractual endeavors may well provide no more than illusory legal protection since courts and juries are not likely to accept wholesale efforts to avoid professional responsibilities."

To date there have not been definitive court decisions applying to specific limitation of liability clauses for design services, but in several cases involving professional services the courts have held such clauses to be in violation of public policy. In some instances the courts have upheld limitation of liability clauses for commercial transactions, provided that the parties were of relatively equal bargaining strength. But in other instances where it has been determined that the contract was a "contract of adhesion", meaning it was prepared on a "take it or leave it" basis, the courts have ruled such a provision invalid.

Another facet for consideration is the reaction of clients when presented with a provision which, in effect, asks the client to share in paying the damages resulting from the negligence of the engineer. Some engineers have reported an adverse reaction to the point of endangering their retention for the job.

Unified Risk Insurance

Approximately one-third of professional liability insurance dollars go to the payment of litigation, including investigations, expert witnesses and appeals.

Suppose it were possible to find a way to eliminate most of the litigation cost? A novel and intriguing idea to accomplish that goal has been advanced and is under study by a joint committee of the professional societies. The idea, which has a long way to go before it will be known if it is feasible, is called "unified risk insurance". In brief, it contemplates that there would be one insurance policy covering the entire risk of the parties involved in the project—owner, design professional, prime contractor, subcontractors, and perhaps material suppliers. The owner would pay the entire premium on the justification that in the long run the owner pays all the costs through fees and construction bids which must reflect the cost of insurance.

Under this approach as a liability issue arose there would not be an attempt, as now, to decide which party was at fault. The single insurance fund would pay the cost of remedial action. It has been compared to home fire insurance. If there is a fire it does not matter from an insurance standpoint whether it was caused by smoking in bed, bad electrical wiring, lightning, or any other cause. The insurance pays the cost of restoring the property to its original state. In a word, it is a form of "no fault" insurance.

There are some obvious questions and limitations. It could not cover non-property claims between the parties, such as a contractor claim for an extra because another party had delayed his performance. That kind of claim would have to be resolved by arbitration or litigation. It could conceivably cover claims by injured third persons, but those kinds of claims could involve litigation to determine if the injury was caused by any of the covered parties, and, if so, the amount of damages.

The idea basically is to have three related insurance policies—one for property damage in the project (the walls crack, there is roof leakage, the HVAC system does not work, and a host of other typical property claims). A second policy would cover third-party claims of the type noted above. And a third policy would extend the coverage to an undefined period of years following completion of the project. One of the many unresolved issues at this point is whether and to what extent there would be deductibles for the various parties, and how they would be allocated.

The insurance consultant retained by the societies to develop the idea has noted that in today's insurance market it would be most difficult to launch such a revolutionary

approach, and it is likely that the insurance industry would require, at best, some form of "stop loss" fund to protect the insurance underwriters; an in-house or captive insurance fund raised by the participating societies.

The current status is that the idea is being explored in depth with representatives of the insurance industry, owners, contractors, subcontractors, and others. Realistically, it will be several years before there is any definitive conclusion as to the merits and feasibility of such an approach to reduction of liability insurance costs.

Statute of Limitations

A more immediate remedial provision is the enactment of statutes of limitation, more correctly identified as statutes of repose. These kinds of state laws, which exist in more than half of the states today, provide that after a stated period of time following substantial completion of the project (usually 6-8 years) a person claiming injury as a result of faulty design or related services is barred from maintaining an action against the design professional. Appendix C lists the states with such statutes and the applicable time period.

In some states, as noted, the courts have held these statutes to be unconstitutional in that they deprive an injured party of his "day in court", although in each such state law it is provided that the bar to suit does not apply to the owner or person in possession of the property. That party is more justifiably accountable for a failure which occurred long after the project was designed and built by virtue of inadequate maintenance of the facility.

The existing statutes of repose vary in detail and should be read in entirety to determine the starting period for the time cut-off, the parties covered by the law and the interpretation of the law by the courts.

Contingent Fees

An area of tort reform drawing considerable attention as the overall liability situation has worsened is the use (or abuse) of contingent fees by lawyers. It is alleged that this system of allowing lawyers to collect substantial fees as a percentage of awards to injured persons generates claims, and there is little doubt that this is true. As a result, several states have now moved to put a limit on contingent fees on a reduced sliding scale. A recent New York law, for example, stipulates that contingent fees will be limited to 30 percent of the first $250,000 recovered, 25 percent of the next $250,000, 20 percent of the next $500,000, 15 percent of the next $250,000, and 10 percent of any amount over $1,250,000.

The contingent fee system relates almost exclusively to injury or death claims, and is therefore of less importance to design professionals than to those in the medical field. However, as previously noted, a limitation schedule of the New York type will be helpful to some extent to engineers in the 20 percent of cases involving bodily injury or death.

A related aspect of this point is the suggestion that one of the major deterrents to unjustified suits would be to adopt the so-called "English Rule" in which the losing party is required to pay the legal costs of the prevailing party. The "American System", to the contrary, has always called upon the parties to pay their own legal costs no matter the outcome. The American Rule has been eroded to a considerable extent in recent years in special types of litigation, such as violation of civil rights, environmental cases, and others in which the legislature has determined that there are special considerations justifying a form of "penalty" on those who violate basic rights of others. But in the design field, and in commercial cases generally, the American Rule still holds.

The "other side of the coin" in considering a change to the English Rule, however, is that it cuts both ways. If the design professional is held to have been negligent he would have to pay the legal costs of the plaintiff.

Punitive Damages

Engineers and other design professionals have rarely been subjected to punitive damages, i.e., sometimes called "smart damages", meaning that the offending party has acted in such a grievous manner that he should feel the sting of his dereliction by having to pay a penalty on top of actual damages. This has become a major concern in injury and death cases, often resulting in enormous awards far exceeding actual economic loss, i.e. loss of wages, medical costs, loss of use of property, etc. The Defense Trial Lawyers' Task Force on Litigation Cost Containment has proposed that punitive damages be eliminated entirely, or at least severely restricted in light of its abuse in recent years.

Richard K. Willard, Assistant Attorney General, Civil Division, Department of Justice, has observed:

> "Another remarkable development in tort actions between private parties is that awards of punitive damages have increased dramatically. Punitive damages were originally intended to punish particularly egregious or malicious conduct. Such damages may have a place in a system bottomed on fault. One would therefore expect that as the tort system moved away from fault, punitive damage awards would become rarer. Instead, the incidence and size of punitive awards seem to be increasing.
>
> If this trend toward massive increases in punitive and noneconomic damages continues, its impact on the economy of this nation is likely to be devastating."

Pain and Suffering

A closely related aspect of the drive for tort reform is huge awards for pain and suffering. This has reached the point of bringing about corrective legislative action in some states. The most notable action along this line was the enactment in California of a flat $250,000 maximum limitation in medical malpractice actions for "non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement, and other non-pecuniary damage."

The statute was promptly challenged on constitutional grounds, but was upheld by the California Supreme Court. Fein v. Permanente Medical Group, 695 P. 2d 665 (1985). An appeal was taken to the U.S. Supreme Court, which dismissed the appeal "for want of a substantial federal question," without written opinion. That type of rejection by the Supreme Court is a decision on the merits, suggesting that a number of other states may well follow the California precedent now that the Supreme Court has found no constitutional objection at the federal level. However, the issue is far from being finally resolved. Justice Byron White, the lone dissenting member of the Supreme Court, opined that the Court should have taken the case for full review because other state courts have rejected similar limits. Justice White predicted, in effect, that the issue will eventually be back before the Supreme Court as more states enact similar limitations.

The issue more directly impacts the medical profession, but is nevertheless significant for the design professions if the trend for a larger share of design cases to involve bodily injury or death continues.

Joint and Several Liability

If a case involves several defendants, which is not unusual in construction industry operations, and if judgment is rendered against all the defendants the state law may make each defendant fully liable for the total judgment, even if a particular defendant was only negligent to a small degree. Thus, the doctrine of joint and several liability, poses serious dangers to design professionals caught up in a multi-defendant case. Suppose that the engineer was only 5 percent negligent, and the contractor, subcontractor, owner, or other liable parties are no longer in business, or have been adjudged bankrupt, or have inadequate assets to pay their share. The engineer in that situation is liable for the entire award.

Various tort reform groups are now pushing for a change in the state laws to eliminate the joint and several doctrine and require that each defendant pay its fair share to the degree it contributed to the damage. The alternative to joint and several, or course, is the doctrine of comparative negligence. This means, of course, that in a particular situation the plaintiff may not collect the full award if one or more of the co-defendants is "judgment proof", but that is a risk that the plaintiff should share in bringing the action in the first place. The obverse argument to the effect that no matter the plaintiff must be "made whole" at the expense of another, even if unfairly, reflects what is perhaps the most basic cause of all of the liability crisis—that we want to live in a risk-free society. But the real issue is not whether we can achieve the impossible of a "risk-free" society, rather how to most fairly allocate those risks.

Structured Settlements

Another area of tort reform much to be desired is a requirement for structured settlements in the case of very large awards. Again, this pertains mainly to injury and death awards. If the award is required to be paid in one lump sum it amounts to much more than the amount of the award in that the large amount is invested and over a period of years may amount to twice or more the original amount. This kind of case arises mainly when an injured person needs a substantial sum each year for an indefinite period to pay for housing, food, nursing care, special equipment, etc. Under a structured settlement arrangement the amount of the award is not changed, but is payable over the years, which means that the liable defendant may put a considerably lesser sum in some form of trust or escrow account to provide the required amount each year, probably adjusted for inflation.

The arrangement is much like the case in which the winner of a state lottery wins a million dollars. In fact, the winner does not receive a lump sum of one million dollars. Rather, he more likely receives $50,000 a year for 20 years, and the state deposits whatever lesser amount is required in a special account to provide that amount out of principal and interest.

Collateral Source Rules

When a judgment is made in favor of an injured plaintiff the jury is required to then ascertain the amount of damages and the amount to be awarded. But the jury is not advised of the amounts which may be received by the plaintiff from other sources, such as worker compensation benefits, private insurance, employer payments, and the like. Thus, the jury is left in the dark in calculating the amount of damages to be awarded in terms of offsetting benefits related to the injury. This so-called "collateral source rule", which prohibits the defendant from offering evidence of other benefits, serves to give the plaintiff additional benefits over and above those determined by the jury.

The basic concept of money damages for one injured by the negligence of another is to reach a result which is said to "make the plaintiff whole", that is, to compensate the in-

jured party for "out-of-pocket" losses (leaving aside here the issue of punitive damages, discussed above).

Several of the state liability reform studies have accordingly recommended that the collateral source rule should be repealed so that a more equitable result will occur for both parties, thereby reducing the impact of liability awards and related insurance costs without penalizing the plaintiff.

In-House Controls

Although it has been said and written ad nauseam, the single best thing an engineer can do to limit, if not avoid, liability claims is to exercise tight control over in-house operations, use legally and technically sound documents, monitor on-site functions of assigned personnel during the construction phase, and, in general, approach every project with one eye on the liability potential.

Among the tools available for general guidance and assistance are the NSPE/PEPP "Architect-Engineer Quality Control Manual", (NSPE Pub. No. 1957), the NSPE/PEPP "Office Policy Handbook", (NSPE Pub. No. 1967), and a 60-minute video seminar entitled "Professional Liability".

Also, as previously mentioned, the Engineers' Joint Contract Documents Committee has over the years developed a set of documents which attempt to provide contract terms which are fair to the engineer, the owner and the contractor. (Appendix D).

There are numerous other sources of information from other societies, private publishers and public agencies which may be helpful. It is recognized that an engineer cannot spend all his time on a project with the only emphasis on liability exposure, but to a reasonable degree the extent to which the liability possibilities are kept in mind and in balance with technical and managerial functions the engineer will be well served.

The Coalition Approach

Part of this special report deals with action items engineering and related societies can tackle on their own, but hopefully with the support of other interested groups. A larger part of the problem areas, particularly those identified as tort reform, will require involvement in broader coalitions of other professions and public groups, such as organizations of municipalities and private concerns hard hit by the liability crisis.

A number and variety of tort reform coalitions are developing around the country. Some of these have been authorized by state legislation, others by action of the governor. The private groups range from manufacturers concerned with product liability, to state chambers of commerce, and to attorney groups, both from the standpoint of defense attorneys and trial lawyers who are the natural opponents of tort reform. NSPE has organized a liability task force to monitor developments at the national level and to cooperate with state groups. It behooves each state society to ascertain the status of these developments in the state, and to participate to the extent possible with such coalitions or separate reform groups in order that the views of the engineering profession are expressed as the campaign for tort reform progresses. It is particularly important that the state societies make early contact with state-sponsored liability study groups and seek appointment of at least one engineer in such bodies.

In the final analysis, every group involved in the reform movement has agreed that the greatest success can be achieved only if the general public is made aware of the issues and the need for corrective action. This is happening already to a considerable extent as child care clinics close, municipalities "go out of business", for lack of insurance or face enormous tax increases to pay the higher premiums, as obstetricians cease practice, as hospital rates soar, and so on down the line. As the general public is made award of the problem, and particularly comes to understand that the ultimate losers are those who pay these taxes and the increased cost of products and services, the opportunity for improvement in the legal justice system will emerge.

In this connection, a potentially significant development has occurred at the federal level with the announcement by Attorney General Edwin Meese of the appointment of an interagency Tort Policy Working Group. This federal group, under the direction of Assistant Attorney General Richard K. Willard, head of the Civil Division, who has spoken out strongly on the need for tort reform, will consider a broad range of policy issues that relate to the current crisis of the tort system.

The federal interagency group is intended to recommend legislative, regulatory and litigative proposals at the federal level. Although the major scene of action in tort reform must occur at the state level, the eventual report of the federal group will not only serve to present specific proposals, but, more importantly, will be a key factor in bringing to the attention of the public the need for action.

AN ACT RELATING TO WORKERS' COMPENSATION; AMENDING 85 O.S. 1981, SECTION 12, AS AMENDED BY SECTION 1, CHAPTER 37, O.S.L. 1982 (85 O.S. SUPP. 1983, SECTION 12); PROVIDING PROCEDURES RELATING TO EXCLUSIVE LIABILITY, EXCEPTIONS, COURT ACTIONS, AND IMMUNITY INCLUDING PERSONS TO WHICH LIMITED LIABILITY APPLIES TO.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 85 O.S. 1981, Section 12, as amended by Section 1, Chapter 37, O.S.L. 1982 (85 O.S. Supp. 1983, Section 12) is amended to read as follows:

Section 12. The liability prescribed in Section 11 of this title shall be exclusive and in place of all other liability of the employer and any of his employees, any architect, professional engineer, or land surveyor retained to perform professional services on a construction project, at common law or otherwise, for such injury, loss of services, or death to the employee, or the spouse, personal representative, parents, or dependents of the employee, or any other person. If an employer has failed to secure the payment of compensation for his injured employee, as provided for in this title, an injured employee, or his legal representatives if death results from the injury, may maintain an action in the courts for damages on account of such injury, and in such action the defendant may not plead or prove as a defense that the injury was caused by the negligence of a fellow servant, or that the employee assumed the risk of his employment, or that the injury was due to the contributory negligence of the employee; provided:

(i) The immunity created by the provisions of this section shall not extend to action by an employee, or the spouse, personal representative, parents, or dependents of the employee, or any other person against another employer, or its employees, on the same job as the injured or deceased worker where such other employer does not stand in the position of an intermediate or principal employer to the immediate employer of the injured or deceased worker;

(ii) The immunity created by the provisions of this section shall not extend to action against another employer, or its employees, on the same job as the injured or deceased worker even though such other employer may be considered as standing in the position of a special master of a loaned servant where such special master neither is the immediate employer of the injured or deceased worker nor stands in the position of an intermediate or principal employer to the immediate employer of the injured or deceased worker; and

(iii) This provision shall not be construed to abrogate the loaned servant doctrine in any respect other than that described in paragraph (ii) of this section. This section shall not be construed to relieve the employer from any other penalty provided for in this title for failure to secure the payment of compensation provided for in this title.

(iv) For the purpose of extending the immunity of this section, any architect, professional engineer, or land surveyor shall be deemed an intermediate or principal employer for services performed at or on the site of a construction project, but this immunity shall not extend to the negligent preparation of design plans and specifications.

RELATING TO DESIGN PROFESSIONAL CONCILIATION PANEL.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. Chapter 672, Hawaii Revised Statutes, is amended by adding two new sections to read as follows:

"§-672 Determination of unsuitability. Any party or any person served with notice of a claim may file a motion with circuit court in the judicial circuit in which the claim arose for a determination that the subject matter of the dispute is unsuitable for review by a panel under this chapter; provided that no such application may be filed within ten days of the date on which the claim is scheduled to be heard by a panel or after such a hearing has taken place.

In determining whether the subject matter of a dispute is unsuitable for disposition pursuant to this chapter, a court may consider:

(1) The magnitude of the potential award, or any issue of broad public concern raised by the subject matter underlying the dispute;

(2) Problems referred to the court where court regulated discovery is necessary;

(3) The fact that the matter in dispute is a reasonable or necessary issue to be resolved in pending litigation and involves other matters not covered by or related to this chapter;

(4) The fact that the design professional's involvement in the matter is distinctly secondary in importance to the involvement of parties not covered by this chapter;

(5) The potential for unreasonable delays in reaching any resolution of the matter by its referral to a panel pursuant to this chapter; or

(6) The fact that there are too many parties or issues involved to be effectively handled by the informal processes of this chapter.

Any such application to the circuit court shall be made and heard in a summary manner and in accordance with procedures for the making and hearing of motions.

§672- Certificate of consultation. (a) any claim filed under this chapter shall be accompanied by a certificate which declares one of the following:

(1) That the attorney has reviewed the facts of the case, that the attorney has consulted with at least one design professional who is licensed to practice and practices in this State or any other state, or who teaches at an accredited college or university and is licensed to practice in this State or any other state, in the same discipline as the design professional against whom the claim is made and who the attorney reasonably believes is knowledgeable in the relevant issues involved in the particular action, and that the attorney has concluded on the basis of such review and consultation that there is a reasonable and meritorious cause for the filing of the claim. The persons consulted may not be a party to the case;

(2) That the attorney was unable to obtain the consultation required by paragraph (1) because a statute of limitations would impair the action and that the certificate required by paragraph (1) could not be obtained before the impairment of the action. If a certificate is filed pursuant to this paragraph, the certificate required by paragraph (1) shall be filed within thirty days after filing the claim; or

(3) That the attorney was unable to obtain the consultation required by paragraph (1) because the attorney has made three separate good faith attempts with three separate design professionals to obtain such consultation and none of those contacted would agree to such a consultation.

(b) Where an attorney intends to rely solely on a failure to inform of the consequences of a procedure, this section shall be inapplicable. The attorney shall certify upon filing of the claim that the attorney is relying solely on the failure to inform of the consequences of a procedure and for that reason is not filing a certificate as required by this section.

(c) For the purposes of this section, the attorney shall not be required to disclose the names of design professionals consulted to fulfill the requirements of subsection (a).

(d) Unless a certificate is filed pursuant to subsection (a) or (b), the claim shall not be received for filing by the department."

SECTION 2. Section 672-1, Hawaii Revised Statutes, is amended to read as follows:

"§672-1 Definitions. For the purposes of this chapter:

"Design professional" means a professional engineer, architect, surveyor or landscape architect.

"Entities employing design professionals" means professional corporations or other business structures under which design professionals may practice and does not include non-design professional entities."

SECTION 3. Section 672-2, Hawaii Revised Statutes, is amended to read as follows:

"§672-2 Actions against architects, professional engineers, surveyors, and landscape architects. In any action for damages arising out of the alleged professional negligence of actions performed in the professional practice of a person holding a license as a professional engineer, architect, surveyor, or landscape architect under chapter 464, before the time of filing the complaint, the aggrieved person shall file a claim with the design professional conciliation panel.

SECTION 4. Section 672-3, Hawaii Revised Statutes, is amended to read as follows:

"§672-3 Design professional conciliation panel; composition, selection, compensation. (a) There are established conciliation panels which shall review and render findings and advisory opinions on the issues of liability and damages in tort claims against professional architects, engineers, surveyors, and landscape architects.

(b) A design professional conciliation panel, hereafter called "the panel", shall be formed for each claim filed pursuant to section 672-4 and after each panel renders its decision or the claim is otherwise disposed of it shall be disbanded. Each design professional conciliation panel shall consist of one chairperson selected from among persons who are familiar with and experienced in the tort claims settlement process, one attorney licensed to practice in the courts of the State and experienced in trial practice, and one architect, engineer, surveyor, or landscape architect licensed to practice under chapter 464. The chairperson shall be appointed by the chief justice of the supreme court of Hawaii. The attorney shall be appointed by the chairperson from a list of not less than thirty-five attorneys experienced in trial practice submitted annually by the supreme court. The architect, engineer, surveyor, or landscape architect shall be appointed by the chairperson from a list of not less than thirty-five design professionals submitted annually by the board of registration of professional engineers, architects, surveyors, and landscape architects.

The chairperson shall preside at the meetings of the panel. The chairperson and all panel members shall be compensated at the rate of $300 per claim handled which will become payable when the decision of the panel is submitted and shall be paid allowances for travel and living expense which may be incurred as a result of the performance of their duties and they shall be paid by the department of commerce and consumer affairs from funds collected from the claimant and defendant, to be shared equally. The claimant shall deposit $450 with the department upon the filing of the claim and the failure to do so shall result in the claim being rejected for filing. The design professional shall deposit $450 with the department within twenty days of being served with the claim and the failure to do so shall result in termination of proceedings under this chapter allowing the claimant to proceed in accordance with section 672-8. If the claim is withdrawn, determined to be unsuitable for proceedings under this chapter, or otherwise terminated without participation by a panel, the department shall return all moneys collected to the respective parties.

The office and meeting space, secretarial and clerical assistance, office equipment and office supplies for the board shall be furnished by the department of commerce and consumer affairs.

The board of registration shall prepare a list of architects, engineers, surveyors, and landscape architects along with their respective specialties who shall then be considered consultants to the panel in their respective fields. Panel members may consult with other legal, technical, and insurance specialists. Any consultant called by the panel to appear before the panel shall be paid an allowance for travel and living expenses which may be incurred as a result of such person's appearance before the panel. Such costs shall be paid by the department of commerce and consumer affairs."

SECTION 5. Section 672-4, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

"(a) Any person or his representative claiming that a tort has been committed by the design professional or entities employing such design professionals shall file a claim with the department of commerce and consumer affairs before a suit based on the claim may be commenced in any court of the State. All claims shall be submitted to the department of commerce and consumer affairs in writing on forms provided by the department. If the claim is presented orally, the department of commerce and consumer affairs shall reduce the claim to writing. The claimant shall set forth facts upon which the claim is or may be based and shall include the names of all parties against whom the claim is or may be made who are known to the claimant. Within five business days thereafter, the panel shall give notice of the claim, by certified mail, to all architects, engineers, surveyors, or landscape architects and others who are or may be parties to the claim and shall furnish copies of written claims to such persons. Such notice shall set forth a date, not more than twen-

ty days after mailing the notice, within which any design professional against whom a claim is made may file a written response to the claim, and a date and time, not less than five days following the date for filing a response, for a hearing of the panel. Such notice shall describe the nature and purpose of the panel's proceedings and shall designate the place of the hearing. The times originally set forth in the notice may be changed by the chairman, on due notice to all parties, for good cause; provided that a party requesting the rescheduling of the hearing within seven days of the scheduled date shall be required in the sole discretion of the panel chairperson to additionally compensate the panel in an amount equal to the fee panel members receive pursuant to section 672-3."

SECTION 6. Section 672-5, Hawaii Revised Statutes, is amended to read as follows:

"§672-5 Design professional conciliation panel hearing; fact-finding; evidence; voluntary settlement. Every claim of a tort shall be heard by the design professional conciliation panel within thirty days after the date for filing a response. No persons other than the panel, witnesses, and consultants called by the panel, and the persons listed in section 672-6 shall be present except with the permission of the chairperson. The panel may, in its discretion, conduct an inquiry of a party, witness, or consultant without the presence of any or all parties.

The hearing shall be informal. The panel may require a stenographic record of all or part of its proceedings for the use of the panel, but such record shall not be made available to the parties. The panel may receive any oral or documentary evidence. Questioning of parties, witnesses, and consultants may be conducted by the panel, and the panel may, in its discretion, permit any party, or any counsel for a party to question other parties, witnesses or consultants. The panel may designate who, among the parties, shall have the burden of going forward with the evidence with respect to such issues as it may consider, and unless otherwise designated by the panel, when the design professional's records have been provided to the claimant for the claimant's proper review, such burden shall initially rest with the claimant at the commencement of the hearing.

The panel shall have the power to require by subpoena the appearance and testimony of witnesses and the production of documentary evidence. When such subpoena power is utilized, notice shall be given to all parties. The testimony of witnesses may be taken either orally before the panel or by deposition. In cases of refusal to obey a subpoena issued by the panel, the panel may invoke the aid of any circuit court in the State, which may issue an order requiring compliance with the subpoena. Failure to obey such order may be punished by the court as a contempt thereof. Any member of the panel may sign subpoenas, administer oaths and affirmations, examine witnesses, and receive evidence. Notwithstanding such powers, the panel shall attempt to secure the voluntary appearance, testimony, and cooperation of parties, witnesses, and consultants without coercion.

At the hearing of the panel and in arriving at its opinion the panel shall consider, but not be limited to, statements or testimony of witnesses, construction documents, inspection reports, calculations, and other records kept in the usual course of the practice of the design professional without the necessity for other identification or authentication, statements of fact or opinion on a subject contained in a published treatise, periodical, book or pamphlet, or statements of experts without the necessity of the experts appearing at the hearing. The panel may upon the application of any party or upon its own decision appoint as a consultant, an impartial and qualified architect, engineer, surveyor, or landscape architect or other professional person or expert to testify before the panel or to conduct any necessary professional of expert examination of the claimant of relevant evidentiary matter and to report to or testify as a witness thereto. Such a consultant shall not be compensated or reimbursed except for travel and living expenses which may be incurred as a result of such person's appearance before the panel. Such expenses shall be paid by the department of commerce and consumer affairs to be paid as provided in Section 672-3. Discovery by the parties shall not be allowed.

During the hearing and at any time prior to the rendition of an advisory decision pursuant to section 672-7, the panel may encourage the parties to settle or otherwise dispose of the case voluntarily."

SECTION 7. Section 672-10, Hawaii Revised Statutes, is amended to read as follows:

"§672-10 Statute of limitations tolled. The filing of the claim with the design professional conciliation panel shall toll any applicable statute of limitations, and any such statute of limitations shall remain tolled until sixty days after the date

the decision of the panel is mailed or delivered to the parties; provided that in no case shall the applicable statute of limitations be tolled for more than twelve months. If a decision by the design professional conciliation panel is not reached within twelve months, the statute of limitations shall resume running and the party filing the claim may commence a suit based on the claim in any appropriate court of this State. The panel shall notify in writing all parties of this provision."

SECTION 8. Section 672-11, Hawaii Revised Statutes, is amended to read as follows:

"§672-11 Duty to cooperate; assessment of costs and fees. It shall be the duty of every person who files a claim with the design professional conciliation panel, every architect, engineer, surveyor, or landscape architect against whom such claim is made, to cooperate with the design professional conciliation panel for the purpose of achieving a prompt, fair, and just disposition or settlement of such claim, provided that such cooperation shall not prejudice the substantive rights of said persons.

After trial of such claim or after settlement of such claim after suit has been filed, any party may apply to the court in which the suit was brought to have the costs of the action assessed against any party or any insurance carrier or any other person providing professional liability insurance to a party design professional or both, for failure to cooperate with the design professional conciliation panel. The court may award such costs, or a portion thereof, including attorney's fees, witness fees, including those of expert witnesses, costs of discovery and transcribing depositions, and court costs to the party applying therefor.

On application of the director of commerce and consumer affairs, the court may award as a civil penalty against any party or any insurance carrier or other person providing professional liability insurance to a party design professional, or all or any combination of such persons, all or a portion of the costs and expenses of the design professional conciliation panel attributable to a claim involving such persons, if the court finds that such person or persons failed to cooperate with the design professional conciliation panel. Such penalty shall be payable to the general fund.

In determining whether any person has failed to cooperate in good faith, the court shall consider, but is not limited to, the following:

(1) The attendance of the persons at the hearing of the design professional conciliation panel;

(2) The extent to which representatives of the parties and counsel representing parties came to panel hearings with knowledge of the claims and defenses and authority to negotiate a settlement or other disposition of the claim;

(3) The testimony of members of the panel as to the facts of the person's participation in the panel hearing;

(4) The extent of the person's cooperation in providing the panel with documents and testimony called for by the panel; and

(5) The reasons advanced by the person so charged for not fully cooperating or negotiating."

SECTION 9. Section 672-14, Hawaii Revised Statutes, is amended to read as follows:

"§672-14 Retroactive application. This chapter shall apply to any claim arising prior to June 22, 1981 if a suit based on the claim has not been filed in a court of competent jurisdiction prior to that date."

Appendix C

Statutes of Limitation for the Design Professionals
(Note—**boldface** indicates a statute subsequently held unconstitutional)

STATE	DATE ADOPTED	NUMBER OF YEARS AFTER SUBSTANTIAL COMPLETION OR OCCUPANCY
Alabama	**1969**	**Seven (Latent Defects)** **Four (Patent Defects)**
Alaska	1967	Six
Arizona	—	No statute
Arkansas	1967	Five (Property Damage) Four (Personal Injury)
California	1971	Ten (Latent Defects) Four (Patent Defects)
Colorado	1979	Ten
Connecticut	1969	Seven
Delaware	1974	Six
District of Columbia	1972	Ten
Florida	1980	Fifteen (Latent Defects) Four (Patent Defects)
Georgia	1968	Eight
Hawaii	**1974**	Six
Idaho	1965	Six
Illinois	**1982**	**Twelve**
Indiana	1967	Ten
Iowa	—	No Statute
Kansas	1963	Ten (Latent Defects) Two (Patent Defects)
Kentucky	**1966**	**Five**
Louisiana	1964	Ten
Maine	1975	Ten
Maryland	1979	Ten
Massachusetts	1968	Six
Michigan	1967	Six
Minnesota	1980	Fifteen
Mississippi	1966	Ten
Missouri	1976	Ten
Montana	1971	Ten

Nebraska	1972	Ten
Nevada	1965	Six
New Hampshire	**1965**	**Six**
New Jersey	1967	Ten
New Mexico	1967	Ten
New York	1963	Three
North Carolina	1963	Six
North Dakota	1967	Ten
Ohio	1963	Ten
Oklahoma	1978	Ten
Oregon	1971	Ten
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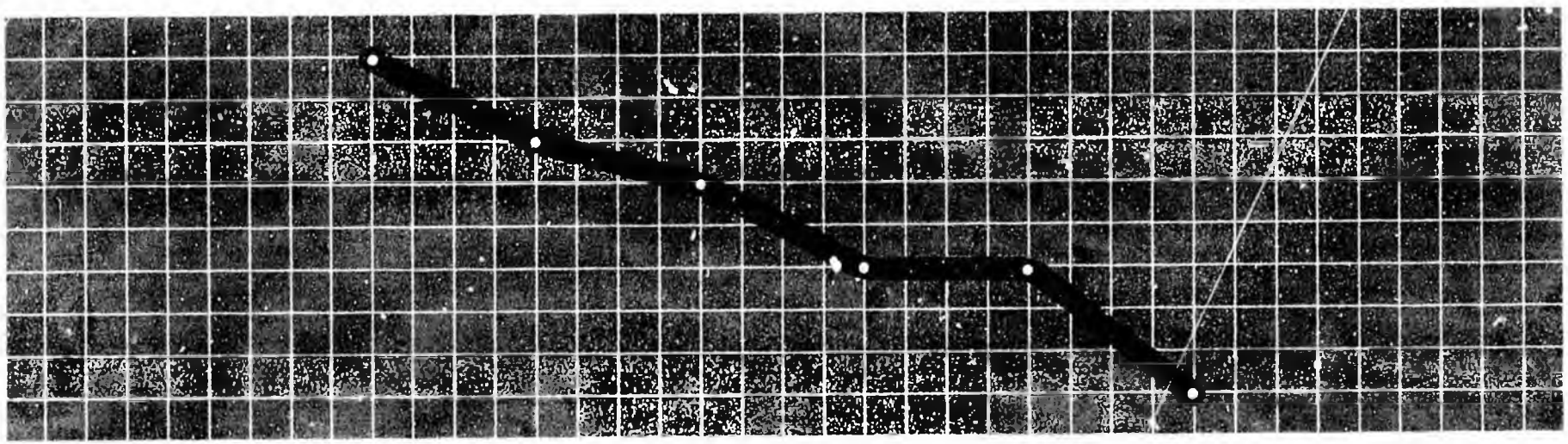


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INSURER PROFITABILITY— THE FACTS

A commentary on the
financial condition of the property/casualty
insurance industry



Insurance Services Office, Inc.
February 1986

Insurance Services Office, Inc. (ISO) is a non-profit corporation that makes available advisory rating, statistical, actuarial, policy form and related services to any U.S. property/casualty insurer.

INSURER PROFITABILITY— THE FACTS

A commentary on the
financial condition of the property/casualty
insurance industry

Insurance Services Office, Inc.
February 1986

PURPOSE

Given the current condition of the property/casualty insurance marketplace—with affordability and availability problems affecting many commercial insurance consumers—several critics have charged that the current large liability premium increases are unnecessary, that the industry's financial condition is improperly stated, and that its accounting procedures are misleading. In this analysis, Insurance Services Office, Inc. provides a fact-based review of the property/casualty insurance industry by (1) presenting a broad perspective of the industry's current financial condition, and (2) responding to factual errors and irrelevant data intended to substantiate the critics' charges, as well as providing a meaningful context for the numbers.

NOTE: Actual year-end 1985 results for the property/casualty insurance industry will not be compiled until late March 1986. Industrywide year-end figures cited by various analysts and critics in January 1986 were estimated results based largely on financial data through the first nine months. In this analysis, ISO references the financial statistics most often cited by critics—those estimates published by A.M. Best Company. This report is being issued prior to the release of year-end 1985 results in order to promptly provide comprehensive information.

The source of all historical financial data through 1984 is A.M. Best Company, with exceptions as noted. Nine-month 1985 financial data come from the A.M. Best Company or ISO compilations.

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- Recent insurance industry financial results would have been worse without unprecedented realized capital gains and tax credits./**15**
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MAJOR CHARGES RAISED BY INDUSTRY CRITICS/17

ACCUSATION: The industry's accounting procedures regularly misrepresent its true financial condition. The profitability "crisis" is manufactured.

CHARGES
- The industry deliberately misstates loss reserves to produce a profitability "crisis," just as it did for medical malpractice 10 years ago./**19**
- Policyholder dividends are not a business expense, but a voluntary distribution of profits./**20**
- Insurers publicize operating income, rather than net after-tax income, in order to show losses./**21**
- The industry's return on net worth would have been 13% in 1984 if premiums had been only 5% higher. And the industry's rate of return for 1985 would be 13%, if you exclude policyholder dividends and unusually high hurricane losses./**23**

ACCUSATION: Price increases are excessive. Losses are not the problem.

CHARGES
- The industry needed to increase premiums only 12-15% in 1985 to achieve a 13-15% return in 1986. Given the estimated 20% premium increase in 1985, no additional price increases are needed in 1986./**25**
- Premium increases are so dramatic today solely because of prior inadequate prices. Losses are not the problem./**25**
- 1985's 71% increase in general liability premium was excessive. If insurers had not slashed liability rates a few years ago, they would have earned handsome profits./**28**
- Since, for medical malpractice, paid losses are less than investment income, this line can be treated on a "pay as you go" basis./**29**

ACCUSATION: Insurers are making substantial profits and paying no taxes. There's nothing fundamentally wrong with industry profitability. This is just a typical cyclical downturn.

CHARGES
- Property/casualty insurer stock prices rose by 50% in 1985, hardly indicative of a troubled industry./**31**
- The industry made $75 billion over the last 10 years and paid no taxes./**31**
- This is a typical cycle for the industry, and it will recover quickly./**33**

ACCUSATION: Insurance is too expensive.

CHARGES
- The total insurance bill in the U.S. rose to more than $300 billion in 1985 /**38**
- Property/casualty premiums rose by $24.6 billion in 1985—an increase of $105 per person./**39**

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EXECUTIVE SUMMARY

A financially sound U.S. property/casualty insurance industry provides a vital service in the form of needed security to individuals and corporations. The cost of insurance affects almost every aspect of American life. Consequently, the economic integrity of this industry, as well as the availability and affordability of insurance, are critical to society.

In the past year, differences have emerged between the property/casualty insurance industry and its critics over the true financial condition of the industry and the need for large commercial liability premium increases. This has occurred despite the fact that quarterly and annual reports of the industry's financial results, as well as several special studies, have documented the weakened state of the industry and its current low profitability.

Critics have taken the industry's published financial information and distorted it to assert that, rather than being in financial peril, property/casualty insurers are actually engaged in price gouging and are hiding current profits. These charges are misleading, unsubstantiated and false.

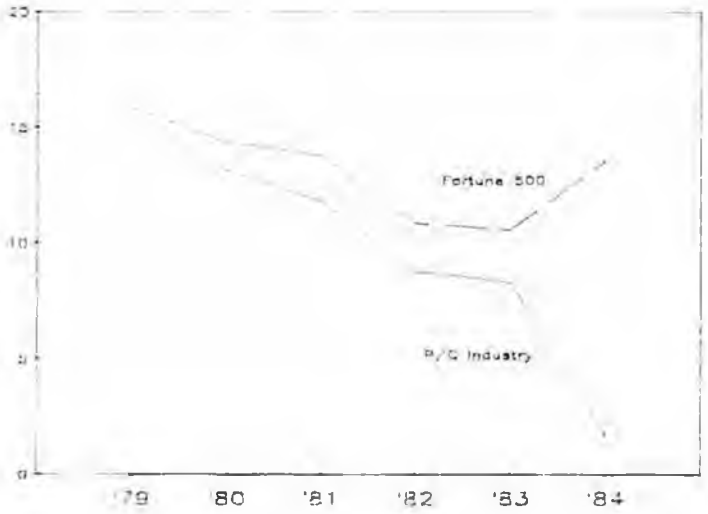
This analysis reviews the current financial state of the industry and refutes, on a point-by-point basis, the critics' charges.

All facts point to the inevitable conclusion that 1984 was the worst year to date for the property/casualty insurance industry. The weakened condition of the industry is highlighted by:

- a return on net worth of less than 2% and an operating loss of nearly $4 billion, both record low levels;
- a record number of insurer insolvencies;
- a record number of insurers placed on a "watch list," based on tests of financial strength developed by the National Association of Insurance Commissioners; and
- a wholesale downgrading of insurer ratings by A.M. Best Company.

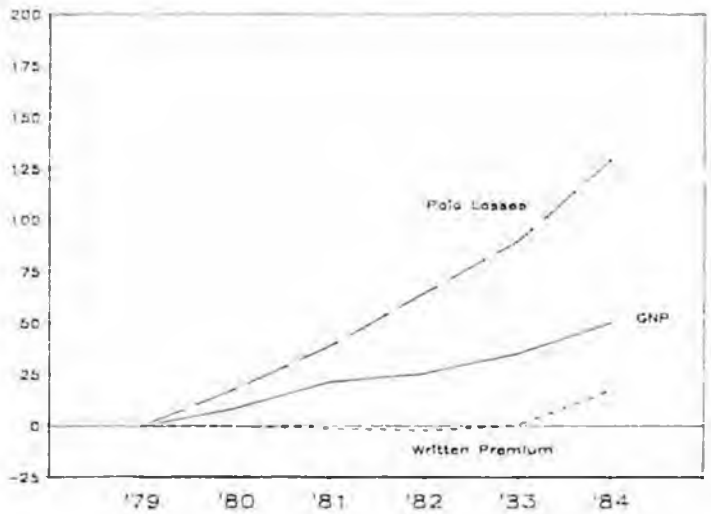
During the 1980's, the return on net worth for the property/casualty industry moved increasingly below the average rate for the Fortune 500 companies. **(See chart A.)** And results for the first nine months of 1985 indicate no major improvement in profitability. The annualized return on net worth was 4%, and operating losses as of nine months were at record levels. Rather than producing large profits for insurers, the 1985 premium increases have slowed the dramatic downslide and possibly signalled the beginning of the long road back to adequate levels of profitability. The number of insurer insolvencies in 1985 has already matched the all-time record, set in 1975, with the books for 1985 insolvencies not yet closed.

Critics have made charges about the industry's financial condition that fall under four



A

Return on Net Worth: Property/ Casualty Industry vs. The Fortune 500 (%)



B

Loss Growth and Premium Growth vs. GNP (%): Commercial Liability

broad accusations. The following paragraphs summarize these charges and ISO's responses.

- **The industry's accounting procedures regularly misrepresent its true financial condition. The profitability "crisis" is manufactured.**

  This analysis notes that the industry's accounting procedures are in accordance with those promulgated by the Financial Accounting Standards Board (FASB) and state regulatory authorities. The analysis refutes the charges that the industry's lack of profitability is due to creative accounting, that loss reserves are overstated whenever the industry chooses to create a crisis, and that policyholder dividends and capital gains are improperly treated.

- **Price increases are excessive. Losses are not the problem.**

  This analysis shows that the recent, substantial commercial liability price increases are necessary. The explosive growth in claim payments, in combination with depressed premiums, continues to create an urgent need for large premium increases in the commercial lines. These premium increases will not recoup lost profits; rather, they have begun the process of bringing current premiums in line with current losses. Losses *are* a serious problem, since loss growth substantially outpaced growth in GNP. **(See chart B.)**

  The underlying causes of loss growth are not discussed in detail in this strictly financial analysis. But it is clear that the property/casualty insurance marketplace's difficulties—low insurer profitability and the impact of premium increases on policyholders—have now led to a significant public debate regarding the nature of liability in our society.

- **Insurers are making substantial profits and paying no taxes. There's nothing fundamentally wrong with industry profitability. This is just a typical cyclical downturn.**

  This analysis demonstrates that long-term profitability has been poor, with insurers' return on net worth below the average of the Fortune 500 companies in eight of the last 10 years. The last two years have been particularly poor, even for a low point in the cycle. This is not a typical cycle. It is both longer in duration and deeper in magnitude than any previous cycle in the property/casualty insurance industry's history. With regard to taxes, the analysis indicates that the industry is in compliance with federal law.

- **Insurance is too expensive.**

  This charge is both misleading and emotionally charged. First, the critics include life, accident and health insurance premiums with those for property/casualty insurance, thereby increasing the figures in their charges. Second, losses have increased dramatically, and the premiums to pay for them must rise as well.

Conclusion

The property/casualty insurance industry's rate of return must improve, and insurers must achieve profits consistent with the risks they assume. Higher returns are needed for the industry to retain its capital base and attract new funds. Such stability and expansion are crucial if insurers are to have the capacity to provide needed insurance in the coming years.

OVERVIEW OF THE FINANCIAL CONDITION OF THE PROPERTY/CASUALTY INSURANCE INDUSTRY

In the past year, differences have emerged between the property/casualty insurance industry and its critics over the true financial condition of the industry. The insurance industry claims that it is experiencing unprecedented losses, while its critics claim that the industry is really profitable. This section will provide the facts.

A critical measure of financial results is the return on net worth, which is commonly used by investors for inter-industry performance comparisons. Responsible analysis of any industry must also look beyond that measure and evaluate the components of economic income. How does the property/casualty industry make its money? What impact do state and federal regulations have on insurance accounting procedures? What are the components of net income after taxes? Which of those components are inextricably tied to the underwriting operations of insurers? Which are subject to fortuitous events?

This section examines the elements that are critical to any analysis of insurer profitability. The following conclusions emerge:

- 1984 was the worst year to date for the property/casualty insurance industry.
- Year-end 1985 results will show no significant improvement over 1984, despite substantial premium increases.
- The companies that insure our nation's businesses have been particularly hard hit.
- Reinsurers have experienced large financial losses.
- Recent insurance industry financial results would have been worse without unprecedented realized capital gains and tax credits.
- Premiums will have to increase faster than claim costs in order to achieve positive operating income in future years.

The key support for each of these conclusions is as follows:

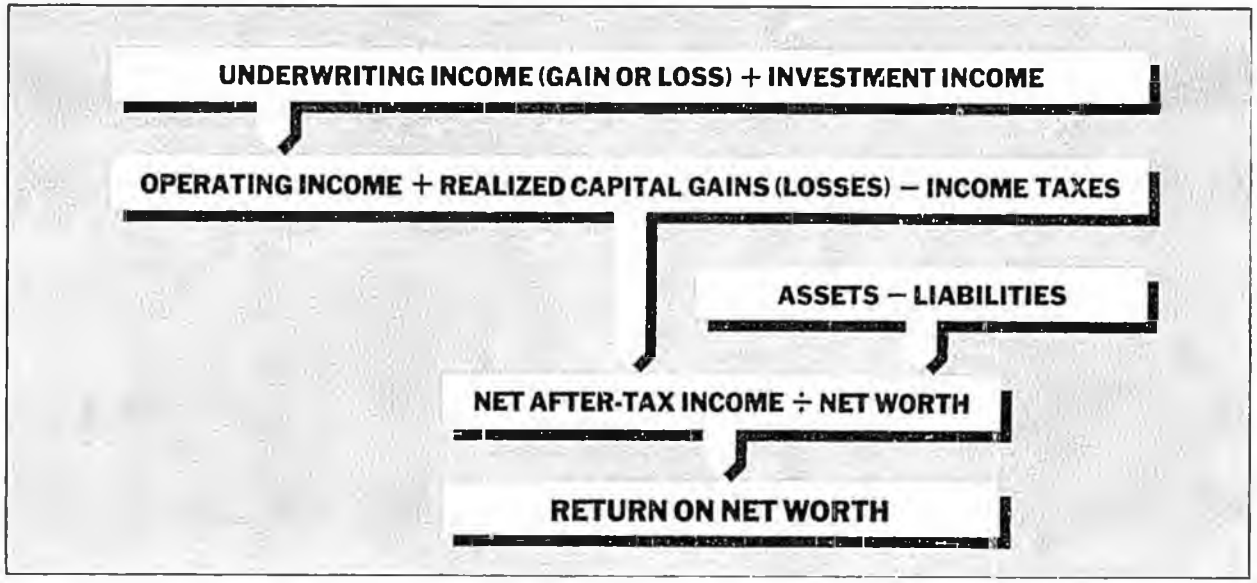
1984 was the worst year to date for the property/casualty insurance industry.
The industrywide *return on net worth*[1] was below 2% in 1984, with total earnings of $1.3 billion. The Fortune 500 companies' median return was 13.6% in 1984, averaged 13.2% over the last ten years, and has never fallen below 10% over that span. During the 1980's, the return on net worth for the property/casualty industry has moved increasingly below the average rate for the Fortune 500. **(See chart 1.)**

Some insurers reported returns higher than the industry average in 1984, while others had

[1]*Return on net worth is net income after taxes divided by total net worth. In this report, both income and net worth figures have been calculated to be consistent with generally accepted accounting principles (GAAP) as set forth by the Financial Accounting Standards Board (FASB). GAAP-adjusted figures for both income and net worth are larger than corresponding statutory figures, which are based on more conservative measurements. For example, in 1984, statutory surplus was $64 billion compared with GAAP-adjusted net worth of $75 billion; statutory net income was $0.8 billion compared with GAAP-adjusted net income of $1.3 billion.*

THE MAJOR COMPONENTS OF INSURER PROFITABILITY

Operating income comprises underwriting income and investment income. It is a component of net after-tax income. The other major components are realized capital gains (losses) and income taxes. An insurer's net worth consists of assets minus liabilities.



lower earnings. Many companies actually lost money overall. In fact, 330 of the nation's 867 insurer groups, representing 40% of industry premiums, recorded negative returns. Eighty-four insurers lost more than one-quarter of their surplus during 1984.

The most important component of insurers' net income after taxes is operating income—the sum of underwriting income and investment income. It represents profit or loss from insurance operations. Other components of net income after taxes include realized capital gains and federal income taxes. The diagram on page 12 illustrates the relationships among the major components of insurer profitability.

Underwriting income (the difference between premiums earned and the sum of losses on claims, expenses and policyholder dividends) has actually been underwriting *loss* beginning in 1979. Each subsequent year brought ever-growing underwriting losses—reaching a staggering $21.5 billion in 1984.

In all but two years of its history, the industry's *investment income* (the interest and dividends received on investments) was enough to offset underwriting losses. **(See chart 2.)** The first time investment income did not exceed underwriting losses was in 1975, when investment income fell short of the underwriting deficit by $300 million. In 1984, a new record was set, with underwriting losses exceeding investment income by $3.8 billion. Only unusually large realized capital gains and tax credits allowed the industry's bottom-line earnings to be positive in 1984.

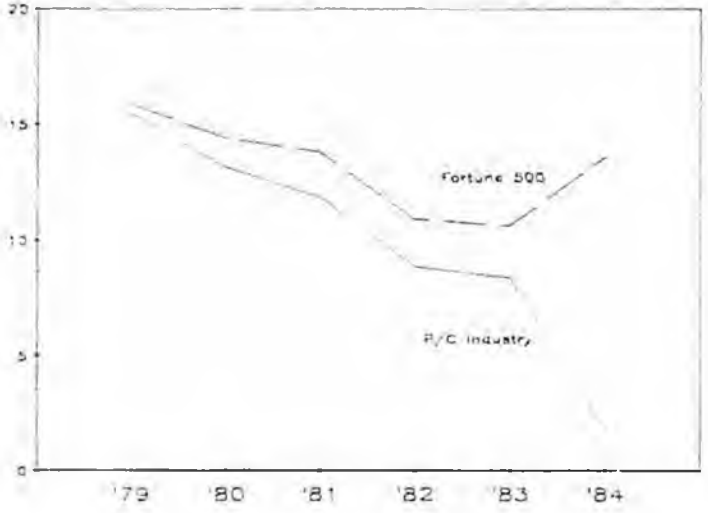
Year-end 1985 results will show no significant improvement over 1984, despite substantial premium increases.

Figures for the first nine months of 1985 showed slight improvement over the comparable period in 1984, but the annualized 4% return on net worth was still far from acceptable by any business standard. It is unlikely that the full-year 1985 returns on net worth will exceed 4%.

The underwriting loss for 1985 will exceed the 1984 record of $21.5 billion. During the first nine months of 1985 the industry recorded an underwriting loss of $17.8 billion, compared with a loss of $15.2 billion for the first nine months of 1984.

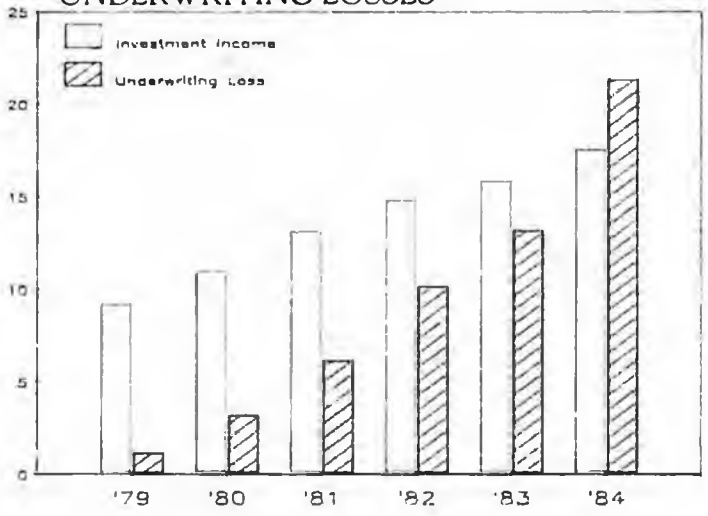
During the first nine months of 1985, investment income fell short of the underwriting loss by $3.5 billion, compared with a

1 PROPERTY/CASUALTY RETURNS HAVE PLUMMETED



Return on Net Worth: Property/ Casualty Industry vs. The Fortune 500 (%) *Returns on net worth for the property/casualty industry have consistently lagged behind those for the Fortune 500 companies, plummeting 12 points below the Fortune 500 in 1984.*

2 INVESTMENT INCOME NO LONGER OFFSETS UNDERWRITING LOSSES



Investment income vs. Underwriting Loss ($ Billions) *Investment income offset underwriting losses in every year from 1979 to 1983. In 1984, investment income fell short—creating a $4 billion operating loss. This operating loss will continue at least through 1985.*

shortfall of $2.5 billion for the first nine months of 1984. All available evidence indicates a record operating loss for 1985.

The companies that insure our nation's businesses have been particularly hard hit. The degree of deterioration in insurers' claim experience has varied greatly by type of insurance. In general, the results for commercial lines (insurance coverages purchased by businesses) have deteriorated more severely.

Since 1979, insurers that concentrated in the personal lines fared better than those that concentrated in the commercial lines. (See chart 3.) While personal lines insurers' profits dropped from 1979 to 1984, their decline was more moderate. The return on net worth for predominantly personal lines insurers fell from over 13% in 1979 to below 8% in 1984.

Insurers that concentrate in commercial lines have experienced a much more dramatic drop in earnings. In 1979, this group achieved a slightly higher return than personal lines insurers, posting a 15% return on net worth. The return declined during the early 1980's, reaching a *negative* 3% return on net worth in 1984.

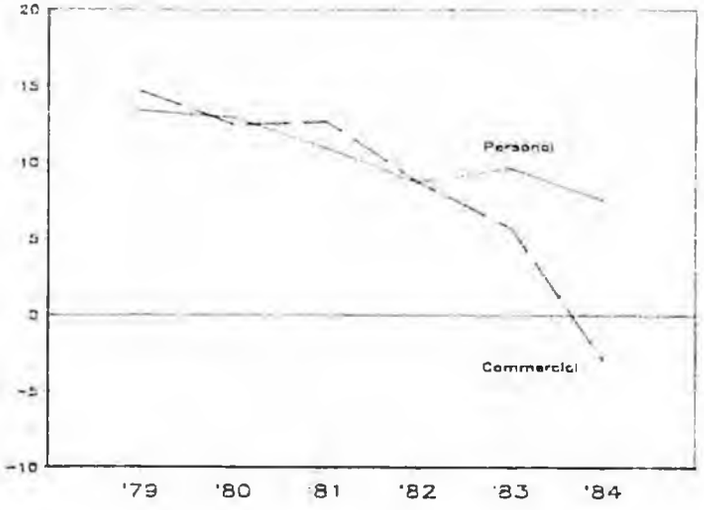
Reinsurers have experienced large financial losses. Insurance companies are in the business of assuming risk, but in many cases the potential claims are too uncertain and too large for any one company to absorb. This is particularly true for liability policies covering government entities and many large corporations, which may require coverage limits of $50 million or more. In response to these expanding liability coverage needs, reinsurers[2] (often described as companies that insure insurance companies) have grown to be an important segment of the property/casualty insurance industry and a crucial link in providing many necessary types of insurance coverages.

Reinsurers are often involved in the riskiest coverages. Financial and economic theory dictates that they should therefore be rewarded with larger expected average returns on net worth. In fact, recent returns for reinsurers have been worse than the industry average.

From 1979 through 1983, U.S. reinsurers' returns on net worth were comparable to those of the entire industry. (See chart 4.) In 1984, reinsurers' returns plummeted to a *negative* 10%, nearly twelve points below the industry

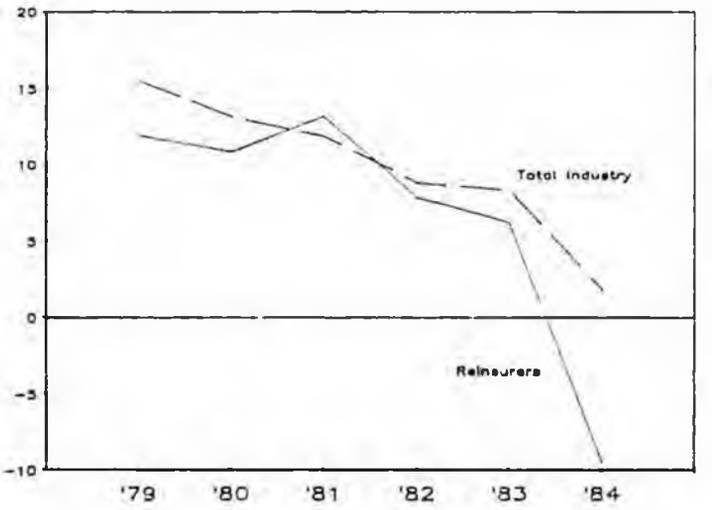
[2]*For a more thorough discussion of reinsurance, see the Appendix.*

3 COMMERCIAL INSURERS LOST MONEY IN 1984



Return on Net Worth: Personal vs. Commercial Insurers (%) *Commercial lines insurers have experienced a dramatic decline in their returns on net worth over the last four years, dropping to negative 3% in 1984. Personal lines insurers' returns also declined, but less precipitously.*

4 REINSURERS LOST MONEY IN 1984



Return on Net Worth: Reinsurers vs. Total Property/ Casualty Industry (%) *U.S. reinsurers lost money in 1984 — a factor in 1985's commercial lines marketplace.*

average. This result was a significant factor in the insurance marketplace disruptions that occurred in 1985. Many reinsurers withdrew partially or totally from writing business; others restructured coverages (adding exclusions or restrictions) and increased prices in an attempt to return to profitability.

Recent insurance industry financial results would have been worse without unprecedented realized capital gains and tax credits.

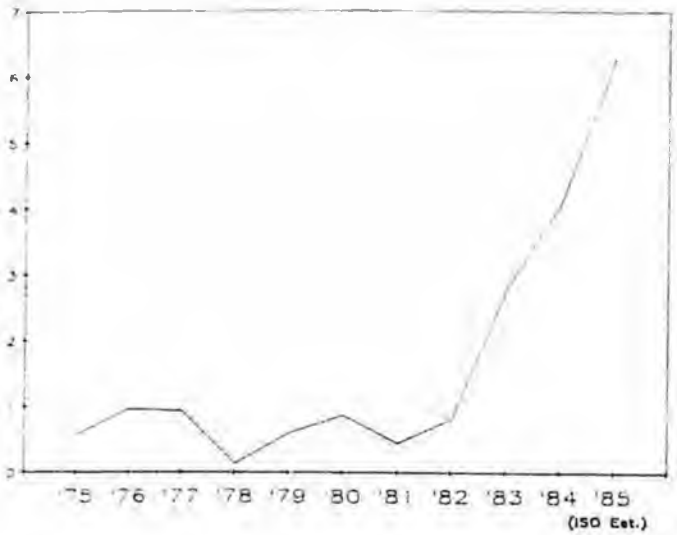
The major components of net income after taxes are operating income (the sum of underwriting income and investment income), realized capital gains and federal income taxes. Although the industry produced an operating loss of $3.8 billion in 1984, this loss was offset by other sources of income. These other sources of income are not predictable or regularly recurring and therefore cannot be depended on to provide similar amounts of additional income in future years.

A major source of non-repeatable income for many insurers during the last three years was *realized capital gains*. These gains occur when insurers sell assets that have risen in value since they were purchased. Until very recently, capital gains realized by the property/casualty industry were relatively insignificant compared to net worth. (See chart 5.) From 1975 to 1982, total realized capital gains never exceeded 1% of net worth. In 1983, the ratio grew to 3% and continued upward in 1984 to 4%.

Capital gains may be realized under two sets of circumstances. If the overall stock market performance is relatively flat, offering little if any appreciation in value for shareholders, large investors with a portfolio of both winners and losers may be able to sell the winners—stocks that increased in value since the time of purchase. These investors will have realized a capital gain. But by keeping the losers, they have incurred an offsetting *unrealized* capital loss, since their portfolio account now consists of stocks with depreciated value. These circumstances generally prevailed in 1984.

Under a second set of circumstances, exemplified by 1985, the stock market rises dramatically. Under those circumstances, investors may be able to realize extraordinary capital gains. But if the existing securities are sold and new ones are purchased, only additional substantial market appreciation will produce

5 REALIZED CAPITAL GAINS AT RECORD LEVELS



Realized Capital Gains (% of Net Worth) *Realized capital gains grew to unprecedented levels in 1984 and 1985.*

further large capital gains. And the effect of large realized capital gains distorts earnings over a short period of time.

Any quantitative analysis of profitability for a particular year requires an adjustment to reduce the distorting effect of abnormal events. Recording the results of a dramatic but short run stock market rise or the realization of a capital gain that actually accumulated over many years as an element of only the latest year's profit is highly misleading. The effect of abnormal realized capital gains—as well as capital losses or any catastrophes—should, for purposes of analysis, be averaged or smoothed over several years. Certainly, in assessing future years' rates of return, only a "normal" amount of realized capital gains should be assumed.

A second major source of non-repeatable income for insurers in the last few years is tax credits. Tax credits are available to those businesses that have incurred a pre-tax net loss for a given tax year and paid taxes during a prior profitable period. Tax credits may also be used by a company that is a subsidiary of an otherwise profitable parent. During the last two years, nearly $4 billion in tax credits have been utilized by the property/casualty industry. Clearly, tax credits at these levels cannot be expected to continue.

In summary, the property/casualty insurance industry benefited from nearly $5 billion of realized capital gains and tax credits in 1984. Without those extraordinary items, the industry would have incurred a large overall net loss. Over the prior twenty years, the average of total capital gains and federal income taxes was a net of only $500 million a year. Given their historically small contribution to total profit, realized capital gains and tax credits cannot be relied upon to provide a continuing and consistent bailout for operating losses. If the industry is to maintain a reasonable level of profitability for the long term, profits must come from operating income.

Premiums will have to increase faster than claim costs in order to achieve positive operating income in future years.

Positive operating income—the difference between underwriting loss (after policyholder dividends) and investment income—has been hard to achieve. Although investment income has grown steadily over the last decade to nearly $18 billion in 1984, its average annual increase since 1980 has been less than $2 billion, while underwriting losses increased at an average annual rate of over $4 billion. All available evidence indicates a record operating loss for 1985, despite substantial premium increases. If operating income is to become a source of profits, underwriting losses must be drastically reduced from the 1984 level of more than $21 billion. For this to happen, premium increases would have to continue to exceed the rate of growth in claim costs.

MAJOR CHARGES RAISED BY INDUSTRY CRITICS

The property/casualty insurance industry has recently been a target of criticism. Critics charge that, by manufacturing a crisis, insurers hope to lobby legislators to implement tort reform. A notion common to many of these criticisms is that the "actual" results reported by insurance companies are not actual at all, because they are based on *estimates* of loss reserves that insurers set aside to cover future loss payments. Some critics argue that the industry inflates the amount of money it reserves when it wants to show that it is unprofitable and puts less money in reserves when it chooses to show a profit. History does not support these charges. Financial analysts of the business have noted that, in times of low profitability, many insurers set aside less than they should to cover future losses on current or past policies.

The following pages contain 13 specific charges, together with the relevant facts that refute these charges, organized under four major accusations:

- The industry's accounting procedures regularly misrepresent its true financial condition. The profitability "crisis" is manufactured.
- Price increases are excessive. Losses are not the problem.
- Insurers are making substantial profits and paying no taxes. There's nothing fundamentally wrong with industry profitability. This is just a typical cyclical downturn.
- Insurance is too expensive.

ACCUSATION

The industry's accounting procedures regularly misrepresent its true financial condition. The profitability "crisis" is manufactured.

CHARGE: The industry manipulates its financial results by deliberately misstating reserves held to make future loss payments. Industrywide estimates of future loss payments are often overstated, thus producing a "crisis." During the last "crisis," the industry seriously overreserved, particularly in medical malpractice. It has again manufactured this current "crisis" in availability and affordability by overstating reserves.

THE FACTS: These charges have no basis in fact and contradict the consensus opinion of acknowledged financial analysts, who believe that current loss reserves are understated. A published ISO study concluded that year-end 1982 industrywide loss reserves were deficient by more than 10%. Subsequent ISO analyses indicate that no significant strengthening occurred in industry loss reserves through year-end 1984. Furthermore, experience has shown that industry loss reserves were seriously *understated* at the time of the last "crisis" in 1976.

It is true that loss reserves are estimates, made by insurers on a given date, of liabilities for additional loss payments that will ultimately be made for a particular set of claims. State insurance commissioners, charged with overseeing the solvency of insurers, suggest that these liabilities be reported at their full ultimate value for most lines of insurance. Reserves are particularly significant for the liability lines, for which the final payout may not be known for many years, which is why such lines are known as "long-tail" lines.

At the time of the last "crisis"—1976—the reserves set aside at year-end 1976, for all claims incurred to that date, were $47.1 billion. As of year-end 1984, $48.6 billion had been paid out on those initial pre-1977 claim reserves. And an additional $8.0 billion was still held in reserve for the same group of claims—for a total payment of $56.6 billion rather than the $47.1 billion originally expected. The nearly $10 billion difference represents an initial reserve deficiency of 20%. **(See chart 6.)**

One reason that reserves set in the past for long-tail lines such as general liability have proven to be deficient is that scientific, technological and societal changes have revealed new sources of exposure to injury and new theories of legal liability. For example, when general liability loss reserves were established 10 to 20 or more years ago, insurers could not have predicted the huge number of claims related to asbestos, Agent Orange, DES, and other alleged causes of latent injuries under policies already written. At that time, no reserves were set up for future payments of those losses. It is now clear

that the initial general liability reserves will prove to be significantly understated.

This pattern of underreserving can easily be seen in two particularly long-tailed lines, general liability and medical malpractice. In 1976, general liability claim payments already made, plus the reserves carried for future payments on policies written through that year, totaled $24.0 billion. At year-end 1984, the estimated costs for those same general liability claims had risen to $28.0 billion, of which $26.0 billion had already been paid. (See chart 7.) This means that, as of year-end 1984, the original 1976 general liability reserve was already *insufficient* by $4 billion.

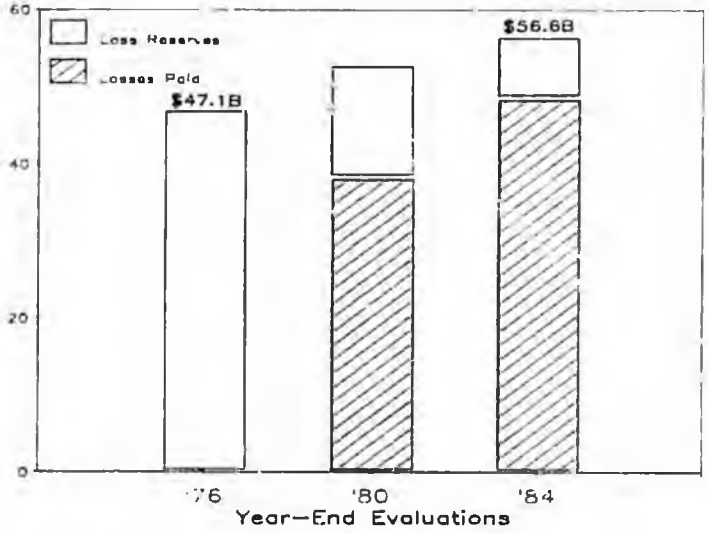
For medical malpractice, the estimate for ultimate claim payments on the policies written through 1976 initially totaled $1.9 billion. The year-end 1984 estimate for those same medical malpractice losses had risen to $2.3 billion, of which $1.9 billion had already been paid. (See chart 8.) This means that, as of year-end 1984, the original 1976 medical malpractice reserve was already *insufficient* by $400 million.

The 1976 loss reserves were not unique. More recent years show a similar pattern of final losses that are likely to exceed the initial reserves. For example, the 1979 reserve for liability lines was $65.3 billion at year-end 1979. As of year-end 1984, $53.8 billion of those reserves had been paid and $15.7 billion was still held in reserve, for a total of $69.5 billion—an initial reserve *deficiency* of more than $4 billion (6%) as of year-end 1984. (See chart 9.) Given recent historical trends, it is likely that estimated final claim payments—and, therefore, the reserve deficiencies—will grow as later evaluations are made.

CHARGE: Policyholder dividends should not be included with losses in determining underwriting results. Policyholder dividends are not a business expense, but a voluntary choice of profitable companies to distribute some of the profit to policyholders.

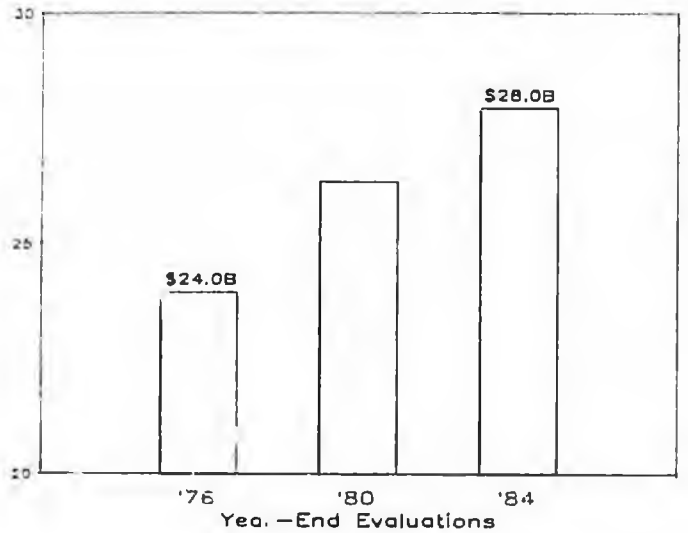
THE FACTS: Policyholder dividends, although not "losses", are price discounts to customers that are legitimate business expenses, deductible from income. This treatment follows that dictated by statutory accounting procedures developed by the National Association of Insurance

6 1976 INDUSTRY RESERVES FELL SHORT



Calendar Year 1976 Loss Reserves ($ Billions) *The reserves set aside at year-end 1976 proved to be nearly $10 billion (20%) short eight years later.*

7 1976 GENERAL LIABILITY RESERVES FELL SHORT



General Liability Incurred Loss Development—1976 ($ Billions) *Estimated costs of general liability claims incurred through 1976 proved to be $4 billion too low by year-end 1984.*

Commissioners and is consistent with generally accepted accounting principles as articulated by the Financial Accounting Standards Board (FASB). The opinion of the independent accounting firm of Coopers & Lybrand supporting this treatment may be found in the Appendix.

The charge for policyholder dividends should not be treated as expenses could just as easily—and just as mistakenly—be applied to any price discount a company offers its customers to encourage the purchase of the company's product or service. And that's what policyholder dividends are: a price discount. When manufacturers offer a $10 refund on the price of a coffeemaker or a $500 rebate on the price of a car, they are not distributing profits; rather, they are incurring an expense that is, in effect, a price cut. As with manufacturers offering price discounts, policyholder dividends are appropriately recognized as an insurer expense that *reduces* profits. Policyholder dividends are not a distribution of profits.

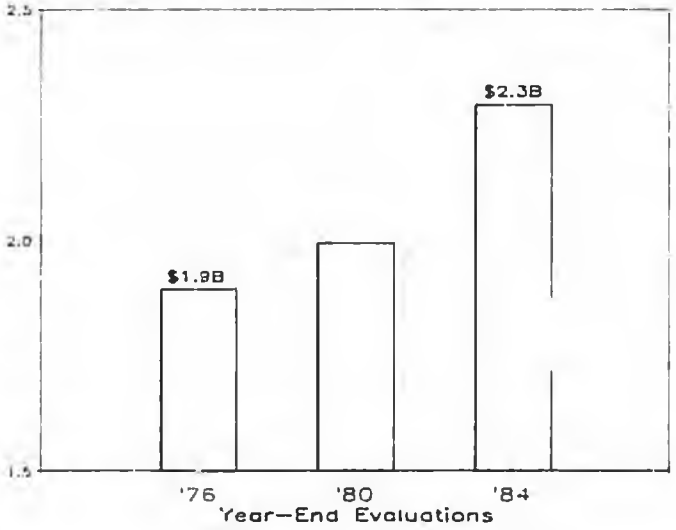
Policyholder dividends are unlike dividends to stockholders. Policyholder dividends represent a portion of gross revenues that a company has designated for return to its policyholders. Many insurer managements pay dividends to policyholders as a competitive tool to retain business. Also, many insurers grant dividends to policyholders whether they are profitable or not, treating the practice as a necessary cost of doing business. (See chart 10.)

On the other hand, dividends to stockholders of *any* business corporation represent a distribution to its owners of a portion of current or past earnings, based on each owner's total holdings. Unlike policyholder dividends, stockholder dividends do not offset income. They are charged directly to net worth.

CHARGE: The property/casualty insurance industry defines "income" to exclude certain items, such as realized capital gains. Insurers report operating income, rather than net after-tax income, to show they had losses when they really made money.

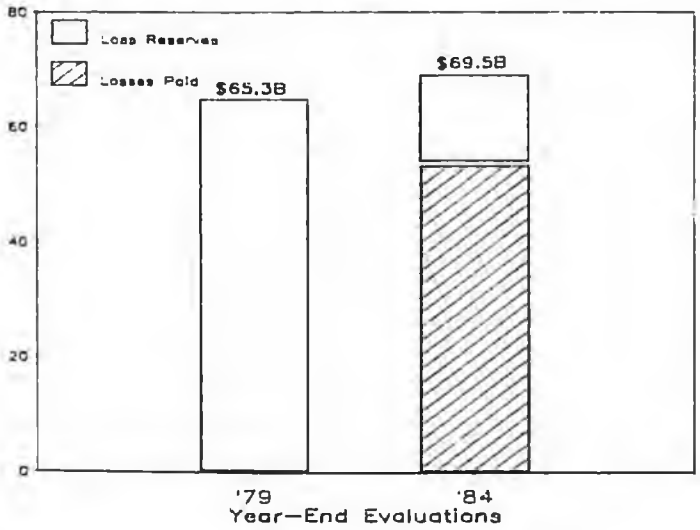
THE FACTS: This charge is false. Every quarter, statistics compiled and released by ISO highlight net after-tax

8 1976 MEDICAL MALPRACTICE RESERVES FELL SHORT



Medical Malpractice Incurred Loss Development—1976 ($ Billions)
Estimated costs of medical malpractice claims incurred through 1976 proved to be $400 million too low by year-end 1984.

9 1979 INDUSTRY RESERVES FELL SHORT



Calendar Year 1979 Liability Loss Reserves ($ Billions)
The reserves set aside at year-end 1979 for liability lines were more than $4 billion (5%) deficient just five years later.

income, which includes realized capital gains, as well as all other components of income.

For example, a widely-distributed November 26, 1985 news release from ISO and the National Association of Independent Insurers began with the following statement:

"The nation's property and casualty insurance industry's consolidated net after-tax income totaled $1.49 billion for the first nine months of 1985, up 118 percent from the nine-month 1984 net income of $685 million."

This news release went on to document various components of net after-tax income, including underwriting results, investment results and pre-tax operating income—all important and commonly-used measures of an insurer's business.

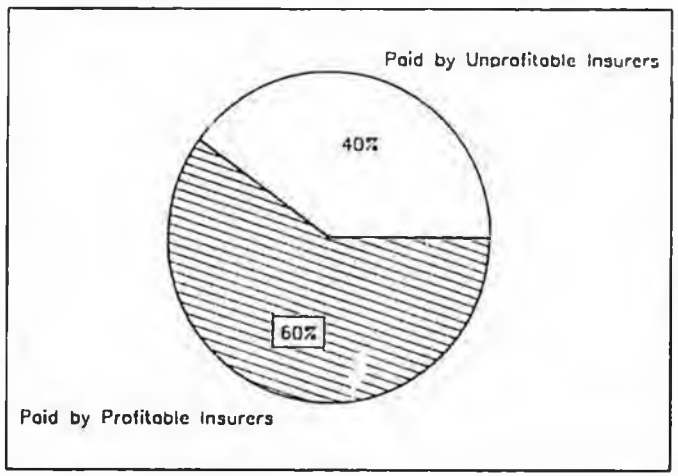
Pre-tax operating income is important to financial analysts, since it is free of the unpredictable and erratic swings exhibited by realized capital gains over a short period. While the total return on net worth (represented by net after-tax income, including realized capital gains) is the more proper measure when comparing insurer results with other commercial and industrial enterprises, operating income is a more precise reflection of the company's insurance operations—how well it is doing in its basic business.

The components of operating income are underwriting income (after policyholder dividends) and investment income (net of investment expenses). While realized capital gains are considered in the determination of taxable income, they are not part of operating income. The opinion of the independent accounting firm of Coopers & Lybrand supporting this treatment may be found in the Appendix.

Realized capital gains reflect a decision to sell assets. Companies may realize capital gains to offset operating losses and/or to utilize federal income tax credits. Prior to 1983, the industry's realized capital gains were not significant, relative to net income after taxes. But in 1984 and 1985, without unprecedented realized capital gains, net income after taxes for the industry would have been a net *loss*. **(See chart 11.)**

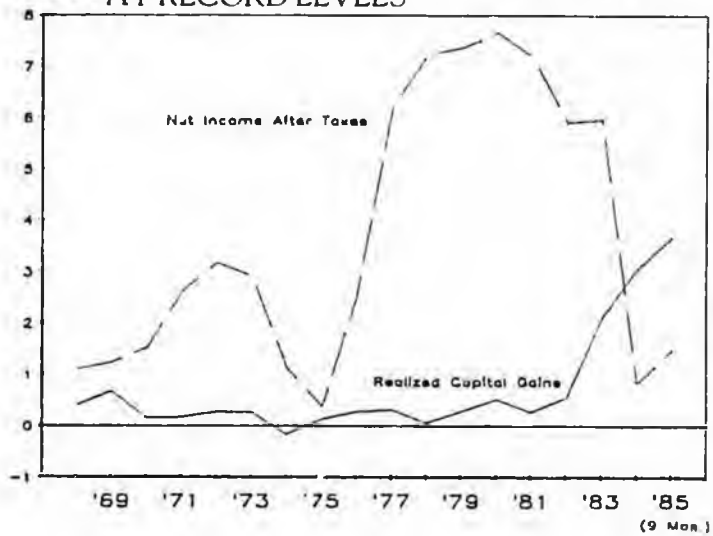
No insurer can guarantee large realized capital gains in a future year. Therefore, operating income has become the common measure for evaluating the success—or lack thereof—of an insurance company's operation.

10 WHO PAID POLICYHOLDER DIVIDENDS IN 1984?



Insurers with a negative return on net worth paid 40% of 1984 policyholder dividends.

11 INSURERS REALIZED CAPITAL GAINS AT RECORD LEVELS



Realized Capital Gains and Net Income After Taxes ($ Billions) *Only the unprecedented levels of gains from the sale of assets allowed the industry to show positive net income after taxes in 1984 and 1985.*

CHARGE: In 1984, property/casualty insurers earned about a 3% rate of return on net worth. That is too low. However, if their premium had been 5% higher, they would have earned a rate of return on net worth of about 13%. In 1985, insurers' return on net worth rose to an estimated 7%. If the effects of dividends to policyholders and unusually high hurricane losses in 1985 were removed, the industry's return on net worth in 1985 would have been about 13%, the average for all American industries.

THE FACTS: The 3% return on net worth quoted by critics for 1984 is wrong. More importantly, the conclusion that an additional 5% of premium would add 10 points to that return is also wrong. Similarly, the estimated 7% return on net worth for 1985 is too high. More importantly, the adjustment to the 1985 return, adding 6 points to the estimated value, is inaccurate, inappropriate and misleading.

First, the 3% rate of return quoted by critics for 1984 is wrong. The actual figure is 1.7%. Second, an additional 5% of premium would have added about 6 points to the return on net worth. This 6-point increment is based on the conservative assumption that fixed expenses will not grow at all despite the increased revenues. If one assumes growth in fixed expenses, the additional return is 5 points.

With regard to 1985, although the critics' adjustments are unsupported, it appears that policyholder dividends have been added back into income (incorrectly raising the return by 3 points) and *all* catastrophe losses have been removed (incorrectly adding another 3 points to the return). The proper adjustments to calculate a hypothetical industry rate of return—for a year with normal events—include removing the effect of all unusual events—not only unusual catastrophe *losses*, but unusual realized capital *gains* as well. These adjustments would lower the 1985 return on net worth by about 3 points—not raise it by 6 points.

Dividends to policyholders are premium discounts to customers, rather than a distribution of profits to owners. They are properly considered as a legitimate business expense in the determination of the rate of return on net worth. Removing the effects of policyholder dividends on income is inaccurate. **(See page 20.)**

Catastrophe losses are defined as events that cause more than $5 million of insured losses. 1985 was indeed a year of unusually high catastrophe losses, totaling $2.8 billion or about 2.1% of premium. The average annual catastrophe loss over the last 10 years has been 1.3% of premium. **(See chart 12.)** To calculate the return on net worth as if 1985 had been a more typical year, an average annual catastrophe loss amount should be substituted for 1985's actual catastrophe losses. Using 1.3% rather than 2.1% to smooth the dollar value of catastrophe losses would raise the return on net worth by approximately 1 point.

But to restate the 1985 return as a more typical year, one should also adjust the component of 1985 insurer profitability that showed the most atypical result—realized capital gains. The average annual realized capital gain over the last 10 years has been 0.51% of assets, while 1985 realized capital gains are estimated to be $5.3

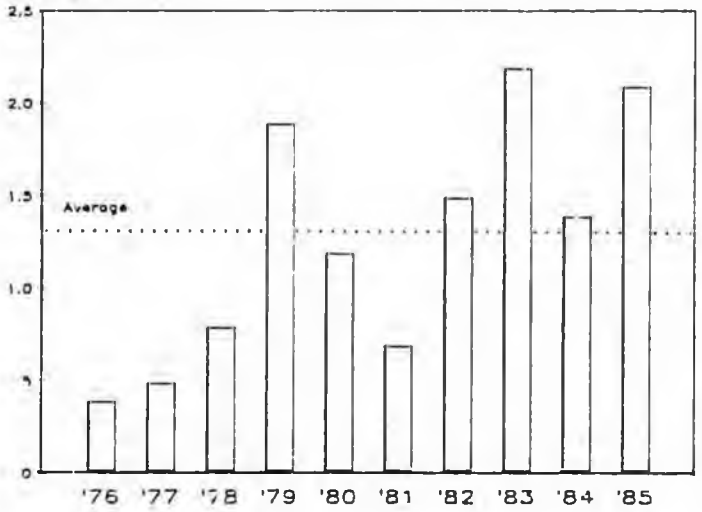
billion or 1.75% of assets—more than three times the 10-year average. (See chart 13.) Substituting the average capital gains for the 1985 amount reduces the return on net worth by 4 points.

Using a long-term average for both catastrophe losses and realized capital gains lowers the return on net worth by approximately 3 points.

Not only do the critics err in how they apply adjustments, but their estimate of a 7% return on net worth for 1985 is too high. This estimate appears to include both unrealized capital gains, as well as an incorrect amount for federal income tax credits as income. Unrealized capital gains are not income and should not be included as such in a calculation of the 1985 return on net worth. The latest estimate of 1985 federal income tax credits is $1.9 billion, rather than the $3.5 billion that appears to be included in the estimate of 7%. Correcting both of these errors would lower the return by several additional points.

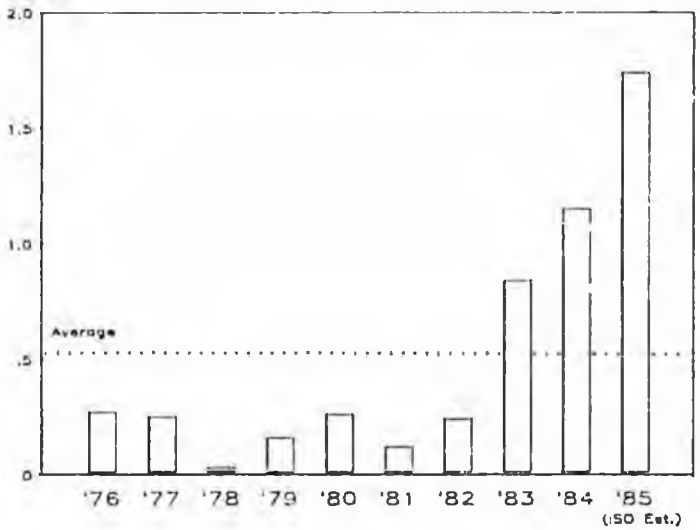
These errors have been partially recognized by critics who, more recently, quoted a revised return on net worth of 6% for 1985—still an overestimate.

12 CATASTROPHE LOSSES CANNOT BE IGNORED



Catastrophe Losses (% of Earned Premium) *Catastrophe losses have varied over the last 10 years, averaging 1.3% of earned premium. Use of a long-term average for catastrophes is an appropriate adjustment in the calculation of expected return on net worth. Total exclusion of all catastrophe losses in 1985 is wrong in determining 1985 profitability for the property/casualty industry.*

13 REALIZED CAPITAL GAINS VARY OVER TIME



Realized Capital Gains (% of Assets) *Realized capital gains have grown in recent years to unprecedented levels. Use of a long-term average of realized capital gains is an appropriate adjustment in the calculation of expected return on net worth. Inclusion of the record levels of realized capital gains in a calculation of the 1985 return is misleading in determining potential profitability.*

ACCUSATION

Price increases are excessive. Losses are not the problem.

CHARGE: The insurance industry needed only a 12-15% increase in written premium in 1985 in order to achieve a 13-15% return on net worth in 1986. Given the magnitude of the premium increases in 1985, no additional price increases are needed in 1986.

THE FACTS: No reasonable set of assumptions could support the above statements. It is not plausible that a 12-15% premium increase in 1985 could produce such a high rate of return in 1986. This analysis cannot refute the specific assumptions or calculations underlying the critics' charges since no supporting data have been provided.

Based on an ISO analysis, if industry written premiums had increased only 12-15% in 1985, further increases in excess of 30% would be required in 1986 to achieve a 13% return on net worth. An overall premium increase of this magnitude would be far larger than any ever achieved by the insurance industry.

Given the estimated 20% premium growth that occurred in 1985, ISO forecasts there will be a smaller increase in 1986. Assuming a 17.5% increase for 1986, ISO projects that 1986 industry returns on net worth will rise. Under reasonable assumptions for loss growth, investment income, realized capital gains and taxes, the 1986 return on net worth will be only 8-9%, which is far below the typical returns for most other U.S. industries and below the median result for the Fortune 500 in each of the last 10 years.

The following facts support the ISO analysis and forecasts.

(1) Recent insurance industry returns on net worth have been low—below 2% for 1984, with modest improvement, at best, in 1985. Roughly a 10-point increase in return on net worth would be required to reach the 13-15% range hypothesized for 1986.

(2) Industry losses have continued to escalate rapidly, rising 15% in the first nine months of 1985. The full-year increase in losses will be at least as high.

The charge that no additional price increases are needed in 1986 is false. If the industry implements no increases in 1986, a return on net worth of only 5% could be expected—and 1987 returns would be even lower. The beginning of another downturn so soon after the longest and most severe downturn in the history of the industry would seriously threaten the industry's ability to make future claim payments.

CHARGE: Insurance premiums are increasing so dramatically today solely because of prior inadequate prices. Increasing losses are not the problem.

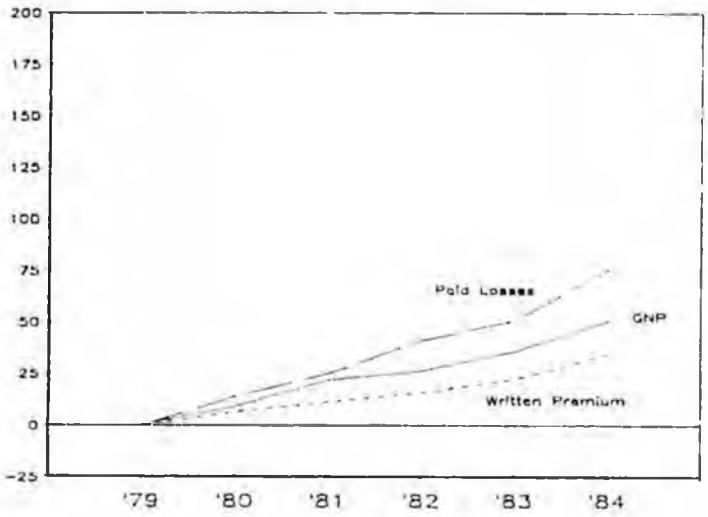
THE FACTS: This charge is incorrect. No one can deny that insurers reduced prices far below the level needed to cover the costs of policies written. However, in the past five years, growth in property/casualty losses has far exceeded the country's economic growth as measured by GNP.

During 1979-1984, GNP grew 50% while written premium increased only 34%, or 2.4 points per year *slower* than the average annual GNP growth rate. On the other hand, paid losses grew 76%, or 3.4 points per year *faster* than GNP. **(See chart 14.)**

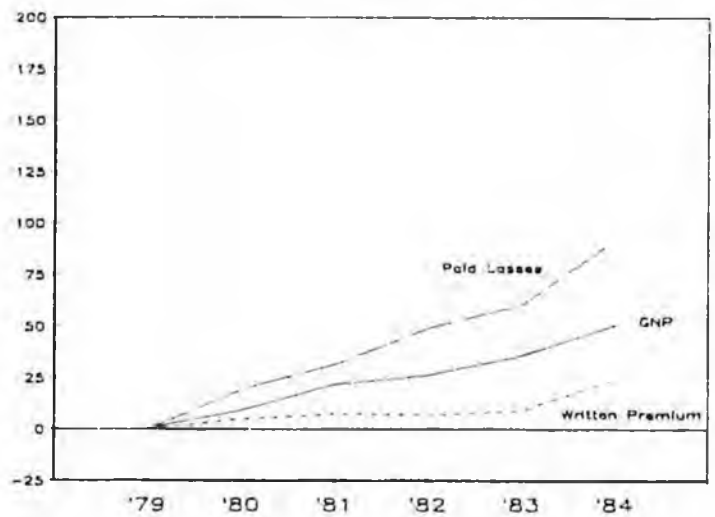
Moreover, the increase in losses was not uniform across all lines of insurance. Commercial lines paid losses grew 92% while personal lines

LOSSES GREW FASTER THAN PREMIUMS, ESPECIALLY FOR COMMERCIAL LIABILITY LINES

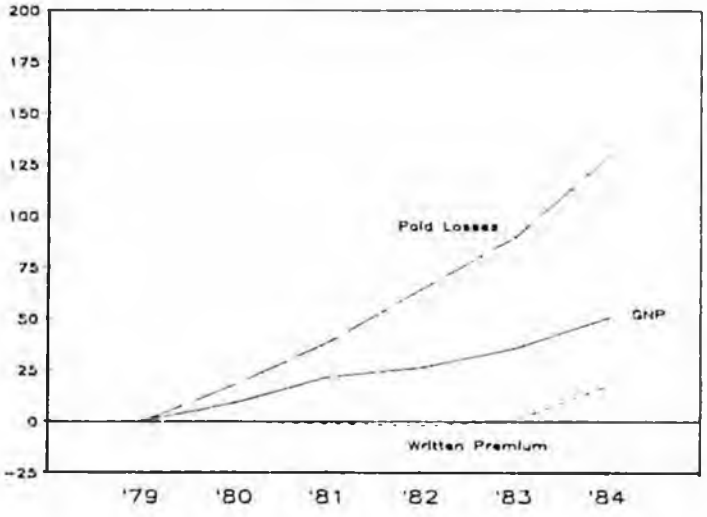
Since 1979, paid losses have grown at a faster rate than either GNP or premiums. The problem is more severe for commercial lines, especially the commercial liability lines.



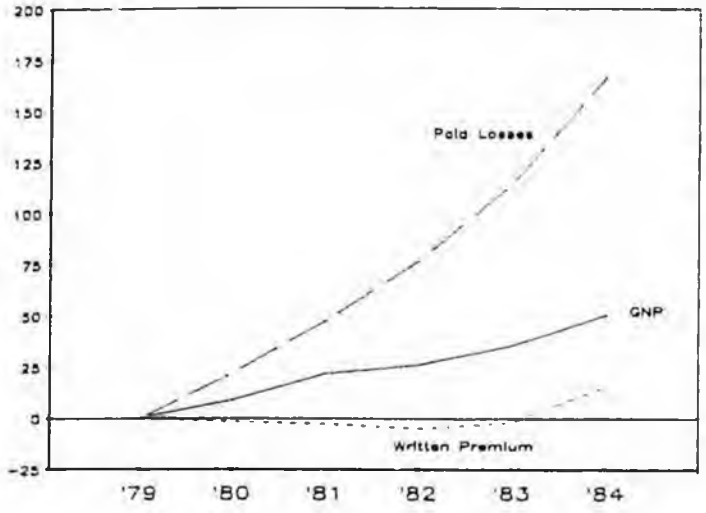
14
Loss Growth and Premium Growth vs. GNP (%): All Lines



15
Loss Growth and Premium Growth vs. GNP (%): Commercial Lines



16
Loss Growth and Premium Growth vs. GNP (%): Commercial Liability



17
Loss Growth and Premium Growth vs. GNP (%): General Liability & Medical Malpractice Combined

paid losses increased 62%, and commercial liability paid losses increased 130% during the period—well over double the GNP growth rate. **(See charts 15 and 16.)**

Finally, general liability and medical professional liability paid losses have grown 167% over the five-year period—more than triple the GNP growth. **(See chart 17.)** From 1979 to 1984, paid loss growth averaged 22% a year—13 points more than the average annual GNP growth rate. **(See chart 18.)**

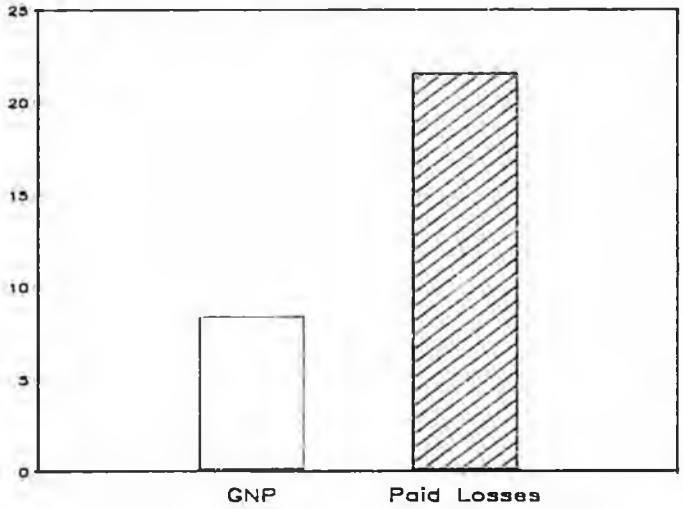
The Administrative Office of U.S. Courts reports that product liability suits filed in U.S. District Courts increased from 1,600 in 1974 to more than 13,500 in 1985—a growth rate of 22% per year. **(See chart 19.)** Very large awards are becoming much more common. Jury Verdict Research, Inc. reports that the number of million-dollar verdicts in the U.S. has increased each year, from 24 in 1974 to over 400 in 1984. **(See chart 20.)**

One aspect of the problem of increasing losses is the accompanying litigation costs. The Institute for Civil Justice studied asbestos litigation and found that a disproportionate share of the expenditures on these claims does not reach the victims. Specifically, only 37% of costs in asbestos litigation become net compensation to victims. **(See chart 21.)**

While current availability and affordability problems are certainly due in part to past price reductions, a major contributor to the problems has been the significant increase in losses. From 1979 to 1984, policyholders had the benefit of low insurance price levels that did not keep pace with losses. But as a result, the insurance industry experienced below-average returns on net worth relative to the Fortune 500 companies in every year since 1979.

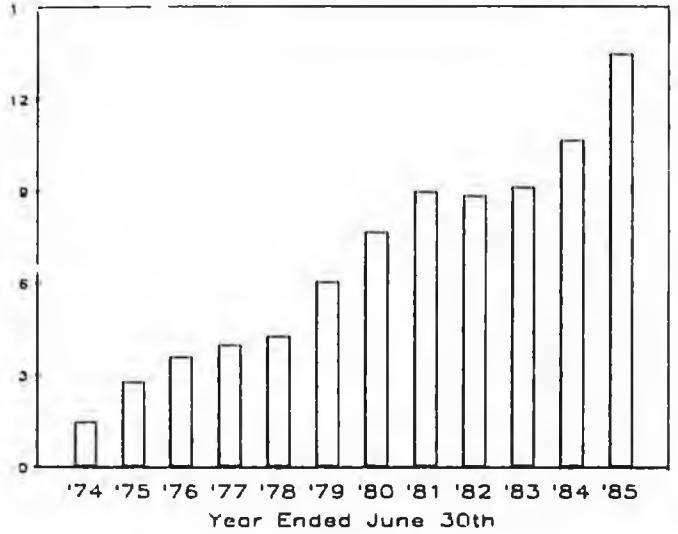
The large premium increases occurring now, particularly for the commercial liability lines, will not recoup past losses nor make up for recent substandard returns. Such increases are needed simply to bring insurance prices in line with the costs of policies written today.

18 LOSS GROWTH OUTPACES ECONOMIC GROWTH



General Liability & Medical Malpractice Losses vs. GNP—1979-84 (Annual % Change) *For the past five years, the average rate of growth in general liability and medical malpractice paid losses was 22% vs. a 9% GNP growth rate, a 13-point annual gap.*

19 LITIGATION EXPLOSION



Product Liability Lawsuits (Thousands) *Since 1974, the number of product liability lawsuits filed in U.S. District Courts has increased more than eight-fold. Source: Administrative Office of U.S. Courts.*

CHARGE: The 1985 written premium increase of 71% for general liability insurance was excessive. If insurers had not slashed liability rates a few years ago, they would have earned handsome profits.

THE FACTS: The 1985 premium increase was not excessive. Even after that increase, current general liability premium levels are still inadequate when compared with current general liability losses.

The 1984 general liability written premium of $6.5 billion was no greater than the 1978 written premium. But from 1978 to 1984, losses and loss adjustment expenses incurred increased 74%, from $4.3 billion to $7.5 billion. **(See chart 22.)** Even after including the estimated 1985 increase, written premium has grown at an annual rate of only 8% since 1978, while losses have grown at an annual rate of 14%.

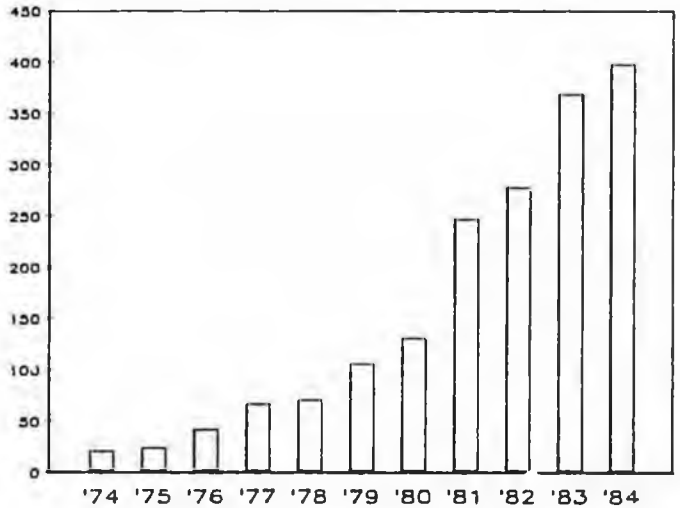
A.M. Best Company estimates the 1985 combined ratio[3] for general liability at 144. At that level, even with a reasonable estimate of anticipated investment income, the general liability lines will lose money. With an estimated annual 8½% interest rate, historical payout patterns for general liability and the A.M. Best combined ratio estimate for 1985, insurers lost 7¢ on every dollar of general liability premium written in 1985. Obviously, the 1985 increase was not sufficient.

One critic has charged that "general liability rates of return on net worth" would have averaged 30% per year from 1976 to 1983, if insurers had not cut premiums. This hypothetical rate of return is flawed by unrealistic assumptions.

- For all lines combined, it assumes that the ratio of earned premium to net worth is 2:1. The actual average for 1976 through 1983 was 1.6:1.
- Further, it assumes that the hypothetical 2:1 earned premium to net worth ratio is

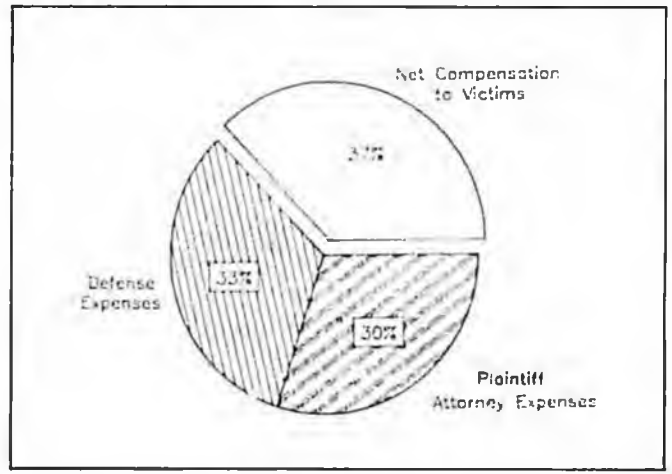
[3]*Combined ratio = incurred losses and loss adjustment expenses divided by net earned premium plus other underwriting expenses divided by net written premium plus dividends to policyholders divided by net earned premium.*

20 NUMBER OF HUGE VERDICTS INCREASING



Million-Dollar Verdicts *From 1974 to 1984, the number of million-dollar verdicts rose dramatically. Source: Jury Verdict Research, Inc., Solon, Ohio.*

21 VICTIMS RECEIVE ONLY 37% OF ASBESTOS CLAIMS EXPENDITURES



Average Expenditures per Tried Asbestos Claim (%) *The Institute for Civil Justice has found that only 37% of asbestos claims expenditures become net compensation to victims.*

the same for general liability as for all lines combined. In a line like general liability, claims remain outstanding for long periods of time while legal standards change; a prudent insurer would therefore require more net worth to support each dollar of general liability premium than for most other lines.

- In rewriting history, the critics assume that, had premiums been greater, *all* the additional premium revenue would have been profit. This assumption ignores the fact that, at a minimum, commissions and premium taxes would be paid and income taxes would rise (or credits decrease).

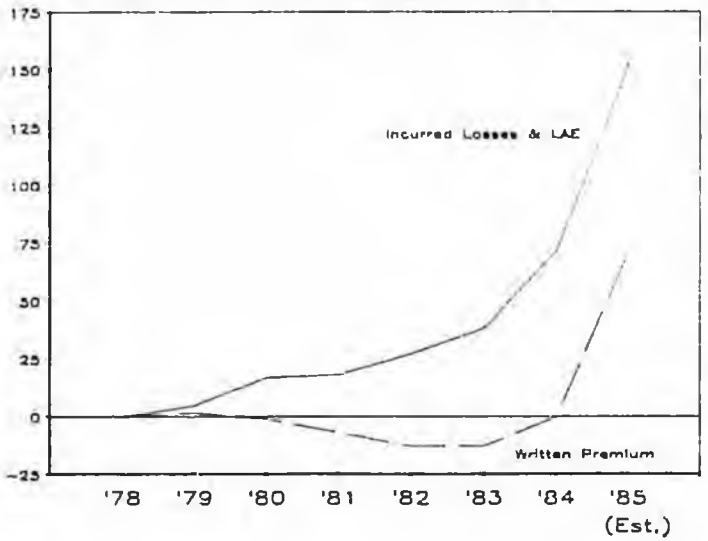
Thus, the conclusion that the "general liability return on net worth" would have been 30% is inaccurate.

CHARGE: Since, for medical malpractice, the industry's paid losses are less than their investment income, this line can be treated on a "pay as you go" basis.

THE FACTS: This charge has two flaws. First, the figures are inaccurate and incomplete; the industry's paid losses alone for medical malpractice are substantially greater than investment income, even without consideration of paid loss adjustment expenses. Second, even if the figures were accurate and complete, the charge is irrelevant. It is inappropriate to consider only actual payments without recognizing future liabilities for injuries that have already occurred but for which the related claims are not yet settled. For long-tail lines like medical malpractice, these claims take many years to settle.

For 1984, A.M. Best reported $970 million in medical malpractice paid losses and $440 million in paid loss adjustment expenses (monies expended in the investigation and settlement of claims), for a total of $1.4 billion.

22 1985 GENERAL LIABILITY PREMIUM GROWTH NOT ENOUGH TO CATCH LOSSES



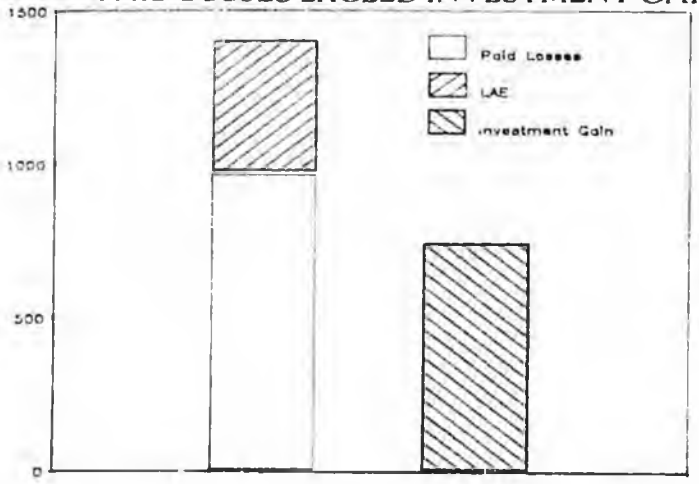
General Liability Premium Growth vs. Loss Growth (%) *1985's large premium growth for general liability was not enough to bring premiums in line with 1985 general liability losses and loss adjustment expenses. And, since 1978, the rate of growth in losses is nearly double that of premiums.*

This compares with only $750 million of net investment gain. (See chart 23.) In addition, underwriting expenses and policyholder dividends of $300 million were paid in 1984.

Even if 1984 paid losses had been less than investment income, comparing the two is naive. An analogy can be made to a pension plan with the vast majority of participants in their 30's and 40's. For many years, premiums paid into the plan will far exceed benefits paid out, but it is quite obvious that the liability for future benefit payments is growing each year and must be funded.

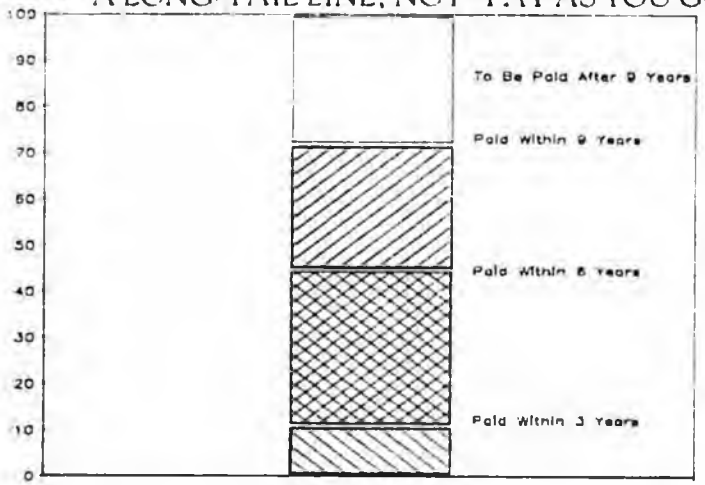
Similarly, medical malpractice claims often take years to emerge and additional years to be litigated. Claims paid out the first year are miniscule, and even after several years, only a small percent of ultimate losses are paid out. For 1976, the year for which the most complete and mature data is available, only 1% of total estimated losses were paid in the first year, only 11% in the first three years and only 72% even after nine years. (See chart 24.) The percentages are similar for other years examined. To conclude anything about the profitability of this line on the basis of paid losses is like saying that the Social Security system is properly funded simply because more money was collected this year than was paid out this year.

23 CRITICS' CHARGES FALSE: MEDICAL MALPRACTICE PAID LOSSES EXCEED INVESTMENT GAIN



Medical Malpractice Insurers' Paid Loss & Loss Adjustment Expense vs. Investment Gain ($ Millions)
For 1984, investment gain for medical malpractice insurance is significantly lower than loss and loss adjustment expenses paid. Critics falsely contended the opposite.

24 MEDICAL MALPRACTICE INSURANCE: A LONG-TAIL LINE, NOT "PAY AS YOU GO"



1976 Medical Malpractice Claims: Percent of Ultimate Losses Paid
After nine years, only 72% of 1976 medical malpractice losses were paid. Claims often take years to emerge and additional years to litigate.

ACCUSATION

Insurers are making substantial profits and paying no taxes. There's nothing fundamentally wrong with industry profitability. This is just a typical cyclical downturn.

CHARGE: The stock index of property/casualty insurers rose by 50% during 1985, almost double the rise of the general stock market. This is hardly indicative of a troubled industry.

THE FACTS: The fact that property/casualty stock prices, as measured by the A.M. Best Company's property/casualty stock index, outperformed the rest of the stock market is no indication that this industry is profitable. Investors expect improvements in rates of return for property/casualty insurers, but investor expectations are merely that—*expectations*. They do not guarantee results.

Signs of a firming in insurance premiums (especially for commercial lines) began to emerge at the end of 1984. This price strengthening continued throughout 1985 and shows no sign of abatement in 1986. It is clear that sophisticated institutional investors believe that insurers have regained control of their financial destinies and that earnings will improve. But investor expectations do not guarantee future results, and investor behavior does not necessarily correlate with future earnings of the industry.

CHARGE: Property/casualty insurers had net income of $75 billion over the last 10 years. This is a huge amount of money to make. And they paid no taxes.

Note: The $75 billion figure in the critics' charge is based on a fact sheet prepared for the House Ways and Means Committee by the General Accounting Office. The GAO produced a chart that contained the following figures for the property/casualty insurance industry.

1975-1984 (in billions)	
Underwriting Gains (Loss)	($ 45.8)
Investment Gains	121.0
Net Gains	$ 75.2

THE FACTS: The $75 billion figure is not net income. It *excludes* policyholder dividends paid and *includes* unrealized capital gains. Net income after taxes averaged $5.1 billion per year, for an average return on net worth of 10.9%. The 10.9% figure is lower than that of the Fortune 500 companies. And insurers' tax credits are based on underwriting losses and the tax status of their investments.

Some critics have used the GAO's figures to reach erroneous conclusions. The underwriting loss shown excludes policyholder dividends paid, and since policyholder dividends are a cost of doing business, they must be deducted from income. (See page 20.)

Investment gains, as shown, include unrealized as well as realized capital gains. Unrealized capital gains flow directly to surplus and do not affect income until realized. A restatement of the 1975-84 totals, with the proper adjustments for policyholder dividends and unrealized capital gains, follows:

PROPERTY/CASUALTY INSURANCE INDUSTRY INCOME, 1975-1984 (in billions)	
Underwriting Gain (Loss) After Policyholder Dividends	($ 60.0)
Investment Income	103.7
Operating Income	$ 43.7
Realized Capital Gains	7.7
Net Income (Before Federal Income Tax)	$ 51.4

Property/casualty insurers received a total of $125 million in federal income tax credits during 1975-1984. Thus, industrywide net income after tax for the 10-year period averaged $5.1 billion per year, not an excessive return. Over the 10-year period 1975-1984, returns on net worth ranged from 1.7% to 19.0%, averaging 10.9%. A comparison with other industries follows:

RETURNS ON NET WORTH, 1975-1984

	P/C Insurance	Diversified Financial	Banks	Fortune 500
Low:	1.7%	8.3%	11.5%	10.7%
High:	19.0	17.5	14.1	15.9
Range:	17.3	9.2	2.6	5.2
Average:	10.9	12.8	12.6	13.2

The property/casualty insurance industry has had the lowest average return, while experiencing the greatest variability of all the industries listed. (See chart 25.) This occurs despite the economic theory that increased variability should be rewarded with greater average returns.

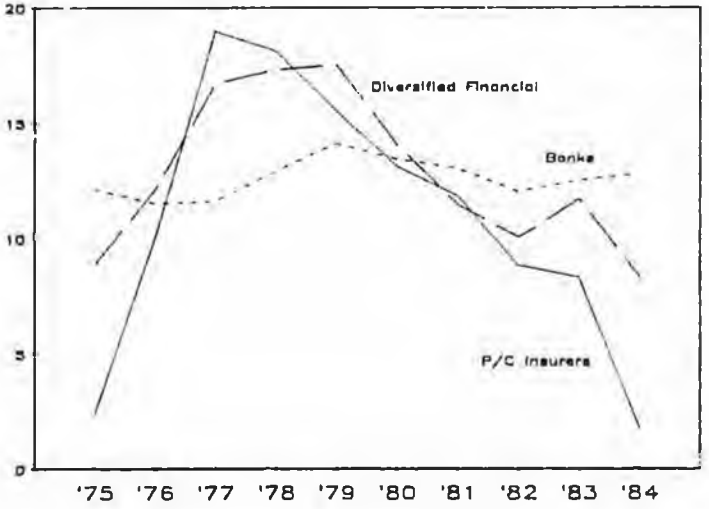
While some critics have argued that the property/casualty insurance industry is a low-to-average risk business, the Majority Report of the Advisory Committee to the NAIC Task Force on Profitability and Investment Income (January 1983) concluded that "the property-casualty insurance business is riskier than the average business in the American economy."

Although property/casualty insurers received a total of $125 million in federal income tax credits during 1975-1984, they paid $21 billion in state and local taxes, licenses, and fees other than payroll taxes. The 1985 federal income tax credit is estimated at under $2 billion, while state and local taxes paid are estimated at over $3 billion.

Net federal income tax credits have accumulated for several reasons. In eight of the past 10 years, the industry posted underwriting losses. Since the 10-year underwriting loss was $60 billion, the positive net income of $51 billion came from investment gains. In achieving this income, property/casualty insurers, like other businesses, benefited from various incentives provided by the federal tax system to help the country achieve certain economic objectives.

For example, to help state and local governments raise money through the sale of bonds, Congress has determined that interest

25. INDUSTRY RETURNS ARE VOLATILE OVER TIME



Return on Net Worth: Property/ Casualty Insurers vs. Other Industries (%) *Returns on net worth for property/ casualty insurers are much more variable than those for other industries. Over the past 10 years, the average rate of return for property/casualty insurers (10.9%) has been below that of the Fortune 500 companies (13.2%), while exhibiting much more variation.*

on such bonds is exempt from federal taxes. This enables such bonds to be sold with interest rates below the market rate, reducing interest costs ultimately paid by state and local taxpayers. Insurers could have earned higher interest income (on taxable bonds) and paid taxes on that interest income, inflating their federal tax bills but leaving state and local governments without a source of low-cost financing.

Over the last six years, 40% of the industry's net investment income has come from non-taxable bonds. Favorable tax treatment also exists for dividends on equities held by insurers, which have accounted for 20% of the industry's net investment income. In addition, property/casualty insurers (like all investors) benefited from reduced tax rates on realized capital gains.

It is inappropriate to criticize insurers for acting in compliance with tax laws and public policy.

CHARGE: This is a typical cycle. The property/casualty industry will recover quickly, just as it has in past cycles.

THE FACTS: This cycle is clearly not typical. The results of the recent past demonstrate that the industry is experiencing anything but a "typical" cyclical period. Underwriting losses, operating losses, combined ratios, the number of insolvencies and the number of companies targeted for immediate regulatory attention were all at record highs in 1984, while the industrywide return on net worth was at an all-time low. And reinsurers, on whom insurers depend as never before, have been seriously weakened.

The 1984 underwriting loss was $21.5 billion. Prior to this cycle, the record underwriting loss was $4.2 billion in 1975. **(See chart 26.)** The 1984 operating loss was $3.8 billion. The previous record was $0.3 billion in 1975. **(See chart 27.)** The 1984 combined ratio was 118.0. Prior to this cycle, the record was 107.9, again in 1975. **(See chart 28.)**

In 1969, the National Committee on Insurance Guaranty Funds began to collect data on insolvencies that trigger state guaranty funds. Until last year, the record number of insolvencies in any two-year period was 25. During 1984-85, there were 40 insolvencies; and the books on 1985 insolvencies are not yet closed. **(See chart 29.)**

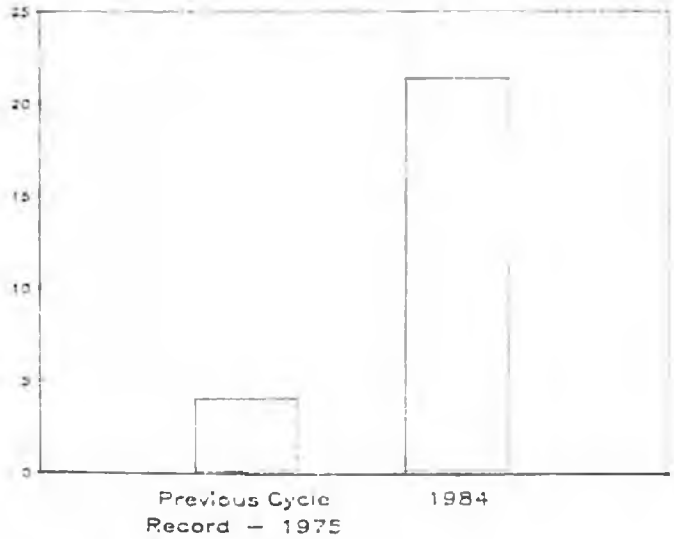
The National Association of Insurance Commissioners (NAIC) developed an early warning system to alert regulators to potential insolvencies. In discussing the 1985 test results, Iowa Insurance Commissioner Bruce W. Foudree, former President of the NAIC, said that 215 property/casualty insurers had been targeted as being in need of immediate regulatory attention under the NAIC early warning system—"the most ever and a 73% increase over last year."

On the basis of bottom-line results, the 1984 return on net worth was 1.7%, despite a record $4.8 billion of realized capital gains and tax credits. The previous low return on net worth of 2.4% occurred in 1975, when the sum of tax credits and realized capital gains was only $0.7 billion.

One of the most important differences between this down cycle and all previous ones is its length. This time, the combined ratio worsened for seven consecutive years beginning in 1978. Previously, the longest continuous

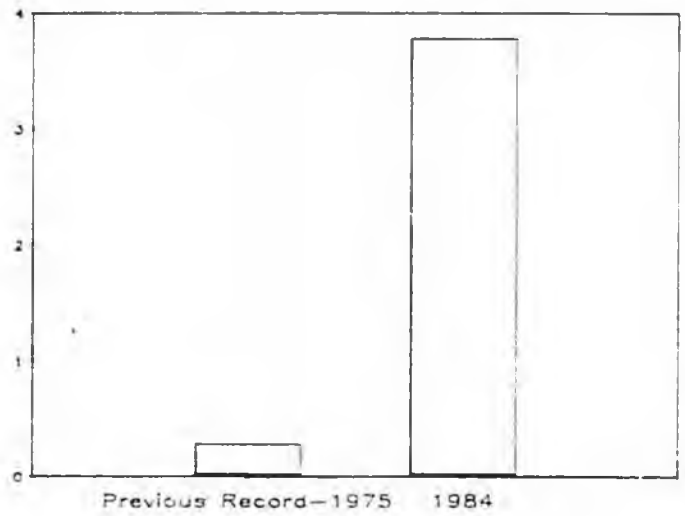
A TYPICAL CYCLE?

By several measures — underwriting loss, operating loss, combined ratio, and insolvencies — it is clear that the cycle that bottomed in 1984 was far more severe than any previous one



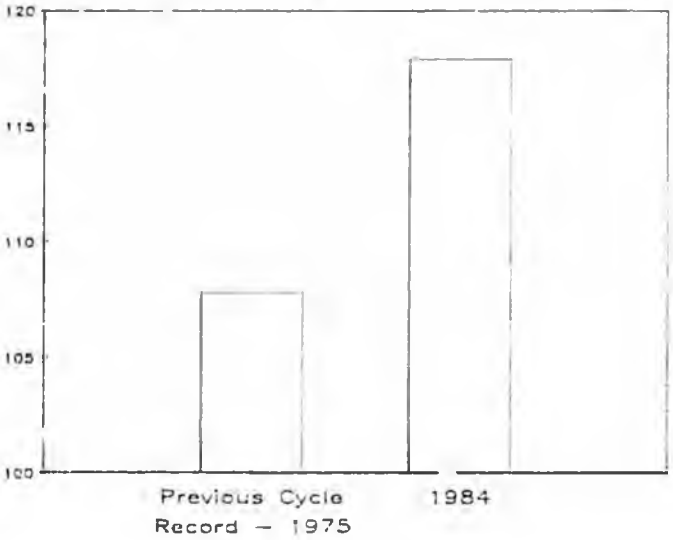
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Underwriting Losses ($ Billions)



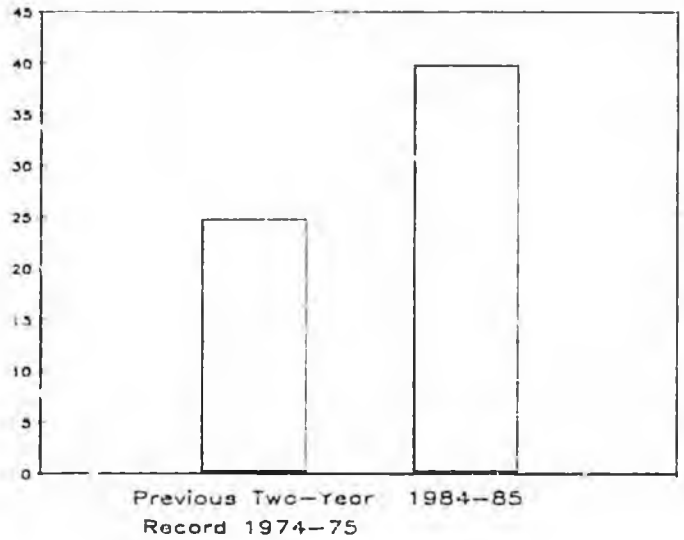
27

Operating Losses ($ Billions)



28

Combined Ratios



29

Insolvencies Covered by State Guaranty Funds

period of deteriorating combined ratios was for the five years 1960 through 1964. During that period, however, the combined ratio worsened by only five points; in this cycle, it deteriorated by 21 points.

Another indicator of the depth of this cycle is the number of insurers receiving reductions in any year from their A.M. Best rating of A+. That number increased from 23 in 1982, to 61 in 1983, to 80 in 1984 and finally to 149 in 1985. (See chart 30.) In 1985, only 24% of the companies rated received an A+, compared with an average of 39% in 1976 and 1977 following the last adverse underwriting cycle.

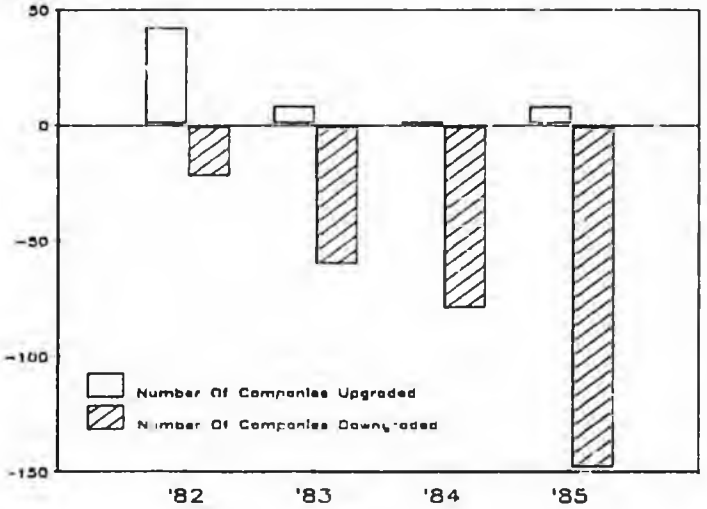
The property/casualty insurance industry is now more dependent on the reinsurance mechanism[4] than ever before. During 1979-1984, reinsurance recoverable (monies owed to insurers by their reinsurers) more than doubled, while surplus grew 50%. (See chart 31.) For reinsurers themselves, the amount recoverable from their reinsurers more than tripled during this period, while their surplus grew 73%. (See chart 32.) During this period, premiums for the industry increased 30%, while reinsurance premiums increased 54%. At the same time as dependence on reinsurance rapidly increased, reinsurers' financial condition seriously eroded. The 1984 return on net worth for the entire insurance industry was nearly 2%, while it was *negative* 10% for reinsurers. In 1985, A.M. Best lowered the ratings of half the reinsurers rated.

For the past two decades, reinsurers' combined ratios have closely paralleled those of the property/casualty industry with the gap never exceeding 4½ points, except for the 6-point gap in 1965, the year of Hurricane Betsy. (See chart 33.) As recently as 1982, the two combined ratios were only one-tenth of a point apart. The gap grew to 6 points in 1983 and then to 13 points in 1984, though this gap has begun to narrow in 1985. Reinsurer combined ratios are still substantially higher than those for the entire property/casualty industry.

Historically, personal and commercial lines results have been similar. Between 1967 and 1982, the difference between the combined ratios never exceeded 6 points. (See chart 34.) As recently as 1981, the ratios were only 2 points

[4] *For a more thorough discussion of reinsurance, see the Appendix.*

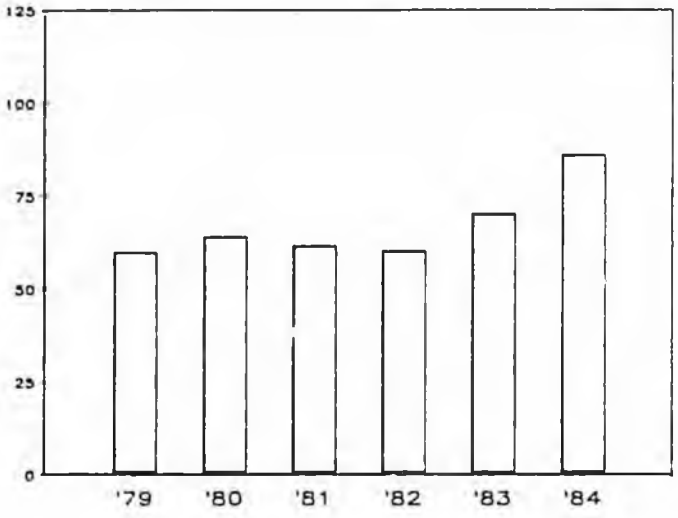
30 INSURERS' FINANCIAL RATINGS DOWNGRADED



A.M. Best's A+ Rating Reductions
A.M. Best's highest rating is an A+, which it gives to companies that it considers to be the most financially secure. In the last ten years, A.M. Best has removed 229 companies from this category, while upgrading only 11.

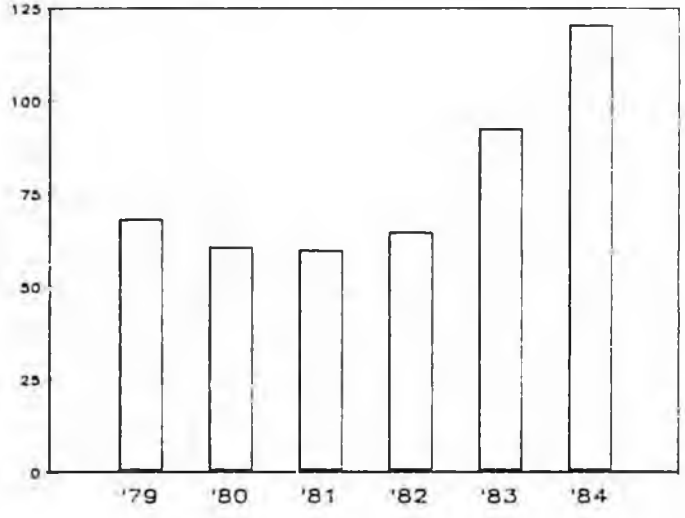
REINSURANCE RECOVERABLES GROWING

The entire property/casualty industry and reinsurers themselves have become more dependent on reinsurance. For the industry, reinsurance recoverable represented 85% of surplus in 1984, doubling in value from $26 billion in 1979 to $55 billion in 1984. For reinsurers, recoverables represented 120% of surplus in 1984, tripling in dollar value since 1979.



31

Industry Reinsurance Receverable (% of Surplus)

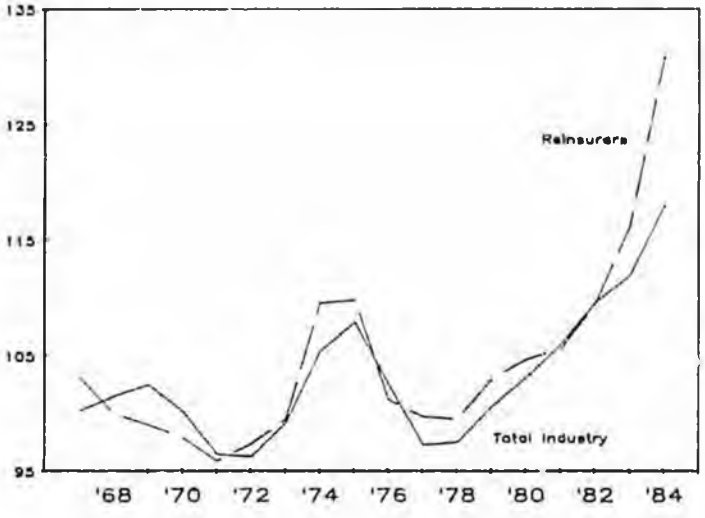


32

Reinsurers' Reinsurance Recoverable (% of Surplus)

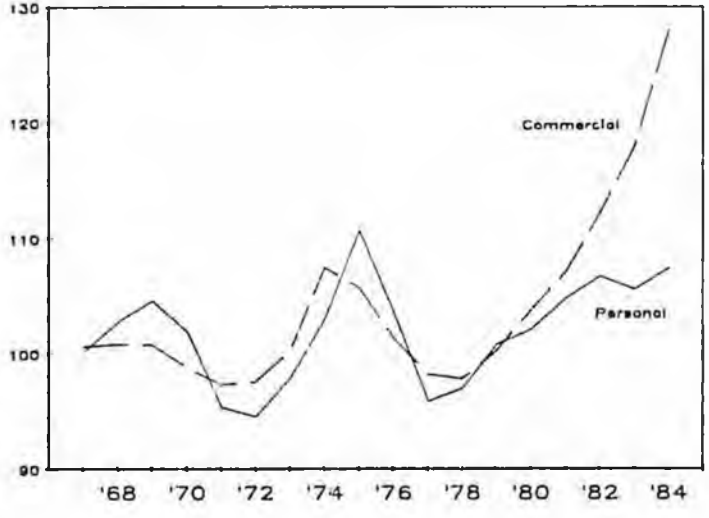
DETERIORATION GREATEST IN COMMERCIAL LINES AND REINSURANCE

Reinsurers have experienced significantly more severe combined ratios than the industry as a whole since 1983, a marked contrast to past cycles. Likewise, commercial lines combined ratios have skyrocketed recently, while those for the personal lines have been more stable.



33

Combined Ratios: Reinsurers vs. Total Property/Casualty Industry



34

Combined Ratios: Personal Lines vs. Commercial Lines

apart. Then in 1983, the gap grew to 12.5 points. In 1984, when it grew to over 20 points, those insurers writing predominantly commercial lines had a negative return on net worth. In 1985, the gap began narrowing but still stood at nearly 15 points for the year ended September 30, 1985.

An even greater concern for commercial lines insurers and reinsurers is that their combined ratios may be understated due to reserve inadequacy. Because of this, the combined ratios for these insurers could be worse than the record highs recorded.

Richard E. Stewart, former Superintendent of Insurance of the State of New York, discusses the current cycle in a December 1985 Marsh & McLennan *Commentary* article. In it, he writes, "...this is not just a routine turn in the underwriting cycle. It has structural as well as cyclical causes." He further notes, "Whereas economic inflation drove the casualty insurance crises of the mid-seventies, the current one is driven by terrible events and by changes in liability law." And he adds, "Insurance has met liability problems before. These are liability disasters. No exclusion is reliable, no excess level out of reach."

All these elements strongly support the conclusion that this is not just a "typical cycle" for the property/casualty insurance industry. Because reinsurers and commercial lines insurers have been hit harder, premium increases will fall unevenly, with some commercial liability policyholders experiencing very large increases. Because the industry's downturn lasted longer than ever before and because the depth of the downturn was worse than ever before, the recovery must be longer and stronger in order to achieve an adequate level of profitability for the industry.

ACCUSATION

Insurance is too expensive.

CHARGE: The total insurance bill in the U.S. will rise from 11.1% to more than 12% of disposable income in 1985—more than $300 billion—displacing personal federal income taxes as the third largest expense in the nation's budget. Only food and housing cost Americans more than insurance.

THE FACTS: These statistics are misleading. The $300 billion figure includes life, health, and accident insurance premiums as well as all property/casualty insurance premiums. The costs of life, health and accident insurance do not belong in a discussion of property/casualty insurance. Moreover, the inclusion of business insurance expenses is inappropriate when making comparisons to disposable income, which is a measure of personal income only.

Personal lines insurance premiums (for private passenger automobile and homeowners insurance) are estimated to be $64 billion in 1985, which would represent 2.3% of disposable income, the amount of 1985 personal income after taxes.

Insurance is not even the largest expense associated with owning either a car or house. In 1984, the Federal Highway Administration conducted a study on the cost of owning and operating typical vehicles in suburban Baltimore, Maryland. The study concluded that insurance was the third largest cost—behind vehicle cost depreciation, and gas and oil for most cars. For large and compact cars, it ranked fourth—behind vehicle cost depreciation, gas and oil, and also maintenance, accessories, parts and tires.

A 1983 countrywide study by the U.S. League of Savings Associations showed that the cost of insurance represents less than 3% of the monthly housing expenses faced by home purchasers in the United States. Insurance costs came in fourth—behind mortgage payments, real estate taxes and utilities.

There are many items that cost Americans more than insurance. One way to analyze relative costs is to examine the components of the nation's personal consumption expenditures, which are included in GNP. According to the Department of Commerce, personal consumption expenditures represent the market value of purchases of goods and services by individuals and non-profit institutions and the value of food, clothing, housing, and financial services received by them. Therefore, the components of personal consumption should be compared with personal lines premiums as follows:

1985 AMOUNT SPENT ($ BILLIONS)	
PERSONAL CONSUMPTION COMPONENT	
Food & Beverages	474
Housing	403
Motor Vehicles & Parts	168
Clothing & Snoes	156
Furniture & Appliances	129
Gasoline & Oil	92
INSURANCE PREMIUMS	
Personal lines insurance premiums[5]	64
Total property/casualty insurance premiums	142

The table indicates six components which are a greater proportion of consumer spending than property/casualty personal lines premiums.

[5]It should be noted that personal lines insurance premiums do not include premiums written on non-profit institutions. However, inclusion of premiums written on non-profit institutions with personal lines premium would have a minor impact and would not raise the total above any of the six personal consumption items listed above.

CHARGE: Property/casualty insurance premiums written rose by $24.6 billion in 1985, from $117.7 to $142.3 billion, while coverage decreased substantially. This works out to an increase of $105 per person for substantially less coverage.

THE FACTS: These figures are misleading. A.M. Best's estimate of the $24.6 billion increase is for all property/casualty premiums, not just personal lines premiums.

Personal lines premium (for the coverages purchased by individuals to protect their autos and homes) increased $6.7 billion, or 11.7% in 1985, an increase of $28 per person, not $105. The 11.7% increase in personal lines premiums in 1985 approximated the 13% increase in personal lines losses. ISO estimates that personal lines paid losses and loss adjustment expenses increased $5.5 billion in 1985, equivalent to an average $23 payment per person. After all losses and expenses, insurer underwriting loss for personal lines was over $1 billion more in 1985 than in 1984.

There do not appear to be significant marketplace problems in the personal lines. Large premium increases are the exception rather than the rul , and restrictions in coverage have been rare.

Most of the 1985 written premium increase was in commercial lines, which increased $17.8 billion or 30%, as the industry reacted to the growth in losses for these lines.

These increases in commercial insurance loss costs are a matter of concern, since they are outpacing the costs of other goods and services. It is precisely this point that has led industry leaders, businesspersons, legislators, regulators and consumers to investigate methods of reducing the upward spiral in insured losses.

APPENDIX

DISCUSSION OF REINSURANCE

Reinsurance is essentially an insurance transaction whereby the reinsurer, for a premium, agrees to indemnify the ceding insurer or reinsured against all or part of the loss which the latter may sustain under its policies of insurance. It is often described as the insurance of insurance companies because it provides reimbursement for an insurer's losses under policies covered by the reinsurance contract. Reinsurance is purchased by the primary or excess ceding insurer for its own benefit so that it can spread its risks and limit its own liability from large or catastrophic losses. The usual reinsurance contract does not involve the policyholder, who looks only to its insurer for defense and indemnity against loss.

Reinsurance was developed to provide capacity essential to the continued growth of the direct insurance industry. In addition to capacity, reinsurance is purchased by a primary insurer to (1) reduce exposure to liability on particular risks, (2) protect against accumulations of losses arising out of catastrophes, (3) reduce total liabilities to a level appropriate to its premium volume and capital, (4) reduce exposure to certain and possibly more hazardous lines of business or alter its "mix" of business, (5) help stabilize operating results, and (6) obtain assistance with new concepts and lines of insurance.

Reinsurance contracts are shaped to meet the specific needs of the ceding insurer . . . There are no standard reinsurance contracts; there are two basic types which are used and adapted to accommodate the buyer's business. A reinsurance *treaty* is a broad and often automatic agreement that covers some portion of a particular class or classes of business, i.e., the ceding insurer's entire workers' compensation or property book of business. In contrast, a *facultative* agreement covers a specific risk of the ceding insurer and requires the insurer and reinsurer to agree on terms and conditions on a contract-by-contract basis. Both treaties and facultative agreements may be based on a *pro-rata* distribution where the two parties share proportionately in premiums and losses. The agreements may also be written on an *excess* basis, where only the losses of the insurer in excess of a predetermined amount, known as the "retention", are reinsured.

Reinsurance Association of America statement before the House Subcommittee on Commerce, Transportation and Tourism, September 19, 1985.

Coopers
&Lybrand

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A worldwide group of firms

February 12, 1986

Insurance Services Office Inc.
125 Maiden Lane
New York, NY 10038

Gentlemen:

You have requested our opinion on the appropriate accounting by property and liability insurance companies for (1) dividends to policyholders and (2) realized gains and losses on investments. Our opinions expressed herein do not relate to assessment enterprises or fraternal benefit societies which may employ different accounting principles.

Generally accepted accounting principles for property and liability insurance companies are set forth in the Statement of Financial Accounting Standards No. 60 (the Statement), "Accounting and Reporting by Insurance Companies". The Statement contains the guidance for our views on the transactions set forth above which are:

Dividends to Policyholders

In our opinion, generally accepted accounting principles for property and casualty insurance companies require that dividends to policyholders be charged to operations.

Realized Gains and Losses on Investments

In our opinion, generally accepted accounting principles for property and casualty insurance companies require that realized gains and losses on all investments (including, but not limited to, stocks, bonds, mortgage loans, real estate and joint ventures) be reported in the income statement below operating income and net of applicable income taxes.

Very truly yours,

Coopers & Lybrand

For additional copies of this analysis, contact:
Insurance Services Office, Inc.
Corporate Communications Department
160 Water Street
New York, New York 10038

Report of the Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in Insurance Availability and Affordability



February 1986

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INTRODUCTION

AND

EXECUTIVE SUMMARY

In October of last year the Attorney General established the Tort Policy Working Group, an inter-agency working group consisting of representatives of ten agencies and the White House. One of the tasks the Working Group was asked to undertake was to examine the rapidly expanding crisis in liability insurance availability and affordability.

The following is the report of the Tort Policy Working Group on the causes, extent and policy implications of this crisis. The primary contributing agencies included the Department of Justice, the Department of Commerce and the Small Business Administration.

Chapter 1 of the report (The Crisis in Insurance Availability and Affordability) describes in detail the significant problems many businesses, professionals and municipalities are having obtaining liability insurance. The Chapter documents a dramatic change in the last two years in the availability, affordability and adequacy of liability insurance. Where insurance is available (and in some areas it simply is not), premium increases of several hundred percent over the last year or two have become commonplace. Few if any private or public entities that rely on liability insurance have escaped the problems generated by this crisis.

Part A of Chapter 2 (The Causes of the Crisis in Insurance Availability and Affordability) reviews the current financial condition of the insurance industry, and the economic factors leading to that condition. The property-casualty industry in the past two years has suffered significant underwriting losses ($21 billion in 1984; $25 billion in 1985) which have limited its ability to offer as much insurance as its customers desire, and have made it reluctant to insure high risk activities which may expose it to further substantial underwriting losses. These underwriting losses appear to be largely a result of coverage written in the late 1970's and early 1980's which may have been underpriced due to the industry's desire to obtain premium income to invest at the then prevailing high interest rates.

Nonetheless, there is little to suggest that the recent massive increases in premiums is related solely to these losses, or that the cost of liability insurance will decline significantly as the industry limits its underwriting losses and restores its desired level of overall profitability. To the contrary,

indications are that developments in tort law are a major cause for the sharp premium increases. 1/

Part B of Chapter 2 reviews the contribution of tort law to the insurance availability/affordability crisis. The Working Group found that in the past decade there has been a veritable explosion of tort liability in the United States. Four specific problem areas are identified and discussed:

- The movement toward no-fault liability, which increasingly results in companies and individuals being found liable even in the absence of any wrongdoing on their part.

- The undermining of causation through a variety of questionable practices and doctrines which shift liability to "deep pocket" defendants even though they did not cause the underlying injury or had only a limited or tangential involvement.

- The explosive growth in the damages awarded in tort lawsuits, particularly with regard to non-economic awards such as pain and suffering or punitive damages. And,

- The excessive transaction costs of the tort system, in which virtually two-thirds of every dollar paid out through the system is lost to attorneys' fees and litigation expenses.

The Working Group was particularly struck by the extraordinary growth over the last decade of the number of tort lawsuits and the average award per lawsuit. A few examples amply illustrate this point:

- Between 1974 and 1985 there has been a 758% increase in the number of product liability lawsuits filed in federal district court.

- The number of medical malpractice lawsuits per 100 physicians doubled between 1979 and 1983, and tripled during that period for obstetricians/gynecologists.

- According to a jury verdict reporting service, between 1975 and 1985 the average medical malpractice jury

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1/ The Working Group also considered whether state regulation of the insurance industry may be a cause of the crisis, and found little compelling evidence that state regulation is a major cause of these problems.

verdict increased from $220,018 to $1,017,716, and the average product liability jury verdict increased from $393,580 to $1,850,452. 2/

- A survey of punitive damage awards in Cook County, Illinois indicates that the average personal injury punitive damage award (measured in constant 1984 dollars) increased from $40,000 in 1970-74 to $1,152,174 in 1980-84.

The above data demonstrates that the insurance industry was selling coverage at constant or even reduced cost over a period of years during which tort liability was undergoing a dramatic expansion. This suggests that a major factor underlying the availability/affordability crisis is the industry's attempt to bring premiums quickly back into line with rapidly growing liability risks. 3/ The high -- and in some areas unaffordable -- insurance premiums reflect the fact that tort law is now placing a massive compensation burden on the private sector.

A second important contribution of tort liability to the availability/affordability crisis is the tremendous uncertainty that has been generated by rapidly changing standards of liability and causation. The "rules of the game" have become so unpredictable that the insurance industry often cannot assess liability risks with any degree of confidence. This appears to have severely exacerbated the problem.

Chapter 3 of the report (Recent Insurance Industry Developments) summarizes a number of responses of the insurance industry, its customers and state regulators to the crisis. These developments include the use of claims-made policies, the inclusion within policy limits of all or part of defense costs, the increasing use of self-insurance and captives, and more exacting state regulation.

In Chapter 4 of the report (Tort Law Reform) the Working Group concludes that while some of the above recent developments in the insurance industry, along with a likely improvement in the industry's financial condition, should relieve some of the current availability/affordability problems, it is unlikely that these changes will provide long-term, systemic relief without

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2/ For purposes of comparison, the dollar lost approximately half of its purchasing power during this period.

3/ While some have suggested that the dramatic premium increases are an attempt by the industry to recoup its past underwriting losses, for the reasons discussed in the report such a theory makes little economic sense.

some fundamental reforms of tort law. Indeed, there are good reasons to believe that absent such reforms, particularly the insurance affordability problem will remain a long-term fixture of the American economy.

The Working Group recommends eight reforms of tort law that should significantly alleviate the crisis in insurance availability and affordability. The Working Group does not at this time recommend how these reforms should be implemented (whether at the federal or state level, or through legislative or judicial modification of the law); nor are these reforms meant to be an exhaustive list of potential reforms. The recommended reforms are:

- Return to a fault-based standard for liability.
- Base causation findings on credible scientific and medical evidence and opinions.
- Eliminate joint and several liability in cases where defendants have not acted in concert.
- Limit non-economic damages (such as pain and suffering, mental anguish, or punitive damages) to a fair and reasonable maximum dollar amount.
- Provide for periodic (instead of lump-sum) payments of damages for future medical care or lost income.
- Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery.
- Limit attorneys' contingency fees to reasonable amounts on a "sliding scale."
- Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

Chapter 5 of the report (Government Insurance: A Non-Solution) details the reasons why government insurance or indemnification would be highly undesirable and would do nothing to remedy the problems underlying the availability/affordability crisis. Such a federal insurance or indemnification program would not only be extremely expensive, but also could exacerbate the problems of tort law by making the "deep pocket" of the taxpayer available in many cases. In addition, such a program could undermine public health and safety, require more extensive government regulation of private sector activities, involve the government in substantial litigation, lead to increased federal involvement in state insurance regulation, and inhibit the ability of the private sector to adapt insurance services to changing economic and social conditions.

The Conclusion to the report lists five conclusions as to the appropriate response of the federal government to the current crisis in insurance availability and affordability. In sum, the Working Group concludes that while there are a number of factors underlying the insurance availability/affordability crisis, tort law is a major cause which the federal government can address in various sensible and appropriate ways. As for some of the other factors underlying the crisis, such as the insurance industry's recent large underwriting losses, there is little the federal government can or should do to remedy these problems.

In that both the tort liability and insurance developments in this report are highly dynamic, and because more detailed data and other studies undoubtedly will become available, the Working Group will continue to follow developments in this area, and, where appropriate, supplement its conclusions and recommendations.

Richard K. Willard
Chairman
Tort Policy Working Group

Robert L. Willmore
Chairman
Task Force on Liability
Insurance Availability

February, 1986

CHAPTER 1

THE CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY

Liability insurance is a linchpin in the operation of the United States economy, yet many American businesses, professionals and municipalities, both large and small, are encountering serious insurance problems arising from premium increases, policy cancellations and refusals to underwrite certain activities.

The liability insurance crisis has three separate but related faces that individually or in various combinations make it difficult for many entities to obtain the desired liability insurance. These problems are availability of insurance, affordability of insurance coverage and adequacy of coverage.

This Chapter describes the current nature and extent of these problems. The Chapter focuses, first, on the problems encountered within the various lines of insurance, and, second, on the effect of those problems on different sectors of the economy.

I. INSURANCE COVERAGE SUMMARIES

The following are insurance summaries taken predominantly from insurance industry reports prepared by the Alliance of American Insurers or published in Business Insurance.

Environmental Impairment Liability Insurance ("EIL")

EIL covers pollution incidents stemming from gradual pollution exposures (as opposed to "sudden and accidental" pollution, which traditionally has been covered under general liability coverage). Two major companies dropped out of the market in 1985, and by the end of the year only two companies were offering EIL coverage. Forty-seven companies were forced to close hazardous-waste management facilities for lack of EIL coverage. Most hazardous waste businesses currently are looking toward captives and self-insurance. Brokers expect significant price increases on the limited insurance still available.

Sudden and Accidental Pollution Coverage

Coverage for sudden and accidental pollution traditionally has been provided as part of general liability coverage. New general liability forms, however, specifically exclude all pollution liability. This is due to court decisions interpreting "sudden and accidental" coverage as also covering gradual and intentional pollution. (See Chapter 3 for a discussion of the new policy forms.) The London market currently is excluding pollution coverage from the large risks it insures.

Directors and Officers Liability ("D & O")

Premiums in 1985 rose 50% to 500%, and include larger deductibles, lower limits, more restrictive endorsements and shorter policy durations. Industries particularly affected include financial institutions, electric (nuclear) utilities, new high technology business, wildcat oil and gas companies, research and development enterprises, real estate developers, highly leveraged businesses, petrochemical companies and the steel industry. Capacity constrictions have hurt larger risks more than smaller risks. Traditional primary and reinsurance capacity has been reduced, but Lloyd's of London, which has in the past not been active in this line, is offering primary coverage up to $20 million. Not surprisingly, business with Lloyd's of London is up to 100% to 200%. Much of the reinsurance market for such coverage has virtually dried up.

Bank Fidelity Bond Coverage

Premiums are up about 300%. A group of fifty banks are creating a mutual insurer to provide D & O and bankers blanket bond coverage.

Motor Carrier Liability Coverage

Bus and trucking companies are having severe difficulties obtaining the insurance coverage required by federal law. The Motor Carrier Act of 1980 requires insurance minimums of from $750,000 for carriers of non-hazardous cargo to $5 million for carriers of hazardous waste and most hazardous materials carried in bulk. The Bus Regulatory Reform Act of 1982 set insurance minimums from $1.5 million to $5 million, depending on the passenger capacity of the bus. Capacity is limited both in the primary and reinsurance markets. Small trucking firms and independent owner-operators have the most difficulty getting insurance.

Liquor Liability Coverage

Liquor liability coverage may be available as part of a commercial lines package, but is severely constrained and virtually nonexistent in some parts of the country as monoline coverage. This line has been affected by the bankruptcy of one of the largest dram shop insurers, Ideal Mutual Insurance Company.

Medical Malpractice Insurance

Availability problems are being encountered by nurse/midwives, obstetricians/gynecologists, pediatricians and dentists. Premiums are being raised and coverage limits are being reduced, sometimes by as much as 50%. Reinsurers are also restricting coverage in this line. St. Paul's Insurance Company, the largest medical malpractice insurer, has placed a moratorium on new policies. St. Paul's writes coverage for approximately 20%

of the Nation's doctors, and wrote an estimated $600 million in malpractice business in 1985. It had a pure loss ratio (excluding loss adjustment expenses and operating expenses) of 81.3% in 1984. Doctor-owned mutual insurance companies account for more than half of the medical liability coverage in the country.

Commercial General Liability ("CGL")

Commercial general liability insurance has undergone significant premium increases. The Insurance Services Office ("ISO"), the property-casualty insurers' statistical and ratemaking organization, has filed a new CGL form which will limit coverage and which contains certain exclusions and policy limitations (see Chapter 3).

Excess Coverage

Excess coverage capacity has been sharply reduced. This coverage currently is offered primarily on a claims-made basis, which may or may not mesh with the primary, reinsurance and other excess layers.

Reinsurance

Reinsurance capacity for the United States market has been severely limited, particularly with regard to Lloyd's of London, which has faced both its own problems and a disillusionment with the American market. This capacity problem is expected to ease somewhat in 1986, but is likely to remain a problem for some time longer.

II. SECTORAL SUMMARIES

The following are summaries of the effect of the insurance availability/affordability crisis on various sectors of the United States economy. This information was obtained from surveys conducted by business groups, articles in the trade press and materials prepared by trade associations or provided by industry representatives. While the following does not include all of the available information, it summarizes the major findings.

Municipalities

Municipalities are among the hardest hit groups by both affordability and availability problems. Local officials preparing their budgets for the next fiscal year report that the market for public entities is "extremely limited" and "diminishing to nothing." Those cities able to secure bids are finding insurance companies' offers prohibitively expensive. Renewal rates have climbed by as much as 400% -- and often for lower coverages with higher deductibles. Some cities are facing premium increases of up to 1,000%.

The United States Conference of Mayors conducted a survey of 39 cities in the summer of 1985. Over half the cities were quoted premium increases of over 100%, and 16 were quoted increases greater than 200%. In addition, a recent report by the Wyatt Company, Public Officials Liability Insurance: Understanding the Market (1986), notes that local governments have reported premium increases of 200% to 300% in the insurance purchased for their officials.

Rather than renew, many cities have decided to "go bare." All cities have been forced to reevaluate and sometimes limit the services they provide their communities. Finally, in the wake of policy cancellations, a number of city and county officials have resigned, fearing personal exposure to lawsuits stemming from their official duties.

Transportation

The American Public Transit Association, the nation's largest organization of transit operators, reports that premiums for those companies able to obtain insurance this year have gone up 500% to 1,000%, and sometimes more. In Los Angeles, the Southern California Rapid Transit District's annual premium jumped from $67,000 to $1.7 million, while coverage was reduced. Transit problems were compounded by the bankruptcy of one of the largest companies involved in insuring mass transit systems. Some local transit systems have had to suspend operations.

Publishing

Newspaper and magazine publishers are finding it more difficult to obtain libel insurance.

Nurse-Midwives

The American College of Nurse-Midwives represents 2,500 members, 1,400 of whom were covered under a blanket policy through the association. The policy was cancelled on July 1, 1985. The association has been unable to obtain other coverage and has been attempting to create a captive insurer. The captive was to have started operation by April 1, 1986, but that deadline will not be met.

Grocers

A survey by the National Grocers Association found that its members' liability insurance premium rates had recently increased from 25% to 500%. The survey covered 161 retailers and 20 wholesalers.

Architects and Engineers

Most architectural and engineering firms, and particularly smaller firms, are experiencing severe availability and affordability problems. Insurance premium rate increases of

200% to 300% have become the norm. Roughly 30% to 40% of smaller firms are going bare. Engineering firms involved in asbestos or other toxic substances abatement activities face extreme difficulties in obtaining insurance, with rate increases, where insurance is available, of 5,000% not uncommon.

Day Care Centers

The National Association for Education of Young Children conducted a survey of day care providers. They covered family day care providers who care for children in a home setting, day care centers and headstart programs. The survey found that 40% of the respondents had had their insurance cancelled or not renewed and the majority of those with coverage had premium increases, most of which rose 200% to 300%..

Toy Manufacturers

The Toy Manufacturers of America recently surveyed its 243 members on insurance cost and availability problems. Final results will not be available until April, but initial responses are:

Members	%Increase in premiums
21	50
9	50-100
12	100-150
2	150-200
11	300-500
7	500-1000
1	over-1000
2	cannot obtain insurance

Companies that normally had three to four months to negotiate a policy renewal have been given only 72 hours to do so this year. This permits insufficient time for policy shopping. The association reports that it had recommended a captive to its members a few years ago. Commercial insurers reduced prices upon learning of the proposal, eliminating industry interest in a captive.

Household Appliance Manufacturers

The household appliance industry has seen sharp reductions in available coverage, and the Association of Home Appliance Manufacturers has lost group coverage it had arranged in 1983. Many companies have been able to obtain only about one-third of the coverage sought for product liability, and the cost of that coverage is increasing. Member companies are having similar problems obtaining D & O insurance.

Automobile Repair

The Automotive Services Councils, an association representing automobile repair shops and garages, conducted a survey with 104 responses. Average premium increases were 70% to 80%. Some 13% of the membership reported purchasing an average of 30% less coverage. Approximately 41% had experienced policy cancellations and 26% were unable to find new carriers.

Medical Equipment

The medical equipment industry has had a captive, MedMarc, an affiliate of the Health Industry Manufacturers Association, since 1979. The captive started with 35 companies and has recently reached 100 member companies. The rate of growth increased in 1985 as the result of cancellations by commercial insurers of about 20% of the Association's members and premium increases of five to ten-fold.

Biotechnology

Biotechnology companies are having a particularly difficult time in the tight market because they are generally new, small companies dealing mostly in research and development in a field largely unknown to insurers. Their inability to obtain coverage causes them difficulty in obtaining bank financing, which, in turn, causes some of these companies to sell out or forego promising research. The industry is exploring the creation of a captive.

Oil and Gas Drilling

The International Association of Drilling Contractors represents 1,500 contractors operating drilling rigs. It estimates maritime liability premium increases of 300% to 700% and inland liability premium increases of 100% to 150%.

Construction Contractors

Constructor magazine (October 1985) estimates average increases in general liability coverage of 40% to 75%. For contractors who were able to negotiate significant discounts in past years increases currently are running up to 300%. In 1985 premium increases for umbrella coverage were approximately 300% for less coverage.

Natural Gas Transportation

The National L-P Gas Association represents 4,100 firms that prepare and transport liquefied petroleum gases for residential and industrial users. According to a spokesman, as many as 25% of the transporters are operating with less than the $5 million in insurance coverage that is required of motor carriers by federal law. Difficulties are attributed to unavailability and prohibitive costs of umbrella insurance.

General Manufacturing

The Machinery & Allied Products Institute ("MAPI") recently conducted a survey of 81 companies producing a broad range of products in the manufacturing industries and obtained an 80% response rate. The typical respondent experienced increases for every type of insurance covered in the survey. The survey covered general liability, D & O, environmental impairment liability, products and other property and casualty coverages. The size of the increases varied with the date of the renewal; consequently, the survey results understate the problem since many of the respondents are not up for renewal until early this year. Significant survey results are shown in the table below.

MAPI Survey Results on Liability Coverages

Premiums	% Higher	% Change (Median)
CGL-Primary	73	40
CGL-Excess	100	250
D & O	72	300
EIL	94	60
Products	95	116
Other	87	40

Lower Limits	% Lower	% Change (Median)
CGL-Primary	13	-36
CGL-Excess	66	-50
D & O	27	-25
EIL	59	-50
Products	33	-50
Other	18	-25

Deductibles & Exclusions	% Higher Deductible	% More Exclusions
GCL-Primary	34	97
GCL-Excess	25	96
D & O	49	95
EIL	50	89
Products	50	100
Other	28	100

In addition to the foregoing, 35% of the MAPI respondents indicated that their general liability coverage excluded "sudden and accidental" pollution coverage, while 49% indicated that it was excluded in some layers and included in others. Some 65% of the respondents indicated that they had some coverages cancelled since January 1, 1985.

Machine Tool Manufacturers

The National Machine Tool Association represents 300 to 400 businesses that manufacture heavy machinery which cuts, shapes and forms metal. Preliminary results of a survey indicated product liability premiums have doubled since 1984, and that about half of the respondents have been or expect to be put on claims-made policy forms.

Battery Recycling & Smelting Companies

Battery recycling companies are typical of many industries where processes create toxic wastes. Recycling 50 million scrap batteries accounts for up to 50% of the annual lead smelter production. If the batteries are not recycled, they will be disposed of in landfills, leading to more serious toxic exposure. One major smelting company was offered a $10 million policy with a $2.5 million deductible at a cost of $650,000. While it deems the policy uneconomic, it has not found an alternative. The problem is widespread with smelters of various metals. The uncertainty of the risk and size of pollution liabilities has lead to substantial reductions in coverage with sharp increases in deductibles and premiums.

Power Equipment Manufacturers

Outdoor power equipment manufacturers had been reporting premium increases of from 50% to 70% during the past year. At the end of the year, with many renewals coming due, some have experienced increases of 400% to 600%. The Association once again is considering establishment of a captive.

General Aviation Manufacturers

The General Aviation Manufacturers Association reports that the cost of liability insurance per aircaft was $51 for the 6,778 business, commuter and private aircraft delivered in 1962, and increased to $211 for the 9,774 delivered in 1972. Currently, for the 2,000 planes delivered in 1985, the liability insurance cost has increased to $70,000 per plane. The cost of liability insurance to air frame manufacturers in 1985 was about $135 million, with a total cost of $175 to $200 million for the entire industry that includes manufacturers of engines, electronics and parts.

Ski Operators

Liability insurance premium increases of up to 400% have been reported by the National Ski Areas Association. Some small ski areas have closed, and the average price of lift tickets has increased substantially.

Aerospace Equipment Manufacturers

Aerospace equipment manufacturers are increasingly concerned that the escalating cost of product liability insurance and other associated costs are causing them to lose their ability to compete with overseas manufacturers of similar equipment.

III. THE NATURE AND EXTENT OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above examples of insurance availability, affordability and adequacy problems demonstrate the broad scope of the liability insurance crisis in the mid-1980's. In a similar crisis in the mid-1970's, the problem areas were largely confined to medical malpractice and product liability. Medical malpractice coverage has been a continuing problem, with almost half that coverage currently underwritten by doctors' and hospitals' mutuals and other alternative markets. Product liability coverage, however, was readily available at declining cost during the late 1970's and early 1980's.

A growing capacity shortage over the last year or more has caused commercial insurers to review carefully their underwriting standards and pricing policies in order to determine where insurance capacity can be utilized most profitably. The inevitable result of this reevaluation has been a severe disruption for insurance buyers.

Insurance Availability

Availability problems are occurring in certain specialty commercial insurance markets. These include pollution, day care, municipal, liquor, motor carrier and D & O liability coverages. The bankruptcies of some specialty insurers, particularly in the lines of motor carrier and liquor liability, have affected the capacity in these coverages.

In each of these lines, insurers have perceived the possibility of significant losses based on highly publicized verdicts and settlements. General line insurers who ordinarily would fill the gap left by specialty carriers are unwilling to do so because they can use their scarcer dollars in less volatile and more profitable lines.

Insurance Affordability

Premiums are increasing in virtually all commercial coverages. Examples of affordability problems include nurse-midwives and general aviation manufacturers, both of which face premium costs which may be warranted by the experience, but are too expensive for the buyers. Solutions to problems like these appear to lie outside of the insurance system.

Insurance Adequacy

Problems of insurance adequacy are being experienced across all commercial lines of coverage. The main problem seems to lie with the fact that many buyers are unable to buy as much

insurance as they desire. This is particularly true for large firms which seek large amounts of excess and higher limits coverage. These problems appear related in part to a capacity crunch created both by the insurance cycle and the withdrawal of capacity by the overseas reinsurers. The lack of capacity related to the insurance cycle shows signs of abating as the corner of the cycle has turned and surplus is increasing. But many firms may have to use alternative market mechanisms for at least a couple of years until this capacity fully returns. It may take much longer to get reentry by overseas reinsurers who have grave concerns about the American tort liability system. A second area of inadequacy lies in the growth of exclusions, deductibles and other policy limitations that are just now being introduced into the market. These are discussed in Chapter 3.

The Insurance Availability/Affordability Crisis

Finally, it should be noted that the crisis in insurance availability and affordability does not appear to be a crisis for the insurance industry. While the industry (as discussed in Chapter 2) is suffering substantial underwriting losses, the Working Group does not perceive this crisis to be a major threat to the financial viability of the industry. Rather, it is a crisis for the insureds who cannot obtain or afford the insurance they believe necessary for their on-going activities. And, to the extent that entities are forced to operate without insurance or with inadequate insurance, it is a crisis for victims of tortious conduct who may find that liable defendants cannot pay them their damages.

CHAPTER 2

THE CAUSES OF THE CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY

A number of reasons have been proffered for the crisis in the availability, affordability and adequacy of liability insurance. Many of these reasons relate to the economic decisions and performance of the insurance industry over the past decade. Other reasons focus on recent developments in tort law. While the two in fact are closely related, this Chapter discusses each of these areas separately. Part A deals with the general economic reasons for the current crisis; Part B reviews the contribution of tort law. 1/

1/ There have been suggestions that the availability/affordability crisis may be caused by certain aspects of state regulation. While some regulatory measures may have aggravated the problem, the Working Group has found little compelling evidence that the crisis is the result of a regulatory failure, either in the sense of insufficient or inadequate regulation, or in the sense of ill-conceived regulation. In this regard, it is worthwhile noting the 1977 report of the Department of Justice to the Task Group on Antitrust Immunities on The Pricing and Marketing of Insurance, which concluded that "in the commercial lines . . . state regulatory schemes are largely illusory and that insurers are generally free to set their own prices." Id., at vii. The report further indicated that rigid state rate regulation, such as is found in automobile insurance, may in fact aggravate an availability problem. Id., at vi.

In this regard, it is worth noting the conclusion of the Medical Malpractice Policy Guidebook (1985), prepared by Henry Manne (general editor) and Barry Anderson, Patricia Danzon, Clark Havighurst, Charles Phelps and Frank Sloan (principal authors) for the Florida Medical Association. The Guidebook concluded that it was difficult to fault the state insurance regulatory system for the high medical malpractice insurance premiums in Florida. Id., at 11. The report concluded that premium increases lag claims costs, and that "malpractice premiums are almost certainly not 'too high' compared to the increases in claims costs emerging over recent years." Id., at 149-50.

Some have pointed to state insurance reserve requirements as a cause of the insurance availability/affordability crisis, to the extent that they believe these requirements to have exacerbated capacity constraints. While the Working Group did not analyze whether state reserve requirements are too high or too low, it should be noted that these requirements exist to ensure the solvency of insurance carriers, and thereby to protect insureds. It also should be noted that the only way that state insurance reserve requirements conceivably could be modified to

(CONTINUED)

A.

I. INSURANCE INDUSTRY PERFORMANCE

Recent news accounts have presented a seemingly conflicting view of the economic performance of the property-casualty insurance industry. In order to understand the financial condition of the industry itself and of some of its specific lines of business, it is useful to compare the condition of the industry as a whole to what has been happening to premiums in the lines which present significant availability/affordability problems.

The table below presents premium and loss data for the property-casualty insurance industry for the period 1981 through 1985.

Year	Net Premiums Written (000)	Loss and LAE (000)	Expenses (000)	Statutory Underwriting Loss after Policyholder Dividends (000)
1981	$ 98,805,725	$75,764,229	$27,132,052	$- [illegible]23,534
1982	103,115,653	82.152,241	28,996,122	-10,415,751
1983	107,802,698	87,719,055	30,799,231	-13,285,049
1984	117,743,957	103,720,652	32,980,082	-21,455,300
1985*	142,300,000	126,846,220	37,353,750	-25,200,000

*Estimated

Source: Best's Insurance Management Reports

The most striking number in the table, of course, is the $25 billion underwriting loss estimated for 1985. This number represents the difference between premiums written and expenses, policyholder

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1/ (FOOTNOTE CONTINUED)

produce lower premiums would be if the reserve requirements were relaxed. It would be difficult to justify relaxing reserve requirements, however, in light of the fact that both insurance company insolvencies and the number of insurance companies reported to be in financial difficulty have increased substantially in the last two years.

The Working Group is continuing to review the contribution, if any, of state regulation to the insurance availability/affordability crisis.

dividends, 2/ estimated losses and loss adjustment expenses ("LAE").

The underwriting loss, however, while significant, represents only part of the industry's overall financial picture. Since premiums are collected well in advance of any anticipated payout, they are invested and earn income. In addition, other income is generated which also must be considered in reviewing the industry's financial condition. Overall income in 1985 resulted in the industry showing a $7.6 billion gain in policyholders' surplus (the equivalent of net worth), 3/ on an underwriting loss of $25.2 billion and net investment and other income of $32.8 billion. Thus, the industry appears to have made an overall profit in 1985, though at a lower rate than historical levels or other sectors of the economy.

In discussing the overall financial review of the property/casualty industry, Best's reported that:

> Investor interest in the property-casualty industry cannot be denied. While the Dow Industrial Average had made headlines by surpassing the 1500 mark (a 25% gain for the year), Best's Index of property/casualty companies has jumped 50% at this writing, and security analysts specializing in insurance--and cognizant of 1985's underwriting losses--nevertheless continue to be optimistic about the industry's prospects. 4/

Two factors must be taken into account in assessing the role of the insurance industry's financial performance in the insurance availability/affordability crisis. First, even though the industry currently is making a profit, that profit is well below the profitability of most other major industries, as well as the insurance industry's historical average. For example, in 1984 the property-casualty insurance industry produced an annual rate

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2/ Questions have been raised as to whether or not the $2.1 billion paid out in policyholder dividends should be included in the underwriting loss. Policyholder dividends are offered to some policyholders in some lines, and reduce the net cost of their insurance coverage. Consequently, any reduction in such premiums simply increases the net cost to policyholders.

3/ Policyholders' surplus is the difference between insurers' assets and liabilities. It is considered "the financial security that stands behind every insurance policy and is that which provides the cushion to support the shock of major catastrophe, stock market declines and loss of reserve inadequacies." ISO, Financial Condition of the Insurance Industry -- An Update (1985).

4/ Best's Insurance Management Reports (December 30, 1985).

of return on net income after taxes as a percent of net worth of 1.8%, whereas the median for Fortune 500 companies was 13.6%. 5/ The comparable rate of return for the property-casualty insurance industry from 1975 to 1984 was 10.9%. 6/

Second, the insurance availability/affordability crisis has not manifested itself across the entire spectrum of insurance services, but only in specific lines. These lines account for a relatively small portion of the industry. For example, the entire property-casualty insurance market accounts for only approximately one-third of the overall insurance market in terms of written premiums. 7/ The two property-casualty lines that have been the primary source of availability/affordability problems -- general commercial liability and medical malpractice -- amounted to only 7% of all the property-casualty lines in terms of 1984 written premiums. 8/ (These two lines thus represent approximately 2.5% of the entire industry's written premiums in 1984.) But, as can be seen in Subsection II, about one-fifth of the property-casualty industry's $21.5 billion 1984 underwriting loss came from these two lines. And in 1985, the two lines accounted for almost one-quarter of the property-casualty industry's estimated $25.2 billion underwriting loss. These two lines, as well as the Commercial Multiple Peril line, 9/ are discussed in greater detail in Subsection II.

II. UNDERWRITING RESULTS BY MAJOR LINES

While the industry overall has been profitable, certain lines have made major contributions to the underwriting losses. This section examines the major commercial lines in which availability and affordability problems have been most prominent.

Commercial Multiple Peril

Commercial Multiple Peril ("CMP") is related to the general liability line of insurance in that it is a packaged line of business which includes some commercial general liability coverage and its long-tail losses; that is, losses which may be

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5/ Insurance Information Institute, 1985-86 Property/Casualty Factbook, page 22.

6/ Id. The comparable statutory accounting rate of return was 11.9%. Id.

7/ Congressional Quarterly Weekly Report, page 150 (January 25, 1986).

8/ Insurance Information Institute, 1985-86 Property/Casualty Factbook, page 16.

9/ If the Commercial Multiple Peril line is taken into account, approximately 14% of the property-casualty industry (in terms of written premiums) accounted for about one-third of its underwriting losses in both 1984 and 1985. Id.

reported many years after the policy year. CMP experience over the past five years is reflected in the chart below.

Commercial Multiple Peril

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Underwriting Expenses (Billions)	Statutory Underwriting Loss After Policyholder Dividends (Billions)
1981	$6.8	$4.6	$2.5	$-0.5
1982	6.9	5.3	2.7	-1.2
1983	7.2	5.9	2.9	-1.7
1984	8.2	7.9	3.2	-2.9
1985*	11.7	10.4	4.1	-3.0

*Estimated

Source: Best's Insurance Management Reports 12/30/85

While the underwriting losses for CMP rose to $3 billion in 1985, it is readily apparent that until recently there had been little premium growth in the line. Best's predicts that the short-tail, non-liability portion of CMP should provide the ability for a fast turnaround for this line. It also notes that ISO's new CGL claims-made form will be added to the standard CMP form, but that market pressures should assure the availability and affordability of the smaller businessowner's package. 10/

Commercial General Liability

Commercial General Liability ("CGL") coverage includes most of the commercial sectors which are experiencing serious availability/affordability problems. It covers product liability, municipalities, day care centers and other commercial coverages. It is the line for which ISO has introduced its new claims-made form. The experience of this line over the past five years is summarized below.

General Liability

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Underwriting Expenses (Billions)	Statutory Underwriting Loss After Policyholder Dividends (Billions)
1981	$6.0	$5.1	$1.8	$-1.0
1982	5.6	5.4	1.8	-1.7
1983	5.7	6.0	1.8	-2.1
1984	6.5	7.8	1.9	-3.2
1985*	11.1	13.2	2.7	-4.6

*Estimated

Source: Best's Insurance Management Report

10 Best's Insurance Management Reports (December 30, 1985).

As is apparent, written premiums dropped in 1982 and 1983 and rose slightly in 1984. The figures for 1985, however, show a dramatic increase of 72% over the 1984 premium. Increases are continuing to occur in the line as policies come up for renewal. Losses increased throughout the period, but did so at a relatively even pace until 1984, when losses increased by over $1 billion dollars over the previous year's losses.

Medical Malpractice

Medical malpractice represents only about 1.8% of property/casualty insurance written, but has been the source of major availability/affordability problems. The following chart summarizes the experience of the line over the past five years.

Medical Malpractice

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Underwriting Expenses (Billions)	Statutory Underwriting Loss After Policyholder Dividends (Billions)
1981	$1.3	$1.6	$0.2	$-0.5
1982	1.5	2.0	0.2	-0.7
1983	1.6	2.1	0.2	-0.8
1984	1.8	2.8	0.3	-1.1
1985*	2.6	3.6	0.3	-1.4

*Estimated

Source: Best's Insurance Management Report

Medical malpractice experience is receiving considerable attention at the state level. Unlike many lines of coverage such as product liability, rates are based on state claims rather than national data.

III. PREMIUM TRENDS

The recent rapid growth in premiums has been a major element in the current availability/affordability crisis. This section examines this trend. The following data was provided by the ISO.

Cash-flow underwriting is generally acknowledged to have played a role in causing the large underwriting losses presently being experienced in the commercial lines. According to ISO, the industry's current underwriting losses are a result of "a

prolonged period of underpricing and rapidly expanding tort liabilities." 11/ In this regard, the ISO report states:

> For the better part of seven years, the insurance industry has been engaged in a brutal price war. During the early 1980's, the price for commercial insurance was decreasing, sometimes sharply, as insurers vied for premium dollars to invest at the high interest rates then in effect. At the time, commercial customers did not complain. Indeed, many realized that commercial insurance in the United States was being sold below cost, even when investment income was considered. 12/

Chart A, based on ISO data, tracks commercial line premiums in constant 1967 dollars. As can be noted from the chart, 1984 marked the first real increase in premiums (in constant dollars) after five consecutive years of declining written premiums. But 1984 written premiums were almost 20% less than premiums collected in 1978, the year preceding the dramatic decline in premiums. At the same time, losses and expenses in 1984 were at an all-time high. 13/

A similar comparison of the general liability premiums written, premiums earned and line outgo over the past ten years (not in constant dollars) is shown in Chart B.

Analyzing this data, the Best's report notes that during the relevant period (1975 - 1985):

> . . . the inflation of liability awards could have been no secret to any underwriter. Had the ascending line of premiums written that was established in 1975 through 1978 continued to rise, the general liability losses of $13 billion incurred in the last six years largely would have been avoided. 14/

11/ ISO, Financial Condition of the Insurance Industry -- An Update (1985).

12/ Id.

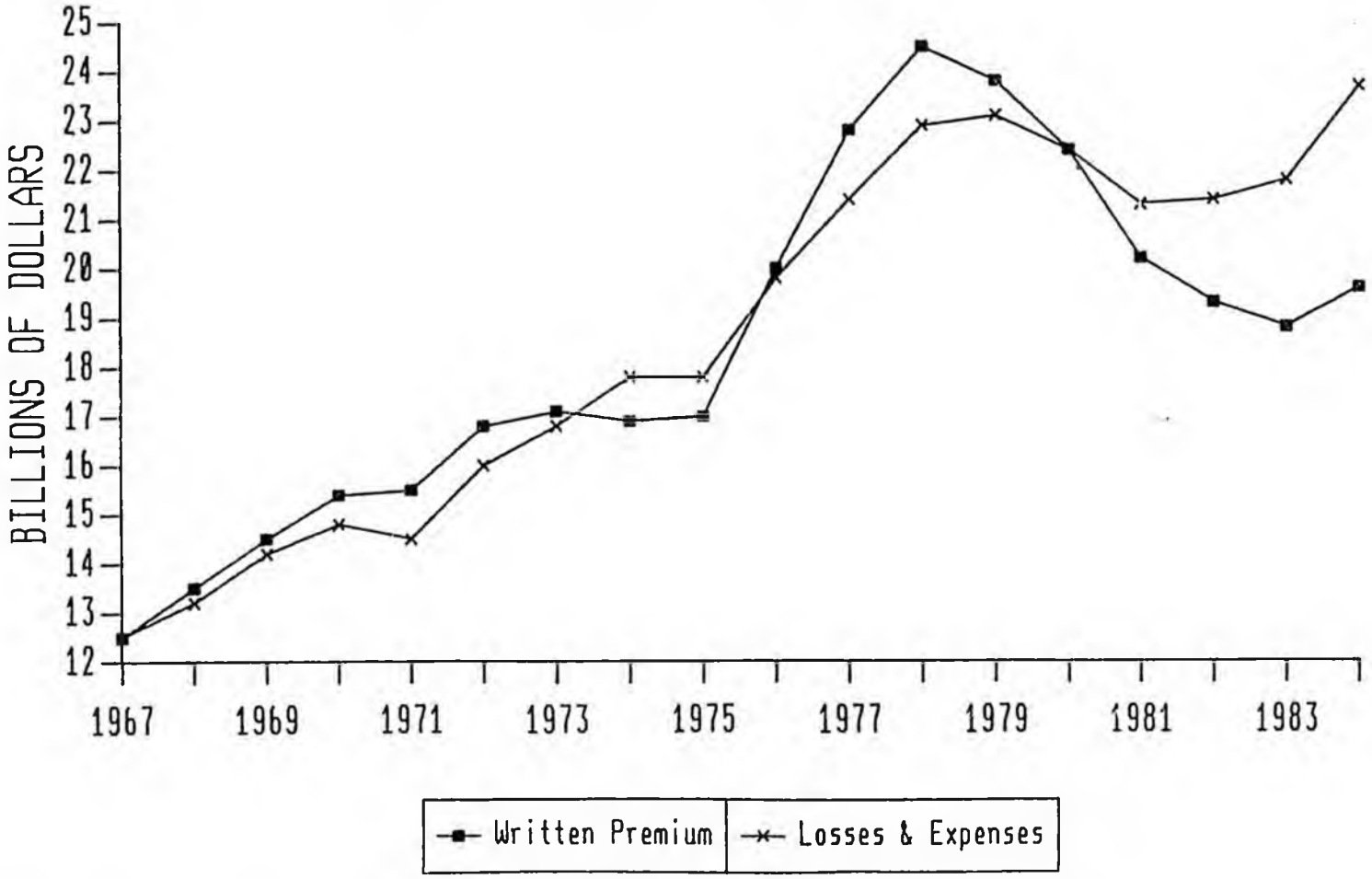
13/ Id.

14/ Best's Insurance Management Reports (December 30, 1985).

CHART A

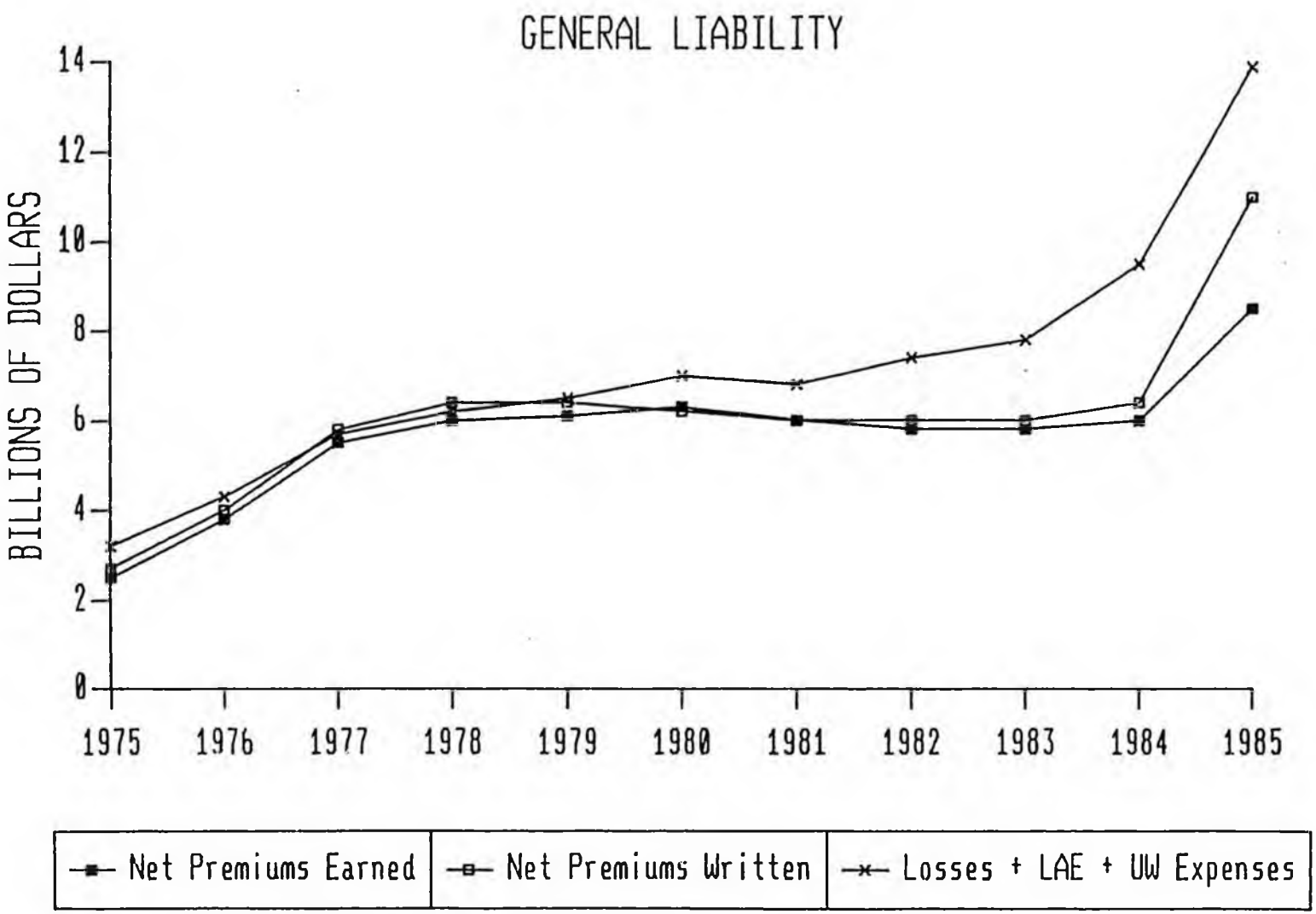
WRITTEN PREMIUM vs. LOSSES & EXPENSES

COMMERCIAL LINES IN CONSTANT 1967 DOLLARS



Source: Insurance Services Office

CHART B



Source: Best's Insurance Management Report, 12/30/85

IV. THE ECONOMIC CAUSES OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above discussion indicates that during the late 1970's and early 1980's the insurance industry engaged in significant premium reductions while claim losses increased steadily. The result, not surprisingly, has been massive underwriting losses in recent years.

It is useful in considering the contribution of such economic factors to the insurance availability/affordability crisis to distinquish two different effects which frequently are confused. The first is the inflationary effect on premiums of the recent decline in interest rates. The second is the premium cutting which took place in the late 1970's and early 1980's as a consequence of the industry's desire to take advantage of high interest rates available during that period.

As to the first effect, there is an obvious inverse relationship between premiums and the prevailing interest rate. A significant portion of an insurer's profits stem from the return on the premium income it invests between receipt of the premium and payout of the incurred liabilities. When interest rates are high, premiums tend to be lower since more of the insurer's income comes from such return on investment; and when interest rates are low, premiums will tend to be higher since the insurer is more dependent on the premium principal to cover the anticipated payout. Thus, as interest rates fall -- as they have in the mid-1980's -- insurance premiums inevitably increase.

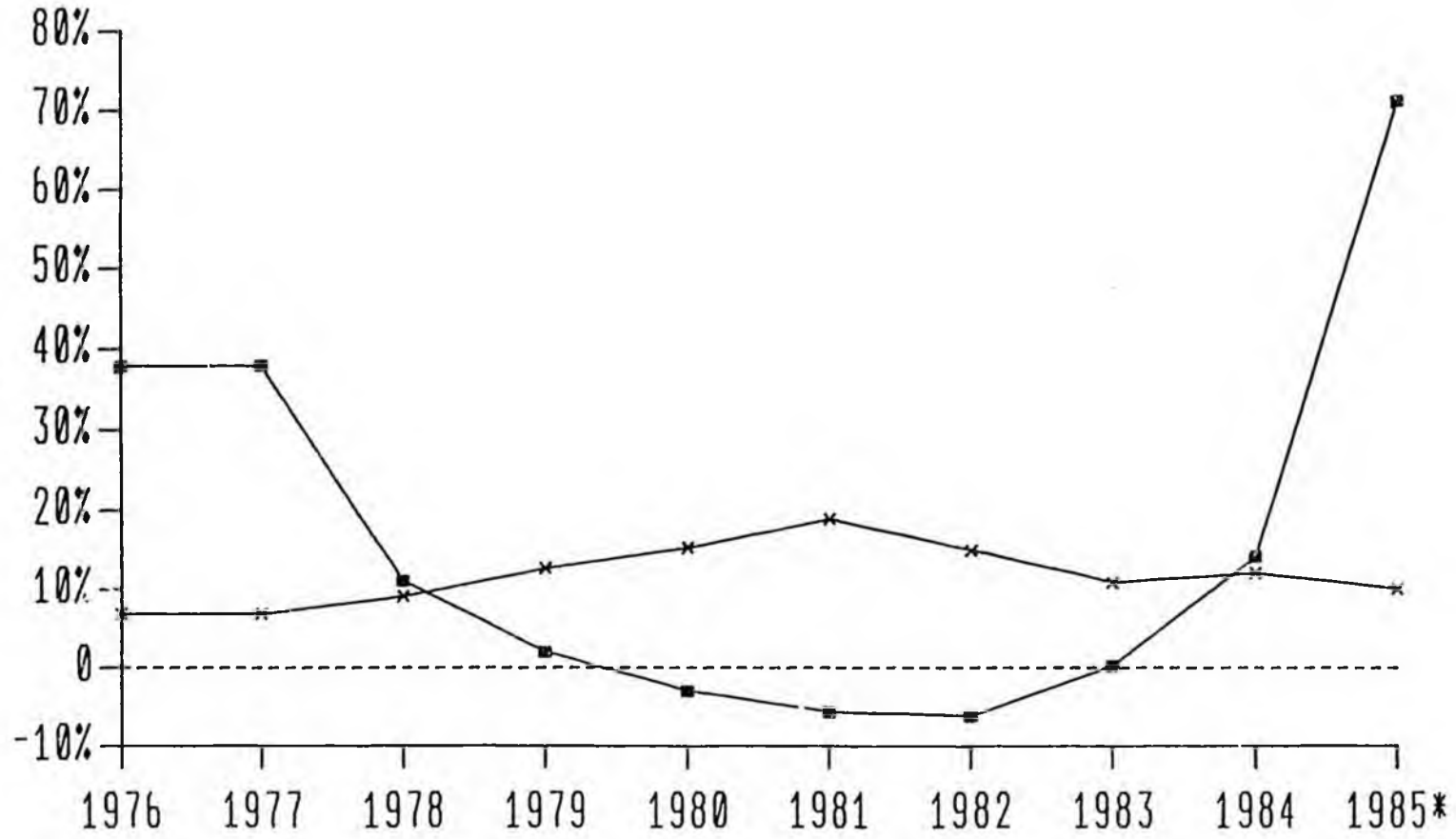
This inverse relationship is illustrated by Chart C, which compares the prime rate in 1976 through 1985 to the annual percentage change of the total Commercial General Liability (CGL) premiums written by the insurance industry in each of those years. 15/ Chart C graphically demonstrates that the rate of growth of the written premiums changes inversely with the movement of the prime interest rate.

To the extent that the recent sharp premium increases are related to the drop in interest rates, there is little the federal (or any) government can or should do to mitigate this market effect. Declining interest rates cause innumerable economic realignments which, on the whole, are quite beneficial to the economy. An increase in insurance premiums resulting from such a reduction in interest rates, while of itself undesirable, is a relatively minor side effect to the far more significant economic consequences of a drop in the interest rate.

15/ The percentage change in 1976 through 1984 is obtained from the Insurance Information Institute's most recent Property/Casualty Factbook. The estimate for 1985 is obtained from the ISO data discussed supra.

CHART C

PERCENTAGE CHANGE IN GCL PREMIUMS COMPARED TO INTEREST RATE



*1985 Data Estimated

Moreover, there is little that can be done to address this source of premium volatility. It would be absurd to try to keep interest rates high simply to keep insurance premiums as low as possible. But as long as interest rates fluctuate, premiums necessarily will reflect such changes.

A second economic factor related to interest rates is the extent to which high interest rates may have triggered "excessive competition" in the insurance industry which led the industry to sell its product too cheaply. For one thing, even assuming one accepts the concept of "excessive competition," it is unclear how such losses in fact contribute to the insurance availability/affordability crisis. As discussed later in this Chapter, such losses are "sunk costs" which the industry cannot recoup simply by charging higher premiums. If premiums in fact are higher than the insured risks and the currently available investment return dictate, either other sources of capital (including insurers who have suffered no losses or lower losses) should offer the same insurance at a lower price, or insureds will retain these "excess profits" for themselves through self-insurance or the formation of captives. The fact that there appears to be little insurance coverage being made available by new or expanding underwriters, and that many insureds are highly reluctant to self insure or form captives (even though many with serious availability problems may have no alternative), strongly indicates that recoupment of losses is not a particularly compelling explanation for the current insurance availability/affordability crisis.

It is particularly puzzling that the proponents of this theory advocate the abolition of the insurance industry's antitrust immunity contained in the McCarran-Ferguson Act (Public Law 79-15) as an appropriate response to the asserted problem of the industry's cash-flow "mismanagement." It is hard to reconcile the argument that the current problems of the insurance industry stem from "excessive competition" with the proffered solution of removing the industry's antitrust immunity. Since the goal of antitrust law is to enhance competition, if one truly believes that the problems of the insurance industry are a result of too much competition, the last thing one would advocate is a legal change which would increase the level of competition. While the Working Group did not review and takes no position on the continuing validity of the industry's antitrust immunity, 16/ it is readily obvious that the suggestion that allegedly "excessive competition" can be cured by even more competition is patently absurd.

16/ Despite the assertions of some, the Working Group found no evidence to suggest that the industry's antitrust immunity is a significant factor in the insurance availability/affordability crisis. It should be noted, however, that the immunity has been criticized for a variety of other reasons. See the 1977 report of the Task Force on Antitrust Immunities, footnote 1, supra.

The reasons why the loss recoupment (or excessive pricing) theories advocated by some make little economic sense can briefly be summarized as follows:

- Insurers, like all profit maximizing companies, charge the price which maximizes their profits. Past gains or past losses are irrelevant to setting the price today which will maximize profits tomorrow. The argument that insurers are charging higher premiums to recoup past losses suggests that absent such losses their premiums would be lower -- that is, that they would not be charging premiums that maximize their profits. That makes little sense.

- Even if excessive premiums were being charged by some insurers to recoup their past losses, for the reasons discussed, other insurers would offer the same coverage at lower prices reflecting the actual risk, or insureds would retain such excess profits for themselves through self-insurance or the formation of captives. 17/

- The commercial lines of insurance, which are at the center of the availability/affordability crisis, in fact are relatively competitive. For example, the 1977 report of the Task Force on Antitrust Immunities (see footnote 1, supra) found that the property-liability insurance industry "appears to possess an atomistic market structure," including over 900 companies. Id., at 7. 18/ The Task Force also found that the restrictions to entry do not appear significant in the property-liability insurance industry, id., at 9, and that there appears to be price competition in this line as a result of "an industry structure that favors competition." Id., at 27-28. 19/ It is, of course,

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17/ Many insurance companies are mutuals, meaning that they are owned by their policyholders. The suggestion that they are charging their policyholder-owners unnecessarily high premiums makes even less sense, since any such excess profits must be rebated through policyholder dividends.

18/ The report states that 20 insurance groups account for 53% of written premiums, and that no single group accounts for a major share of the market. Id., at 8. This is consistent with the analysis of the Medical Malpractice Policy Guidebook (H. Manne, 1985), which found the medical malpractice insurance market in Florida to be "substantially and effectively competitive." Id., at 166.

19/ See also page 348 of the report summarizing the Task Force's (CONTINUED)

difficult to conceive how premiums are being kept at artificially high levels for a line of insurance in which prices appear to be competitively determined.

- Finally, many of the strongest proponents of the loss recoupment theory also contend that these losses were the result of excessive price competition in the industry. Obviously, it is difficult to reconcile these arguments. 20/

In sum, to the extent that purely economic factors underlie the insurance availability/ affordability crisis, they do not appear to be the type of problems which can be cured by different or more intensive forms of government regulation -- either at the state or federal level -- of the insurance industry. There, however, is a cause of the availability/ affordability crisis at the very heart of that crisis which the government is well placed to address in a variety of constructive ways. That cause is tort law, and its role in the crisis is discussed in Part B of this Chapter.

B.

The above discussion has focused largely on the current financial condition of the insurance industry, and the economic factors leading to that condition. The following discussion examines the state of tort law, and its central role in the insurance availability/affordability crisis.

Unlike the above related economic data on the insurance industry, it is difficult to obtain good empirical data indicating precisely what has happened to tort liability in

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19/ (FOOTNOTE CONTINUED)

conclusion that the "industry is structured in a manner conducive t competition." It should be noted that these conclusions did not appear to apply to some other lines of insurance such as life insurance.

20/ These same points apply equally well to arguments that premiums are set excessively high to recoup losses resulting from mismanaged investment portfolios. Just as past losses are irreleva to determining the premiums which will maximize profits, investment portfolio losses should have no bearing on premiums. In this regar however, it should be noted that the property-casualty industry mad $32.8 billion from net investment and other income in 1985. See supra.

recent years. 21/ It is plain even to the most uninitiated that tort law has changed dramatically in recent years -- from a relatively quiescent legal backwater into one of the most important and dynamic areas of the law today. 22/ Moreover, a growing body of case examples and empirical data suggest that the current tort system has serious problems and is operating quite poorly. The insurance availability/affordability crisis is one symptom -- albeit the most dramatic and acute symptom -- of the dislocations and problems generated by a malfunctioning tort system.

I. PROBLEM AREAS IN TORT LAW

In attempting to understand what has happened to tort liability in the United States, the Working Group has focused on four interrelated areas: fault, causation, damages and transaction costs. Each is discussed separately below.

The Movement Toward No-Fault Liability

One of the most disturbing aspects of the current tort system is the degree to which it has moved toward no-fault liability. While this movement began in earnest over twenty years ago, it appears to have accelerated dramatically in recent years.

Beginning in the early to mid-1960's it became fashionable to reject the twin pillars upon which tort law historically had been constructed -- deterrence and compensation -- in favor of seemingly more enlightened theories based largely on concepts of societal insurance and risk spreading. 23/ While many of these

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21/ The Rand Corporation, through its Institute for Civil Justice, has produced the best empirical data and analyses available in the area. While the Institute has only been able to research discrete areas of civil justice, the conclusions drawn from those analyses are invaluable to understanding many broader problems. The recently published five-year overview of the Institute's program offers an excellent summary of the research, results and continuing work of the Institute's staff.

22/ For example, at the end of fiscal year 1975, what is now the Torts Branch of the United States Department of Justice contained 39 attorneys, who handled or supervised about 4,000 cases totalling approximately $1 billion in claims. At the end of fiscal year 1985, the Torts Branch had grown to 124 attorneys handling or supervising about 11,000 cases totalling approximately $200 billion in claims.

23/ One of the most explicit statements of such a theory can be found in the decision of the New Jersey Supreme Court in Beshada v. Johns-Manville Products Corp., 90 N.J. 191, 447 A.2d 539 (1982), in which the Court expressly denied defendants

(CONTINUED)

theories were couched in terms of economic efficiency, they represented the beginning of a devastating, and to this day, c.- going challenge to the role of fault as a predicate of tort liability. The long-term effect of this development has been less to promote a more efficient or sensible tort system, 24/ than to undermine the importance of fault (or wrongdoing) as a moral an. doctrinal justification for and limitation on tort liability. As this limitation has been removed or undermined in certain areas of tort liability, tort law increasingly has come to rest only on the pillar of compensation, with compensation often awarded merely for the sake of compensation.

As the tort system moves away from fault it increasingly imposes liability upon persons and companies that have done nothing wrong. This has been accomplished in a variety of ways: by directly reducing or even eliminating the fault requirement; by

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23/ (FOOTNOTE CONTINUED)

the opportunity to raise a "state of the art" defense. The Court held that even if the danger at issue was scientifically unknowable at the relevant time, defendants nonetheless were still liable for having failed to warn of an unknowable risk. As justification for its holding, the Court relied heavily on risk spreading. In the words of the Court, "manufacturers and distributors . . . can insure against liability and incorporate the cost of the insurance in the price of the product." 447 A.2d at 547. The Court went on to opine that the likely increase in premiums to compensate for unanticipated risks was "not a bad result." Id.

24/ The belief that tort liability should be no-fault so as to serve as a risk spreading mechanism for all injuries is in fact quite anti-consumer. Such a view of tort liability effectively would mean that the price of every product and service would include an insurance surcharge for the risk of any injury related to the product or service. It has long been understood, however, that because of the extraordinarily high transaction costs of the tort system, such compulsory insurance through the tort system would be among the most inefficient and costly ways for consumers to purchase insurance. Thus, for every $1 of compensation, the tort system requires the consumer to pay approximately $3 in premiums (assuming, as discussed infra, two-thirds transaction costs), while that same $1 of compensation can be obtained through first-party health and disability insurance for only $1.25. H. Manne, Medical Malpractice Policy Guidebook 143 (1985). It is highly ironic that many proponents of no-fault liability argue that such liability is in the best interest of consumers. In fact, since consumers ultimately pay the premiums of whatever compensation scheme is devised, quite the contrary is the case. See also Epstein, "Products Liability as an Insurance Market," 14 J. Legal Stud. 645 (1985).

defining new duties that effectively create fault where no fault existed previously; and, by engaging in after-the-fact analyses that "find" fault wherever there has been an injury. 25/ The ultimate effect of these developments has been the same -- to shift liability for compensation to "deep pocket" defendants that have the resources to compensate plaintiffs generously. 26/

Fault has not, however, been openly (or completely) rejected as part of our tort law. One reason is that fault remains the only vehicle in tort law capable of distinguishing wrongful (or undesirable) from beneficial (or desirable) conduct. If fault were rejected altogether, it would mean that desirable activities would be just as likely to incur liability as wrongful conduct. An open rejection of fault thus necessarily would result in a sweeping transformation in the public's attitude toward tort law, which continues to be bottomed on the concept of tort liability as a form of justified redress for wrongful conduct. A second reason why fault continues to be part of tort law (and why courts often will engage in amazing distortions of relevant facts or legal doctrines to find fault rather than simply reject the principle of fault) is that fault is the basis of much of the structure and process of tort law.

25/ The duty to warn has been a particularly fertile ground for such after-the-fact compensation oriented findings of fault. It is all too easy after the occurrence of an injury to postulate a warning that might have influenced the plaintiff to be more careful or to reconsider his action, no matter how fanciful or unreasonable such a warning might appear prior to the injury. Such analyses have been a major factor in the medical malpractice and product liability litigation explosion.

26/ A recent and almost classic example of such compensation oriented liability findings is the California Supreme Court's decision in Bigbee v. Pacific Tel. & Tel. Co., 34 Cal.3d 49, 665 P.2d 947 (1983). In that case, a man was injured when an allegedly intoxicated driver lost control of her car, veered off the street into a parking lot, and crashed into a telephone booth in which the man was standing. Suit was brought against the companies responsible for the design, location, installation, and maintenance of the booth. The Court, in an opinion authored by Chief Justice Rose Bird, found that the risk that someone might veer off the road and crash into the phone booth was not unforeseeable as a matter of law. The Court also determined that it was of no consequence that the harm to plaintiff came about through the negligent or reckless acts of an allegedly intoxicated driver. In a concluding footnote, Chief Justice Bird stated that "there are no policy considerations which weigh against imposition of liability" against the defendants even though their "conduct may have been without 'moral blame,'" and referred specifically to "the probable availability of insurance for these types of accidents . . . ." 665 P.2d at 953 n. 14.

If fault were no longer a central element in determining liability, the current tort system would in many ways be wasteful, inefficient and unfair in the extreme. 27/

Tort law thus has gradually (with a marked acceleration in recent years) been moving in the direction of no-fault liability without an adequate acknowledgement of either the existence or the implications of this development. The result is an increasingly common and perverse combination of fault-based levels of compensation based on no-fault liability.

The Undermining of Causation

Tort law traditionally has sought to place liability only upon those actors whose wrongful conduct actually caused an injury. This principle is found in the concept of "proximate cause," which requires a reasonable relationship between a given cause and effect. For some time, however, proximate cause has been under systematic attack. No single doctrinal change can be identified as the primary vehicle for this attack. Rather, the challenge has come through a variety of questionable practices and doctrinal innovations.

One such development has been the increasing use of joint and several liability to shift the cost of compensation to "deep pockets." Joint and several liability developed in the context of defendants acting in concert. 28/ Over the years, however, it increasingly has been used to make a defendant with only a limited role in causing an injury bear the full cost of compensating plaintiff, even in some cases where the plaintiff may have been largely responsible for his own injury. 29/ The result has been that joint and several liability in the absence of concerted action can and does lead to highly inequitable

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27/ For example, the way in which damages are measured and awarded can only be justified, if at all, on the basis of redressing wrongful conduct. Once wrongdoing is removed as an element of liability, many of the principles involving damages become grossly unfair.

28/ See generally Prosser and Keeton on Torts (5th ed. 1984), Chapter 8. As may be obvious, as with so many other aspects of tort law, fault remains a central and essential justification for joint and several liability.

29/ The application of joint and several liability in cases where there in fact is no concerted action is discussed in some detail in Speiser, Krause & Gans, The American Law of Torts § 3:7 (1983). It is interesting to note that the English courts apparently have maintained the traditional common law basis for joint and several liability, and have refused to apply such liability in the absence of concerted action. Id.

treatment of defendants, particularly "deep pocket" defendants. 30/

A related development is the way in which joint and several liability has been applied by some courts to theories of "enterprise" or "market share" liability for injuries caused by generic products (e.g., DES). "Market share" liability, in its pure theoretical sense, allocates liability among manufacturers of a generic product on the basis of their share of the relevant market. While there can be some serious problems and inequities with this approach, as long as all relevant manufacturers (and their respective market shares) are accounted for, and the product is truly generic in nature, such an allocation of liability may be the only way plaintiffs in some cases can obtain compensation for injuries caused by wrongdoing on the part of the manufacturers of such a product. Serious problems with this approach arise, however, when not all relevant manufacturers are accounted for, or where the product is not truly generic in nature. Even more troublesome is the approach of several courts which use some industry liability allocation formula, but then apply joint and several liability to all defendants. See, e.g., Abel v. Eli Lilly & Co., 418 Mich. 311, 343 N.W.2d 164, cert. denied., 105 S.Ct. 123 (1984); Collins v. Eli Lilly Co., 116 Wis.2d 166, 342 N.W.2d 37 (1984). This, in fact, represents a clear abuse of joint and several liability, and cannot be justified on the basis of the unique difficulties plaintiffs sometimes face in identifying the manufacturer of an injury causing generic product.

A third means that has been used to undermine causation -- increasingly common in toxic torts cases -- is the use of presumptions or burden-shifting techniques to force the defendant to prove the lack of causation in order to avoid liability. 31/ Frequently, this amounts to asking the defendant

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30/ The legal doctrine of contribution in theory could serve to mitigate some of those inequities. In certain areas of the law, such as antitrust law, where joint and several liability generally tends to be applied to established businesses, contribution appears to function quite well. (And, in any event, joint and several liability in antitrust cases is virtually always based on concerted action -- the traditional basis for such liability.) In personal injury cases, however, many multi-defendant cases involve a "deep pocket" and one or more defendants who are either judgment proof or have limited assets or insurance coverage. In such cases, the belief that contribution serves as a mitigating factor is largely illusory.

31/ A particularly dramatic example of such a practice can be found in Allen v. United States, 588 F.Supp. 247 (D. Utah 1984), a low-level radiation exposure case in which the court shifted to the government the burden of proving that particular cancers were not caused by radiation exposure.

to meet an impossible burden of proving the negative.

Another way in which causation often is undermined -- also an increasingly serious problem in toxic tort cases -- is the reliance by judges and juries on noncredible scientific or medical testimony, studies or opinions. It has become all too common for "experts" or "studies" on the fringes of or even well beyond the outer parameters of mainstream scientific or medical views to be presented to juries as valid evidence from which conclusions may be drawn. The use of such invalid scientific evidence (commonly referred to as "junk science") has resulted in findings of causation which simply cannot be justified or understood from the standpoint of the current state of credible scientific and medical knowledge. 32/ Most importantly, this development has led to a deep and growing cynicism about the ability of tort law to deal with difficult scientific and medical concepts in a principled and rational way.

These are but four developing areas that are causing defendants to be found liable for injuries they did not cause. The one common attribute of these developments is that the defendants to whom liability is shifted almost invariably happen to be those with the deepest pockets.

The Explosive Growth in Damage Awards

Another area of great concern is the explosive growth in tort damages awards over the last decade. A few statistics will illustrate this point.

Jury Verdict Research, Inc., publishes data on the average jury verdict in product liability and medical malpractice cases. The service's latest report 33/ shows that the average medical

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32/ An instructive decision in this regard is the district court opinion in Johnston v. United States, 597 F.Supp. 374 (D. Kansas 1984). The court there exhaustively reviewed the theories and credentials of a number of plaintiffs' experts on the effects of low-level radiation, and rejected their testimony as biased, contradictory and totally without scientific merit. Of particular interest is the court's frustration that these same experts had played prominent roles in major radiation cases such as Silkwood and Allen, and that their testimony was being used in numerous cases throughout the country. The court noted its disappointment that such "so-called experts can take such license from the witness stand [to] say and conclude things which . . . they would not dare report in a peer-reviewed format." Id. at 415.

33/ Jury Verdict Research, Inc., Injury Valuation: Current Award Trends No. 304 (1986). The 1985 data provided by the service is incomplete, and is subject to refinement. The (CONTINUED)

malpractice jury verdict increased from $220,018 in 1975 to $1,017,716 in 1985 (see Chart D), a 363% increase. 34/ Average product liability jury verdicts during this same period increased from $393,580 to $1,850,452, a 370% increase (see Chart E). 35/

Interestingly, much of this increase can be attributed to a remarkable growth in verdicts above $1 million. In 1975 there were three million-dollar medical malpractice verdicts and nine million-dollar product liability verdicts reported by Jury Verdict Research, Inc. In 1984, the numbers had grown to 71

33/ (FOOTNOTE CONTINUED)

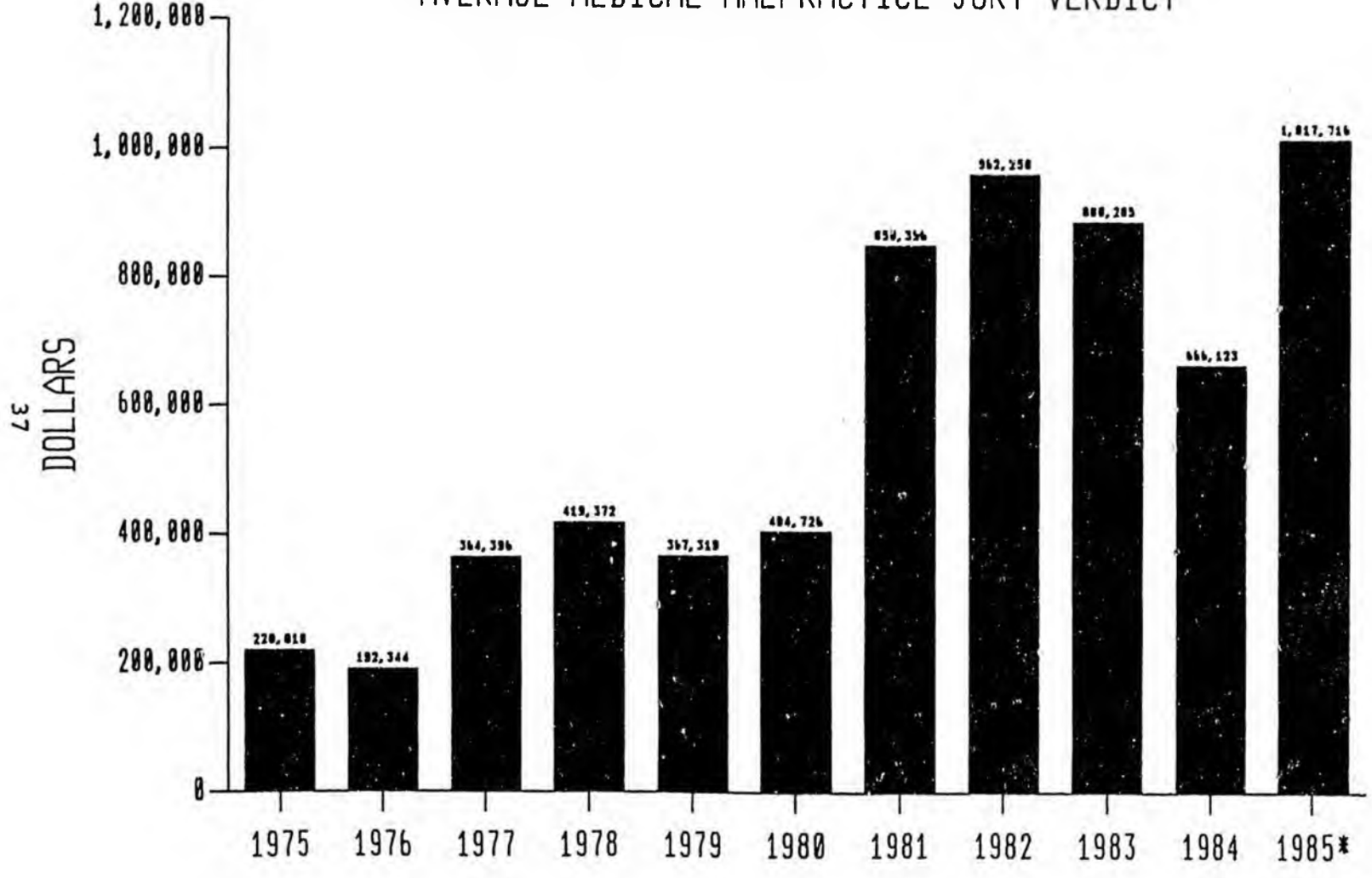
service indicates that it bases "its findings, values and probabilities upon collected verdicts using accepted statistical methods in their analysis and application." Nevertheless, the reported average annual verdicts are not used by the Working Group as an accurate statement (though they may very well be) of the average jury verdict in any particular year. Rather, the Working Group found the Jury Verdict Research data useful for purposes of showing the trend in jury verdicts over the last decade. In this regard, it should be noted that the service has used the same basic methodology since well before the relevant reported years. Moreover, while there are different estimates of average jury verdicts for particular areas and years, a number of other sources that have collected such data -- including the Institute for Civil Justice -- corroborate the overall trends reported by Jury Verdict Research, Inc.

34/ This percentage increase is consistent with a survey of California Superior Court medical malpractice verdicts. That survey shows the average medical malpractice award as increasing from $152,970 in 1975 to $649,210 in 1983, a 324% increase. American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the '80s (October 1984). Because the $250,000 cap in California on awards for non-economic damages in medical malpractice cases was only recently affirmed as constitutional (see Chapter 4), it is unclear what effect, if any, the cap has had on malpractice verdicts in California. It is worth noting, however, that the recent insurance problems for medical malpractice have been far less serious in California than in many other states, and that in California the insurance crisis primarily has affected areas other than medical malpractice (e.g., municipal liability).

35/ This remarkable increase is also reflected in the Institute for Civil Justice study of civil jury verdicts in Cook County, Illinois. For example, the average wrongful death award in Cook County increased (in constant dollar terms) from $166,000 in 1970-74 to $336,000 in 1975-79, a doubling over roughly half a decade. M. Peterson, Compensation of Injuries: Civil Jury Verdicts in Cook County 54 (1984).

CHART D

AVERAGE MEDICAL MALPRACTICE JURY VERDICT

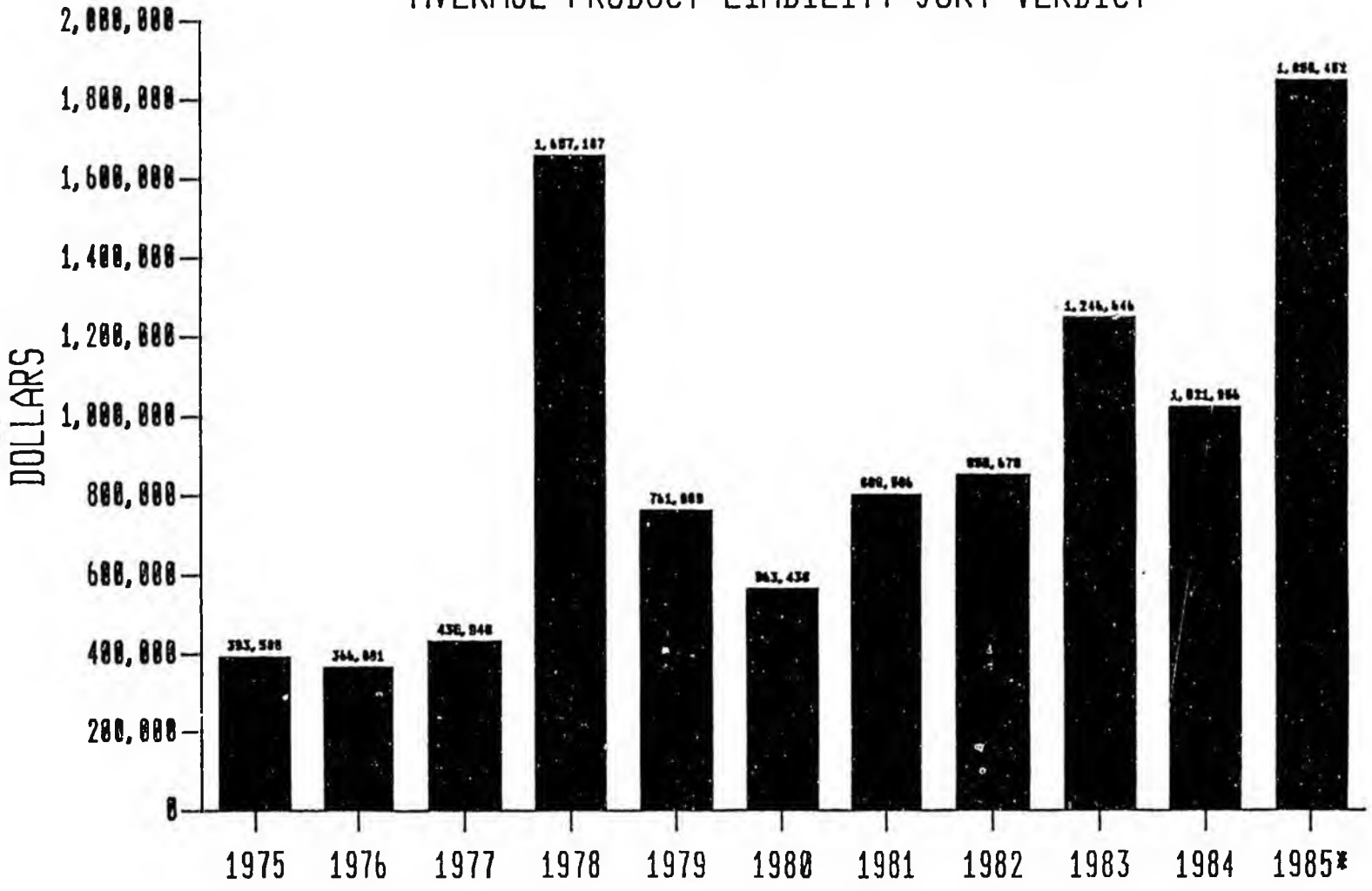


Source: Jury Verdict Research, Inc.

* 1985 Information Not Complete

CHART E

AVERAGE PRODUCT LIABILITY JURY VERDICT



Source: Jury Verdict Research, Inc.

* 1985 Information Not Complete

million-dollar medical malpractice verdicts and 86 million-dollar product liability verdicts (see Chart F), an increase of over 1200% in the number of such verdicts. 36/ If these million-dollar verdicts are deleted, the increase in average verdicts is reduced sharply. For example, the increase in the average medical malpractice jury verdict from 1975 to 1985 drops to 26% and the comparable average product liability verdict jury increase is 87%. 37/ This clearly suggests that the explosion in damages has come largely at the high end of the awards scale.

The Jury Verdict Research data is of only limited value on the absolute number of million-dollar payments, since in all likelihood the vast majority of such payments are through settlements rather than verdicts. The data is highly relevant, however, in that it shows that the percentage rate of increase of verdicts is far higher for large verdicts than for small or medium-size verdicts. Since a significant distinguishing factor between large verdicts and small or medium-size verdicts is that large verdicts tend to be composed to a far greater extent of non-economic damages, 38/ this strongly suggests that non-economic damages play a major role in the explosive growth in large verdicts (as compared to the much more moderate growth in small and medium-size verdicts).

While it is not possible to quantify precisely how much particular elements of damages have contributed to this explosion, it appears that non-economic damages are a substantial factor. Such damages include non-pecuniary compensatory damages for intangible injuries such as pain and suffering and mental anguish, as well as punitive damages. Such non-economic damages are inherently open-ended and subjective, and, therefore, easily susceptible to dramatic inflation. Of interest in this regard is a recent preliminary study by the Institute for Civil Justice which indicates that the average punitive damage award in Cook County, Illinois, increased from $63,000 in 1970-74 to $489,000 in 1980-84 (see Chart G). 39/ Of

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36/ Jury Verdict Research, Inc., supra. The trend toward million-dollar verdicts is also documented by the Institute for Civil Justice. M. Shanley & M. Peterson, Comparative Justice: Civil Jury Verdicts in San Francisco and Cook Counties, 1959-1980 26-30 (1983).

37/ Jury Verdict Research, Inc., supra.

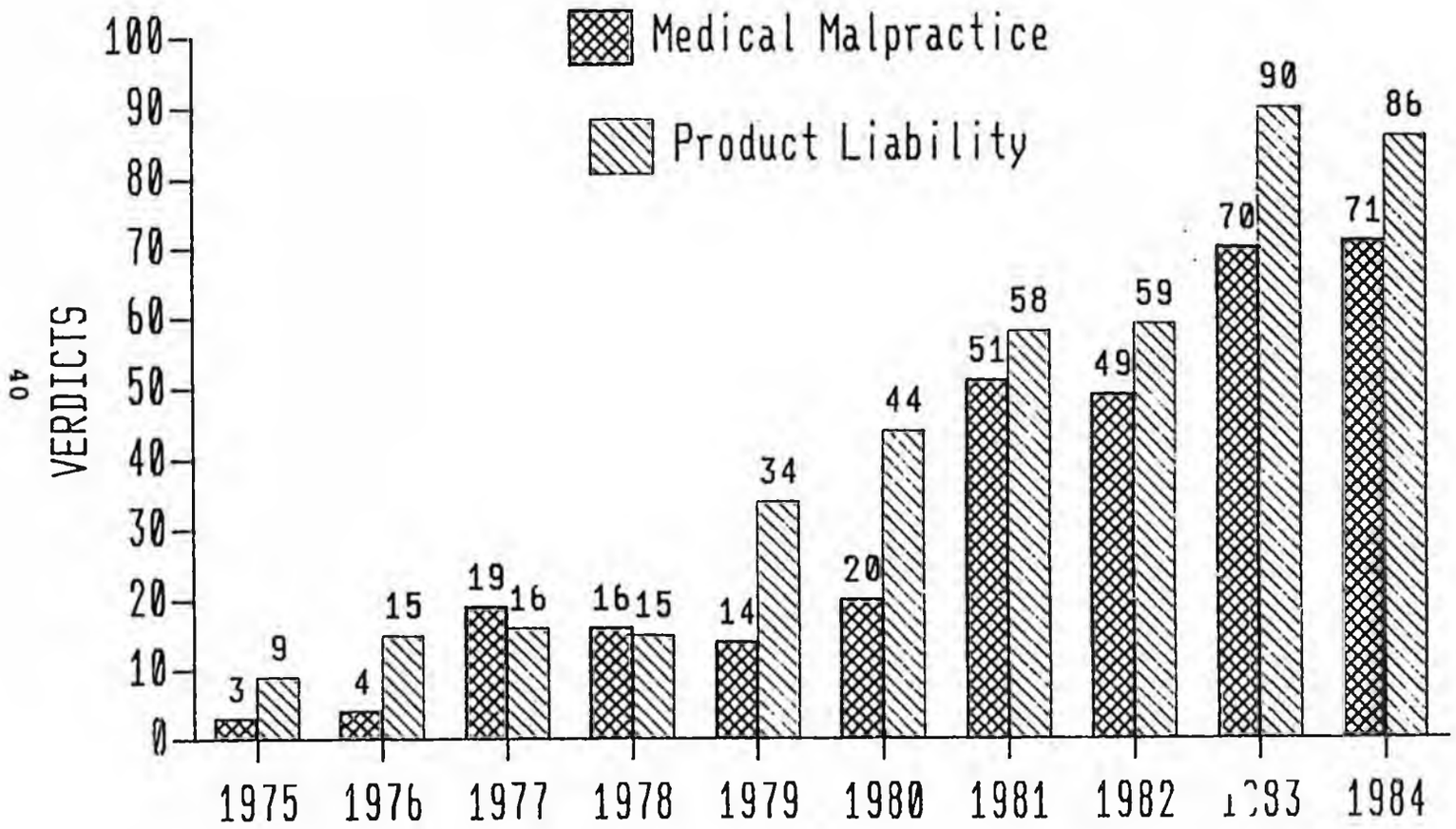
38/ H. Manne, Medical Malpractice Policy Guidebook 138-39 (1985). The study shows that for medical malpractice awards between $100,000 and $200,000, non-economic damages account for approximately 27% of the total award, while for awards above $600,000, the non-economic share increases to 54%.

39/ M. Peterson, Punitive Damages: Preliminary Empirical

(CONTINUED)

CHART F

MILLION DOLLAR JURY VERDICTS

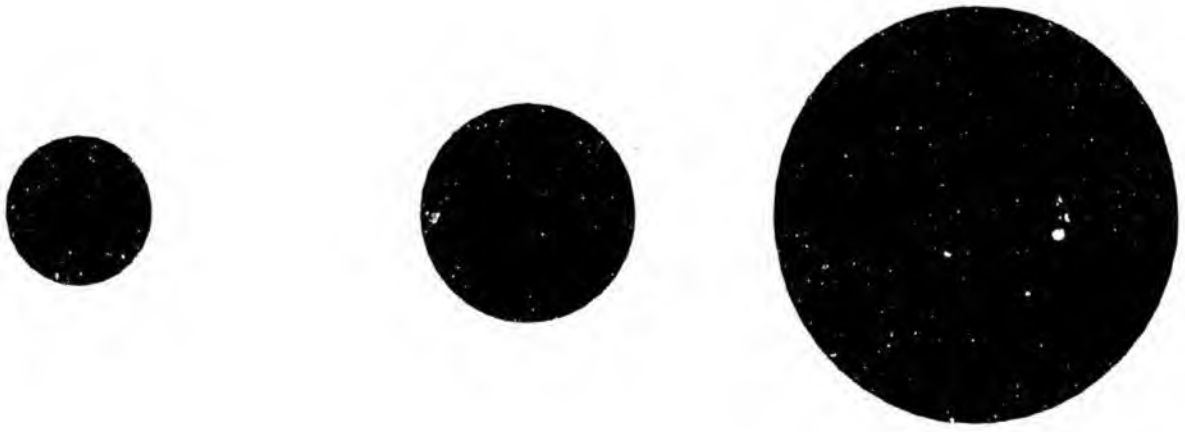


Source: Jury Verdict Research, Inc.

CHART G

AVERAGE PUNITIVE DAMAGE AWARD IN COOK COUNTY*

$63,000 (25 Awards)	$135,000 (39 Awards)	$489,000 (90 Awards)



1970-74	1975-79	1980-84

particular interest is that the average Cook County punitive damage award in personal injury cases increased from $40,000 in 1970-74 to $1,152,174 in 1980-84 (see Chart H). 40/

This explosion in damage awards, particularly in the case of non-economic damages, is vastly in excess of the rate of inflation over the comparable period. 41/ For whatever reasons, tort damage awards have suddenly soared in the United States without any apparent justification.

*1984 Dollars

Excessive Transaction Costs

Another serious problem of the tort system is its extraordinarily high transaction costs. A study by the Institute for Civil Justice of the asbestos litigations shows that out of every dollar paid out by the asbestos manufacturers and their insurers as a result of the asbestos litigation, 62 cents on the verage is lost attorneys' fees and litigation expenses (see Chart I). 42/ This does not include the transaction costs borne by the courts in adjudicating these claims.

It also is worthwhile viewing the transaction costs from the

39/ (FOOTNOTE CONTINUED)

Findings 13 (1985). These averages were adjusted for inflation and are stated in terms of the 1984 dollar. The study's analysis of punitive damage awards in San Francisco also showed an increase in such awards, though of lesser magnitude than in Cook County.

40/ Id., at 25 (also adjusted for inflation). Peterson notes that personal injury punitive damage awards in Cook County between 1980-84 amounted to over half of all punitive damages awarded in all case categories by Cook County juries from 1960-84.

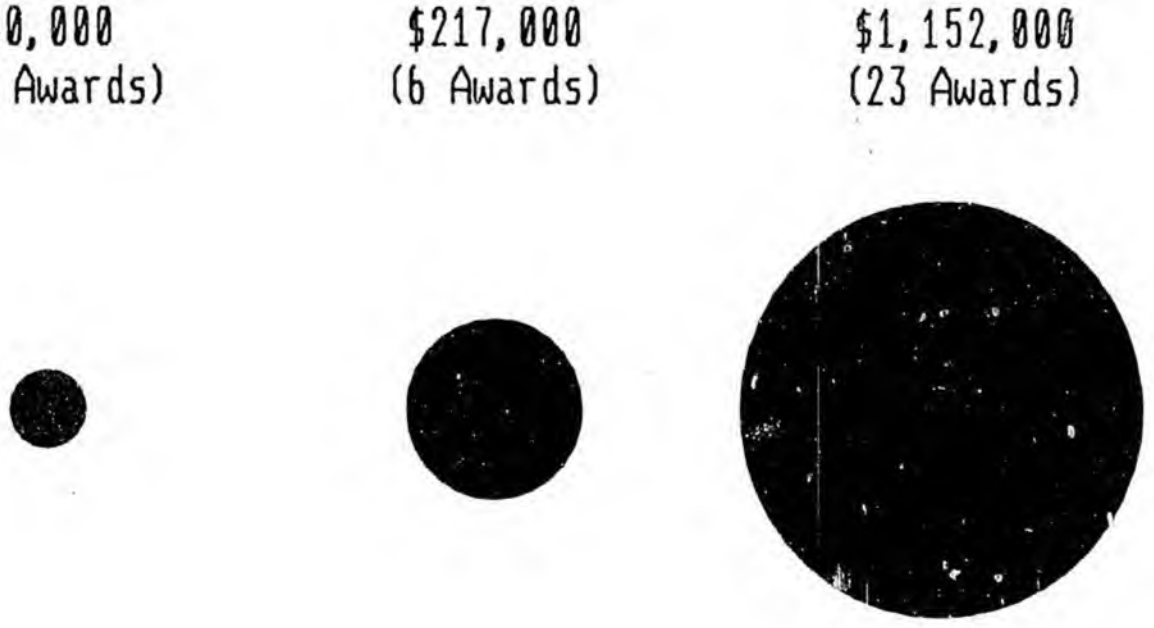
41/ For purposes of comparison, one dollar in 1985 had approximately half the buying power of one dollar in 1975.

42/ J. Kakalik, P. Ebener, W. Felstiner, G. Haggstrom & M. Shanley, Variations in Asbestos Litigation Compensation and Expenses xviii (1984). These costs, of course, include both plaintiffs' and defendants' litigation expenses. In comparing the costs attributable to defendants' litigation expenses to the costs attributable to plaintiffs' litigation expenses it is useful to remember that defendants incur such costs whether or not they prevail, and, indeed, may incur substantial costs defeating even clearly frivolous claims. Measurements of plaintiffs' litigation expenses (such as in Chart I), reflect only those cases in which plaintiffs prevail, while defendants' litigation expenses include all cases, whether or not plaintiffs prevail.

Source: Institute for Civil Justice

CHART H

AVERAGE PERSONAL INJURY PUNITIVE DAMAGE AWARD IN COOK COUNTY*



Source: Institute for Civil Justice

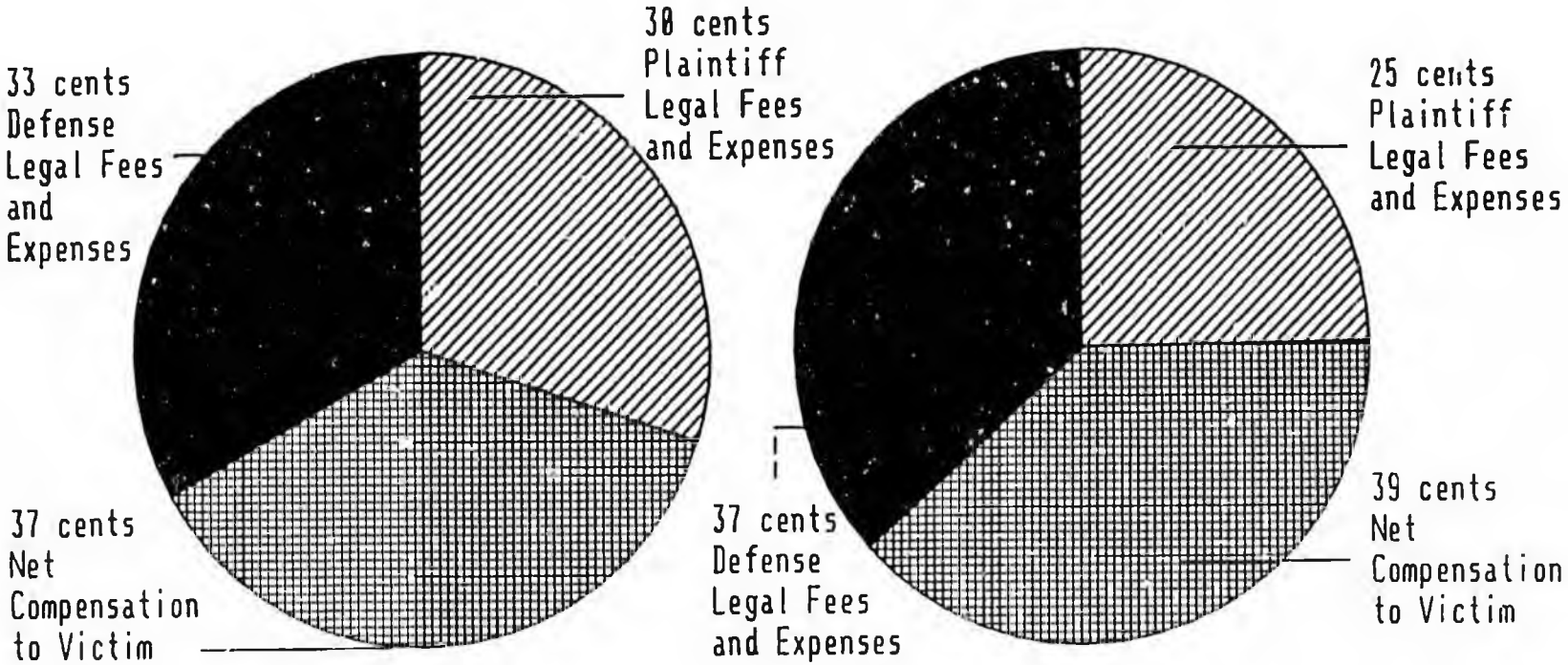
*1984 Dollars

Source: Institute for Civil Justice

*1984 Dollars

CHART I

ALLOCATION OF EVERY DOLLAR PAID OUT IN ASBESTOS CLAIMS



Average Tried Claim

Average Closed Claim

Source: Institute for Civil Justice

perspective of the prevailing plaintiff. The study also shows that for every dollar awarded to plaintiff, 34 cents on the average is lost to legal fees and an additional 5 cents is lost to legal expenses. 43/ In some cases, legal fees alone amounted to as much as 45% of plaintiff's award. 44/

It is difficult to justify such extraordinary transaction costs. But it is particularly difficult to justify such costs when the costs often are borne largely by the seriously injured and by consumers who ultimately must pay for these costs through higher prices for goods and services. The only clear beneficiaries of this system appear to be lawyers.

II. BURGEONING TORT LIABILITY AS A MAJOR CAUSE OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above discussion describes a tort system that in recent years has dramatically increased in scope. One way of measuring that increase is in terms of the increase in the number of tort lawsuits and in the level of damages awarded in such lawsuits. While the available data is limited, and by no means perfect, it clearly confirms that there has been a substantial increase in recent years in both the number of tort lawsuits and awarded damages.

The growth in the number of product liability suits has been astounding. For example, the number of product liability cases filed in federal district courts has increased from 1,579 in 1974 to 13,554 in 1985, a 758% increase (see Chart J). 45/ There is no reason to believe that the states courts have not witnessed a similar dramatic increase in the number of product liability claims.

A similar trend can be found in medical malpractice, where claims 46/ filed against physician-owned companies increased from 10,568 in 1979 to 23,545 in 1983, a 123% increase in four

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43/ Id., at 84. For tried claims, these costs increase to 39 cents and 6 cents respectively. Id.

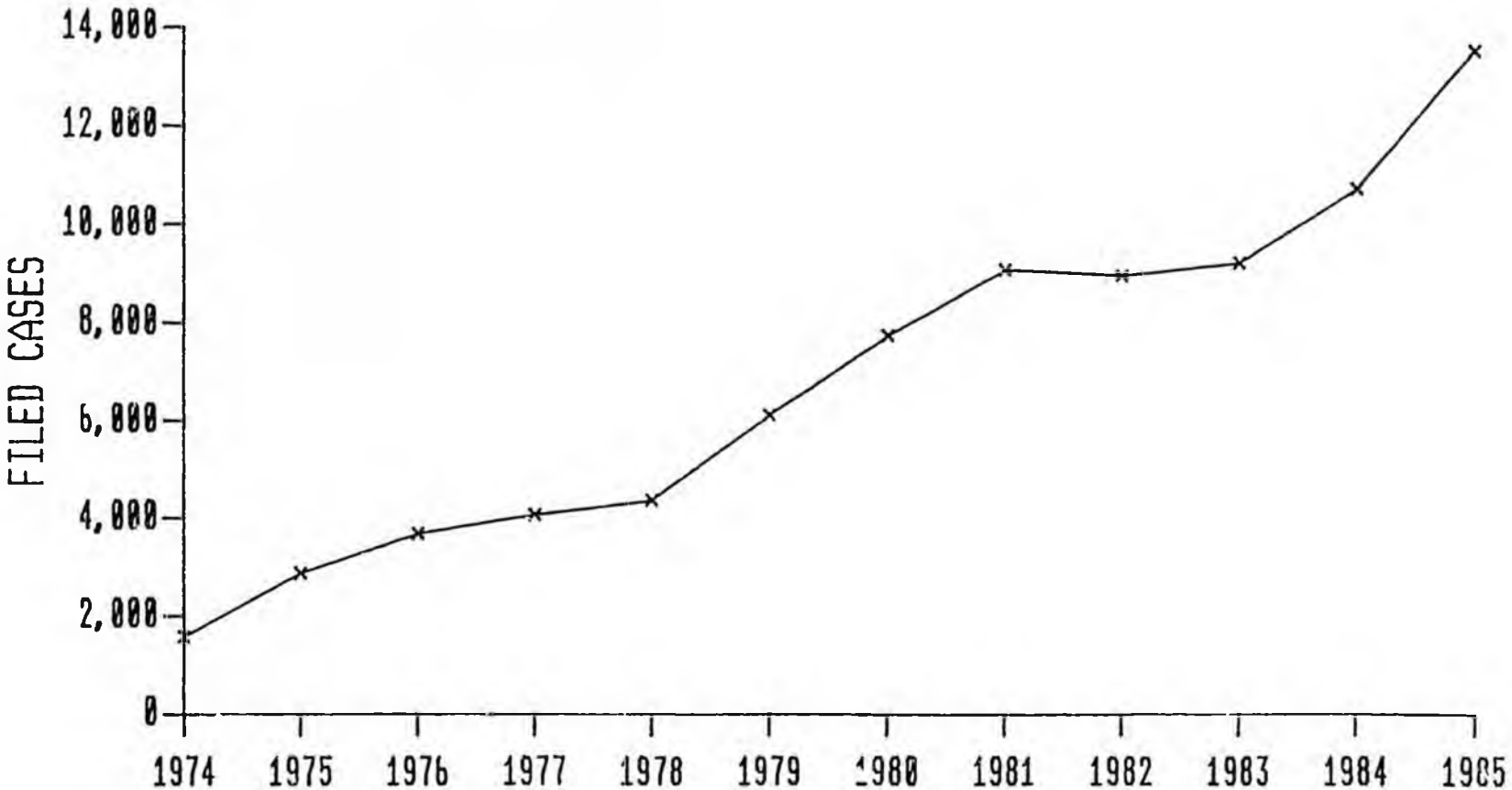
44/ Id. With legal expenses of 5%, prevailing plaintiffs in such cases receive only half of the awarded verdict.

45/ Administrative Office of the United States Courts.

46/ Claims do not, of course, translate directly into lawsuits, since most claims are resolved prior to the filing of litigation. But a substantial increase in claims almost certainly means a corresponding substantial increase in litigation.

CHART J

PRODUCT LIABILITY CASES FILED IN FEDERAL DISTRICT COURT



Source: Administrative Office of the United States Courts

years. 47/ The number of medical malpractice lawsuits per 100 physicians more than doubled from 1976 to 1981, and for obstetricians/gynecologists actually tripled during this period. 48/ In federal courts, which contain only a fraction of all medical malpractice claims, such claims have increased almost three-fold in the last decade (see Chart K). 49/

A similar increase can be found in claims filed against municipal and county officials. A survey of over twelve hundred local governments found that such claims had increased by 141% between 1979 and 1983. 50/ Tort claims against municipalities also have increased dramatically in recent years. For example, New York City witnessed a 375% increase from 1977 to 1985 in personal injury claims, with a corresponding 345% increase in average settlement cost. 51/ The City's long-term liability for tort claims already filed is projected to be $1.5 billion. 52/

The explosive growth in damages over the past decade has already been related in detail. Suffice it to say that the increase in the average tort award appears to have outpaced even the extraordinary increase in the number of such lawsuits. The extent of some of these increases are difficult to comprehend. For example, one verdict reporting service found that the average jury verdict in personal injury lawsuits had increased by approximately 25% or more in three separate years (24.5% in 1980, 30.49% in 1981 and 27.54% in 1983). 53/ The average annual increase in such awards since 1975 has been over 15%. 54/ A subcategory of damages that dramatically illustrates this development is the average jury verdict for the wrongful death

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47/ American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the '80s 6 (November 1984).

48/ H. Manne, Medical Malpractice Policy Guidebook 18 (1985).

49/ Administrative Office of the United States Courts.

50/ Wyatt Co., Public Officials Liability Insurance: Understanding the Market (1986), page 22 (the provided 1984 data is incomplete, see pages 9-10, and therefore is not used for comparison).

51/ Statement by Mayor Edward I. Koch before the Governor's Advisory Commission on Liability Insurance, Feburary 21, 1986.

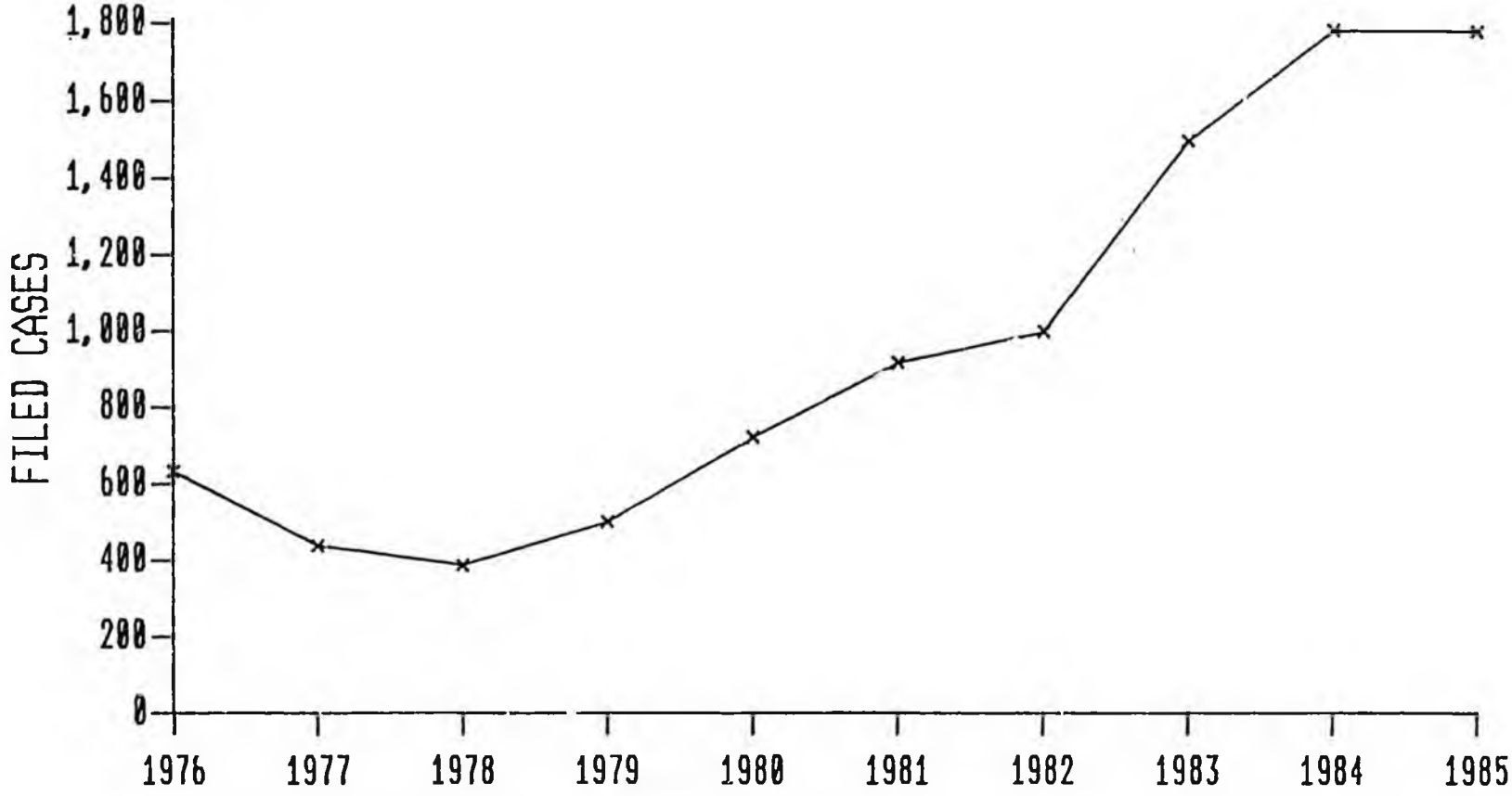
52/ Id.

53/ Jury Verdict Research, Inc., supra.

54/ Id. This is more than double the average annual CPI increase during the same period. Id.

CHART K

MEDICAL MALPRACTICE CASES FILED IN FEDERAL DISTRICT COURT



Source: Administra[illegible] Office of the United States Courts

of an adult male. The average award increased from $223,259 in 1975 to $946,140 in 1985, a more than four-fold (324%) increase in ten years (see Chart L). 55/

The increase in the number of tort lawsuits and the level of awarded damages 56/ (or settlements) in and of itself has an obvious inflating effect on insurance premiums. To illustrate, assuming all other factors are held constant, 57/ if the number of lawsuits against a company or person doubles in ten years, and if the average damage award (or settlement) doubles over this same period, that company or person will experience at least a four-fold increase in insurance premiums over those ten years. As noted above, however, for both medical malpractice and product liability the last ten years have witnessed much more than a doubling in lawsuits and average awards.

The above observation leads to an important but troubling insight into the current insurance availability/affordability crisis. Some have speculated that the crisis is the result of the attempt by the insurance industry to recoup losses resulting from its underpricing in the late 1970's and early 1980's. If this theory is correct, then it would seem likely that as such losses are recouped, premiums would decline. The above analysis, however, suggests that while the insurance industry may have underpriced its product for a period of time, the current explosion in premiums results in large part from the fact that now that the insurance industry is facing substantial underwriting losses, it must price coverage to reflect the actual risks presented by tort law. In other words, for a variety of reasons, the insurance industry appears to have kept prices constant or engaged in price reductions in a period during which the risks generated by tort liability increased

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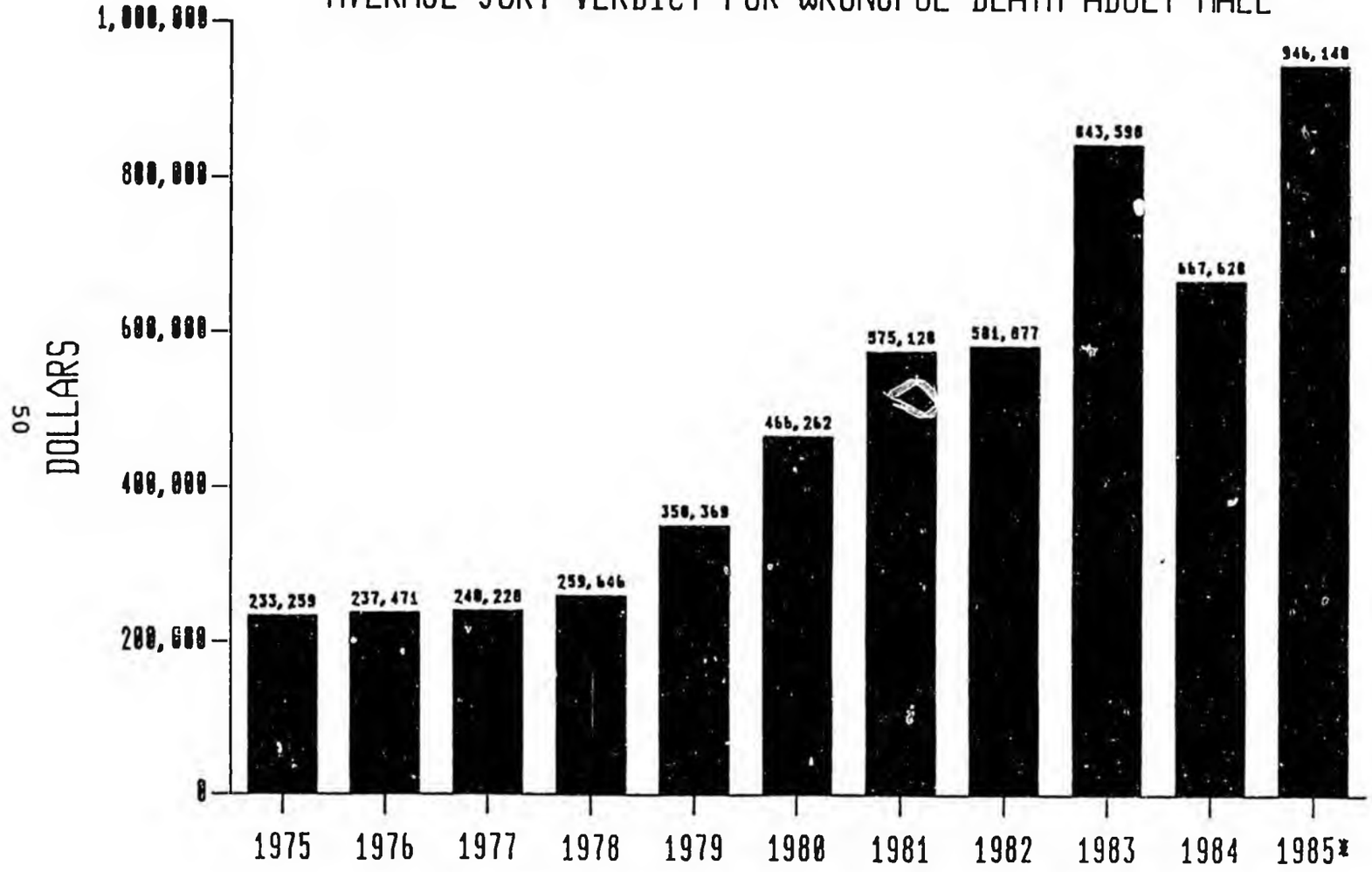
55/ Id.

56/ Jury verdicts, of course, represent only the tip of the claims resolution process. Most claims are resolved before trial. However, settlements by their very nature reflect the range of verdicts available to the plaintiff. Thus, as jury verdicts skyrocket, so do settlements. Settlements also reflect the plaintiff's likelihood of success. As tort law becomes more and more favorable to plaintiffs -- particularly in reducing or even eliminating plaintiff's burden of showing fault or causation -- settlements further increase. Accordingly, in addition to the obvious effect on settlements of increasing jury verdicts, liberalized standards of fault and causation increase the percentage of claims resolved favorably to plaintiff and increase the size of settlements.

57/ Of course, all factors are not held constant. For example, if there is an increase in the percentage of claims resolved favorably to plaintiffs, premiums would have to be increased correspondingly.

CHART L

AVERAGE JURY VERDICT FOR WRONGFUL DEATH ADULT MALE



Source: Jury Verdict Research, Inc.

* 1985 Information Not Complete

dramatically. Now that the industry is attempting to match premiums to risk, there appears to be a dramatic, pent-up increase in premiums to bring premiums back into line with rapidly growing liability risks.

The above analysis, if correct, is troubling in that it suggests that even after the insurance industry's underwriting profitability is restored, premiums are likely to remain relatively high. That is, while the more extreme availability problems may be resolved once the industry controls its underwriting losses, affordability problems may remain as a long-term fixture absent significant reforms of tort law.

There is, however, another important contribution of recent developments in tort law to the availability/affordability crisis which goes beyond the number of lawsuits and size of damage awards. The changing standards of liability and causation have generated tremendous uncertainty. The "rules of the game" of tort liability have changed so dramatically and rapidly in recent years that few are willing to speculate on what those rules will be even a few years hence. Invariably, however, those rules seem to have been changed to the prejudice of parties with pockets sufficiently deep to bear increasingly generous awards of compensation.

This uncertainty as to what the rules of tort liability applicable to any particular company, person or activity will be in future years makes it extremely difficult for the insurance industry to assess risk (and establish appropriate premiums) with any degree of confidence. This undoubtedly exacerbates the affordability problem, and may be a major factor underlying the availability problem. Simply put, insurance, like other business activities, operates most efficiently within a stable legal regime. Tort law, unfortunately, over recent years has been anything but stable.

The recent explosion in tort liability and the lack of legal certainty is a particularly noxious combination that seems to react almost synergistically in promoting the insurance availability/affordability crisis. The rapidly accelerating growth in both the number of tort lawsuits and the size of damage awards in and of itself significantly increases future liability risks. But that risk is magnified by the perception -- based in large part on the lack of a stable legal regime -- that this accelerating growth will continue unabated. The insurance industry thus appears to be extrapolating the massive liability surge of recent years into the future, and seems to be setting its rates in part on the assumption that the on-going deterioration of tort law will continue for some time. Simply put, assessments of future liability risks reflect not only the recent rapid growth in such risks, but the perceived likelihood

that past excesses will be outpaced by the excesses yet to come. 58/

In conclusion, the current problems of tort law can be summarized as follows:

- Too many defendants are found liable (or forced into settlements) where there should be no liability, either because they engaged in no wrongful activity, or because they did not cause the underlying injury.

- Damages have become excessive, particularly in the area of non-economic damages such as pain and suffering, mental anguish and punitive damages. And,

- Transaction costs are far too high.

The ways in which these aspects of the tort system are contributing to the current insurance availability/affordability crisis can be summarized as follows:

- The private sector is being asked to carry a compensation burden which in some instances it simply cannot afford to carry without substantial economic dislocations. Thus, even where insurance is available, in order to carry this compensation burden, it often is priced at unacceptable levels.

- The affordability/availability problem is greatly exacerbated by the lack of a stable legal regime which would allow the insurance industry to assess liability risks with some degree of confidence.

58/ A recent Administration study of the childhood vaccine industry, for example, found that uncertainty as to tort liability was a major factor underlying the severe insurance availability problems facing the industry and jeopardizing the childhood vaccination program. See the Report of the Working Group on Vaccine Supply and Liability (April, 1985).

CHAPTER 3

RECENT INSURANCE INDUSTRY DEVELOPMENTS

The insurance availability/affordability crisis has led both the insurance industry and its customers to consider various changes to the ways in which liability risks are insured. The following is a description of the most significant of these developments and their immediate implications.

I. COVERAGE CHANGES

One of the most important of these changes has been the development of new commercial policy forms by the Insurance Services Office ("ISO"), the statistical and rate-making organization for the property-casualty industry. While these new forms have been filed with each state insurance department, most states have not yet acted on the new submissions.

These new policy forms are more limited in scope than the old forms in that they are written on a claims-made basis and permit certain coverages to be excluded entirely.

Claims-Made Policies

General liability insurance, including product liability coverage, traditionally has been written on an occurrence basis; that is, the policy applies to all injuries and damages that occur during the policy period irrespective of when claims are presented. Under claims-made coverage, the policy covers injuries and damages which occur during the policy period and for which claims are filed during the policy period.

The ISO submission provides that a policyholder can purchase unlimited tail coverage (the period during which claims are covered after termination of the policy) for a cost of up to 200% of the original premium. In addition, a five year extended claims reporting period for known claims is provided for situations where no other insurance is applicable. There is still disagreement over the reinstatement of aggregate policy limits for tail coverage and the effect of defense cost inclusions.

A claims-made policy covers claims occurring after the "retroactive date," ordinarily, the inception date of the policy. Under some circumstances, insurers will be permitted to advance the retroactive date, necessitating the purchase of tail coverage for incidents occurring during the prior period. The retroactive date may be advanced when: (1) there is a change of insurer, (2) there is a change in the insured's operation, (3) if the insured fails to inform the insurer of risks he knew or should have known about, or (4) with the consent of the insured.

The ISO has indicated that it does not intend to limit the use of claims-made policies to specific problem areas such as long-tail or latent injury exposures.

The claims-made forms have not yet been approved by the states, and twelve states have expressly disapproved them as filed. The ISO is working with the Insurance Commissioners to resolve differences.

The insurance industry has indicated that it wishes to use claims-made policies. In general, 1986 is viewed as a transition year during which insurers will train their personnel in the use of the new policy forms and adapt their computers to accommodate the changes. Insurers have indicated that in states where the new forms are not insured, they may use non-admitted subsidiaries or surplus lines carriers to provide the coverage to their clients on claims-made basis for large complex risks and risks in "volatile" classes, or else simply not provide coverage to those risks.

Claims-made policies and other limited coverages also are being adopted by reinsurers. Lloyd's of London has introduced a new claims-made form, as have Weavers and Trenwick American Reinsurance. Each policy is somewhat different. Trenwick, a United States reinsurance company, has stated that it will not write any general liability reinsurance on an occurrence basis after January 1 of this year. Trenwick also has written a claims-made form for use by its ceding companies for "difficult" risks. Other reinsurers have indicated they would reinsure both occurrence and claims-made policies, but would strongly encourage the use of claims-made for heavy casualty risks. As indicated in Chapter 1, some businesses already have been asked to take claims-made coverage for their excess limits coverage. Because of the many different claims-made forms currently being used, this is likely to cause gaps in coverage.

Laser Endorsements

The ISO policy form also includes "laser endorsements" which can be used to limit coverage. These provisions permit an insurer to exclude claims from a specific incident, product or period of time. Several Insurance Commissioners have objected to this provision and stated that, at a minimum, it should be revised to require the signature of the insured indicating an awareness of the exclusion. The inclusion of a laser endorsement would necessitate either the insured's purchase of tail coverage for that product or incident, or the insured's "going bare" for that liability.

Pollution Exclusion

Both the new ISO and Lloyd's of London claims-made commercial general liability policies specifically exclude pollution

coverage. Traditionally, the general liability policy has included the business community's liability for damage caused by the "sudden and accidental" discharge of toxic substances. Environmental Impairment Liability ("EIL") policies are used to cover damages from gradual pollution incidents. In a number of highly controversial cases, courts have expanded the meaning of "sudden and accidental," causing insurers to be liable for EIL-type (gradual pollution) coverage when it was not intended under the policy.

As a result, insurers currently are reluctant to provide any pollution coverage, though Lloyd's of London has indicated a willingness to cover some liability at additional cost on a "named peril" basis only.

Defense Cost Inclusion

Ordinarily, the costs of defending against liability claims are not included within the aggregate limits of the commercial general liability policy. Insurers traditionally have controlled the defense of claims against their insureds by engaging defense counsel and by governing the vigor with which a claim is challenged. The insurers paid all costs, and the full amount of the policy limits were available to pay any settlement or judgment against the insured.

During the product liability crisis of the mid-1970's there were a number of allegations that insurers were, in fact, fueling the claims situation by settling too quickly in many cases that the insureds believed should have been more vigorously contested. As a result, many companies insisted that their insurance contracts include a right to at least partial, if not full, control of defense strategy.

In the mid-1980's, defense costs have escalated rapidly, mostly because of the cost of attorneys' fees, and possibly, in part because of the insureds' desires to contest claims to the fullest degree possible.

In order to control costs, the ISO had proposed to change the commercial general liability form to include defense costs within the aggregate limits of the policy. This practice already is incorporated in at least some other policy forms. 1/

1/ Business Insurance, December 9, 1985, page 1.

The proposal brought a sharp response from insureds, the bar, and the Risk and Insurance Management Society, a trade association of risk managers and insurance buyers. They believe that there will be cases of defense costs exceeding the limits, leaving no money to pay a settlement or judgment. Some are concerned that defense counsel may urge settlement of unworthy claims in order to prevent defense costs from exhausting all available coverage. Others believe that there will be a spate of bad faith claims against insurers when the policy limit is used for legal costs and the insured is left liable for damages.

In response to the concerns of insurance customers, regulators and brokers, the ISO has revised its proposal so that up to 50% of the aggregate limits may be spent on defense costs before the policy limits will begin to be reduced by those expenses. An endorsement will be available so that up to 300% of the limit may be spent on defense costs before the policy limit is affected. A discount will be applied if the policyholder buys less than the 300% endorsement. Insurers apparently will have the option to apply an endorsement which will charge all defense costs to the policy limits. 2/

At its annual meeting in December, the National Association of Insurance Commissioners passed a resolution urging states not to approve the ISO proposal until the proposal can be studied by the Commissioners. The ISO, which had hoped to initiate the defense cost change in July of 1986, will postpone filing its request with the states until at least February 15, 1986. 3/

II. ALTERNATIVE INSURANCE MECHANISMS

As liability insurance becomes unavailable or unaffordable, means of liability protection outside the conventional insurance markets increasingly are being sought and used.

2/ Business Insurance, December 16, 1985, page 1.

3/ Business Insurance, December 23, 1985, page 1.

Insurance Company Creation (Captive or Other)

One response available to large companies unable to buy the insurance coverage they need is to set up their own insurance company. Thirty-three major United States companies recently have established an offshore insurer, A.C.E. Insurance Company, which began operation in November, 1985, and provides up to $150 million in liability coverage. Founding companies include IBM, GE, U.S. Steel and Chase Manhattan, as well as other companies. While A.C.E. offers coverages not available elsewhere, its policies are available only to large companies since it only pays claims exceeding $100 million.

In addition, it recently was announced that a group of fifteen chemical and petrochemical companies are creating a company called CASEX, which would provide excess limits coverage for products, directors and officers, and sudden and accidental pollution liability.

Another group of fifty United States banks are creating a mutual insurer, Bankers' Insurance Co., Ltd., to provide directors and officers liability coverage and bankers blanket bonds.

During the medical malpractice crisis in the early to mid-1970's, groups of medical professionals unable to obtain malpractice coverage formed their own companies, commonly known as bedpan mutuals, to handle their claims. Such insurance groups currently provide about half of the coverage in the malpractice liability market.

Self-Insurance

Some industry groups and trade associations, as well as municipalities in several states, have joined together to self-insure as groups, and others have been able to set up a formal self-insurance program just to handle their own claims. 4/

Self-insurance, either individual or group, also has been a useful vehicle for municipalities for which insurance has become either unavailable or unaffordable.

One major problem encountered by firms seeking to set up self-insurance programs is that reserves for self insurance are not

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4/ A formal self-insurance program is different from "going bare" in that the former sets up reserves to cover claims and treats it similar to an insurance system whereas the latter simply hopes claims do not occur, which may cause financial difficulties if and when they do occur.

accorded the same tax treatment as insurance company reserves, in that self-insurance reserves are fully taxable. While this presents no problem for municipalities and other tax-exempt entities, it is a major hurdle for private entities.

Small firms are generally unable to establish a meaningful self-insurance program individually, but may benefit from group self-insurance if no other insurance is available.

Product Liability Risk Retention Act Groups

The Risk Retention Act ("RRA"), 15 U.S.C. § 3901 et seq., was intended as a mechanism to (1) create an alternative product liability insurance market, and (2) provide a means for smaller insurance buyers to purchase general liability insurance -- including product liability coverage -- as groups. The RRA evolved from an intensive interagency study of the product liability "crisis" in the mid-1970's. President Reagan signed the Act in September 1981, noting that it was a "marketplace solution" to provide product manufacturers, distributors and sellers with affordable product liability insurance.

A Risk Retention Group ("RRG") is formed by any number of product sellers as an insurance company licensed to operate under the laws of any state. The RRG may provide only product liability and completed operations coverage to its members. (Completed operations is work performed by a contractor or product manufacturer installing its product.) The RRG may sell insurance in any state without meeting the licensing or other regulatory requirements of any state other than its domicile. No state may discriminate against an RRG, but states may impose normal premium taxes and enforce compliance with unfair claims settlement practices statutes.

The Act is restrictive in that it limits a RRG to products and completed operations coverage, but permits the establishment of a domestic group captive that is able to do business countrywide.

A Purchasing Group ("PG") may be formed to negotiate for a group policy from any insurer to cover product liability completed operations, and commercial general liability when either of the first two coverages are included. The PG and any entity providing services to the PG are exempt from any state law which would prohibit the PG from purchasing this coverage on a group basis.

A group of companies purchasing together presents an attractive premium base with lower administrative costs to the insurer. In a tight market small companies are subject to cancellation or sharply higher prices because an insurer may prefer to use its

resources on a few large risks. The provisions for purchasing groups was necessary to overcome statutes and regulations in about forty-four states which prohibited so called "fictitious groups" set up for the purpose of buying property or casualty insurance on a group basis.

Very few companies have used the RRA to date, but the rapid change in market conditions likely will lead to a much greater interest in its provision.

One reason that the RRA has been little used is the fact that it is limited to products and completed operations coverages, although groups may include other coverages as long as products is the primary purpose. It is a useful means of expanding insurance capacity, and would provide additional capacity in the alternative market if the products limitation were removed.

III. STATE REGULATORY DEVELOPMENTS

State legislators and insurance regulators have recognized the severity of the liability insurance crisis, and have responded in a variety of ways. One state has barred cancellation or non-renewal of policies and prohibited any increases in the cost of policies in effect. Several other states are considering similar actions. The National Association of Insurance Commissioners adopted a resolution opposing mid-term cancellations and short notices of non-renewal. Other states are implementing or considering the use of Market Assistance Programs, which are voluntary assigned risk pools designed to take risks such as day care centers on a rotating or shared basis. Yet other states are considering joint underwriting associations in which the state regulator mandates the sharing of certain risks

Half the states have "file and use" rate regulation in which the insurance department is notified of a rate increase which becomes effective without action by the regulator. Many of these states reportedly are rethinking their systems because of the sharp increases in the rates of some of the problem lines of coverage.

Regulators normally have viewed commercial insurance as transactions between knowledgeable buyers and sellers, and, accordingly, have refrained from interfering with the market's operation. The recent concerns expressed by the Insurance Commissioners is a measure of the depth of the availability/ affordability crisis, and may foreshadow a heightening in the regulatory "oversight" of commercial insurance.

CHAPTER 4

TORT LAW REFORM

As discussed in Chapter 2, two primary areas have been the focus of the Working Group's examination into the crisis in liability insurance availability and affordability: the current economic difficulties of the insurance industry; and, the extraordinary growth in tort liability in recent years. For the reasons discussed in Chapter 2, while it seems likely that the insurance industry will be able to work its way out of its present economic straits, it is very unclear -- if not doubtful -- that this will significantly alleviate the crisis in insurance availability and affordability. Early indications are that insurers will continue to avoid areas that present a high risk of tort liability, or, where they do provide insurance, will demand high premiums. That is, while the more extreme aspects of the availability crisis may be resolved once the industry regains its desired level of profitability, it appears unlikely at this time that the high premiums that have led to serious affordability concerns will be reduced significantly.

For these reasons, as well as for the other reasons discussed in Chapter 2, there appears to be little that can or should be done by the federal or any other government to "remedy" the economic factors that underlie the current availability/affordability crisis. The excesses of the tort system, however, present a very real opportunity to address a major cause of the insurance crisis with sensible and appropriate reforms. And while some of the changes in the insurance market currently under contemplation (see Chapter 3) probably will relieve some availability/affordability problems, it seems unlikely that these changes will provide long-term, systemic relief without fundamental reforms of tort law.

The following is a list of eight tort reforms that would bring a greater degree of rationality and predictability to tort law, and thereby significantly assist in resolving the availability/affordability crisis. This is by no means an exhaustive list of possible tort reforms. Nor does the accompanying discussion of these reforms indicate how they necessarily should be implemented; that is, on the federal or state level, or through legislative or judicial modification of the law. Rather, this list identifies eight recommended tort reforms which if implemented should return tort law to a credible fault-based compensation system that provides a fair and reasonable level of compensation to deserving plaintiffs through a more predictable and affordable liability allocating mechanism. While these reforms undoubtedly will be resisted by some, they in fact are quite modest and should not dramatically alter the basic principles of tort law as those have existed for centuries.

Recommendation No. 1: Retain fault as the basis for liability.

For the reasons discussed in Chapter 2, fault should be retained as a basis for tort liability. As noted there, fault is the only mechanism in tort law for distinguishing desirable from undesirable conduct, and is an indispensable predicate to many other aspects of the tort liability system without which the system would generate arbitrary and unfair results.

For non-product liability cases, negligence should remain the applicable standard of liability. Strict product liability should under no circumstances be extended outside the traditional area of product injuries. Thus, theories which would apply strict product liability to landlords or to professionals providing services (e.g., pharmacists, architects, etc.) should be strongly resisted and expressly rejected. The trend in some states 1/ to extend strict liability doctrines outside the area of product injuries is a highly pernicious development which will significantly undermine the ability of those sectors of our economy to function properly.

Strict product liability in its traditional sense represents a sensible application of fault-based liability to the realities of modern industrial life. The Working Group, accordingly, does not recommend the abolition of strict product liability, provided the doctrine is kept within its traditional bounds. Unfortunately, strict product liability has been subject to extensive abuse that often has had the effect of transforming the doctrine in practice into absolute liability.

The following are the elements of a strict product liability standard which does not present an impossible or unfair burden to plaintiffs in demonstrating fault on the part of defendant-manufacturers, while at the same time not establishing a scheme of absolute liability which simply uses the manufacturer as an insurer for all risks of injury.

- Liability should be predicated on the existence of a defect which is found to make the product unreasonably dangerous.

- Defendants should only be held liable for uses of a product that are both reasonable and foreseeable. Liability should not be predicated upon unreasonable or unforeseeable alterations of a product that cause the injury, particularly where such alterations are prohibited or warned against. (Alterations, in this regard, can include the failure to provide required and reasonable safeguards, maintenance or inspections.)

1/ See in this regard the recent opinion of the California Supreme Court in Becker v. IRM Corp., 38 Cal.3d 454, 698 P.2d 116 (1985), extending strict product liability to landlords.

- Manufacturers should not be liable for defects which have been the subject of an adequate warning or which are readily apparent to the reasonable consumer. Manufacturers should only be required to warn with regard to uses of a product that are both reasonable and foreseeable.

- Manufacturers should only be held to the state of the art in existence at the time of manufacture of the product. Manufacturers should not be held liable for unknown or unknowable hazards.

The above elements, if applied in a principled manner, should ensure that strict product liability will serve to compensate persons injured as a result of a manufacturer's fault, while preventing that liability doctrine from simply being used as a risk spreading mechanism designed to operate as a product-based insurance scheme.

Recommendation No. 2: Base causation findings on credible scientific and medical evidence and opinions.

One of the most pernicious developments in tort law has been the extent to which causation findings are based on fringe scientific or medical opinions well outside the mainstream of accepted scientific or medical beliefs. Increasingly, juries are asked to make difficult decisions about highly complicated issues of science and medicine. Unfortunately, the personality and demeanor of expert witnesses often may be more critical in making such determinations than decades of evolving scientific and medical investigation and thought.

This problem has resulted in the growing perception that the tort system often is wholly arbitrary in allocating liability in cases involving difficult issues of science and medicine. This is a particularly problematic situation in toxic tort and drug liability cases. 2/

There are a variety of reasons for this problem:

- Many judges do not have the training or inclination to understand complicated scientific and medical concepts, and are unwilling or unable to devote the time and energy needed to educate themselves in a complex body of knowledge.

- In order not to deprive plaintiffs of their opportunity for compensation, many courts allow plaintiffs to take

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2/ For example, see the discussion of Johnson v. American Cyanamid Co., infra.

whatever scientific or medical views they may have -- however incredible -- to the jury.

- Many in the legal system do not appreciate how credible scientific and medical views develop, and the degree to which legal decisionmaking is a poor vehicle for developing such views.

- There often is an understandable frustration with the fact that science and medicine frequently cannot offer the kind of certainty that the legal decisionmaking mechanisms strive to obtain.

The inability of the tort system to deal credibly with complicated scientific and medical issues strikes at the very heart of the ability of tort law to deal with the growing number of cases involving highly complicated scientific and medical issues. While there are no easy answers, there are several remedial actions that the Working Group recommends:

- Greater deference must be paid to government agencies and certain private institutions that have devoted decades of attention and millions of dollars to researching and trying to assess the value of medical and scientific developments. Where such agencies and institutions have determined that particular products, services or techniques are safe or socially beneficial, courts should tread very carefully in overruling those judgments through the vehicle of tort law. Lay juries are a very poor mechanism for second-guessing the judgment of established mainstream scientific and medical views. Other legal mechanisms for determining those views, such as rulemaking and licensing proceedings, generally are far superior in making credible determinations involving complicated issues of science and medicine.

- Courts must be more aggressive in determining the credibility of scientific and medical evidence and opinions before trial, and not simply allow parties to present any theory to the jury. Appellate courts, in turn, should give trial courts greater latitude in making such decisions in early stages of litigation. Judges, where feasible, should receive training on basic methods of scientific, medical and statistical analysis so that they can make such determinations. If necessary, impartial masters with appropriate training should be used for this purpose.

- Studies and opinions that have not been subjected to the peer review process should be presumed invalid. Where peer review has taken place, judges (or masters, where appropriate) should acquaint themselves with the results of such review.

- Courts must learn to accept the reality of uncertainty. They must understand that the fact that some degree of uncertainty always exists does not mean that every scientific or medical belief is as credible as the next. Judges and legislators must not try to "force" scientific certainty where such certainty simply is not possible. Attempts to do so through burden-shifting, presumptions or by requiring agencies to issue scientific "findings," simply create a misleading and deceptive gloss of scientific certainty that in fact does not exist. 3/ Ultimately, the legal system must accept the fact that some things are unknown, and, given existing methods and data, perhaps unknowable for the foreseeable future.

Recommendation No. 3: Eliminate joint and several liability.

One of the most troubling problems in tort law arises from injuries caused by multiple tortfeasors. Historically, such cases were handled by bringing separate actions against each defendant; joint and several liability only existed where concert-of-action was shown (see discussion in Chapter 2). Further, under the doctrine of contributory negligence, a negligent plaintiff could not recover damages from any defendant. Such an approach seemed harsh where plaintiffs were only minimally at fault for their own injuries. Eventually, and in part to remedy the harshness of the old rule, the doctrines of comparative fault and joint and several liability were developed to make it easier for plaintiffs to obtain compensation.

Comparative fault operates to assure that each party, including the plaintiff, is liable for its own fault. Joint and several liability, although originally applied to situations where concert-of-action was shown, is now in many cases applied to all defendants, regardless of their connection to the injury. Comparative fault, when coupled with the doctrine of joint and several liability, allows plaintiffs to recover the entire judgment from "deep pocket" defendants -- even if such defendants are only found to be minimally at fault. Joint and several liability thus frequently operates in a highly inequitable manner -- sometimes making defendants with only a small or even de minimis percentage of fault liable for 100% of plaintiff's damage. Accordingly, joint and several liability in the absence of concerted action has led to the inclusion of many "deep pocket" defendants such as governments, larger corporations, and insured entities whose involvement is only tangential and who probably would not be joined except for the existence of joint and several liability.

3/ As noted, the Working Group does not believe that scientific uncertainty can be handled simply by requiring government agencies to issue pronouncements of risk or causation for which there in fact is no credible basis.

Another problem area is the relationship of joint and several liability to "enterprise" or "market share" liability. See Sindell v. Abbott Laboratories, 26 Cal.3d 588, 607 P.2d 924, cert. denied, 449 U.S. 912 (1980). In theory, "market share" liability such as that established in the California Supreme Court's seminal opinion in Sindell attempts to allocate liability for a generic product (e.g., DES) among various producers on the basis of their share of the relevant market. Even assuming such an allocation is reasonable, 4/ some jurisdictions have devised variations of or alternative approaches to Sindell which apply joint and several liability among the producers of a generic product. 5/ See, e.g., Abel v. Eli Lilly & Co., 418 Mich. 311, 343 N.W.2d 164, cert. denied, 105 S.Ct. 123 (1984); Collins v. Eli Lilly Co., 116 Wis.2d 166, 342 N.W.2d 37 (1984). 6/ The difficulties plaintiffs face in attempting to show which manufacturer of a generic product was responsible for plaintiff's injury in fact can be (but are not always) substantial. While the Working Group does not advocate one approach over another, it firmly believes that any allocation of liability on the basis of market share should limit a manufacturer's liability to its specific share, and that such liability should not, in the absence of actual concerted action, be joint and several in nature.

The Working Group thus recommends elimination of joint and several liability, except in the limited circumstances where the plaintiff can demonstrate that the defendants have actually acted in concert to cause plaintiff's injury. 7/

4/ Because of a number of problems and inequities associated with Sindell, only a few states have embraced the position of the California Supreme Court. See Schwartz & Mahshigian, "Failure to Identify the Defendant in Tort Law: Towards a Legislative Solution," 73 Calif. L. Rev. 941 (1985).

5/ It is unclear whether even Sindell is a true "market share" allocation decision, since under Sindell plaintiff must only sue manufacturers representing a substantial share of the market, and may allocate all liability among those defendants in proportion to their respective market shares.

6/ Particularly disturbing are decisions such as Abel which appear to distort the principles of concerted action to impute concerted action to manufacturers of a generic product.

7/ Joint and several liability as discussed in this report should not be confused with the legislatively enacted schemes for allocating financial responsibility for the cost of cleanup of hazardous waste sites and spills under the Nation's environmental laws, and, in particular, under the Superfund Act

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Recommendation No. 4: Limit non-economic damages to a fair and reasonable amount.

Non-economic damages such as pain and suffering, mental anguish and punitive damages are inherently open-ended. 8/ They are entirely subjective, and often defy quantification. For example, in many instances it simply is not possible, no matter how much money is awarded, to compensate someone fully for the pain and anguish of the loss of a loved one or from a serious injury. Moreover, because such damages are essentially subjective, awards for similar injuries can vary immensely from case to case, leading to highly inequitable, lottery-like results. Accordingly, such damages are particularly suitable for a specific limitation.

The open-ended nature of such damages makes them a particular problem from the standpoint of achieving predictability. Unlike economic damages (medical expenses, lost earnings, etc.), which can be reviewed objectively and thus can be predicted within a given range, non-economic damages are entirely subjective and unpredictable.

Non-economic damages also can serve as a significant obstacle in the settlement process. Plaintiffs and defendants often can

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7/ (FOOTNOTE CONTINUED)

(the Comprehensive, Environmental Response, Compensation and Liability Act of 1980) and the Resource Conservation and Recovery Act (RCRA). Unlike the tort system, which is intended to compensate injured persons and to deter wrongful conduct (see Chapter 2), Superfund and RCRA represent a legislative choice to allocate the cost of these programs among those who contributed to the problems the programs are designed to remedy. Thus, Superfund and RCRA liability, like the liability established under other environmental laws, are founded upon congressional objectives which provide that those who contributed to the problem or profited from the manufacture which created the waste, ought to bear the cost of cleaning it up. Those whose specific contribution to the site can be identified and severed from the whole are not jointly liable under this scheme. Without some degree of joint and several liability under Superfund and RCRA, the effective enforcement of these programs could be seriously impeded as a result of protracted and costly litigation among responsible parties over the precise allocation of cleanup costs.

8/ There are two types of non-economic damages: compensatory (pain and suffering, mental anguish, etc.) and punitive (sometimes called exemplary damages). The latter are designed purely to punish the defendant.

agree quickly on the amount of economic damages, but disagree sharply on non-economic damages. Plaintiffs frequently have unrealistic expectations of non-economic damages in the hundreds of thousands or millions of dollars to which defendants simply are unwilling to agree. Plaintiffs thus often reject settlement offers that from the standpoint of compensation for economic damages are quite reasonable. Plaintiffs' attorneys also often see high non-economic damage awards as necessary to justify high contingency fees, which may lead them to press for a high non-economic damage award when it may be in their clients' interest to obtain a quick and fair settlement.

Nevertheless, plaintiffs should be entitled to reasonable compensation for their pain and suffering and mental anguish. The key in this regard is to provide such compensation, but to ensure that it will be kept within reasonable bounds.

The Working Group believes that $100,000 would be such a reasonable limitation. In this regard, it should be noted that only a handful of claims involve non-economic damages in excess of $100,000. For example, it is estimated that only 2.7% of all medical malpractice claims (5.6% of all paid medical malpractice claims) receive non-economic compensation in excess of $100,000. 9/ However, in those medical malpractice cases going to verdict where non-economic damages above $100,000 are awarded, the non-economic damages award averages between $428,000 and $738,000 (the latter figure being the "best estimate"). 10/ For such awards including non-economic damages in excess of $100,000, on the average 80% of the total award is for the non-economic damages component of the award. 11/ Since the non-economic damages in excess of $100,000 awarded in these cases (including verdicts and settlements) account for between 28% and 50% of all paid out medical malpractice damages, the non-

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9/ H. Manne, Medical Malpractice Policy Guidebook 132-48 (1985). In comparison, approximately half of all claims that end in a jury verdict in favor of plaintiff include a non-economic damages award in excess of $100,000. Id. This suggests that non-economic damages are a major factor in forcing claims to trial.

As discussed in Chapter 2, the Guidebook was prepared for the Florida Medical Association. Henry Manne served as the general editor, and the analysis on the effect of a $100,000 cap was prepared by Patricia Danzon -- "perhaps the most widely known and published economist in the country on the subject of medical malpractice." Id., at 10.

10/ Id.

11/ Id. In this regard, it is worth noting that non-economic damages as a percentage of overall damages increases substantially as the overall damages increase. Id., at 138-39. See discussion in Chapter 2.

economic damages payments in excess of $100,000 alone account for up to half of all medical malpractice damages. 12/ Thus, a $100,000 limitation on non-economic damage awards would affect only a relatively small percentage of all claims, but would introduce substantial predictability into the tort system. 13/

It also is necessary to deal with punitive damages. While some thought was given to an absolute ban on punitive damages, or perhaps a separate limitation, the Working Group concluded that the best approach would be to include punitive damages within the $100,000 limitation on all non-economic damages. Nevertheless, punitive damages should only be awarded for willful conduct bordering on a criminal violation. Specifically, the Working Group recommends that an award of punitive damages be predicated on a demonstration of actual malice.

Even if these recommendations are adopted, punitive damages at best have a tenuous basis in tort law. Increasingly, there has been growing skepticism among legal scholars about the role of punitive damages, 14/ and numerous instances of extraordinary

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12/ Id. The best estimate of the Guidebook is that pain and suffering awards above $100,000 account for nearly 39% of all medical malpractice damages.

13/ Some states have struck down such limitations on constitutional grounds, primarily on the basis of equal protection, on the theory that it is unfair to limit the recoveries of certain plaintiffs (e.g., medical malpractice claimants) while allowing other plaintiffs to receive unlimited recoveries. Recently, however, both the California Supreme Court and the Court of Appeals for the Ninth Circuit upheld such a limitation for medical malpractice verdicts awarded under California law. See Fein v. Permanente Medical Group, 38 Cal.3d 137, 695 P.2d 665 (1985); Hoffman v. United States, 767 F.2d 1431 (9th Cir. 1985). The Supreme Court refused to hear either case, finding with regard to the former that no substantial federal question was presented. Constitutional concerns such as this, however, can only be sensibly considered in the context of specific legal proposals.

14/ See, e.g., Owen, "Problems in Assessing Punitive Damages Against Manufacturers of Defective Products," 49 U. Chi. L. Rev. 1 (1982); Seltzer, "Punitive Damages in Mass Tort Litigation: Addressing the Problems of Fairness, Efficiency and Control," 52 Fordham L. Rev. 37 (1983); Sugarman, "Doing Away With Tort Law," 73 Calif. L. Rev. 555 (1985); Schwartz, "Deterrence and Punishment in the Common Law of Punitive Damages: A Comment," 56 S. Cal. L. Rev. 133 (1982); Ellis, "Fairness and Efficiency in the Law of Punitive Damages," 56 S. Cal. L. Rev. 1 (1982).

abuses. 15/ Punitive damages add considerable uncertainty, and frequently have very little real deterrent effect because they are awarded years after the offending conduct. In any event, the punishment of misconduct is primarily a function of the public law enforcement system, and should not be a common purpose of private litigation.

Nevertheless, the Working Group does not recommend prohibiting punitive damages in tort cases provided they are included within the limitation on non-economic damages. If this is infeasible, the Working Group recommends that punitive damages be abolished. 16/

Recommendation No. 5: Provide for periodic payments of future economic damages.

Traditionally, a losing defendant is required to pay all of plaintiff's future damages in one lump-sum payment. When damages were within reasonable limits, this generally was not a major problem. But as average damages have skyrocketed into the hundreds of thousands of dollars this has become an increasing burden on the defendant (or defendants' insurers). The Working Group, therefore, recommends that future economic damages be paid periodically. 17/

Allowing defendants to pay for plaintiff's damages periodically has several advantages. First, it gives defendants the ability in some cases to digest major adverse judgments by spacing

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15/ One of the most flagrant examples is the $8 million dollar punitive damage award against the defendant in Johnson v. American Cyanamid Co., (District Court No. 81 C 2470), for its decision to produce the Sabin rather than the Salk polio vaccine. Despite the fact that the defendant had complied in this decision with the well established medical judgment of the United States government and virtually the entire medical community, the jury apparently decided to use punitive damages to overrule this judgment and to force the Sabin vaccine off the market. Ironically, the Sabin vaccine has proven far more effective than the Salk vaccine in combating polio. The case presently is on appeal to the Kansas Supreme Court, and the federal government has filed an amicus brief urging reversal.

16/ It frequently is noted that the deterrent effect of punitive damages could be achieved through a system of civil fines.

17/ Where there is legitimate concern that a particular defendant may not be able to make the periodic payments in future years the court should be empowered to require the defendant to ensure the periodic payment through the purchase of an annuity.

payments out over time, much in the same way that many consumers can afford major purchases by buying on installment. Second, society is benefited by the fact that plaintiffs have a guaranteed stream of income, and cannot deplete their awards within a few years. This sharply reduces the possibility that severely injured plaintiffs eventually will become wards of the state.

An important additional advantage of requiring courts to award damages in terms of periodic payments rather than lump-sum awards is that it uses the market's rather than a court's assessment of the applicable interest rate. Under the existing practice in most states, the trial court determines plaintiff's economic loss over plaintiff's lifetime, and then awards plaintiff the present value of those losses in a lump sum. The interest rate used to make that present value calculation is critical, and can significantly reduce or inflate the lump-sum payment. Frequently, courts in making that calculation use interest rates that bear no reasonable relationship to what in fact is available in the market.

A periodic payment requirement effectively avoids this problem by having the court determine the stream of future economic losses and require defendant to purchase an annuity providing a corresponding stream of compensation (where defendant is sufficiently large, an actual annuity probably would be unnecessary). Under such a procedure, the market determines the appropriate interest rate for calculating the present value of those payments (the present value would equal the cost of the annuity). Since the payments are guaranteed through the annuity, subsequent changes in the interest rate would have no effect on plaintiff's compensation. Defendant, on the other hand, would have the market rather than a judge or jury determine the correct interest rate for assessing the present value of future damages.

Periodic payments, as noted, are not unfair to plaintiffs because the payments would be scheduled to be made as the damages are in fact incurred (that is, as earnings are actually lost, or as certain expenses actually occur).

Because the benefits of such a provision would be relatively limited for smaller awards, the Working Group recommends that periodic payments only be required where the total economic damages award exceeds $100,000.

Recommendation No. 6: Reduce awards by collateral sources of compensation for the same injury.

The collateral source rule prohibits the finder of fact from taking collateral sources of income related to the same injury into account in making an award of damages to the plaintiff. This effectively permits the plaintiff to obtain double recovery of certain components of his damages award.

In an era when collateral sources of income were financed largely by plaintiff himself, the collateral source rule may have been sensible. Today, however, when many collateral sources are provided or subsidized by the government or by third parties (such as employers, who often are required by law to provide certain collateral benefits), the traditional justification is called into question. Increasingly, the collateral source rule simply permits a windfall recovery by the plaintiff.

As to publicly provided collateral sources of compensation, there is no justification for not taking such sources into account in determining plaintiff's ultimate damages. The collateral source rule in such circumstances has the effect of requiring citizens to pay compensation twice -- once as taxpayer, and once as the consumer of the product causing the injury. 18/

The situation is somewhat more complicated in dealing with private sources of collateral compensation, particularly where subrogation is involved. 19/ Where a third party (such as an insurer) is subrogated to plaintiff's claim, the collateral source rule may not in fact result in any double recovery. As a practical matter, however, subrogation often is not a significant consideration in many tort actions. In some areas, such as automobile accidents, subrogation is quite common. In other areas, however, such as medical malpractice, subrogation is far less common.

As to private sources, the best approach appears to be to require collateral sources of compensation related to the same injury to be taken into account as long as a third party is not subrogated to that portion of plaintiff's claim. Further analysis may suggest that elimination of subrogation (that is, simply offsetting all collateral sources against the award, and prohibiting subrogation arrangements) may have a limited effect and be justified on the basis of significant reductions in transaction costs.

While the correct approach to workers' compensation benefits must be considered very carefully, workers should be required to seek their workers' compensation benefits where appropriate. The Working Group takes no position on whether subrogation and indemnification actions between employers and manufacturers

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18/ Another reason to be concerned about such a windfall is that much of the windfall is in fact a windfall for attorneys in the form of attorneys' fees.

19/ In the context of insurance, subrogation allows the insurer to obtain from the tortfeasor-defendant all or part of its payments to the insured-plaintiff arising from the injury caused by the tortfeasor.

found liable as third party defendants should be eliminated, as has been proposed in some legislation. The Working Group will continue to review the merits of proposals dealing with such subrogation and indemnification actions.

Recommendation No. 7: Schedule contingency fees.

Currently, plaintiffs' attorneys receive a flat percentage of their clients' awards, usually between 30% and 40%, but sometimes as high as 50%. Where plaintiff's award is moderate, such a contingency fee may, in fact, be quite reasonable, since the attorney has significant costs and may face substantial risks that must be reimbursed. But as the average plaintiff's verdict has increased in recent years, such a high percentage becomes difficult to justify. Increasingly, there are indications of extraordinary abuses where attorneys receive fees in the hundreds of thousands of dollars for limited work. Particularly in mass liability cases where the groundwork for liability has been laid in previous cases by other attorneys, the fees often bear no relationship whatsoever to the work of or the risk to plaintiff's attorney. 20/

Nevertheless, the Working Group does not recommend, as some have suggested, the abolition of contingency fees. Often, such fees are the only means available to the poor to afford an attorney and obtain access to the legal system. The problem with contingency fees emerges when awards become very high, and a flat contingency rate becomes excessive. The Working Group, therefore, believes that contingency fees should be scheduled to decrease as awards increase.

Specifically, the Working Group recommends the following schedule: 25% for the first $100,000, 20% for the next $100,000, 15% for the next $100,000, and 10% for the remainder. Thus, for an award of $500,000, plaintiff's attorney would receive $80,000 rather than $166,666 (assuming a one-third contingency fee), and for an award of $1,000,000, would receive $130,000 rather than $333,333.

There are a number of justifications for scheduling contingency fees:

- Verdicts often are inflated by judges and juries to compensate plaintiff for what is well understood to be high attorneys' fees. Defendants thus pay for such fees through higher insurance premiums or awards,

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20/ As discussed in Chapter 2, the prevailing plaintiff is not only liable to his attorney for the agreed to contingency fee, but also for litigation expenses. Such expenses often can amount to an additional five to eight percent of the underlying award.

which, in turn, are passed on to consumers through higher prices. It is difficult to justify placing such a burden on American consumers for the purpose of paying what often amounts to exorbitant attorneys' fees.

- Similarly, in order to compensate plaintiffs for very high contingency fees, settlements often are higher than otherwise would be the case. As with high awards, these payments ultimately are passed through to the consumer. More problematic; however, is that attorneys' fees often can become a major impediment to settlements since defendants may balk at paying a higher than justified award in order to compensate plaintiffs for exorbitant attorneys' fees. In such situations, attorneys' fees create an additional burden by causing cases not to be settled that otherwise would be settled.

- Contingency fees also distort the incentives of attorneys. Such fees may lead plaintiffs' attorneys to hold out for high non-economic damages (and, potentially, windfall profits for the attorney requiring only minimal additional work on the attorney's part), while the clients may be best served with obtaining economic damages and more limited non-economic damages as promptly as possible.

- Scheduling contingency fees also should substantially reduce the excessive transaction costs presently plaguing the tort system. This is particularly important in such areas as the asbestos litigations where there are only limited resources available to compensate a large pool of plaintiffs.

In this regard, it is worth noting that the Federal Tort Claims Act contains a 25% cap on attorneys' fees for lawsuits filed under the Act, and a 20% cap on attorneys' fees for settlements obtained under the Act's administrative claims process. 28 U.S.C. § 2678. Violations of these limitations are punishable by fine or imprisonment, or both. A similar 25% attorneys' fee cap (with similar sanctions) is found in the Social Security Act. 42 U.S.C. § 406. None of these caps appears to have had any significant effect on the ability of persons suing the government to obtain adequate legal representation. In fact, the number of lawsuits filed under both the Federal Tort Claims Act and the Social Security Act has increased substantially in recent years.

The Working Group has considered and recommends against the adoption of the English Rule on attorneys' fees, which would transfer attorneys' fees to the losing party. While such a rule might deter some frivolous litigation, it also would inhibit many lawsuits that may be merited but where some preliminary discovery may be necessary to determine the strength of plaintiff's claims. Moreover, because many plaintiffs essentially are judgment proof, the widely held belief that such

a rule would significantly deter frivolous litigation may be largely illusory.

A preferable (but still problematic) alternative approach to the English Rule would be to use a transfer of attorneys' fees as a means of motivating parties to settle their claims at an earlier point in litigation. Thus, a rule modeled on Rule 68 of the Federal Rules of Civil Procedure, 21/ but including attorneys' fees, might be useful. Perhaps the most promising approach would be to combine alternative dispute resolution with a transfer of attorneys' fees.

Recommendation No. 8: Develop alternative dispute resolution mechanisms.

The Working Group believes that alternative dispute resolution holds much promise. Experimentation and experience, however, is the only reliable vehicle for determining which systems will work. Alternative dispute resolution proposals range from binding arbitration to mediation, and include such procedural innovations as mini-trials and expedited discovery techniques. Many of these proposals are worthy of serious consideration, and states represent excellent laboratories in which to develop and explore these various alternative dispute resolution proposals.

The Working Group strongly supports alternative dispute resolution, and believes that the organized bars, legislatures, and jurists should be more receptive to alternative dispute resolution proposals. Where necessary, particularly in areas such as medical malpractice, states should be encouraged to consider seriously the necessary constitutional changes to permit the use of alternative dispute resolution.

The Working Group believes that the most promising use of alternative dispute resolution will be to encourage the early settlement of lawsuits. For example, requiring non-binding arbitration where part or all of attorneys' fees shift to the party which rejects an arbitration award and obtains a less favorable result in litigation, much as costs of litigation are shifted for rejected offers of settlement under Federal Rule of Civil Procedure 68 (see supra), might be an effective means

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21/ Rule 68 ("Offer of Judgment") provides that costs of litigation will shift to a plaintiff who has rejected an Offer of Settlement made under the rule and not obtained a judgment more favorable than the rejected offer. There currently is a proposal under consideration to include attorneys' fees in Rule 68, as well as to make other changes to the Rule. Inclusion of attorneys' fees in Rule 68, however, has a number of serious problems that must be considered very carefully. These and other problems have led the Department of Justice to caution against the proposed changes to Rule 68.

for using alternative dispute resolution to facilitate and expedite early settlements.

The Working Group does not believe, however, that alternative dispute resolution needs to or should involve major changes to the standards of liability or causation in tort law. The merits of alternative dispute resolution are largely unrelated to which standard of liability is used in resolving disputes. The value of alternative dispute resolution lies in procedural rather than substantive changes in the law.

CHAPTER 5

GOVERNMENT INSURANCE: A NON-SOLUTION

The growing liability insurance availability/affordability crisis has spawned calls for government insurance or indemnification for persons or companies unable to obtain adequate insurance coverage through the private sector. For the reasons discussed below, such government insurance or indemnification would be highly undesirable and would do nothing to remedy the problems underlying the availability/affordability crisis.

The most serious deficiency with the various schemes for government insurance or indemnification is, as noted, the fact that such proposals do not address the problems that have led to the availability/affordability crisis. Instead, these schemes simply would pass the costs of the crisis directly to the taxpayer. While it is difficult to estimate the potential cost of such a program to the American taxpayer, it should be noted that the insurance industry suffered an estimated $25 billion underwriting loss in 1985 (see Chapter 2). This loss does not include self-insurance or captive insurer losses, which in all likelihood represent additional billions of dollars.

A government insurance or indemnification program would by definition certainly involve the riskiest activities; that is, those activities that even the insurance industry is unwilling to underwrite. To the extent that the government attempts to address affordability problems by offering coverage more cheaply than the industry, the government, of course, simply would be subsidizing certain purchasers of insurance. Again, the cost of such subsidization is difficult to estimate, but considering that the insurance industry paid out over $126 billion in 1985, with related expenses of $37 billion (see Chapter 2), such a subsidy easily could involve tens of billions of dollars annually. 1/ (Again, these figures do not include self-insurance or captive insurers).

Government insurance or indemnification would not only pass these costs to the taxpayer, but could exacerbate the current problems of the tort system. One of the few constraints left in tort law is the recognition that "deep pockets" are not after

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1/ For example, over recent years the National Flood Insurance Fund has been subsidizing flood insurance by roughly $150 million annually. The cumulative loss for the program to date is approximately $1.4 billion. The President, in his latest budget submission, reiterated his intention to continue to phase out this costly subsidy. The riot insurance program, which existed from 1968 to 1984, was able to sustain itself through collected premiums. The relative success of the program, however, was largely due to the decline in urban riots after the program was instituted.

all bottomless -- that there is a finite amount of resources that can be reallocated through tort liability. Government indemnification or insurance would remove that last restraint, since the resources of the Federal Government are all too often viewed as without limit. Thus, courts and juries might be even more willing to skew liability and causation standards to ensure compensation, and to award the most generous compensation conceivable.

There are, however, a number of compelling reasons for rejecting the concept of government insurance or indemnification other than because of its potential cost and the failure to address the real problems underlying the crisis. Perhaps foremost among those reasons is that such a program would most likely jeopardize among the most effective and important mechanisms currently existing in the private sector to protect public health and safety. The insurance industry plays a vital role in promoting public health and safety by policing insureds to ensure that risks of injury are minimized. Insureds who fail to minimize such risks, or who experience higher than normal claim rates, may find the desired level of insurance coverage more difficult to obtain and more expensive. The insurance industry thus plays an important role in creating incentives that protect public health and safety, both in policing insureds, and in passing the benefits of safety back to the insureds through lower premiums.

While the role of insurance in promoting public health and safety is by no means perfect, and the above description admittedly is somewhat idealized, insurance creates important health and safety incentives which cannot be dismissed lightly. This critical function of insurance is undermined to the extent that the government supplants the private sector in providing insurance or indemnification, particularly for high risk activities. The government, even if and when it demonstrates the best of intentions, simply does not have the resources, experience, flexibility or incentives to replicate the activities of the private sector in policing insureds' practices and setting premiums to reflect claims experience. In addition, were the government to undertake such activities, the existing health and safety bureaucracies almost certainly would prove inadequate. Substantial additional funds, personnel and resources would need to be devoted to these activities, and in many areas new bureaucratic structures would need to be established. 2/ If, as seems likely, such additional investments of government resources are not made, government insurance or indemnification would operate as a clear disincentive to greater safety since insureds would receive

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2/ The necessary collection and analysis of relevant information would of itself be a major undertaking requiring substantial investment of additional government resources.

the benefit of a risk transfer to the government (and, accordingly, would have less incentive to protect public health and safety) without any corresponding checks upon their conduct or activities. Both the consumer and the taxpayer would be the ultimate losers.

To the extent that the government institutes an insurance or indemnification program, such a program also would increase significantly in two ways the involvement of the government in the private sector. First, while the government, as noted, cannot replicate the efforts of the insurance industry, it would have to become involved in the activities it has insured or indemnified to ensure that such insurance or indemnification does not lead to completely open-ended liability on the part of the government. This necessarily would involve new additional forms of government supervision and regulation of private sector activities.

A second undesirable but inevitable effect of such a program would be that the government frequently would be forced to manage, or at least actively oversee, the litigation of cases involving the liability of its insureds, since the insureds often would have only a limited incentive to contest aggressively claims, however meritless, against which they are fully insured or indemnified. Even putting aside the consideration of the massive investment of litigation resources that would be needed by both the insuring agencies and the Department of Justice, this could involve the government directly and actively in some of the most controversial and visible tort litigation in our society, much of which would involve litigation in state court under substantive, procedural and evidentiary rules of state law.

An additional consideration is that such a program necessarily would involve the federal government in state regulation of the insurance industry since such regulation could have a significant impact on the kind of insurance or indemnification the federal government would have to provide. For example, state regulators who might wish to avoid approving politically unpopular rate increases or policy provisions might be far more inclined to withhold such approvals if they perceived the federal government as ready and willing to provide an alternative source of insurance. The federal government, in turn, in order to avoid such wholesale transfers of the insurance burden, could very easily find itself compelled to regulate the insurance industry directly, or to regulate the state regulators. Either way, it would represent a substantial intrusion by the federal government into the regulation of the insurance industry.

Finally, a federal program of insurance or indemnification would interfere with and perhaps severely inhibit the ability of the market to devise new policies, insurance mechanisms, and specific contractual provisions to meet changing economic and

social conditions. Where the current services of the insurance industry prove inadequate or unacceptable, insurers and insureds have strong incentives to restructure those services so that the needs of the marketplace can be met (witness, for example, the current discussions over the introduction of claims-made policies and the inclusion of defense costs). Where government insurance or indemnification is available, however, insureds may be far more inclined to seek such insurance (particularly where it is subsidized, either intentionally or unintentionally) than to negotiate with insurers or invest considerable effort and resources shopping for better conditions. Insurers, in turn, who may feel themselves compelled to offer otherwise unattractive services to customers they wish to retain, may find a government insurance or indemnification program a convenient dumping grounds for the risks they would rather spin-off. 3/ The end result could very well be that the ability of the marketplace to respond to new conditions with innovative solutions could be severely chilled if the "safe harbor" of government insurance or indemnification were available to both the insureds and the insurers. 4/

In sum, government insurance or indemnification would be a highly undesirable and counterproductive response to the current availability/affordability crisis. It effectively would amount to the nationalization of a potentially large portion of one of the Nation's leading financial industries. And, given the history of past government involvement in the private sector, it is all too apparent that removing the federal government from the insurance industry once the purported justification for its presence had passed would be an arduous if not ultimately futile endeavor.

3/ Such risks most likely would include the type of long-latency, catastrophic risks endemic to toxic torts. As is apparent from the asbestos litigations, such insurance would expose the taxpayer to potentially massive liability. The problem of insurers spinning off certain types of business very likely would generate pressure for some form of federal regulation of such practices.

4/ It should be noted in this regard that the contractor indemnification provision which the Administration supports in the context of Superfund reauthorization is purely discretionary in nature, is limited to cleanups under the control of the Environmental Protection Agency, is linked to a critical limitation on liability (liability would be predicated only on negligence), and would be provided only because it will be extremely difficult, if not impossible, to keep this vital program in operation without such limited and closely regulated contractor indemnification (which presumably will include both limits and deductibles).

CONCLUSION

This report contains within it a number of observations, conclusions and recommendations. The most important of these, however, for the purposes of the Tort Policy Working Group, are what this report implies as to the appropriate response of the federal government to the current crisis in insurance availability and affordability. In this regard, the pertinent conclusions are straightforward and relatively apparent.

First, tort law appears to be a major cause of the insurance availability/affordability crisis.

Second, there are a number of beneficial reforms of tort law that the federal government can support and promote in sensible and appropriate ways.

Third, to the extent that other factors -- such as the recent large underwriting losses of the insurance industry -- underlie this crisis, there is little the federal government can or should do to remedy these problems. While the contribution of these economic factors seems clear, it is likely that these problems will work themselves out in the short-term as the insurance industry restores its desired level of profitability, and as other insurance industry developments (see Chapter 3) are implemented. It seems highly unlikely, however, that these changes will substantially alleviate the crisis, particularly the affordability aspect of the crisis, without substantial reforms of tort law.

Fourth, the Working Group found nothing to support the suggestion that this crisis could be remedied through federal regulation of the insurance industry or of state insurance regulators.

Fifth, while a federal insurance or indemnification program obviously could provide subsidized insurance where insurance is unavailable or unaffordable, for many reasons (see Chapter 5) such a program would be highly undesirable and ultimately counterproductive.

In sum, tort law appears to be a major cause of the insurance availability/affordability crisis which the federal government can and should address in a variety of sensible and appropriate ways. But significant, long-term reform cannot and should not come solely from the federal government. Ultimately, state governments and courts must address the current excesses of tort law. Their active participation is essential to finding workable solutions to the increasingly debilitating problems of tort law.

*U.S. GOVERNMENT PRINTING OFFICE: 1986-491-510:40094

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date : _____

REQUEST

Bill/Resolution No. : CSSB 377 (L&C)
Title : An Act Relating to Tort Reform

Sponsor : _____
Requestor : _____
Date of Request : _____

FISCAL DETAIL

Agency Affected : Alaska Court System
BRU : Trial Courts

Components : _____

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		80.7	80.7	80.7	80.7	80.7
TRAVEL		6.2	6.2	6.2	6.2	6.2
CONTRACTUAL		797.4	797.4	797.4	797.4	797.4
SUPPLIES		1.0	1.0	1.0	1.0	1.0
EQUIPMENT		6.7				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		892.0	885.3	885.3	885.3	885.3
CAPITAL						
REVENUE						

FUNDING : (Thousands of Dollars)

GENERAL FUND		892.0	885.3	885.3	885.3	885.3
FEDERAL FUNDS						
OTHER						
TOTAL		892.0	885.3	885.3	885.3	885.3

POSITIONS :

FULL-TIME		2	2	2	2	2
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

Prepared by : Karla Forsythe/Robert G. Fisher Phone : 264-8215
Division : Alaska Court System Date : 4/9/85

Approved by Commissioner : Arthur H. Snowden, II AHS II Date : 4/9/85
Agency : Alaska Court System

Distribution (by Agency preparing fiscal note) :
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

10/25/85

CSSB 377 (L & C) Fiscal Note Narrative

This legislation impacts the court system in two areas: expanded judicial workload and mandatory arbitration.

Expanded Judicial Workload

The presiding judge for the third judicial district anticipates that new procedures incorporated in this bill (such as hearings to determine whether defendants who have defaulted on periodic payments should be held in contempt and the amount of related damages which should be assessed) will increase the court's workload by 20% for each trial. This estimate also includes judge time expended on additional litigation which will result from attempts to transfer proportional liability to persons who have signed releases before trial, and litigation to resolve interpretation questions with the legislation. Also, more cases will go to trial because of diminished incentives to settle resulting from restrictions on the award of Civil Rule 82 Attorneys Fees.

It is anticipated that the increased workload could be handled statewide by funding the equivalent of a pro tem judge. Pro tem funding is less costly than funding new judge positions because salary and benefits for retired pro tem judges are significantly lower. Additionally, since these judges are not permanently assigned to one court location, normal space and staffing requirements are avoided.

The provisions of this legislation which establish new procedures for the court come into play only when a case goes to trial. According to figures provided by the Anchorage trial court, approximately 5% of the cases filed go to trial, resulting in 105 personal injury trials statewide.

It is estimated that a personal injury trial averages two weeks. The total number of personal injury trials multiplied by two weeks of a judge's time total 210 judge weeks.

The estimated 20% additional judicial workload attributable to these expanded proceedings totals 42 judge weeks. Since a standard judicial work year averages 40 work weeks (excluding holidays, vacation and training), it is estimated that one judge would be required to process the additional statewide workload.

In order to avoid duplicative hearings, the court system favors binding arbitration rather than the option of de novo court trials. In the event that this legislation is not amended to provide for binding arbitration, the court system assumes for purposes of this fiscal note that the court would be required to bear the cost of arbitrators for those parties who are unable to afford this expense. It is estimated that 1341 personal injury cases statewide would be subject to the mandatory arbitration provision because they fall under $100,000. It is assumed that a third of the parties will not be able to afford the expenses of arbitrators. Thus, the court system will be required to bear these expenses in 443 cases.

Assuming an arbitration lasting 12 hours and an estimated average hourly compensation rate for the arbitrator of $150, the cost of an arbitration totals $1,800. The estimated total cost of an arbitrator for all cases under $100,000 is $797,400. Additionally, the court system assumes that for parties in outlying rural areas who are unable to afford the costs of arbitrators, it will be less costly to fly these persons to central urban areas rather than to fly arbitrators to the outlying areas and pay for their room and board. The additional air fare and per diem costs total $6,155. Based on these assumptions, the total costs of mandatory arbitration is $803,555.

ALASKA COURT SYSTEM

CSSB 377 (L & C) - TORT REFORM

FISCAL IMPACT

Personnel:

	Salary	Benefits	Total
Pro Tem, Superior Court Judge (PFT, using fully-vested retired judge) (See Schedule #2)	$19,332	$26,779	$46,111
In-Court Clerk (PFT, 12B)	25,740	8,863	34,603
Total Personnel			80,714
Travel costs for indigent bush parties in mandatory arbitration cases. (See Schedule #3)			6,155
Contractual cost of arbitrators for indigent parties in mandatory arbitration cases. (See Schedule #3)			797,400
Supplies			1,000
Equipment: (one-time items)			
New employee equipment - office furniture and reference materials			6,759
Total FY 87 Cost			$892,028

Schedule 2

ALASKA COURT SYSTEM

ESTIMATION OF JUDICIAL RESOURCES
NEEDED TO PROCESS INCREASED WORKLOAD

CSSB 377 (L & C) - TORT REFORM

	Anchorage	Rest of State	Total
Number of civil damage cases (a)	1,458	638	2,096
Estimated percentage of cases going to trial	5%	5%	5%
Estimated number of trials	73	32	105
Estimated length of trial in weeks	2	2	2
Estimated judicial time in weeks	146	64	210
Estimated workload increase from legislation	20%	20%	20%
Estimated additional judicial workload in weeks	29	13	42
Estimated average number of work-weeks in judicial year (b)	40	40	40
Estimated number of judges needed to process additional workload	0.73	0.33	1.05

Notes:

(a) Based on FY 85 case filings. All civil damage case filings assumed to be personal injury cases.

(b) Estimated number of work-weeks, net of holidays, vacation and training.

Schedule #3

ALASKA COURT SYSTEM

ESTIMATED FISCAL IMPACT OF MANDATORY ARBITRATION

SSB 377 (L & C) - TORT REFORM

	Anchorage	Rest of State	Total
Number of civil damage cases (a)	1,458	638	2,096
Estimated percentage of cases under $100,000	64%	64%	64%
Estimated number of cases under $100,000	933	408	1,341
Estimated percentage of indigent parties	33%	33%	33%
Estimated number of cases involving indigent parties	308	135	443
Estimated average length of arbitration hearing in hours	12	12	12
Estimate average hourly rate of arbitrator	$150	$150	$150
Estimated average cost of each case	$1,800	$1,800	$1,800
Estimated total cost of arbitrators	$554,400	$243,000	$797,400
Estimated travel cost for indigent parties living in bush areas. (See Schedule #4)	$0	$6,155	$6,155
Estimated total cost of mandatory arbitration	$554,400	$249,155	$803,555

Notes:

(a) Based on FY 85 case filings. All civil damage case filings assumed to be personal injury cases.

Schedule #4

ALASKA COURT SYSTEM

ESTIMATED TRAVEL COSTS FOR INDIGENT BUSH PARTIES

CSSB 377 (L & C) - TORT REFORM

Bush Courts	Number of Case Filings	Percent Under $100,000	Number of Cases Under $100,000	Percent Indigent Defendants	Number of Indigent Cases	Air Fare to Nearest Urban Court (a)	Estimated Air Fare Cost	Estimated Per Diem Cost (b)	Estimated Total Travel Cost
Barrow	5	64%	3	33%	1	$500	$500	$315	$815
Bethel	30	64%	19	33%	6	302	1,812	1,680	3,492
Kotzebue	5	64%	3	33%	1	426	426	280	706
Nome	6	64%	4	33%	1	426	426	280	706
Valdez	6	64%	4	33%	1	156	156	280	436
								Total Cost	$6,155

Notes:

(a) Bush courts served by urban courts:

Barrow served by Fairbanks
Bethel served by Anchorage
Kotzebue served by Anchorage
Nome served by Anchorage
Valdez served by Anchorage

(b) Estimated to require three and one half days of per diem.

HB 532 file

Martin Shaner, M.D., P.C.
P.O. Box 74401
Fairbanks, AK 99707
907-451-7792

March 12, 1986

Senator Patrick Rodey
Alaska State Legislature
Pouch V (MS 3100)
Juneau, AK 99811

Dear Senator Rodey:

I am writing you to urge you to lobby for the Coalition Bill for Tort Reform, HB 532.

As an anesthesiologist, my insurance premiums are already high. Without tort reform to limit malpractice settlements these premiums will only continue to escalate. The resultant increase in my operating costs will have to be reflected in an increase in billing costs to the patient. The patient is the one who ultimately loses.

I want to be able to continue to deliver good patient care at a reasonable cost to the patient. Whether or not HB 532 passes will have a great effect on the cost factor. I therefore, urge you to work to pass HB 532 during this session.

Sincerely,

Martin Shaner M.D.

Martin Shaner, M.D.

lk

SB 377 file

MedAlaska

DIMOND • 5340 RAINY PLACE • ANCHORAGE, AK 99502 • (907) 349-9611
RASPBERRY • 3901 RASPBERRY • ANCHORAGE, AK 99502 • (907) 248-0808

Sen Patrick Rodey

Alaska State Legislation
Box V.
Juneau, Alaska 99801

Dr. Peter Powers
2718 Lord Baranof
Anch, Alaska 99517

Dear Sen Rodey:

I am writing in regards to legislation affecting Tort reform in Alaska. I am one of your concerned constituents.

I am a Medical Doctor and face tremendous increases in my medical malpractice insurance. The current projections are that my coverage will increase in cost in the range of 50% each year for the next 3-5 years, but nobody really knows. These very high insurance rates have prevented me from doing any Obstetrics work this past year, and threatens to make a lot of my colleagues stop doing Obstetrics also. I don't know how women in Anchorage are going to be able to find someone to deliver their babies.

I feel this issue is at a crisis stage and demands all of our attention.

I urge you to support H.B.532 and S.B.377. I strongly support these attempts at Tort reform and the Citizens Coalition for Tort reform.

Respectfully and Earnestly,

Peter Powers MD

Peter Powers M.D.

ALASKA STATE LEGISLATURE
SENATE JUDICIARY COMMITTEE

SENATOR PATRICK RODEY, CHAIRMAN
SENATOR TIM KELLY, VICE-CHAIR
SENATOR JAN FAIRS
SENATOR RICK HALFORD
SENATOR ROBERT ZIEGLER, SR.

POUCH V
JUNEAU, ALASKA 99811
(907) 465-3717

March 2, 1986

Mr. Charles G. Estes
C.G. Estes Co.
4015 Borland Drive
Anchorage, Alaska 99517

Dear Mr. Estes:

Thank you for your letter expressing your concern about the ever increasing cost of insurance. Tort reform has become one of the major issues facing this legislature. The Senate Judiciary Committee which I chair will be one of the more important committee referrals for the tort reform legislation which is now wending its way through the legislature.

In preparation for dealing with this issue, we have done a great deal of research, and listened to several nationally prominent experts on the subject. It is my hope that we can at least begin to find some satisfactory solutions to this dilemma by the end of this legislative session.

Thank you for your interest and your concern. I can appreciate that tort reform is an issue which effects all of our lives, and will do my best to alleviate some of the burden.

Very truly yours,

Patrick M. Rodey

Tort Reform:

A Comprehensive Solution To The Crisis in Civil Justice and Insurance

The Citizens Coalition for Tort Reform
738 H Street, Suite 100
Anchorage, Alaska 99501

Civil Justice: Unnecessarily Inefficient and Costly

A tort is literally a wrong. Tort actions seek to redress wrongs in a court of law. A close look at how the tort reparations system works in 1986 reveals that it's not working. The system is mired in inefficiency, punctuated with greed and demonstrably unable to deal with the great bulk of its caseload in a timely and fair manner.

It often takes three to five years to settle a case. Only 30 to 40 per cent of the costs of reaching a settlement go to victims, and that does not include costs of the court system.

The economic costs to society are staggering and difficult to precisely quantify. It is clear that the hefty increases in insurance rates affect the price of nearly every product or service we purchase. *It is a tax—a tax imposed by default, without full political and social evaluation of its impact.*

A society that can send men to the moon ought to be able to settle liability claims in a more effective way. Most other western countries do.

The Comprehensive Solution

The tort reparations system needs a thorough overhaul. Alaska can no longer afford the luxury of having its courts administer a giant lottery where a victim may win a fortune, but more likely will find the pot at the end of the rainbow empty.

Alaska and other states have been dabbling in tort reform for ten or 15 years and there is adequate evidence major changes in the tort reparations system are essential. The fundamental goal of tort reform is to restore predictability to the tort system.

All manner of solutions to the insurance crisis have been proposed including tighter regulation of insurance companies, state-backed insurance funds and reform of the tort system. More regulation may be useful and a state-supported fund may provide temporary relief to some. However, *without stopping the flagrant abuses of the tort system, liability will continue to be a serious problem for business, government and consumers.*

The following proposals address the major faults of the tort system. They are intended to restructure the process to allow more efficient and effective dispute resolution. These reforms would get a higher proportion of damage payments into the hands of plaintiffs while protecting the rights of defendants and the public which ultimately pays the bills.

Joint and Several Liability

If more than one defendant is found partly responsible for an injury, each can be held "jointly and severally" liable for all damages. This means that if one defendant is unable to pay, the other defendants must pay the entire award. *Responsibility should be apportioned according to the degree of fault and each defendant's requirement to pay damages should reflect his share of responsibility for the injury.*

Noneconomic Awards

Noneconomic awards compensate a victim for intangible losses— loss of consortium, pain and suffering, traumatic experiences and other things for which no established economic value exists. *A limit on this kind of arbitrary award will help establish consistency and fairness in this no-man's land. We suggest a maximum award of $250,000 per incident. The U.S. Supreme Court has upheld such a law in another state.*

Structured Settlements

Damages awarded for predicted future losses should be computed at their present economic value. The injured party would have an option to accept lump-sum payment at present value or accept structured payments running over a period of years and equal to the total award. *This guarantees financial support and care for a long time, often for life.*

Collateral Income Sources

Insurance payments which have been made to an injured party should be disclosed to the jury and should be protected from recovery in the event the victim receives an award. *Under current rules, juries cannot be told about existing medical or other insurance coverage.* If the injured party receives an award, the insurance companies which have fulfilled their obligations may sue for repayment from the victim.

Sliding Contingency Fees

Plaintiff attorneys today can take upwards of 40 percent of a total award verdict. A sliding scale will increase the proportion of the award which actually goes into the victim's pocket as the size of the award increases. *Where the sliding scale is now in effect, lawyers still work on contingency fees, but victims recover a greater share of awards. The U.S. Supreme Court has upheld this principle.*

Itemized Jury Awards

Jury awards for damages should specify amounts for monetary losses, noneconomic losses, future losses, past expenses and other losses. *This will help to eliminate arbitrary awards based upon showmanship or prejudice and introduce an element of rationality in award construction.* An itemized award which is grossly unfair to either the victim or defendant can be more effectively appealed than a lump-sum award.

Rule 82

Rule 82 is unique to Alaska. It is a device to increase attorneys' fees above the agreed level by order of the court. The rule was originally adopted to apply in certain public interest lawsuits, but it has been extended to cover most liability suits. *It simply adds up to 10 percent to the cost of awards without serving the originally intended public purpose.*

Arbitration

Tort litigation is time consuming and expensive. Claims under $50,000 should be required to go to arbitration before being heard in Superior Court. Either party would be free to appeal the arbitration decision to the courts, however the results of the arbitration could be admitted in evidence at any subsequent trial. *Experience indicates that the effect would be to reduce the number of cases going to court, lower the costs of resolution and ultimately get more money into the hands of victims without great delays.*

Notice of Policy Cancellation

Individuals, businesses and professionals have been suddenly cut off from their insurance programs. *Companies should be required to give 60-day notice of changes in coverage.* This would avoid drastic disruptions in people's ability to earn a living.

Pre-judgment Interest

Interest is often paid on awards. It should accrue from the date an action is filed. Currently, interest accrues in many cases from the date of the occurrence—even if no claim is filed for years. *A defendent should not be required to pay interest covering that period of time when he may have had no knowledge of his liability.*

Wrongful Death Statute

Where there are no dependents, wrongful death monetary awards should be limited to $25,000. *A wrongful death is always unfortunate, but it is questionable public policy which permits—even encourages—distant relatives and lawyers to reap a windfall at the expense of other policy holders and the public.*

Punitive Damages

Punitive damages is the civil justice system's way of punishing defendants for conduct particularly offensive to society, therefore, punitive damages should be paid to the State of Alaska. *Society as a whole should share the benefits of punitive damages (which are rarely covered by insurance).*

Statute of Limitations

The current statutes of limitation must be clarified to make sure that lawsuits are brought within a reasonable time. Recent court decisions make it possible to file suits in the distant future, making risks totally unpredictable. The alternatives to a functional statute of limitation are insurance devices which effectively establish these limits without benefit of public policy considerations. *These devices (claims-made policies) can cause severely reduced public protection and even reduced availability of some goods and services.*

Frivolous Suits/Untrue Allegations

An Indiana woman purchased a box of Cracker Jacks. The usual prize was not in the box, so she filed suit against the manufacturer. Someone had to defend the suit, even if it was only to ask for dismissal. A responsible legal system should require that plaintiff attorneys certify that the facts have been reviewed and there is reasonable and meritorious cause for filing the action. This certification should be made in writing. *Rules have been adopted by the U.S. Supreme Court and ten states to curb these abuses of our court system.*

Full Disclosure

Essential data should be made available to state regulatory authorities on a quarterly or semi-annual basis, to allow proper regulation of regulated companies regarding reserves, premium rates, loss ratio, investment and other data so as to properly protect people of Alaska.

Comparative Negligence v. Contributory Negligence

When the claimant has contributed to the accident, his or her degree of fault should diminish the award proportionate to the degree. This would reduce damages where the claimant contributed to the mishap. As an example, in single car-auto accidents, cities have been successfully sued by the drivers for faulty road design or maintenance, even where the drivers have been proven to have been drinking or using drugs.

Who is the Citizens Coalition for Tort Reform?

The Citizens Coalition for Tort Reform is an organization composed of representatives from a broad cross section of Alaskan businesses and professions.

They include these companies, associations and agencies:

Alaska Air Carriers
Alaska Broadcasters Association
Alaska Chapter, American Institute of Architects (AIA)
Alaska Dental Society
Alaska General Contractors
Alaska Chapter, American Optometric Association
Alaska Movers Association
Alaska Oil Marketers Association
Alaska Rental Association
Alaska Section, Fairbanks Branch, American Society of Civil Engineers
Alaska Society of Professional Engineers
Alaska State Health Association (Hospitals)
Alaska State Medical Association
Alaska Support Industry Alliance
Alaska Truckers Association
Alaska Visitors Association
Anchorage Board of Realtors
Anchorage Restaurant and Beverage Association (ARBA)
Cabaret Hotel and Restaurant Retailers (CHAR)
Childbirth Educators
Daycare Operators Association
Fairbanks North Star Borough
Financial Managers
Hotel and Motel Association
Insurance Brokers and Agents Association
Nurse Midwives Association
Pension Consultants
Professional Physical Therapists Association
Risk Management Association
Southern Alaska Association of Life Underwriters

The Citizens Coalition for Tort Reform
738 H Street, Suite 100
Anchorage, Alaska
(907) 276-1135

C. G. ESTES CO.
4015 Borland Drive
Anchorage, Alaska 99517
(907) 243-6656

February 14, 1986

Pat Rodey
Alaska State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Rodey:

I am a small general construction contractor and have been in business in the Anchorage area for the past three years and have worked in construction in the State of Alaska for the past 20 years.

Insurance costs have been rising so rapidly that the required insurance is cost-prohibitive, if obtainable at all. My "umbrella" policy expired last month and when I tried to renew the insurance was told that my insurance company would no longer issue insurance in Alaska. I have contracts with the Municipality and federal government which require a million dollar "umbrella" policy and if I am unable to obtain this insurance I will be in violation of my contracts. These jobs were all bid in good faith as I had coverage at the time the jobs were bid and I did not anticipate any problem in renewing.

Apparently this problem has been brought about by the many liability lawsuits filed in Alaska and the skyrocketing amount of the awards. The Citizens Coalition for Tort Reform has come up with a comprehensive solution: legislation must address changes in the way liability issues are tried and decided, and inequities in the legal system's handling of liability lawsuits. Laws now undermine statistical probabilities which make insurance risks predictable and the present system of handling lawsuits is expensive and unfair.

This is an urgent matter. Unless there are drastic changes in the cost and availability of insurance, I will be unable to stay in business. Apparently many insurance companies have been forced out of business and those remaining are loaded and do not want to insure companies doing less than three million a year.

Anything you can do to effect legislation that will relieve this situation will be appreciated by all of us experiencing insurance problems in Alaska.

Sincerely,

C. G. ESTES CO.

Charles G. Estes

Alaska Legislative Digest

An Inside View of Alaska Policy

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Insurance Crisis a Reality, But . . .

INSURANCE OR TORT REFORM?

After intense hearings last week, the insurance crisis became a clear reality to House lawmakers, but the solution to that crisis is still a question between tort reform, insurance reform, or a combination of both. The House Labor and Commerce Committee held three meetings last week to begin their review of the many insurance bills currently before them. The first bill under consideration was HB-532, by Cotten, which encompasses all proposals put forth by the Citizens Coalition for Tort Reform. Cotten said he introduced the bill because insurance costs are rising and general liability insurance is becoming unavailable. Cotten also admitted that he didn't know if legislative action would reduce insure costs, or if anyone could promise that.

Ames Luce, a trial lawyer from Anchorage, believes the insurance crisis is a result of "the way the insurance companies have been conducting their business over the last seven to eight years." Luce told lawmakers that tort verdicts and settlements have kept fairly consistent with inflation over the last several years, but insurance premiums have not. In 1984 when interest rates began to fall, insurance companies finally raised their premiums to prevent extreme losses. Luce believes that if the companies had kept their premiums up with inflation, there wouldn't be a crisis today. (Continued on page eight)

Major FY '87 Budget Cuts?

The announcement by SOHIO of a $4.00 per barrel cut in the price of Prudhoe Bay oil, and continued drops in the spot market have convinced virtually everyone in Juneau that major cuts will be required in the budget proposed by Governor Sheffield in December. According to the Office of Management and Budget, the spot price for Alaska North Slope crude on the U.S. Gulf is now at $13.35, down $1.50 a barrel from a week ago. Analysts say every one dollar drop in the price cuts $150 million from state revenues.

Inside this week's Digest:

**NEW SCHOOL FUNDING BILLS: Last week five new school funding proposals were introduced. Most of the bills are a variation of the Governor's measure. (See story page 2)

**ALASKA MINERS SPEAK OUT: Alaska miners told the Senate Resources Committee last week that state government shares responsibility in the "locking up" of vast tracts of Alaska lands from mineral exploration. (See story page 3)

**AHFC MOBILE HOME LOANS: Lawmakers have introduced legislation in reaction to AHFC's decision to double the down payment requirement for mobile homes. (See story page six)

**SEVERANCE TAX CHANGES CONSIDERED: Oil company analysts in Anchorage say the new ELF formula won't decrease taxes on new fields as much as claimed, and would increase taxes on two out of three marginal North Slope fields now producing. (See story page 7)

. . . Local Government . . .

School Funding Bills In

Last week, five new school funding proposals were introduced, but observers believe no final action will be taken on a school funding plan until the amount of funding available for school financing is determined. The Governor finally introduced the Dept. of Education bill, but surprised many by putting it in on the House side. Most of the bills introduced are a variation of the Governor's bill, HB-604, with the exception of the bills introduced by Sen. Ferguson (SB-408) and Rep. Taylor (HB-637).

SB-408, by Sen. Ferguson, would return school funding to an ADM (average daily membership) formula from 1978. Funding would be based on a weighted instructional unit as opposed to a weighted student in the DOE proposal. Taylor's bill is also based on the ADM formula, but differs from Ferguson's bill by counting PL 874 funds as local wealth in calculating a district's needed range of funding. HB-637 also sets up a special account for handicap assessment.

The Fahrenkamp, Koponen bills come from a proposal offered by the Fairbanks Borough and school district. The bills call for a 3.5 mill local contribution as opposed to the 2 mill in the DOE bill, and would take into consideration local communities that have a contribution larger than 3.5 mills in determining how much gain they could receive in FY 87 under the new formula.

HB-575, by Larson, also calls for a 3.5 mill local contribution. There is no "hold harmless" provision under this measure, meaning there are no caps set for maximum gains or losses. The DOE bill allows a maximum gain and loss of five percent. The bill also sets up an emergency account, to be funded by interest from the Public School Fund.

All the school funding measures, including SB-345 introduced earlier, have referrals to HESS and Finance. The House HESS committee hearings will begin hearings on the House bills March 4.

Municipal and School Insurance "Pooling"

Municipalities, school districts, and REAA's would be able to form insurance pools under a bill before the House Labor and Commerce Committee last week. Sponsor substitute for HB-506 would also put the state in the reinsurance business by establishing an Alaska Reinsurance Fund to aid companies in Alaska who are unable now to obtain insurance due to availability or price. Many believe a bill such as this would solve the problems of insurance availability and price in Alaska, ending the need for tort changes. Labor and Commerce members heard an initial overview of the bill, however, no action was taken. Rep. Kay Wallis has introduced similar legislation, HB-585, which relates only to school districts. Both bills have been referred to the House Special Loans, Judiciary and Finance Committees.

From The Backrooms . . .

ON THE CAMPAIGN TRAIL: Former Gov. Wally Hickel has reportedly been talking with California's campaign media whiz Clint Riley. Riley has been San Francisco Mayor Diane Feinstein's media expert. What's strange about the rumor is that Riley usually works only for Democrats.

IN OTHER DEVELOPMENTS: GOP candidate Arliss Sturgulewski has made a July 28th - August 7th TV time buy. What's unusual is that she didn't buy the last week before the primary. The buy, however, has attracted the immediate attention of GOP candidates Bob Richards and Joe Hayes, who are hurrying to match it. Apparently Sturgulewski is viewed as the candidate to watch by the rest of the GOP field. It seems that their strategy is not to let Sturgulewski have any unopposed media blitzes. Watch for intermittent media blitzes.

COWPER'S MEDIA ADVISOR: Former Alaskan and Egan press secretary Joe Rothstein, now a national media consultant, will be the media advisor for the Cowper campaign. Reportedly the Cowper media package, however, will be produced locally.

Miners: State "Locking Up" Alaska Lands

Usually, federal agencies are blamed for "locking up" vast tracts of Alaska lands from mineral exploration. But according to Alaska miners, state government also shares responsibility. That was the message to Alaska miners gave Senate Resources Committee members in Anchorage last week during a mining "overview" session. The Alaska Miners' Association expressed particular concern, amoung other things, over "soft closures" of 11.1 million acres of upland terrain with potential mineralization, and another 908,500 acres where exploration has been explicitly closed by DNR mineral orders that may be in violation of the law. These figures do not include 3 million acres set aside in state parks and recreation areas and another 1.8 million acres in state game refuges, critical habitat areas and game sanctuaries, also closed to exploration. Without a land-base for exploration, mining can never grow from its current $250 million annual economic contribution to a potential $1 billion within the near-term the miners said.

Nine hundred thousand acres are affected by mineral closing orders may violate a statute requiring legislative approval of closures greater than 640 acres. "These closures are being made because of an interpretation of multiple-use which we believe is contrary to the intent of the Alaska constitution that most lands should be available for development," said Chuck Hawley of Hawley Resources, speaking for the Association on this point. "Instead of accepting this broad mandate and managing to allow potentially conflicting uses to sometimes occur, DNR is defining multiple-use as narrowly as possible in order to allow it to close lands wihout going back to the legislature for concurrence."

State's Land Plans Result in "Soft Closure"

A big block of lands - 11.1 million acres - are open to exploration in theory, but have primary uses designated as wildlife habitat or recreation, Hawley said. Most of this (9 million acres) is in the Bristol Bay Management Area, and another 2.1 million acres is in the Nelchina Public Use Area.

Much of this "soft closure" has been done as a part of state land planning efforts done under AS 38.04.065, but, "we seriously question whether the amount or direction of planning conforms to other guidelines of this section, which first of all advise the commissioner to 'use and observe the principles of multiple-use and sustained yield' and 'give priority to planning and classification in areas of potential settlement and potential envronmental concern.' We believe the entire section does not suggest that the state have a massive planning staff and start to immediately plan and zone all the remaining parts of Alaska, but this is what has happened," Hawley said.

Should Alaska Intervene in Sierra Club vs. BLM?

Other points made by the association: (1) A plea for state intervention in the recently-filed Sierra Club vs. BLM, a case similar to that filed against the National Park Service last year that shut down mining in parks and wildlife refuges. By affecting BLM-managed lands, this suit could shut down most placer mining in the state; (2) State agency near-term effort should be applied toward development of mining practice and technology aimed at reaching environmental standards rather than on punitive enforcement of strict water-quality standards; (3) State government's problem is one of attitudes at lower to mid-level within agencies, rather than lack of supportive policy guidance from on top. In inter-agency planning, large manpower resources within ADF&G overwhelm more limited staff in other agencies. Result: An anti-development 'tilt' to state agency land management.

. . . Status Of Bills . . .

Key House Bills Introduced

--HCR-49, AHFC Reqs. Mobile Home Loans,
(by Pourchot).....to HSL & FIN
--HCR-65, Foreign Marketing Pink Salmon
(by Herrmann).....to RES & L&C & FIN
--HJR-66, Fed. Tax Imported Oil,
(by Pignalberi).....to O&G & FIN
--HB-575, State Support Education,
(by Larson).....to HESS & FIN
--HB-578, Fish/Game Res. Man. Regions,
(by Wallis).....to RES & FIN
--HB-579, Financing Fish Processors,
(by Herrmann).....to HSL & RES & FIN
--HB-581, [illegible] Cooperative Corp. Act.,
(by Koponen).....to L&C & JUD
--HB-582, Mult. Convictions/Veh. Theft,
(by Koponen).....to JUD
--HB-584, State Contracts/Products/Serv
(by Pignalberi).....to SA & FIN
--HB-585, School Dist/Joint Insurance,
(by Wallis).....to L&C & JUD & FIN
--HB-587, Mun. Land Entitlements,
(by Adams).....to CRA & FIN
--HB-588, Grant North Slope Borough,
(by Adams).....to CRA & FIN
--HB-589, State Group Life/Health Ins.
(by Sund).....to L&C & JUD & FIN
--HB-591, Prostitution,
(by Jenkins).....to JUD & FIN
--HB-595, Gambling in Municipalities,
(by Marrou).....to CRA & JUD & FIN
--HB-596, Fishermen's Liens,
(by Marrou).....to HSF & JUD
--HB-604, School Funding Formula,
(by Governor).....to HESS & FIN
--HB-605, Shuyak State Game Refuge,
(by Thompson).....to RES & FIN
--HB-609, Increasing Alcohol Tax,
(by Clocksin).....to SA & FIN
--HB-610, Power Eminent Domain/Muni.
(by Clocksin by Req).....to CRA & JUD
--HB-611, Air Carriers,
(by Cato).....to TRANS & FIN
--HB-612, Leases Land Ak. Railroad Corp.
(by Davis).....to L&C & TRANS & FIN
--HB-613, Ak. Minerals Commission,
(by Frank).....to RES & FIN
--HB-616, Discrimination/Residency,
(by Koponen).....to SA & FIN
--HB-617, Business Trusts,
(by Koponen).....to L&C & JUD & FIN
--HB-618, Enforce. Comm. Mot. Veh. Laws
(by Davis).....to L&C & SA & TRANS

House Bills Introduced (Cont'd)

--HB-619, Scholarship Loan Program,
(by Herrmann).....to HSL & HESS & FIN
--HB-620, Reg. Certain Dealerships,
(by Pignalberi).....to L&C & JUD & FIN
--HB-622, Int. Rates/Delinquent Taxes,
(by Pignalberi).....to JUD & FIN
--HB-629, Geographic Pay Differentials,
(by Governor).....to SA & JUD & FIN
--HB-630, Suspended Imposition Sentence,
(by Governor).....to JUD
--HB-633, Ak. Export Dev. Authority,
(by Martin).....to L&C & FIN
--HB-635, Willow Creek State Rec. Area,
(by Larson).....to RES & FIN
--HB-637, State Support Education,
(by Taylor).....to HESS & FIN
--HB-638, Emerg. Water/Sewer Assess/Loan
(by Boucher).....to HSL & FIN
--HB-641, Generic Drugs/Bd. Pharmacy,
(by Gruenberg).....to L&C & HESS & FIN
--HB-643, Corporations,
(by Gruenberg by Req).....to L&C & JUD
--HB-644, Arrest/Surety/Remission Bail,
(by Gruenberg).....to JUD & FIN
--HB-645, Prevailing Wage/Pub. Const.
(by Herrmann).....to SA & JUD & FIN
--HB-647, Mun. Rep/Ins. Hazardous Waste
(by Hurley).....to CRA & SA
--HB-648, Leasing Limited Entry Permits,
(by Herrmann).....to HSF & RES
--HB-650, Ak. Transportation Comm,
(by Pignalberi).....to TRANS & L&C & FIN
--HB-652, Limited Entry Permit Brokers,
(by Herrmann).....to RES & FIN
--HB-653, Penalties Work-Safety Laws,
(by Koponen).....to SA & JUD & FIN
--HB-656, Amt. Bonded Indebt/Munis.
(by Marrou by Req)....to CRA & HSL & FIN
--HB-657, Worker's Compensation,
(by Koponen).....to L&C & JUD & FIN
--HB-659, Reg. Alcoholic Beverages,
(by Binkley).....to SA & JUD & FIN
--HB-662, Down Payment Reqs. Mobile Home
(by Collins).....to HSL & FIN
--HB-663, Foreclosures Liens Munis.,
(by Furnace).....to CRA & JUD
--HB-665, Reg. Cable Television Service,
(by Taylor).....to L&C & FIN
--HB-666, Coastal Management,
(by Herrmann by Req)...to SA & RES & FIN
--HB-668, Scholarship Loans,
(by Koponen).....to HSL & HESS & FIN

. . . Status Of Bills . . .

House Bills Introduced (Cont'd)

--HB-669, State Support Education,
(by Koponen).....to HESS & FIN
--HB-670, Int. Airports/Anch. Fairbanks
(by Hanley).....to HSL & TRANS & FIN
--HB-671, Approp. Study Airport Man.,
(by Hanley).....to HSL & TRANS & FIN
--HB-672, Notice of Hazardous Waste,
(by Koponen).....to SA & RES
--HB-673, Transp. Haz. Sub. Munis,
(by Koponen).....to SA & RES
--HB-676, Classification Study,
(by Governor).....to SA & FIN
--HB-677, Seldovia Nat. Assoc. Land Exc.
(by Marrou).....to RES & FIN
--HB-678, General Relief Asst. Program,
(by Governor).....to HESS & JUD & FIN
--HB-679, Purchase Ak. Products,
(by Governor).....to SA & JUD & FIN
--HB-681, Unemployment Insurance,
(by Governor).....to L&C & JUD & FIN
--HB-683, Commercial Fishing Vessel Reg.
(by Herrmann).....to HSF & RES & JUD
--HB-685, Patronizing a Prostitution,
(by Jenkins).....to JUD & FIN
--HB-688, Tax Credits/Cont. Ed. Inst,
(by Gruenberg).....to HESS & FIN
--HB-689, Motor Vehicles,
(by Cotten).....to TRANS & JUD & FIN
--HB-490, Commercial Fishing Viol. Fines
(by Herrmann).....to HSF & RES & JUD

Key House Committee Action

--HB-277, Fish Processor/Buyers,
RES "DO PASS".....to FIN
--HB-345, Dram Shop,
SA "MIX REC".....to JUD
--HB-503, Games of Chance,
L&C "DO PASS".....to JUD
--HB-534, Violent Crimes Compensation,
SA "DO PASS".....to JUD

Key House Floor Action

--HB-63, Plumbing Code,
HOUSE PASSED.....to SENATE
--HB-530, Special Mortg. Loan Program,
HOUSE PASSED.....to SENATE

Key Senate Bills Introduced

--SJR-39, Rt. Citizen Bear Arms,
(by Rodey).....to JUD

Senate Bills Introduced (Cont'd)

--SJR-41, Am. Const. Approp. Limit,
(by Faiks).....to JUD & FIN
--SB-403, Adv. Vote State Income Tax,
(by Zharoff).....to JUD & FIN
--SB-405, Loans/Ak. Grain Res. Program,
(by Coghill).....to RES & FIN
--SB-407, Approp. North Slope Borough,
(by Ferguson).....to CRA & FIN
--SB-408, State Aid Education,
(by Ferguson).....to HESS & FIN
--SB-410, Fin. Shore-based Fish. Proc.,
(by Zharoff).....to RES & FIN
--SB-412, Claims Against the State,
(by Faiks).....to SA & JUD
--SB-413, Illegally Controlled Ent.
(by Rodey).....to JUD & FIN
--SB-414, Municipal Land Entitlements,
(by Ferguson).....to CRA & FIN
--SB-415, School Board Composition,
(by Ferguson).....to HESS
--SB-416, Warranties Used Motor Vehs.,
(by Josephson).....to TRANS & JUD
--SB-417, Approp. Payoff GO Bonds,
(by Fahrenkamp).....to FIN
--SB-418, Ak. Minerals Commission,
(by Bennett).....to RES & FIN
--SB-421, Attach. Permanent Fund Div.,
(by P. Fischer).....to JUD & FIN
--SB-422, Prospecting for Coal,
(by Bennett by Req).....to RES
--SB-423, Missing Persons Info.,
(by Faiks).....to SA & JUD
--SB-426, Tele/Elect. Utilities/APUC,
(by Coghill).....to L&C
--SB-427, Homesite/Ag. Land,
(by Coghill).....to RES & FIN
--SB-429, Regs/Small Bus/Organ/Gov.,
(by Fahrenkamp).....to L&C & JUD
--SB-430, Reduce Royalty/Coop. Unit Plan
(by Fahrenkamp).....to RES & FIN
--SB-431, Preference State Residents,
(by Bennett).....to L&C & JUD & FIN
--SB-433, State Support Education,
(by Fahrenkamp).....to HESS & JUD

Key Senate Committee Action

--SB-344, Number of Sup. Court Judges,
JUD "MIX REC".....to FIN
--SB-350, Ad. Vote Perm. Fund Dividend,
SA "MIX REC".....to FIN
--SB-374, State Toll Facilities,
TRANS "DO PASS".....to FIN

. . . Business . . .

Subcontractor, Supplier Payment

Overbuilding in the Anchorage area coupled with a general slowdown in Alaska's construction industry has led to payment problems for construction suppliers and subcontractors. HB-494, by Rep. Cotten, would require bankers to pay suppliers and subcontractors for their services when foreclosing on a builder or contractor. The measure is not popular in the banking community because it increases their lending risks and may lead to decreased loan availability for small construction firms. Subcontractors and suppliers claim that the proposal is necessary to guarantee that they receive payment for their services. The bill has L&C and JUD referrals.

$1 Billion into the Permanent Fund?

Many were accusing the Senate of playing politics last week when they voted to deposit the Undistributed Income Account (UDI), almost one billion dollars, into the corpus of the Permanent Fund. The Senate made that move when they passed HB-28 and SB-346. The bills deposit the entire billion dollar UIA into the Fund and also delete the current five year averaging used to determine monies available for distribution. The House majority doesn't appear favorable to the change in averaging, and many believe it will increase dividends in the short run but decrease contributions to the Fund over the long haul. Some question whether the Senate made this move to justify expenditure of all the recent 'windfall' monies.

Tax Increase on Alcohol

State taxes on alcoholic beverages would be increased under HB-609, by Rep. Clocksin. Increased revenues would be used for alcohol abuse programs and to provide assistance for victims of alcohol abusers. The bill would raise the tax on beer from 35 cents/gal. to 64 cents/gal.; on wine from 85 cents/gal. to $1.56/gal.; and on beverages containing 21 percent or more alcohol from $5.60/gal. to $6.00/gal.

AHFC Bill Moving in Senate

**The Alaska Housing Finance Corp. (AHFC) refinancing bill, HB-530 by Rep. Duncan, was sent to the Senate last week. A hearing is scheduled for the bill in Senate Finance this Tuesday, February 25. Looks like the bill will move quickly to the Senate floor.

**Two measures were introduced last week in reaction to AHFC's decision to double the down payment requirement for mobile homes purchased with AHFC financing. AHFC believes that the increase is necessary to help curb the increasing default rate in mobile home loans. Some lawmakers, however, worry that the down payment hike will limit the home ownership opportunities for low and moderate income persons.

HCR-49, by Rep. Pourchot, would request that AHFC reconsider its decision to single out mobile homes for down payment increases. It is noted in the resolution that the default problem is not exclusive to mobile home owners and that any action taken should apply to all types of residences handled by the AHFC. The resolution has been referred to House Loans and Finance.

Similarly, a bill introduced by Rep. Collins would force the AHFC to reverse its decision to increase mobile home down payments. Under HB-662, down payments for AHFC financed mobile home purchases could be no higher than those required for other types of residences. The measure goes to House Loans, chaired by Rep. John Sund, and to the Finance Committee.

**Approval for $600 million in state guaranteed AHFC revenue bonds to purchase veteran's mortgages would be sought on the November ballot under HB-533. The measure, which was introduced by the Governor, passed out of House Loans last week and has also been referred to the Finance Committee.

**AHFC would be allowed to purchase refinancing loans through their Special Mortgage Loan Purchase Program under SB-438, by Sen. Rodey. The bill has a single Senate referral, to Finance.

. . . Resources . . .

Oil Tax Hearings in House

Several oil companies testified last week to House Finance regarding changes in the Economic Limit Factor (ELF) provision in the state's severance tax proposed in HB-545. According to Dept. of Revenue economist Chuck Logsdon, the proposed ELF change would raise the state an additional $156 million in revenue over the next two years. Taxes at Prudhoe Bay would rise under the proposed formula and oil company representatives say that will jeopardize investments aimed at increasing oil recovery. Logsdon said that the loss of recovery at Prudhoe between now and the year 2000 will be 22 million barrels, or the equivalent of about 15 days output at current production levels.

Sponsors hope that HB-545 will lower taxes on North Slope "marginal" fields while increasing tax on the larger Prudhoe Bay and Kuparuk fields. But oil company analysts in Anchorage, after studying the impact of the new ELF formula, say the bill wouldn't decrease taxes on new fields as much as claimed, and would slightly increase taxes on two out of the three marginal North Slope fields now producing. Company analyses show slight increases in overall taxes on Endicott and Lisburne, but a decrease for Milne Point, Conoco's new small field now producing 20,000 bpd. (Conoco has so far not expressed an opinion on the bill.) Taxes on Seal Island, a new discovery, would also increase under the bill, analyses indicates.

Industry findings are at variance with the analysis by the Office of Management and Budget which shows decreasing taxes on these fields. One reason for the variation industry people speculate, might be that OMB used lower assumptions for field production levels and higher estimates for the number of wells than will actually be the case. For example, OMB apparently assumed Endicott would produce 65,000 bpd, instead of the 100,000 bpd planned by the operator, Sohio. Assumptions for the number of wells at Endicott might also differ.

State, Chugach Make a Deal

After several months of negotiations, Commissioner of Natural Resources Esther Wunnicke and Chugach Electric Board Chair Dr. Joyce Murphy announced they had reached agreement on their Cook Inlet royalty gas valuation dispute, dependent upon passage of CSSB-309. The announcement was made at a Senate Resources Committee meeting last week. The legislation authorizes the Commissioner to value the state's royalty share of natural gas sold by the state's oil and gas lessees to instate nonprofit or government-owned utilities or cooperatives based upon the arms-length gas sales contract price.

Wunnicke told members that she was comfortable that the new language in the CS would give her the authority to recognize consumer concerns when determining value. Dr. Murphy urged quick action by the legislature because of ongoing litigation and their need to begin negotiations on future gas contracts. The bill was moved onto Finance.

Royalty Oil Contract Moving?

The Petro Star/Chevron royalty oil contract (HB-559) was well received by members of the House Oil and Gas Committee last week and should move from that Committee on Wednesday. Members questioned Petro Star President Steve Louis how he can offer a cheaper product than MAPCO Refining when the proposed Petro Star royalty contract is more expensive than the state's contract with MAPCO. Louis replied that his company markets products to end-users mostly in rural Alaska, rather than distributors, trying to eliminate the middle man. Committee members asked the Division of Oil and Gas to supply them with a comparison of the major features of the state's royalty oil contracts including the proposed Petro Star/Chevron contract.

**HB-470, creating an Oil and Hazardous Waste Response Fund has been sent to a Subcommittee of Finance chaired by Rep. Pourchot. A committee substitute will be worked on this week.

Insurance or Tort Reform (Continued)

(Continued from page one) Ames Luce called for insurance reform rather than tort reform, which would include: full financial disclosure by insurance companies; a state emergency insurance pool; a law precluding arbitrary cancellation without giving the policy holder adequate tiime to find a replacement policy; and establishment of a consumer advocate within the Division of Insurance.

Placing restrictions on the contingency fees of attorneys, another feature of the Cotten bill, was addressed by both the tort reform advocates and the trial attorney's, who say they are there on behalf of the victims. "The contingency fee is the key to the court house for those who are not wealthy," stated Bernard Kelly, an Anchorage attorney. Al Tamagni, Chair of the Coalition, told lawmakers that the Coalition believes larger percentages of awards should go to injured parties. Tort reform advocates also believe that lower attorney's fees will mean lower settlements and thus lower insurance costs. Luce told committee members that contingency fees have nothing to do with insurance premium costs, that attorney's fees from an economic award are not an "add on." Rep. Mike Navarre believes that if a cap is placed on contigency fees, "there will be no way for plaintiffs' attorneys to recover costs, and defense costs are built into insurance premiums." Luce called the bill a "massive takeaway of victim's rights," but Tamagni later countered that all parties are victims in this crisis.

All those involved appear to agree that current law relating to comparative negligence should be changed to apportion the damages between the respon-sible parties. The House Judiciary Committee heard HB-368 last week calling for adoption of the Uniform Comparative Fault Act. Many see this bill as the start of a compromise on the insurance issue. Juneau attorney Av Gross, representing the trial attorneys, told members his group does not support this bill now, but is willing to work to resolve their problems with the Committee. Another bill seen as a compromise is HB-506, by Taylor, aimed at increasing the availability of insurance by allowing municipalities and school districts to pool insurance and creating a state Reinsurance Fund, to provide insurance to those companies that cannot obtain it due to price or availability. The House Labor and Commerce Committee will continue hearings this week in Anchorage on February 24th and February 25th in Juneau.

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JACOBS GOES DEEPER INTO THE OIL PATCH

Despite the threat posed by plummeting oil and gas prices, Irwin L. Jacobs is pouring more money into two big and seemingly ill-timed plays in the oil patch. The Minneapolis investor, impatient with efforts by Pioneer Corp. President C. David Culver to restructure the Amarillo natural gas producer, says he will launch a tender offer for the 86% of Pioneer he does not yet control. Jacobs is offering $23 a share, or $655 million—well below the roughly $26 a share he paid for his initial stake in late 1984 but at least 10% above the current market for Pioneer's gas reserves. Those reserves are being reappraised, and Jacobs may be betting on a big upward revision. He also has boosted, to 15.4%, his stake in Tidewater Inc., which services offshore oil rigs. Jacobs paid $26 a share for his initial 5% stake in early 1984; Tidewater stock is trading now at below 10. Jacobs also holds 9% of HNG-InterNorth Inc., a gas pipeline.

CHEWING TOBACCO FACES AN AD BAN

The House of Representatives passed a bill that would bar radio and TV advertising for snuff and chewing tobacco. The measure, which the Senate is expected to approve, also would require makers of the products to place on packages such warning labels as "This product may cause mouth cancer." The measure also calls for the Health & Human Services Dept. to set up programs to educate the public about the dangers of smokeless tobacco.

'REAL MOMENTUM' FOR NORFOLK'S BID

The Senate approved, 54 to 39, Norfolk Southern Corp.'s proposal to buy the government's 85% stake in Consolidated Rail Corp. for $1.2 billion. The vote gives Transportation Secretary Elizabeth H. Dole, who favors the sale to Norfolk Southern, an expected victory in the battle over Conrail's fate. The Senate support, she said, will "send this to the House with some real momentum." But the sale faces greater opposition there. House Energy & Commerce Committee Chairman John D. Dingell (D-Mich.) promises to resolve the issue this year, but first he wants to examine documents from the Justice Dept.'s review of the deal and from all bidders for Conrail. Another key representative, James J. Florio (D-N. J.), said that all the bids for Conrail are "woefully deficient" and must be improved.

BEATRICE APPROVES A REVISED BUYOUT

Directors of Beatrice Cos. approved a modified buyout offer from Kohlberg Kravis Roberts & Co. The offer facilitates out-of-court settlements of more than a dozen shareholder suits challenging the compensation plans for Beatrice executives and the proposed takeover of the Chicago-based conglomerate. Kohlberg Kravis still will pay $40 in cash and $10 in preferred stock for each Beatrice common share under the new agreement, but the preferred's dividend will jump to 15.25% annually from the 14% announced in January. Golden parachutes for Beatrice's six top executives will be reduced from $23.5 million to $20.1 million. Beatrice also agreed to consider terminating the deal should the board receive a better offer.

MICROSOFT: CAPPING A SUCCESS STORY

William H. Gates III dropped out of Harvard in 1975 and started a company to write software programs for then-new microcomputers. Now his company, Microsoft Corp., in Bellevue, Wash., is going public. Chairman Gates, 30, the son of a prominent Seattle lawyer, will sell 80,000 shares, worth from $1.3 million to $1.5 million at the proposed offering price of $16 to $19 a share. That will leave him the owner of 44.9% of Microsoft shares with a worth of about $200 million. Co-founder Paul G. Allen, 33, will own 25.2% of Microsoft. It earned $17 million on revenues of $85 million in the first half, ended Dec. 31. Microsoft is trying to overtake Lotus Development Corp., which had $225 million in revenues last year, as the largest personal computer software company.



GATES: HOLDING A STAKE OF $200 MILLION IN MICROSOFT

UNDOING STEEL'S WAGE UNIFORMITY

The United Steelworkers opened negotiations on separate contracts with three of the nation's six major steelmakers. In exchange for early bargaining, LTV Steel, Bethlehem Steel, and National Steel agreed to join with the union in a campaign to persuade Washington to give major relief to the industry. The union also gave a special exemption to ailing LTV by allowing it to defer a wage and cost-of-living increase due on Feb. 1. Inland Steel and Armco are expected to join the union campaign, but U. S. Steel, the nation's largest and healthiest producer, has yet to set a date for early talks. The six producers are seeking concessionary pacts to replace contracts that expire on Aug. 1 and cover 145,000 workers. The negotiations are expected to result in the end of wage uniformity in the industry.

IBM WILL REBUILD UNITED AIR'S SYSTEM

United Airlines Inc. said the bulk of the $1 billion rebuilding of its Apollo reservations system will be spent on a computer network to be developed by International Business Machines Corp. The new system will improve the ability of travel agents to service large corporate accounts. It will also handle the internal business tasks of travel agencies, in effect providing an automated office for each. The system will use IBM hardware, communication networks, and software.

THREE INSURERS BOLSTER RESERVES

Three insurance companies admitted they underestimated future claims on property and casualty policies issued before 1985. Philadelphia-based Cigna Corp. charged $1.2 billion against fourth-quarter earnings to boost its property and casualty reserves by 28%. The charge, by far the largest taken by an insurer, will result in a 1985 operating loss of $853 million. After Wall Street reacted favorably—Cigna stock fell less than $1—Continental Corp., in New York, unveiled a $220 million charge against fourth-quarter earnings to bolster reserves. USF&G Corp., in Baltimore, followed with a $100 million charge against fourth-quarter earnings to prop up its reserves 23% to $3.2 billion. The charges reflect higher jury awards in liability suits, broader legal interpretations of policy coverage, and industrywide failure to set aside sufficient loss reserves. The industry is just now recovering from years of price competition and lower underwriting standards that also punished earnings. ▣

INSURANCE

BOTTOM-FISHING IN CARL LINDNER'S SWAMP

To most of its hapless creditors, customers, and equity holders, Mission Insurance Group Inc. is one big swamp. Its largest unit, Mission Insurance Co., is insolvent, under the conservatorship of California since Oct. 31, with no easy solution to its problems. Yet a couple of adventurous bottom-fishers have plunged into the muck—and hope to find a fortune there.

Martin J. Whitman, a specialist in securities of bankrupt companies who manages more than $200 million, is leading the expedition. He's drawn in Carl Marks & Co., a New York investment house that has dabbled in everything from venture capital to czarist bonds. Between them, the partners have acquired Mission notes and debentures worth only about $2 million—but enough, they believe, to get them in on a revival of Mission.

SIMPLE LOGIC. Whitman has also rallied some angry longstanding Mission bondholders with much more at stake. The biggest is Retirement Systems of Alabama, a $5 billion pension fund that holds $24 million worth of Mission bonds. Mission skipped two interest payments "without contacting anybody," complains David G. Bronner, the fund's chief executive.

The bondholders argue that as creditors they would be first in line in a Chapter 11 reorganization—something that everyone wants to avoid. But so far they aren't making much headway with Cincinnati financier Carl H. Lindner, whose American Financial Corp. owns 49.9% of Mission. Lindner's preliminary agreement with the California regulators provides for a restructuring of the debt that would reduce the bondholders' stake. Dozens of large and small reinsurance clients are also waiting in line with claims on Mission's assets.

For Whitman, a part-time finance teacher at Yale University who eschews suits for work, dressing "only well enough to get into the Yale Club for lunch," the logic is simple. He claims that he and the bondholder group, along with unidentified potential backers, are ready to inject millions of dollars in new equity into Mission and maybe even take the reins. In return, they want a chance to profit from the turnaround they say can be engineered. This is substantially what Lindner would like to work out—but to AFC's benefit instead.

A turnaround won't be easy. Mission, traditionally a well-regarded vendor of workers' compensation insurance, expanded pell-mell into reinsurance in the late 1970s and has since seen claims run three times as high as premiums. The company lost $198 million in 1984 and $65 million more in 1985's first nine months. But Whitman has high hopes for the workers' compensation business and firming rates in property-casualty lines. "This could be another Geico," he predicts in his gravelly voice. "If there's one chance in ten of that, it would be well worth our while." Geico, threatened with insolvency in the mid-1970s, made a splendid turnaround under new management. Since then, the insurer's stock has blossomed 40-fold.

Whitman's group may face deeper problems in Mission, however. There are all those reinsurers waiting to be paid. "I'd be very surprised if after all the claims emerge there's anything left for the bondholders," says David J. O'Leary, an analyst at Fox-Pitt Kelton Inc. At Mutual Shares Corp., an investment firm similar to Whitman's, partner Michael F. Price says he "wouldn't touch it with a 10-foot pole."

But Whitman's team has a different view. Since Mission's shareholder equity has evaporated—the shares were delisted last December by the New York Stock Exchange—the bondholders figure that they already "own" the company. That, they argue, should give them clout in structuring a reorganization. They've proposed a solution in which they'd put up cash and receive new equity and Lindner's group would continue running the company. But they say Lindner turned them down.

In January the Whitman group filed to push Mission's holding company into Chapter 11 proceedings. That would open the whole company for reorganization, although the fate of insurance assets would remain up to state regulators. Mission has not yet responded. But California Insurance Commissioner Bruce A. Bunner was shocked: "I thought the bondholders would be the least of our problems, but they could destroy everything."

LAST RESORT. After all, Bunner and American Financial had been hammering out their own restructuring agreement. Lindner, who injected $75 million in new capital into Mission last year, would contribute at least $125 million more to back up part of its policy-writing business. But Bunner says there's at least a $169 million gap between assets and liabilities.

The tangle of payments Mission owes dozens of reinsurance clients may put it even deeper in the hole. For weeks, executives at these companies have been meeting with Mission officials and Bunner to settle their claims, which run into the hundreds of millions. If a settlement isn't reached, Bunner will move to liquidate the unit under his conservatorship.

Whitman depicts Chapter 11 as a last resort. Lindner's AFC won't comment. In the meantime, Mission is said to be suffering defections by customers and brokers. "I don't think Mission as an entity is viable," says analyst O'Leary. He wonders if the bottom-fishers will come away with anything but debris.

By Elizabeth Ehrlich in New York, Zachary Schiller in Cleveland, and Teresa Carson in Los Angeles



FINANCIER WHITMAN BELIEVES MISSION "COULD BE ANOTHER GEICO"

ROB KRAMONTH

ALASKA STATE LEGISLATURE
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March 2, 1986

Ms. Renee Murray
605 W. 42nd
Anchorage, Alaska 99503

Dear Ms. Murray: Renee

Thank you for your note and the article on the increasing cost of insurance. Tort reform has become one of the major issues facing this legislature. The Senate Judiciary Committee which I chair will be one of the more importart committee referrals for the tort reform legislation which is now wending its way through the legislature.

In preparation for dealing with this issue, we have done a great deal of research, and listened to several nationally prominent experts on the subject. It is my hope that we can at least begin to find some satisfactory solutions to this dilemma by the end of this legislative session.

Thank you for your interest and your concern. I can appreciate that tort reform is an issue which effects all of our lives, and will do my best to alleviate some of the burden.

Very truly yours,

Pat

Patrick M. Rodey

LAW

SEARLE: STARING AT SOME LONG DAYS IN COURT

When G. D. Searle & Co. withdrew the Copper 7 and Tatum-T intrauterine contraceptive devices from sale in the U. S., it said the products were safe. The move, it said, was meant to curtail mounting litigation costs. But lawyers for plaintiffs who are suing Searle, claiming that the devices caused pelvic infection and infertility, see the company's Jan. 3 action as an acknowledgment that it is in for a long, tough series of legal battles.

Searle, a subsidiary of Monsanto Co., has been fighting 775 lawsuits, 305 of which it says are still pending. The company says it spent $1.5 million to defend itself in just four of these suits. Searle says it has won 8 of 10 trials and that more than 150 other cases have been dismissed. "The financial burden is not created by payments to the plaintiffs but by payments to lawyers," says Tod Hullin, a Searle vice-president.

And there are sure to be more suits filed. Plaintiffs' lawyers say they are reviewing hundreds of new claims. And Ira J. Bornstein, a lawyer who represents Monsanto shareholders who have filed suit charging that Searle failed to inform them of the suits, believes that by taking the IUDs off the market, Searle is "acknowledging that there is tremendous potential liability out there."

BARELY A RIPPLE. All sides are closely watching a similar but unrelated situation involving A. H. Robins Co.'s Dalkon Shield. Robins filed under Chapter 11 last August after it had won 27 cases and lost 33. A court-ordered advertising campaign aimed at potential plaintiffs has resulted in an avalanche of new claims—11 years after the Dalkon Shield was withdrawn from the market. Searle's withdrawal of its product from the U. S. (it is still sold overseas) means "we are on the Dalkon Shield track," says Patricia Jo Stone, one of the plaintiffs' trial lawyers.

Searle maintains there are important differences. Unlike the Dalkon Shield, Searle's Copper 7 and its labeling were approved by the Food & Drug Administration. Moreover, the FDA has recently investigated allegations that Searle suppressed adverse findings and deflated the incidence of pelvic inflammatory disease in its test results. The agency continues to stand behind the products. "We found that Searle had reported adverse findings in a timely fashion. In our judgment, Searle did not mislead FDA," says Susan M. Cruzan, an FDA spokeswoman.

Discontinuance of the products will hardly cause a ripple on Monsanto's income statement. Last year its IUD sales in the U. S. were $11 million, a tiny part of Monsanto's $6.75 billion in sales. Searle's move, however, practically extinguishes the nation's IUD industry. Since Robins took the Dalkon Shield off the market in 1974, others have followed, and Alza Corp. of Palo Alto, Calif., is the only U. S. company that still produces an IUD. But the decision to stop selling the devices has not put a stop to the controversy about them.

By Ellyn E. Spragins in Chicago and William B. Glaberson in New York

EXECUTIVE SUITE

GM'S SHUFFLE: THE CALM BEFORE A SLAUGHTER?

A predictable shift in top management? That's how General Motors Corp. characterized the raft of promotions it announced on Feb. 3. But insiders believe the appointments mean much more: a new phase in the broad reorganization GM began two years ago. Its ultimate goal is to trim white-collar employment in auto operations by at least 25% within 10 years.

Staff cuts are a logical result of the new structure GM outlined two years ago (BW—Jan. 23, 1984). That plan aimed to reduce the auto giant's reaction time to market changes by arranging its five car divisions—Chevrolet, Pontiac, Buick, Oldsmobile, and Cadillac—under two groups. Each group now performs most of the staff functions once spread out through the company.

But critics say GM has been slow to reduce its executive ranks even after streamlining operations. That, they figure, contributes significantly to GM's production costs, which analysts agree are higher than any other domestic auto maker. "There's no question you could slash the fat in the middle of GM," confides one executive. Another insider predicts the company will begin to attack its manpower glut within six months in a "massive restructuring" of executive jobs. "The change is going to bring pain, but it has to come," he says.

GM's goal is to match the management efficiency of Toyota Motor Corp., the industry leader in that category, by eventually eliminating at least 25% of the salaried jobs in its carmaking business. The changes announced this month do not reduce the number of top GM executives. But they do restructure responsibilities so the chairman and president can concentrate on policy decisions. The shuffle was triggered by the decision of Alexander A. Cunningham, 60, to retire for health reasons. The affable Cunningham had been a board member and executive vice-president in charge of North American passenger-car operations. He has resigned both positions.

'NEW DAY.' GM sources describe Cunningham's departure as a tremendous loss for the company. But it has also prompted GM to unleash a younger management team. "It's a new day, as far as I'm concerned," declares pleased board member H. Ross Perot. "These guys are so competitive, they can't live with themselves until they beat anybody in sight."

Cunningham's duties will be split between two new executive vice-presidents. Lloyd E. Reuss, 49, will manage all U. S. auto operations. Robert C. Stempel, 52, will run the company's truck and overseas operations. Reuss formerly headed GM's "small-car" unit, the Chevrolet-Pontiac-GM of Canada Group, while Stempel ran the "big-car" unit, the Buick-Oldsmobile-Cadillac Group. Both men also become directors.

Reuss and Stempel are regarded as leading contenders to replace F. James



REUSS AND STEMPEL: WITH A NEW TOP-LEVEL TEAM IN PLACE, PINK SLIPS MAY FLY

PHOTOGRAPHS BY PETER YATES

ALASKA STATE LEGISLATURE
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"Preferential treatment"

AAMGA president attacks agreement to "rescue" Mission

WASHINGTON, DC—The "rescue" of the Mission Insurance Company may well seal the fate of state regulation, according to Avrohm I. Wisenberg, president, American Association of Managing General Agents, in his monthly letter to the membership.

Commenting on the December 6 letter of agreement from Mission American Insurance Company to California Insurance Commissioner Bruce Bunner which sets forth the terms and conditions for the rehabilitation of the Mission Insurance Company, Wisenberg said the intricate maneuvers and switching of assets and liabilities contained in that agreement will only accomplish the transfer of loss to the Mission's reinsurance customers who are largely located outside of California. "The Mission did tremendous reinsurance business all over the United States," said Wisenberg, "based on a healthy rating, and the continued blessing of the California insurance department under which the company operated.

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The WEEK in A MINUTE

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California initiative

Deep pocket issue approved for vote in June election

SACRAMENTO—California Secretary of State March Fong Eu has qualified the "deep pocket" initiative for the June 3 primary election ballot.

Insurance and other organizations circulated petitions to put the controversial joint and several liability doctrine issue to a public vote after the assembly refused to approve a senate-passed bill providing some relief from huge judgments against only partially at fault defendants in tort cases.

According to the secretary of state valid signatures of voters were estimated at 462,071 from the more than 681,000 signatures turned in. The inititative needed 393,835 valid signatures of registered voters to qualify.

The "deep pocket" issue will be the only initiative proposal on the ballot in June, although there will be at least five proposed constitutional amendments submitted by the legislature.

Businesses, public agencies and professional associations are expected to join the insurance industry in the campaign to get the initiative proposal

(Continued on page 4)

INSURANCEWEEK COVERS THE WEST

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[redacted] WATCH NEWS

Policy change info asked of insurers

NEW YORK — A resolution urging companies to provide insurance buyers with information explaining major changes in liability policies has been adopted by the Independent Insurance Agents of America.

The resolution, passed by the IIAA National Board of State Directors during their recent winter meeting in San Antonio, follows:

"Because of major changes in liability policies, the Independent Insurance Agents of America strongly encourages insurance companies to provide a written explanation outlining significant policy changes. These clarifications should be included with their policies for presentation to insurance buyers. While IIAA recognizes that changes in liability policies may vary by company, the Association nevertheless believes that certain basic changes to the liability forms should be included in any written explanation, particularly as they relate to claims-made forms. Insurance companies, producers, and consumers will all benefit from such an effort to clarify these key coverage differences between expiring and renewed policies."

* * *

Fund names Davis to top claim post

NOVATO, CA — Fireman's Fund Insurance Companies has announced that Morgan Davis will become executive vice president, claims, starting February 3. Davis was senior vice president, claims management, at CIGNA Corporation, Philadelphia, with responsibility for worldwide claims operations.

Davis, 35, joined INA in 1975 after graduating from Harvard's Graduate School of Business. He served in claims management positions in Georgia and St. Louis, and was branch manager in eastern Missouri, Seattle and Atlanta.

* * *

AAMGA president attacks agreement to "rescue" Mission

(Continued from page 1)

"Those who have long defended the state regulation of insurance are appalled at this obvious preferential treatment of certain creditors at the expense of others," said Wisenberg. The repercussion of the California department's action may well have a "domino effect" on other companies who have a substantial amount of reinsurance recoverable from Mission at year end.

The primary function of the state regulation of insurance is to prevent insolvency, according to Wisenberg. The Mission failure, therefore, represents a failure of one state's regulators, he charged. It appears that the purpose of these maneuvers in California is to avoid further embarrasment to the insurance department from yet another assessment to their guaranty fund which already leads the nation with record assessments in excess of $55 million, Wisenberg said. Moreover, the bailout comes at the expense of other companies throughout the country who will have to bear the cost of this failure of state regulation, he contended.

Those who are inclined toward a federal solution to problems of this kind will see the "Mission Rescue" as clear evidence that states are unwilling, or incapable, of containing their regulatory failures within state boundaries, Wisenberg said. The California department has given a creditable argument to those who have long advocated federal regulation as a necessary and prudent successor to the efforts of the states, he concluded.

Calif. labor to push comp benefits hike

SACRAMENTO — The California Labor Federation, AFL-CIO, has notified the state lawmakers of its priorities for the 1986 session of the legislature and the list includes "equitable" workers' compensation benefits among the top items.

The federation's executive council voted to sponsor legislation to take the place of a workers' compensation bill vetoed last year by Gov. George Deukmejian.

It will take the form of the vetoed bill or a new approach if warranted by findings in the report of a study begun in 1983 by a joint study committee and expected to be completed soon by the senate industrial relations committee.

The federation's position, it was announced, "served clear notice that labor will make an election year issue of the veto by the governor and will vigorously resist an employer-backed bill introduced in the waning days of the last session as a workers' compensation 'reform' but denounced by trade unionists and their legislative allies as a major ripoff of injured workers."

Deukmejian vetoed Senate Bill 1273 by Sen. Bill Lockyer (D), Hayward, which would have increased the maximum temporary weekly benefit from $224 to $273 for a worker injured on the job and raised the death benefits from $70,000 to $85,000 where there was one survivor and from $95,000 to $115,000 where more than one dependent survived a worker killed on the job.

* * *

Deep pocket issue approved for vote in June election

(Continued from page 1)

approved by the voters.

Reports indicate the California Trial Lawyers Association, the major opponent, is preparing to spend millions of dollars to try to defeat the measure.

The initiative is designed to change the "deep pocket" rule to allow defendants in tort cases to pay for non-economic losses according to the degree of fault. Under existing law a defendant may have to pay 100% of the damages in a lawsuit even if the defendant is as little as 1% at fault.

"The court doctrine that requires firms or individuals to be liable for all of a damage award even if they are only marginally to blame for an injury is clearly unfair," said Kirk West, president, California Chamber of Commerce.

* * *

Riding elected surplus line chairman

SAN FRANCISCO — The annual meetings of the Surplus Line Association of California were held January 14 in San Francisco, and January 16 in Los Angeles and new officers and a new executive committee for 1986 were elected.

D. F. Riding of Brown & Riding Insurance Services was named chairman. W. N. Richards of Swett & Crawford was elected secretary-treasurer.

The new executive committee will be: I. H. Anderson of Marsh & McLennan, Inc.; P. E. Beauchamp of Alexander & Alexander, Inc.; E. F. Casey of Stewart, Smith West, Inc.; D. W. Grant of Western Reinsurance Brokers, Inc.; J. J. Grigg of Southern Marine & Aviation Underwriters; R. P. Keul of Montgomery & Collins, Inc.; G. O'Gorman of Johnson & Higgins of California; W. B. Rosenfeld of Canon Insurance Service; G. J. Sullivan of Gerald J. Sullivan & Associates, Inc.; R. P. Welch of Welch & Company and J. C. Widgren of INC Insurance Services.

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CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

Vol. 1, No. 1 February 8, 1986

COALITION PROPOSALS ON THE TABLE IN THE LEGISLATURE

Tort reform legislation is fast becoming a major focus of this legislative session. Measures reflecting the position of the Citizen's Coalition were introduced in both houses on Friday, Jan. 31.

Eagle River Democrat Sam Cotten led the charge in the House of Representatives as the prime sponsor of the Coalition's bill (HB 532). He was joined by Reps. Johne Binkley, Virginia Collins, Marco Pignalberi and Dave Thompson, all Republicans.

In the Senate, Rules Committee Chairman Tim Kelly put in most of the Coalition bill (SB 377) and pulled along nine co-sponsors. They are Republicans Mitch Abood, Jack Coghill, Edna DeVries, Jan Faiks, Paul Fischer and Arlis Sturgulewski. Democrats Jalmar Kerttula and Fred Zharoff also joined on as co-sponsors. Sen. Kerttula also put in the the essence of the Coalition proposal as SB 382.

The Coalition's bill was put into form for introduction through the assistance of Sen. Kelly and his staff.

In placing the full Coalition proposal before the House, Cotten said, "There are some controversial aspects of this bill, but insurance has become a major concern of many people throughout the state and every idea should be laid on the table."

IS TORT REFORM POSSIBLE? -- THE COSMETIC SOLUTION

Both Houses of the Legislature recognize that the unavailability of some kinds of liability insurance and the high cost when offered is a critical problem for many Alaskans. Only a few legislators seem to make the solid connection between the evolution in the way the courts treat liability suits and the so-called "insurance problem." The Alaska Legislature has faced this problem before, in 1975 and in 1979, but their actions failed to adequately address the problems.

The Coalition's best intelligence is that the feeling among many key legislators, particularly in the House, is to simply offer some kind of "cosmetic" legislation to take the heat off and have something to point to during the up-coming election campaign.

Therefore, in order to get an effective solution to the liability insurance issue, it is essential that legislators become thoroughly informed on both the causes and effects of the evolution in the civil justice system's approach to resolving liability disputes.

HOUSE LABOR AND COMMERCE COMMITTEE SETS HEARINGS

Pending last minute revisions, the House Labor and Commerce Committee headed by Kenai Rep. Mike Navarre has set a series of hearing dates for mid-February on insurance-related bills, including tort reform. As this newsletter goes to press, it appears the Senate Labor and Commerce Committee chaired by Sen. Fred Zharoff will join with the House to make these joint hearings.

Feb. 17, 19 and 20: Hearings in Juneau and possibly on the teleconference network. These hearings will be on specific legislation, however the details had not been released at press time for this newsletter.

Feb. 24: A panel of experts on insurance issues, including tort reform, will appear before the Committee in Anchorage. A morning session will focus on Alaska experts with authorities from outside of Alaska joining local professionals in the afternoon

Feb. 25: A continuation of the panel of experts in Juneau.

HELP ENACT EFFECTIVE TORT REFORM -- TELL YOUR STORY

Plan to tell your story to the House Labor and Commerce Committee... In person in Juneau or by teleconference from elsewhere in Alaska. Call your nearest Legislative Information office or the CITIZENS COALITION FOR TORT REFORM office for details.

JOIN THE FIGHT FOR THE PRINCIPLES IN HB 532, SB 377 AND SB 382

738 H Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-1135

DOES TORT REFORM WORK? A LOOK AT CALIFORNIA

Ten years ago California enacted some major elements of the Coalition's tort reform proposal. A recent Rand Corporation (think tank) study reports:

"...when a state moved to cap verdicts or eliminate specific dollar requests by plaintiffs or permit payment of awards for future losses in periodic installments, the net effect was to reduce trial awards by 30%, cut the average out-of-court settlement by 25%, raise the portion of cases dropped from 43% to 48% and reduce the share of cases going to actual verdict from 5.1 to 4.6%."

SUPPORT THE COALITION'S EFFORTS -- YOUR TIME WILL COUNT

What's happened to your liability insurance this year? Tell your legislator. Call or write. A personal letter gets the idea across in the best possible way. That way your representative or senator knows you mean business. And when you mean business, they'll listen; it's their job. The address is:

Your representative or senator
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

NEED MORE INFORMATION? WRITE OR CALL THE COALITION

The Citizens Coalition for Tort Reform
738 H Street, Suite 100
Anchorage, AK 99501
(907) 276-1135

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Hon. Patrick Rodey
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

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Contribute to the campaign to restore common sense to the tort system.

Individual:	$10 [ ]	$100 [ ]	$500 [ ]	
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THE CITIZENS COALITION FOR TORT REFORM

Participating Organizations:

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Alaska Dental Society
Alaska General Contractors
Alaska Chapter, American Optometric Association
Alaska Movers Association
Alaska Oil Marketers Association
Alaska Rental Association
Alaska Section, Fairbanks Branch, American Society of Civil Engineers
Alaska Society of Professional Engineers
Alaska State Health Association (Hospitals)
Alaska State Medical Association
Alaska Support Industry Alliance
Alaska Truckers Association
Alaska Visitors Association
Anchorage Board of Realtors
Anchorage Restaurant and Beverage Association (ARBA)
Cabaret Hotel and Restaurant Retailers (CHAR)
Childbirth Educators
Daycare Operators Association
Financial Managers
Hotel and Motel Association
Insurance Brokers and Agents Association
Nurse Midwives Association
Pension Consultants
Professional Physical Therapists Association
Risk Management Association
Southern Alaska Association of Life Underwriters

Pat Rodey
Alaska State Legislature
Box V (MS 3100)
Juneau, Alaska 99811

February 24, 1986

Dear Mr. Rodey:

The attached correspondence is furnished to you as information since Alaska and the Nation appears to be on a collision course on liability, tort, insurance costs, and professional integrity of a few participants in our legal system.

The case in enclosure seems to have several ramifications.

> What is being done to protect citizens against attorney malpractice since they seam reluctant to confront each other and exuberant to sue any other profession.
>
> Why are unions paying attorney fees for services not related to employment. The Plaintiff in the attached case is an employee of the State of Alaska so I have to assume that State revenues, directly or indirectly, supported a frivolous case against me that cost me nearly $2,000.00 in direct cost plus some indirect costs.
>
> America has had the strongest free enterprise system known to mankind and it is now being eroded by the best judicial system ever known to mankind. I wonder who is setting on their hands. While medical costs go off the end of the chart, young mothers in Massachusetts wonder if they can get a doctor to deliver their baby, because liability risks become more important than the new infant.

As a 49 year old American, 28 year Alaskan, and father of a budding member of Valley free enterprise; it concerns me that we may be turning our future over to the whims of a sue happy society nurtured by greedy attorneys. What is even more terrifying is HBH's recent announcement that IUKI is good for the country and needs no change.

Recently, Chief Justice Warren Berger stated on national radio that we have to get a handle on frivolous suits.

As you are surly aware, in the near future a computer access data bank will be established to identify sue happy members of our society for the purpose of the medical profession obtaining information to govern the decision to accept patients. With no imagination one can see how the ramifications of such a system could spread as the pendulum swings. For example, attorneys who take liability cases and their family members unable to get medical care except on the Black Market. The same for judges and jury members who award high settlement for frivolous cases. Who will repair their automobile, right insurance, issue airline tickets, sell a new car or airplane, repair a leak in the roof, let your imagination run wild!

Our grandmothers said "a stitch in time saves nine", and our grandfathers said "fish or cut bait". I hope we don't cut bait until it takes nine stitches.

Farris E. McIver
dba McIver Construction
SR Box 5219
Wasilla, Alaska 99687

Chief Justice
Alaska Supreme Court
303 K Street
Anchorage, Alaska 99501

February 20, 1986

Dear Sir:

This is to request whatever action feasible to protect the Alaska Public from malicious abuse of Process displayed by attorney (attorney) of (law firm)

In 1985 I was sued (BULBUC VS. MCIVER) regarding repairs I had accomplished to a septic system 2 1/2 years Prior. Plaintiff was represented by (attorney).

(Attorney)'s case fell apart at the first deposition; however he continued to grasp at smaller and smaller straws, deposition after deposition, until arriving in court with nothing left but one innuendo that obviously didn't impress Judge Cutler and Plaintiff quickly lost.

Justice was served except for the financial aspect. The work performed on the septic system cost $227.00. My attorney fees were $3,591.00. Plaintiff's attorney fees were Paid by a union. Plaintiff declined three offers of settlement and the court awarded reimbursement of my attorney fees of $1,600.00 which was Paid Personally by the Plaintiff.

This appears to be a case of greed motivated malPractice on the Part of (attorney) and something needs to be done to Protect unsuspecting Alaskan's from such a financial burden.

Court records at Palmer, Alaska contain all details.

I ask your assistance since I share many Alaskan's distrust for the Bar Associations cronyism.

Copies of this correspondence with the attorney's name removed is being furnished Ted Stevens, Frank Murkowski, Don Young, Jay Kerttula, Edna DeVries, Katie Hurley, Ron Larson, and all members of Alaska Judiciary Committee.

Harris E McIver

Farris E. McIver
dba McIver Construction
SR Box 5219
Wasilla, Alaska 99687

negligence. Insurance may not be available to cover all risks or may be too costly for many people.

Two of the four major MICRA provisions, if extended to all negligence actions, would help solve the current dilemma of rising insurance premium costs and shrinking insurance availability. The two provisions recommended for extension are limits on attorney contingency fees[61] and the provision for periodic payment of damages.[62] The actual relief that would result from an extension cannot be forecast precisely.[63] Industry analysts predicted, however, that medical malpractice payouts would decrease by twenty percent after the 1975 enactment of MICRA.[64] Empirical evidence from some states showed awards decreased as much as fifty percent from 1975 to 1977.[65]

After MICRA was enacted, insurers were able to halt increases in malpractice insurance rates because of lower payouts and settlements.[66] In fact, one appellate court acknowledged that medical malpractice premiums went down by twenty-five percent without adjusting for inflation after the enactment of MICRA.[67] Analogous provisions extended to all negligence cases may be expected to have a similar effect on liability insurance premiums in general. Steps toward reform, beginning with the extension of selected MICRA provisions, would improve the capability of the tort system to meet the needs for which

61. *See supra* note 40 and accompanying text.

62. *See* CAL. CIV. PROC. CODE §667.7(f).

63. The American Bar Association estimated that one of the MICRA provisions, abrogation of the collateral source rule, alone would reduce medical malpractice payouts by up to 20%. An empirical study following 1985 medical malpractice reforms nationwide showed that in states requiring reduction of awards by the amount of collateral source payments, payouts dropped 50% from 1975 to 1977. Bell, *Legislative Intrusions into the Common Law of Medical Malpractice: Thoughts About the Deterrent Effect of Tort Liability*, 35 SYRACUSE L. REV. 939, 946 (1984).

64. *Id.* at 947. A smaller reduction in medical malpractice awards resulted from the cap on noneconomic damages. *Id.* States that enacted caps in 1975 had malpractice awards 19% lower in 1977. *Id.*

65. *Id.* at 948. In addition to this finding, economists who have studied states that enacted limitations on attorneys' contingent fees concluded that the limits have increased the number of cases dropped by five percent, decreased the size of settlements by nine percent, and reduced by eleven percent the number of cases tried. The MICRA provisions taken together resulted in a 25% decline in medical malpractice premiums for most hospitals in the state in the years following enactment of MICRA. American Bank & Trust Co. v. Community Hospital of Los Gatos-Saratoga, Inc., 36 Cal. 3d 359, 382-83, 683 P.2d 670, 685, 204 Cal. Rptr. 671, 686 (Mosk, J., dissenting) (1984).

66. *American Bank & Trust*, 36 Cal. 3d. at 382-383, 683 P.2d at 685, 204 Cal. Rptr. at 686.

67. *Id.* at 382-383, 683 P.2d at 685, 204 Cal. Rptr. at 686 (1984); Brief of Amicus Curiae, Fred J. Hiestand at 7, American Bank and Trust Co. v. Community Hospital of Los Gatos-Saratoga, Inc., Civil No. 24171 (Cal. Supreme Court filed Aug. 9, 1983) (on file at the Pacific Law Journal).

the system was established.[68] Each MICRA provision will be analyzed individually in the context of extension, beginning with the limitation on contingency fees and followed by the periodic payments provision. Policy considerations will be addressed first, followed by discussion of constitutional questions.

A. *Extension of the Limitation on Contingency Fees*

The first MICRA provision proposed for extension to all negligence actions is the sliding scale limitation on contingent attorneys' fees. The United States is one of very few nations that permits plaintiffs' attorneys to set fees as a percentage of either court awards or settlements.[69] The medical malpractice insurance crisis provided the impetus for enactment of the MICRA limitation on contingency fees.[70] By enacting the contingency fee limitation, the California Legislature decreased the high cost of medical malpractice insurance premiums which threatened the availability of medical care.[71] In addition, the legislature sought to avoid potential recovery problems created by insufficient liability coverage for patients injured by medical malpractice.[72] The legislature determined that the limited sliding fee scale of MICRA would reduce costs to malpractice defendants and insurers, particularly in the large number of cases resolved through settlement.[73] Since the attorney fee limitation of MICRA[74] permits an attorney a smaller portion of the settlement, plaintiffs may be more likely to agree to a lower settlement.[75] In addition, the limit on attorneys' fees deters attorneys from litigating marginal cases or encouraging clients to hold out for unrealistically high settlements.[76]

Certain immutable characteristics of the contingency fee arrangement have made this method of compensation the subject of vigorous debate over the years.[77] The confluence of interest between attorney and client bound by a contingency fee agreement is marginal.[78] In

68. Report of the California Citizens' Commission on Tort Reform, Righting the Liability Balance, Sept. 1977, at 141.

69. *Id.* at 159. For example, Great Britain has banned the contingency fee. *Id.*

70. *See supra* note 3 and accompanying text.

71. *Id.*

72. *Id.*

73. Roa v. Lodi Medical Group, 37 Cal. 3d 920, 930-32, 695 P.2d 164, 170-71, 211 Cal. Rptr. 77, 83-84 (1985).

74. CAL. BUS. & PROF. CODE §6146.

75. *Roa*, 37 Cal. 3d at 926-27, 695 P.2d at 166-67, 211 Cal. Rptr. at 79-80.

76. *Id.* at 930-31, 695 P.2d at 170, 211 Cal. Rptr. at 83.

77. MacKinnon, *Contingent Fees for Legal Services* 39 (1964).

78. *Id.*

fact, conflicts of interest are inherent in the contingency fee arrangement.[78] Since the fee is paid regardless of the amount of time spent on the case, early settlement may be advantageous to the attorney, especially when a small claim is involved. Extensive bargaining or a trial might yield a higher recovery for the plaintiff, but the additional amount of compensation to the attorney may be insignificant or wholly disproportionate to the amount of time necessary to pursue the claim.[80]

Those opposed to extending MICRA argue that giving a smaller percentage to the attorney representing a plaintiff with high damages in a negligence action actually harms the plaintiff.[81] The rationale is that attorneys will not vigorously prosecute or even undertake cases if compensation per unit of time expended is insufficient.[82] This argument is not supported by evidence obtained from jurisdictions in which fee limitations are applied. For example, New Jersey has adopted a sliding contingency fee scale for all tort actions.[83] Despite a fee scale that was even less generous to attorneys than the MICRA scale when it was adopted, no problems resulting from the fee limitation were reported in New Jersey.[84] In fact, commentators in New Jersey have indicated that New Jersey's limited contingency fee detractors were wrong in predicting that the poor would suffer impaired access to the courts.[85]

Contingency fee arrangements are not as risky for the attorney as the name suggests.[86] A noted authority states that plaintiffs recover, either by suit or settlement, in the vast majority of cases in which a lawyer is retained.[87] The argument for limitation of contingency

79. *Id.* Schwartz & Mitchell, *An Economic Analysis of the Contingent Fee in Personal Injury Litigation* 22 STAN. L. REV. 1125, 1136-39 (1970); Brief of Amicus Curiae, Fred J. Hiestand at 4, Roa v. Lodi Medical Group, Civil No. S.F. 24435 (Cal. Supreme Court filed Aug. 10, 1982) (on file at the Pacific Law Journal).

80. MacKinnon, *supra* note 77 at 198.

81. Brief of Amicus Curiae, Fred J. Hiestand at 17, Roa v. Lodi Medical Group, Civil No. S.F. 24435 (Cal. Supreme Court filed Aug. 10, 1982) (on file at the Pacific Law Journal).

82. *Id.*

83. The percentage of the recovery permitted for attorneys' contingency fees has been increased by the New Jersey Legislature since the original enactment of a sliding scale limiting contingency fees. NEW JERSEY RULES OF GENERAL APPLICATION, 1:21-7, 1984.

84. *Id.*

85. *New Jersey's Maximum Contingent Fee Schedules: The Validity of Rule 1:21-7*, 5 RUT.-CAM. 534 (1974). "The [New Jersey] rule's detractors may have overstated their objections by predicting impaired access of the poor to the courts." *Id.* at 549.

86. Connell, *The Lawsuit Lottery* 145 (1979). In other words, "there is very little that is contingent about the contingent fee." *Id.*

87. *Id.*, citing address by Professor Maurice Rosenberg, Columbia Law School, American Bar Association Convention (1976).

fees is strongest when recovery is almost certain.[88]

Since 1975 California legislators have repeatedly offered bills for consideration that would limit or regulate contingency fees.[89] The MICRA scale is the most reasonable quantitative proposal offered thus far, and should be extended to all negligence actions.[90] In addition, constitutional challenges to MICRA have been met successfully and similar constitutional challenges to a MICRA extension can be overcome.

The contingency fee limitation of MICRA was upheld as constitutional by the California Supreme Court in *Roa v. Lodi Medical Group*.[91] *Roa* was one of a recent series of cases involving the constitutionality of the various MICRA provisions.[92] The Court in *Roa* applied a rational basis standard of review to hold that the sliding scale for contingency fees was not a denial of due process or a violation of equal protection.[93] The rational basis standard of review is the lower tier of the traditional two-tier approach to judicial review of legislation on constitutional challenges.[94] In order to meet the rational basis standard of review, the statute being challenged must bear a rational relation to any conceivable legitimate state interest.[95]

88. *Id.*

89. The legislature considered at least nine bills seeking to limit or regulate contingent fees in 1975. They ranged from AB 7 (no maximum schedule but subject to court approval) to AB 14, 1672 (a flat 10% except that counsel and client may split the first $1,667 any way they wish). *See also* SB 407, SB 397, AB 1, AB 926 and AB 1941 (on file at Pacific Law Journal).

90. Report of the Committee on Medical Professional Liability, 102 ABA Annual Rep. 786, 851 (1977). *See also* Dept. of HEW Report of Secretary's Committee on Medical Malpractice 919730 pp. 34-35; Kohlman, *An Equitable Contingency Fee Contract* 50 STATE BAR J. 268, 295-98, n.42 (1975). A sliding scale approach has been recommended as the preferable form of regulation. Attorneys fees should be related to the amount of legal work and expense involved in handling a case and not to the fortuity of the plaintiff's economic status and degree of injury. A decreasing maximum schedule of attorney's fees, set on a state by state basis and reasonably generous in the lower recovery ranges, would prevent the denial of access to legal representation. *Id.*

91. 37 Cal. 3d 920, 695 P.2d 164, 211 Cal. Rptr. 77 (1985). Upon a denial of petition for rehearing on the date of judgment, February 7, 1985, plaintiff/appellants petitioned the U.S. Supreme Court for certiorari on the ground that Business & Professions Code §6146 violates the first and fourteenth amendments of the US. Constitution. Docket A85216 U.S. filed July 12, 1985 (notes on file at the Pacific Law Journal).

92. Other cases included American Bank and Trust Co. v. Community Hospital of Los Gatos-Saratoga, Inc., 36 Cal. 3d 359, 683 P.2d 670, 204 Cal. Rptr. 671 (1984) (upholding the MICRA provision authorizing periodic payment of future damages in medical malpractice actions); Barme v. Wood, 37 Cal. 3d 174, 689 P.2d 446, 207 Cal. Rptr. 816 (1984) (upholding the MICRA provision that bars a collateral source from obtaining reimbursement from a medical malpractice defendant).

93. Roa, 37 Cal. 3d at 926-27, 695 P.2d at 166-67, 211 Cal. Rptr. at 79-80.

94. *See* G. GUNTHER, CASES AND MATERIALS ON CONSTITUTIONAL LAW 657-897 (9th ed. 1975); Bice, *Standards of Judicial Review Under the Equal Protection and Due Process Clauses*, 50 So. CAL. L.R. 689 (1977).

95. Westbrook v. Mihaly, 2 Cal. 3d 765, 784, 471 P.2d 487, 500, 87 Cal. Rptr. 839, 852

Application of the rational basis standard of review includes extreme deference to the legislature[96] and a presumption of constitutionality.[97] In addition, the burden of proving the statutory classification unconstitutional is on the party challenging the statute.[98] Historically, the rational basis test has been applied to economic and social welfare legislation.[99] Since MICRA relates to public health care, the statute is appropriately analyzed under the rational basis standard of review.[100]

In contrast to the rational basis test, the strict scrutiny standard of review requires that the challenged legislation be necessary to serve a compelling state interest.[101] The strict scrutiny test has been applied when legislative classifications impinge on suspect classes[102] or fundamental rights.[103] The legislative classifications in MICRA do not require application of the strict scrutiny standard of review[104] because neither a suspect class nor a fundamental right is affected by the Act. Therefore, the rational basis test has been chosen repeatedly by courts reviewing medical malpractice legislation[105] and was applied by the California Supreme Court in the four MICRA challenge cases.[106]

(1970), *accord*, McDonald v. Board of Election Commissioners, 394 U.S. 802 (1969) (presumption of constitutionality; statutory classifications deemed unconstitutional only if no circumstances reasonably may be conceived for justification); *see also* McGowan v. Maryland, 366 U.S. 420 (1961).

96. Lindsley v. Natural Carbonic Gas Co., 220 U.S. 61, 78 (1911).

97. *See, e.g., McGowan*, 336 U.S. at 420.

98. *See, e.g., Lindsley*, 220 U.S. at 78-79.

99. G. Gunther, *supra* note 94, at 658; Larson, *Constitutional Law: Equal Protection—An Emerging Standard of Review*, 13 WASHBURN L.J. 106, 107 (1974).

100. *See, e.g., Roa*, 37 Cal. 3d at 926-27, 695 P.2d at 166-67, 211 Cal. Rptr. at 79-80.

101. L. TRIBE, AMERICAN CONSTITUTIONAL LAW, §16-4 at 1000-02 (1978).

102. San Antonio Independent School District v. Rodriguez, 411 U.S. 1, 28 (1973). Classifications are considered suspect when the class is subjected to a history of purposeful unequal treatment, or is relegated to a position of political powerlessness so as to need special protection from the majoritarian political process. *Id.* The U.S. Supreme Court has held that suspect classifications include those made on the basis of race. *Id.* Classifications based upon alienage are considered suspect. Truax v. Raich, 239 U.S. 33, 39-43 (1915). National origin classifications also are deemed suspect and may not be used to deny equal protection. Hernandez v. Texas, 347 U.S. 475, 478-80 (1954).

103. *San Antonio*, 411 U.S. at 33-34. Fundamental rights are those rights explicitly or implicitly guaranteed by the U.S. Constitution. *Id.*

104. D'Amico v. Board of Medical Examiners 11 Cal. 3d 1, 18, 520 P.2d 10, 22-31 Cal. Rptr. 786, 798-99 (1974) (right to practice medicine not fundamental); Jones v. State Board of Medicine, 97 Idaho 859, 555 P.2d 399 (1976) (limits on recovery for medical malpractice neither infringe a fundamental right nor affect a suspect class), cert. denied, 431 U.S. 914 (1977); Paro v. Longwood Hospital, 369 N.E. 2d 985, 987-88 (1977) (classifications made under malpractice act do not violate equal protection clause of the fourteenth amendment of the United States Constitution).

105. *See supra* note 104 and accompanying text.

106. *See supra* notes 91-92 and accompanying text.

Applying the rational basis standard, the court in *Roa* stated the legislature could reasonably have concluded MICRA's sliding scale limitation on attorneys' fees would be more equitable than a flat contingency fee.[107] The sliding scale ensures that an attorney does not receive a "windfall" simply because a client is seriously injured.[108] In order to relate an attorney's fee more closely to the amount of legal work and expense involved in a case and less to the plaintiff's economic status and degree of injury, a decreasing schedule of fees should be set by each state. The schedule should be generous with regard to smaller awards so potential plaintiffs are not deprived of representation.[109] The sliding scale guarantees that the most seriously injured plaintiffs will retain the largest share of any recovery secured on their behalf.[110]

The rationale in *Roa* for upholding the constitutionality of the MICRA contingency fee limitation can be applied to all negligence actions.[111] The limitation does not infringe on the right of negligence victims to retain counsel.[112] The provision merely places a limit on the compensation an attorney may receive when representing an injured plaintiff under a contingency fee arrangement.[113] The validity of legislative regulation of attorneys' fees is well established[114] and the constitutionality of this limiting regulation as an exercise of the police power has been settled.[115] Therefore, extension of the limitation on attorneys' contingency fees can be supported.

107. *Roa*, 37 Cal. 3d at 933, 695 P.2d at 172, 211 Cal. Rptr. at 85.

108. *Id.* at 929, 933, 695 P.2d at 169, 172, 211 Cal. Rptr. at 81-82, 85.

109. Report of Committee on Medical Professional Liability, 102 ABA Annual Rep. 786, 851 (1977).

110. *Roa*, 37 Cal. 3d at 929, 933, 695 P.2d at 169, 172, 211 Cal. Rptr. at 81-82, 85.

111. Statutory limitations on attorneys' fees are not uncommon, either in California or other states. *See, e.g.*, American Trial Lawyers v. New Jersey Supreme Court, 66 N.J. 258, 330 A.2d 350 (1974); Gair v. Peck, 6 N.Y. 2d 97, 188 N.Y.S. 2d 491, 160 N.E. 2d 43 (1958), *appeal dismissed*, 361 U.S. 374 (1960). In California, attorneys' fees have long been regulated both in workers' compensation proceedings (LAB. CODE §4906) and in probate proceedings (Prob. Code §§910, 911). Other states have already adopted maximum fee schedules that apply to all personal injury contingency fee arrangements. *Id.* In addition, the United States Congress has passed several laws limiting the amount of attorney fees chargeable in various types of cases. *See, e.g.*, 28 U.S.C. §2678 (1966) (limit on attorneys' fees in actions under the Federal Tort Claims Act); 42 U.S.C. §406 (b)(1) (1968) (limit on attorneys' fees in actions under the Social Security Act); 38 U.S.C. §3404 (1958) (limit on attorneys' fees for claims under the Veterans' Benefit Act).

112. *Roa*, 37 Cal. 3d at 929, 695 P.2d at 169, 211 Cal. Rptr. at 81-82.

113. *Id.* at 929, 695 P.2d at 169, 211 Cal. Rptr. at 81-82.

114. *See, e.g.*, Calhoun v. Massie, 253 U.S. 170 (1920).

115. *Roa*, 37 Cal. 3d at 926-927, 695 P.2d at 166-67, 211 Cal. Rptr. at 79-80. *See, e.g.*, Frisbie v. U.S., 157 U.S. 160, 165-66 (1895) (attorneys must accept limited fees for the processing of federal pension claims); Yeiser v. Dysart, 267 U.S. 540, 541 (1925) (state may place

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

TO: ALL LEGISLATORS

FROM: CITIZENS COALITION FOR TORT REFORM

SUBJECT: INFORMATION ON CONTIGENCY FEES

THE OTHER SIDE OF CONTIGENCY FEES BENEFIT TO ALL PARTIES

READ THE LOGIC

Sincerely,

Al Tamagni, Sr.
Chairman

738 H Street, Suite 100 • Anchorage, Alaska 99501 • (907) 276-1135

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

TO: ALL LEGISLATORS

FROM: CITIZENS' COALITION FOR TORT REFORM

SUBJECT: ENCLOSED DATA FOR YOUR USE AND REVIEW

Thanks,

Al Tamagni, Sr
Chairman

738 H Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-1135

The Honolulu Advertiser

Established July 2, 1856

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George Chaplin — *Editor-in-Chief*
Buck Buchwach — *Executive Editor*
John Griffin — *Editorial Page Editor*
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RECEIVED M.I.E.C JAN 3 1986 UNDERWRITING

Friday, January 31, 1986

Liability insurance

Time to reform it

Among the state Legislature's top priorities this year should be reform of our outmoded liability insurance system.

Legislators have a special opportunity to come to terms with some of the inequities and excesses of rules that often penalize taxpayers and subvert the laws' intent.

A GROWING number of lawsuits and higher liability awards have led to skyrocketing insurance premiums. What's worse, some "high-risk" individuals, firms and governments — from doctors, bars and child care centers to municipal agencies — can't find insurance. That situation is clearly intolerable.

A number of areas deserve special and immediate attention. First, the state should change the "deep pocket" rule whereby a government or company that is found marginally at fault can be required to pay an entire judgment simply because other defendants can't pay.

A fairer system would be to make defendants pay only that percentage of damages for which they have been found at fault.

Second, there should be a cap on the amount of damages awarded. In California, there's a $250,000 limit for non-economic damages (such as pain and suffering) over and above what an injured party needs for out-of-pocket expenses, future medical care and wage losses.

RELATED TO this should be a cap on attorneys' fees. One good suggestion calls for a maximum 35 percent for recovered damages up to $100,000, 25 percent between $100,000 and $200,000 and 10 percent of damages over $200,000.

Such a sliding scale may help curb some of the demeaning "ambulance chasing" by plaintiff attorneys, whose advocacy of victim's rights often appears overshadowed by financial gain.

Third, legislators should look hard at limiting "punitive" damages, which are often awarded to punish a defendant and to deter similar future behavior.

Complementing these proposed changes will be a worthwhile program, announced this week by Hawaii Chief Justice Herman Lum, requiring most personal injury lawsuits to be handled through arbitration. In theory, the program should reduce costs for plaintiffs and defendants and reduce the caseload of the overburdened court system.

THE UNITED States is the most litigious society in the world. To be sure, victims deserve prompt and just compensation. But too often suits are filed merely to try to squeeze — either in court or through out-of-court settlements — astronomical damages out of companies, individuals and municipalities.

Directly or indirectly, Hawaii residents pay for these suits. It's time for legislators to restore fairness and balance to our liability insurance system.

WALL STREET JOURNAL

REVIEW & OUTLOOK

TUESDAY 2/4/86

Torts Control

G.D. Searle announced Friday that it is taking its intrauterine birth-control devices off the market because the cost of defending the products in personal-injury cases has become prohibitive. Its Copper-7 was the most commonly used device among the 2.3 million women who use IUDs. The weight of medical evidence, including a recent report by the FDA, says that the devices are safe. Claims that the devices have injured women have been tried in 10 courts, with eight victories for Searle.

After settling more than 450 cases—for what the company says was less than the cost "to keep a file warm in some lawyer's office"—Searle is faced with the prospect of defending some 300 more suits claiming that the IUD causes pelvic inflammatory diseases, including sterility. In the latest trial, no damages were awarded, but the defense cost Searle more than $1 million. Annual sales of the IUD bring in $11 million; Searle says this simply doesn't warrant the legal expenses, so it is discontinuing the product.

The decision leaves only one IUD available in the U.S., a hormone-releasing device that has a small market share. A recent study by Planned Parenthood recommended the Copper-7 devices for most women; a group spokesman expressed "dismay" that the Searle IUDs will not be available.

Plaintiffs' lawyers and activist judges can claim another victory in the tort wars. The rest of us can view this as still more evidence that the torts system has gone berserk.

The problem is that enough class-action, contingency-fee lawyers have tried enough cases in enough jurisdictions to get some judges to revoke the common law. The traditional rule was that there would be no liability if the product was made using state-of-the-art knowledge; it was unreasonable to expect anything more. Activist judges, however, have expanded the notion of liability to reach into the "deep pockets" of defendants, often corporations, even when there is no fault. For example, a court in Maryland held a gun manufacturer liable because one of its guns was used to shoot the plaintiff.

Plaintiff lawyers get rich practicing a form of greenmail on defendants—they threaten that if there's no settlement, the defendant will spend millions on lawyers. If there is a trial, juries sometimes take pity on a suf-

to award damages even if there was no fault. Rand Corp.'s Institute for Civil Justice estimates that when contingency-fee cases are won, two-thirds of the damage award goes to lawyers and only one-third goes to the plaintiffs. The large class-action suits give nickels and dimes to the injured, but make millionaires of the lawyers. So the incentive for the plaintiff's bar is to pick the most widely used products and most sympathetic injured clients.

What could be better than mothers and prospective mothers? The class-action lawyers were encouraged, of course, by the way their colleagues cashed in on the unhappy history of the Dalkon Shield, which A.H. Robins took off the market in 1974 when medical opinion concluded it was dangerous. So they took on Copper-7 as well, despite the weight of medical opinion.

Nor is this the first time a safe drug has been forced out of the market. Merrill Dow felt forced to drop Bendectin, a remedy for morning sickness used by 33 million women from the time it was developed in 1956 until 1983. The FDA approved its use and Merrill Dow lost no cases in court, but the company removed the product and created a $120 million settlement fund rather than face some 700 cases claiming that the anti-nausea drug caused birth defects.

This is becoming a major problem for society. One result is such legal uncertainty that liability insurance is no longer even available in scores of industries, from midwifery to day-care centers. Lloyds has pulled out of the litigious U.S. market. This judicial activism also discourages risky ventures by entrepreneurs, creating a huge hidden cost to the technological society. Who will bother to develop the next generation of birth-control methods if new devices cannot be sold profitably under today's tort laws?

The situation also is bringing disrepute on the legal system. Somehow the incentives in the system have to be changed. Our favorite proposals include limiting contingency fees and damages, as California has already done, having the loser pay both sides' legal and court costs, charging user fees for courts and strictly limiting class actions. But even more than these procedural reforms, what's needed is for judges and the bar to return to the ancient wisdom of the common law on torts: There shall be

Medical Insurance Exchange of California
Medical Underwriters of California Attorney-in-Fact

February 4, 1986

The Honolulu Advertiser
ATTN: John Griffin
Editorial Page Editor
P.O. Box 3110
Honolulu, HI 96802

Dear Sir:

Your editorial of January 31, entitled "Liability Insurance - Time to Reform It", is as clear and succinct a statement of the problem as we've seen.

This kind of public understanding and legislative action will improve the situation. We are sending copies of your editorial to the other states where we insure doctors, where reform efforts are being made, and to our reinsurers in London. They will welcome it.

Yours very truly,

William K. Scheuber
President
Medical Underwriters of California

WKS/ka/04FEB01/cor11

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points, to 159, due to a slight improvement in the loss adjustment expense ratio and a more than two-point improvement in the underwriting expense ratio. Ratios aside, the underwriting loss increased 30%, from $1.1 billion to $1.4 billion.

Medical malpractice gained 43% in net premiums written in 1985 and 34% in premiums earned. Written 61% by stock companies, 21% by mutuals and 18% by reciprocals, medical malpractice had results in terms of combined ratios that were comparable for the three sectors, but stock companies had markedly higher underwriting expense ratios and lower loss ratios than the others.

In only one year since its critical nature earned it a separate line in the annual statement in 1975 has medical malpractice turned in an underwriting profit. That was 1977. Since then, total underwriting losses have mounted annually. Although medical malpractice represents only 1.8% of property/casualty premiums written (and 5.6% of underwriting losses), the attention that has turned to the line because of public interest has made it a focal point of attention by regulators and legislators. Resultant experiments in search of a solution to the medical malpractice problem may or may not produce models to be followed by other lines. Claims-made policies, limits on pain and suffering awards, and arbitration of claims all have potential for broader application.

Medical Malpractice

Year	Net Premiums Written $000	Loss & LAE Ratio %	Und. Expense Ratio %	Combined Ratio Before Divs. %	Combined Ratio After Divs. %	Statutory Und. Gain or Loss After Divs. $000
Stock Companies						
[illegible]1	723 032	119 23	20 15	139 39	139 66	-284,781
[illegible]2	814 368	122 79	20 58	143 37	143 52	-346 589
[illegible]3	893 529	121 03	20 63	141 66	141 73	-364,141
[illegible]4	1,084 151	137 04	19 68	156 72	156 67	-583,552
1985*	1,550,000	141 20	17 20	158 40	158 40	-829,010
5 Yrs	5,065,080	130 29	19 30	149 60	149 66	-2 408,073
Mutual Companies						
1981	319 164	128 70	7 14	135 84	138 78	-118,123
1982	350 279	155 52	7 74	163 26	167 07	-224,351
1983	352,866	153.34	8.55	161 89	165 15	-232,388
1984	350 569	167 08	10 13	177.20	180 03	-269,628
1985*	540,000	151 00	7 20	158 20	160 90	-291,270
5 Yrs	1,912 878	151 26	8 07	159 63	162 72	-1,135,760
Reciprocals						
1981*	294,085	114 84	10 25	125 10	130 42	-80,512
1982	323 702	139 57	11 21	150 78	154 13	-140,814
1983	317,849	139 62	12 21	151 83	155 68	-167,224
1984	353,830	145 41	11 17	156 58	159 16	-223 420
1985*	465,000	147 20	10 00	157 20	159 70	-282,580
5 Yrs	1,754 466	139 39	10 90	150 29	153 60	-894,550
Total Industry						
1981	1,336,281	120 62	14 87	135 49	137 39	-483,416
1982	1,488,349	133 82	15 52	149 35	150 97	-711,754
1983	1,564,244	132 35	16 19	148 55	150 11	-763,753
1984	1,788,550	144 76	16 12	160 88	161 98	-1,076,600
1985*	2,555,000	144 43	13 78	158 20	159 27	-1,402,860
5 Yrs	8,732,424	136 82	15 15	151 97	153 36	-4,438,383

*Estimated

MEDICAL MALPRACTICE

At the top of the list of high combined ratios is the line of medical malpractice. This line's pure loss ratio stayed at 112 for 1985, but the combined ratio was down almost three

Medical Insurance Exchange of California
Medical Underwriters of California Attorney-in-Fact

FEB 3 1986

January 28, 1986

TO: MIEC Board of Governors
MUC Board of Directors

FROM: Ron Neupauer

RE: Insurance Industry Results - Medical Malpractice

The enclosed article and five year chart from the January, 1986 issue of Best's Review tells the story of what lies behind the recent rate increases and market restrictions for primary, excess and reinsurance coverages in medical malpractice.

Malpractice insurance represents only 1.8% of property/casualty premiums but is responsible for 5.6% of the underwriting losses. Although premiums increased by 43% ($700 million) between 1984 and 1985, the malpractice line still produced a combined ratio of 158.2% in 1985, an improvement of just 2%. The five year ratio is also terrible: 152%. No wonder the management of most commercial carriers has again decided it is just not worth bothering with malpractice insurance, given its relatively small overall premium volume and its very unpredictable but historically adverse underwriting results. Even counting the substantial investment income generated because of lengthy delays between the occurrence of losses and their eventual payment, ultimate payouts are so large and increasing so rapidly that high investment income no longer helps.

A compounded average annual investment return of 9% over four years would yield about $1.20 on 85% of original written premiums. This would then produce operating losses of $.38 for every dollar of malpractice premium written industrywide during 1985. Losses of this magnitude cannot be tolerated for very long.

While the rest of the property/casualty insurance industry may very well recover from the recent down cycle within the next 24 months, medical malpractice seems likely to remain a problem for a longer period of time.

We think the problem can best be solved through careful professional management by well-funded and well-operated doctor-owned carriers which have a permanent stake in the business and have both the incentive and the resources to handle its unique problems better than the commercial insurance industry. Evidence of this is apparent in the operating ratios of some doctor-owned companies, including MIEC, which were 20-50 percentage lower than the industry totals. Even with the best management and utilization of funds, the professional liability insurance industry needs tort reform if it is to survive.

RN/ka/27JAN06/corll

cc: Dave Willett
Jim King
Tom Hermes
John Griffiths

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The Executive Letter

FEB 18 1986
DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

February 18, 1986 Vol. 18 No. 40

HEARINGS SCHEDULED ON McCARRAN-FERGUSON ACT

Rep. Peter Rodino (D-NJ) has announced that the House Judiciary Committee's Subcommittee on Monopolies and Commercial Law will hold a hearing March 19 on the McCarran-Ferguson Act and current liability insurance problems of price and availability. Recalling 1983 hearings on the McCarran-Ferguson Act, which gives the states responsibility for regulating insurance, Rodino questioned the effectiveness of state regulation. He said the "lack of federal information and antitrust safeguards" may have contributed to the liability insurance crisis and added, "It is clearly time to determine whether McCarran-Ferguson should be modified or repealed."

JURY AWARDS $2.5 MILLION TO FIRED UNIVERSITY PROFESSOR

A federal court jury in Atlanta has awarded a fired University of Georgia (UGA) English professor more than $2.5 million -- $2.3 million for punitive damages. Dr. Jan Kemp brought suit against UGA administrators charging that she was unfairly dismissed from her teaching position in 1982 after she protested preferential academic treatment for student athletes (U. S. District Court, Northern Dist. of Ga.-Atlanta Div. Case No. 83-330A, Jan Kemp vs. Leroy Ervin and Virginia Trotter).

After deliberating for about 10 hours over a three-day period, the six-member jury found that UGA administrators "maliciously violated Dr. Kemp's constitutional right to free speech by demoting her and then dismissing her." The award, which also contained almost $80,000 in lost wages and $200,000 in compensatory damages, has set off reactions of shock and disbelief among state officials in Georgia and around the country. Since it was a federal court case, the judge has the discretion to review the award and reduce it if he finds it to be excessive. Additionally, State Attorney General Michael Bowers said he will review the order to decide if he will appeal the verdict or the size of the award.

Georgia had liability insurance with the now insolvent Transit Casualty Co. of Missouri. Since the state's Insolvency Pool will only provide the state $100,000 in liability coverage, the General Assembly could have to appropriate the remainder of the

money to pay the large award and legal costs. Ironically, the day after the huge award was handed down, Robert Hunter, president of the National Insurance Consumer Organization, held a press conference in Atlanta attacking the insurance industry and said that there is no crisis in the nation's civil justice system and no need for major tort reform efforts.

DOCTORS, LAWYERS BATTLE OVER TORT REFORM

The American Bar Association last week rejected all tort reform proposals that have been put forward by physicians. The ABA's House of Delegates, in Baltimore for its annual meeting, specifically opposed collateral source rules, restrictions on attorney's contingency fees, caps on pain and suffering, and prohibitions on punitive damage awards. However, the group called for further study and endorsed working with physician groups and insurers to develop a consensus on the compensation of injured persons.

James H. Sammons, executive director of the American Medical Association, said tort reform is needed "to create a climate in which doctors can practice, can render care, without looking at each patient who walks in the door as a potential lawsuit." He called the ABA's blanket rejection of tort reform proposals "absolutely incredible" and noted that many of the physician's proposals were included in a 1977 ABA report.

Sammons said insurers are not the problem, noting that many doctors are insured by physician-run, non-profit mutuals. The AMA owns a reinsurer that covers over 90,000 doctors, he said, and added that it is losing money. He estimated that only 5 or 6 out of nearly three dozen physician-run mutuals are in good financial condition today.

PENNSYLVANIA LEGISLATURE VOTES TO RETAIN GENDER-BASED RATING

Pennsylvania Gov. Dick Thornburgh has 10 days to act on a bill (HB452) that would retain gender-based rating for auto insurance and other property/casualty lines. His signature or no action makes the bill the law. A veto can be overturned by a two-thirds vote of both houses; the bill was passed by both chambers by more than a two-thirds majority. Unisex rating had been mandated in the state by court decisions and insurance department regulations, and was due to take effect on March 1. Meanwhile, the National Organization for Women, a strong supporter of unisex rating, said it would file a court challenge if gender-based rating is retained.

CONSUMER ADVOCATES DISPUTE CASE FOR TORT REFORM

Consumer advocate Ralph Nader and Robert Hunter, president of the National Insurance Consumer Organization, said last week that the current crisis in the liability insurance market is not, as insurers claim, related to the U.S. tort law system. They

pointed to the recent experience of Ontario, Canada, where many of the changes in tort system proposed by the insurance industry are in effect. NICO said that despite the changes made in Ontario, municipalities, day care centers and various other groups are having serious difficulties obtaining affordable liability insurance. (See Special Report for comment on the Nader/Hunter charges.)

VERMONT COMMISSIONER BARD RESIGNS AFTER 13 MONTHS IN OFFICE

Vermont Banking and Insurance Commissioner David Bard will resign March 10 after serving 13 months in the administration of Gov. Madeleine Kunin. Bard had been in the spotlight recently as his department took actions to meet public concerns over affordability and availability problems in commercial liability insurance. Bard had worked with the industry to organize a MAP for day-care and municipal liability, and now is pushing for legislative approval to give his office the authority to activate a Joint Underwriting Association for any problem area of liability insurance. That legislation is pending, and Bard said he believes his leaving will not affect chances of passage for any legislation proposed by his department.

WASHINGTON COALITION'S REFORMS GAIN SENATE COMMITTEE APPROVAL

A bill comprising the lion's share of the Liability Reform Coalition's efforts to reform Washington's tort system won Senate committee approval. The measure would impose a $250,000 cap on non-economic damages in all tort cases, modify joint and several liability rules in cases where the plaintiff was partially responsible to comparative negligence liability, require structured settlements when awards exceed $100,000 and require plaintiff attorney fees to be reviewed and approved by the court. Senate approval is considered fairly certain since almost two-thirds of the Senate are co-authors of the bill. The action by the committee came just a few days following testimony in opposition to the bill by consumer activist Ralph Nader.

"COMPROMISE" BILL TO LEVEL PREMIUM TAX PASSES WASHINGTON SENATE

A bill to level the foreign and domestic insurance company premium tax in Washington at 2% plus an assessment for operations of the Washington Department of Insurance passed the State Senate 38-10 and awaits House Ways and Means Committee action. Under the measure, the assessment could be no more than .125%, making the maximum premium tax rate 2.125%. Several domestic insurance companies which had opposed other attempts to level the foreign and domestic premium tax rates and attempts to set up a special fund for the insurance department removed objections to this proposal (Senate Bill 3636). Currently, the premium taxes are 1.21% for domestic companies and 2.25% for foreign companies. There is no assessment for operations of the department currently.

MASS. LIQUOR JUA, IN FIRST MONTH, WRITES NEARLY 500 POLICIES

The Massachusetts Liquor Liability Joint Underwriting Association, established in 1985 by the state legislature, has bound applications for 485 policies since starting up Jan. 6. Coverage written to date will produce $3.2 million in annual premiums. A spokesman for the plan says the amount of opening business shows how many liquor providers were "going bare, waiting for some sort of relief." Policies are being written on an occurrence basis, with limits of $100,000/$200,000, $250,000/$500,000 and $500,000/$1 million. A claims-made policy also will be used following regulatory approval. The JUA must accept all applications and cannot cancel or non-renew except for loss of license or non-payment of premium, although loss experience will be accumulated as future underwriting criteria. The plan is being serviced by The Commerce Insurance Company of Webster, Mass.

ILLINOIS GOV. THOMPSON CITES NEED FOR TORT REFORM

Legislation to counteract the growing insurance availability and civil justice crisis needs to be passed in the upcoming General Assembly, said Illinois Gov. James R. Thompson in his annual State of the State address. Thompson said he endorses a legislative package that would stem what he termed the "insurance crisis" that has driven up premiums and has threatened availability of coverage for businesses, municipalities and other tax-supported agencies. In his address, Thompson said jury awards should be capped but he added that insurers should be required to provide detailed claims information on request and to provide 60 days notice before cancellation of a commercial policy.

COMMERCIAL AUTO RISKS DRIVE UP SHARED MARKET ASSIGNMENTS IN 1985

New applications to the nation's automobile assigned risk plans increased significantly in 1985, due in part to a major influx of commercial risks, according to the Automobile Insurance Plans Service Office (AIPSO). Total applications rose 26.8%. Applications for commercial risks jumped 37.8%, and private passenger applications were up 25.9%.

All but four states showed increases in applications for commercial auto liability insurance in 1985. States showing the highest percentage increases include Pennsylvania (124.3%), Florida (92.3%), California (91.1%) and New York (42.6%).

In the private passenger liability insurance shared market in 1985, nearly as many states had decreases as had increases in applications. The most significant increases occurred in California (133.5%), Kentucky (93.1%), Virginia (38%) and Connecticut (23%). New Jersey had the most significant decrease in both private passenger and commercial auto applications, 50.2% and 11.9% respectively.

Carl C.A. Lee, Editor

Insurance Information Institute

The Executive Letter
Special Report

February 18, 1986

NADER'S CHARGE ABOUT ONTARIO TERMED INACCURATE AND MISLEADING

At a press conference in Washington, D.C., on Feb. 10, Ralph Nader told reporters that Ontario, Canada, is experiencing high premiums and a shortage of insurance coverage despite having laws which have many of the tort reform measures being proposed in the United States. Representatives for the National Insurance Consumer Organization said that Ontario already has a cap on compensation for pain and suffering, restrictions on punitive damages, prohibitions on injured parties specifying the amount of the award they are seeking, restrictions on attorneys' contingency fees, few jury trials, and penalties for frivolous suits.

This represents another misleading charge from Nader/Hunter. Here are the facts:

* On a per capita basis, commercial liability insurance premiums are much lower in Canada than in the U.S. In 1985, liability premiums (excluding auto) averaged $18 (C$25) per capita in Canada, compared with $60 per capita in the U.S. The different legal system in Canada is the most likely factor explaining this wide divergence in the cost of insurance.

* There are problems in commercial liability insurance in Canada, but they are not as severe as in the U.S.

* The problems in commercial liability insurance in Ontario, Canada reflect:

1. The i[illegible] recent statutes, which increase the incentives to liti[illegible].

2. An erosion of traditional common law disincentives to sue.

3. The impact of the worldwide contraction in liability insurance capacity.

[illegible]ommercial liability premiums in Canada are expected to show an increase of 15% for 1985, contrasted with a 72% increase in the U.S.

There are, however, some problems of availability of commercial liability insurance in Ontario. This province is known to be litigious. Specific statutory provisions have increased the number and size of claims in Ontario Province:

a. The Family Law Reform Act of Ontario Province (1978). This law extended the number of persons who could sue. For example, under this law a person with only passing acquaintance with another relative (say a cousin or nephew) can sue for loss of companionship.

b. The province of Ontario passed a prejudgment interest act, which adds interest to awards from the date of filing.

Also, judicial procedures in Ontario have tended to increase awards beyond expectations. For example, courts in Ontario have tended to add to the award enough money to cover the taxes on interest earned from the award in future years.

In addition, Canada is affected by the worldwide shortage of liability insurance, caused mainly by severe losses by reinsurers in the U.S. market.

The Province of Ontario did not enact a series of tort reforms as might be inferred from the Nader charges. The reforms mentioned are features of the common law system and are not statutory law. Since they are part of common law, they are subject to change by judicial decision and, in fact, there has been erosion in these areas in recent years.

The following reviews the elements of the legal system in Ontario, Canada, that are highlighted in the Nader charge:

1. Cap on compensation for pain and suffering. In the early 1970s, Canadian courts established through case law a cap of C$100,000 on pain and suffering awards. The cap has since been eroded and the figure now is C$180,000. (Since the cap is set by case law, it can be changed by case law.)

2. Restrictions on punitive damages. These restrictions also are set by case law and have been in place for many years. The restrictions in Canada are in general tougher than those used by U.S. courts.

3. Prohibition on injured parties specifying the amount they are seeking. This prohibition holds that a jury cannot be directly informed or led by evidence to know the amount of damages sought by a plaintiff. This rule is a common law rule and has been in place for decades.

4. Restriction on attorneys' contingency fees. In Ontario, attorneys' fees are set by the Law Society. Contingency fees are prohibited. This system has been in place for decades.

5. Few jury trials. Traditionally, Canada uses juries infrequently in civil cases.

6. Penalties for frivolous suits. Defendants who win suits can collect legal fees and other costs from plaintiffs. This system has been in place for decades.

Sean Mooney, Ph.D., CPCU
I.I.I. Senior Vice President and Economist

McCOOL-McDONALD
OF ALASKA INC. ARCHITECTS

March 25, 1986

The Honorable Pat Rodey
Pouch V
Juneau, Alaska 99811

Re: Liability Insurance
Tort Reform

Dear Senator Rodey:

Please look carefully into tort reform legislation which could equitably reduce the unpredictable costs of litigation. I believe this, in part, has caused dramatically increased cost of professional liability insurance for Architects and Engineers.

As you are probably aware, State contracts with Architects and Engineers require professional liability insurance. This makes availability and affordability of insurance critical to the State design process.

I have been practicing architecture in Alaska for over twenty years. The past nine months I have been a member of the Alaska American Institute of Architects-Consulting Engineers Council Committee on Professional Liability Insurance. My insurance has risen 290 percent from 1981 to 1985. Some Architects and Engineers have been unable to renew their insurance at any price.

As I see it, improvement is needed on several fronts to make insurance affordable:
1. Architects need to more diligently pursue quality control over their services.
2. Insurance companies need to more carefully manage their investments.
3. Courts need fair, but not unreasonable, high settlements for cost of pain and suffering (tort reform).

I assure you, the Architects of Alaska are improving the quality of their services. Please see that fair tort reform laws are enacted to combat the attitude that, "Oh well, you're insured ..." doesn't inflate court settlements and ultimately raise insurance premiums.

Sincerely,

McCool-McDonald of Alaska, Inc.

John E. McCool, Architect
Alaska Registration No. A-3534

JEM/lgh
A

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COMMITTEE REPORT

SENATE

FURTHER: FINANC

3/20/86

Date 2/17/86

Mr. President

The Committee on JUDICIARY considered SB 377

relating to civil actions; amending Alaska Rules of Civil Procedure 11, 49, 52, 58 68 and 82; efd.

and (a majority of the committee) (the committee) reports it back with the following recommendations:

[ ] do pass

[ ] do pass with attached amendment(s)

[✓] replace with/or adopt CS for SB 377 (JUDICIARY)
[✓] new title
[ ] same title and recommends

[ ] and attached a "LETTER OF INTENT" [✓] NEW FISCAL NOTE

[✓] reports it back without recommendation

[ ] recommends referral to Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS

Rick Halford DO NOT PASS UNLESS AMENDED

Zaugg - N/R

Jan Faiks - N/R

Tim Kelly - Do Pass if amended.

Patrick Rodey
Chairman

DO PASS
Chairman recommendation

Valley Medical Center, Inc.

P.O. BOX 879, 425 E. DAHLIA, SUITE M, PALMER, ALASKA 99645 — Telephone (907) 745-4268

Family Practice
James F. Ivey, M.D., F.A.A.F.P.
David P. Werner, M.D., F.A.A.F.P.

April 9, 1986

Senator Pat Rodey
Chairman, Senate Judiciary Committee
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Rodey,

I am writing to ask you and your committee to support SB 377, which was discussed on the teleconference of April 10, which I could not attend for lack of time. I send my thoughts and observations.

I am a family physician and have been practicing in Palmer, Alaska since the summer of 1974. I endured the "malpractice crisis" of 1975 and even practiced "bare" for a short period before insurance again became available. Practicing "bare" does not give a feeling of security. I have purchased coverage with MICA (Medical Indemnity Corporation of Alaska) since it's inception in 1975 and in the last 3 years my annual premium has gone from $8,000 to $12,000 to $21,000 (claims made only), rising largely because I deliver 40 to 50 babies a year. My coverage is now one fourth the amount I used to buy at $8,000 a year. In effect, my coverage is about ten times as costly. Malpractice insurance used to be a minor part of my overhead and now it is 10% of my gross charges. If I were neither assisting at major surgery nor practicing obstetrics, my premium would today be down in the $6,000 range. In addition, my $21,000 annual premium doesn't take into account the "tail" coverage I will have to pay should I discontinue practice or change companies. The tail will amount to 1 1/2 to 2 times the present annual premium. This extra cost adds $300 to $400 to my fee for pregnant patients and in the present economy families who are self-pay are not in the position to easily pay that amount. If the differential for obstetrics is ignored, $3 of each $30 office call goes right off the top to pay MICA.

MICA was created in the mid 70's as an answer to the "malpractice insurance crisis". MICA is not a "commercial insurance company" but has had the same premium increases and coverage cuts as has any of the companies guilty of cash flow underwriting, predatory pricing practices or poor investment results. This would lead me to doubt that state sponsored liability insurance for other forms of liability would be successful. I seriously doubt that the state should make itself the "deep pocket" either. It might find itself liable for financial obligations far greater than any expectations.

Many family doctors are seriously considering discontinuing obstetrics depending on what next year brings with regard to premium increases. The bottom line is: women soon may not find a family doctor who will deliver a baby in a small town or in the bush. If she can find such a doctor, his fees may be more that she can afford. This is a pro-consumer issue, after all.

Premium costs aside, you undoubtedly are aware that many qualified physicians have given up the practice of obstetrics because of undue "risk". I speak of risk to the physician of being sued, which continues for 21 years after a baby is born. Despite our advances in medicine, we often have little knowledge or control over the things that can affect the development of a fetus and less than optimal ways of diagnosing intrauterine defects. There are still

unpleasant surprises during labor and delivery, many of which can be detected and remedied, but many which cannot. People today take safe childbirth for granted (to the point of doing it at home), and expect a flawless process and infant every time. When it isn't flawless some people are quick to sue their doctors and hospitals even when "fault" or "negligence" as many would define it has not occurred. I will not defend careless and negligent medical care by any means, but a "poor outcome," without negligent care, should not automatically guarantee a lawsuit and an award. That's why many qualified physicians are leaving this field; because the interpretation of "fault" is so liberally applied plus the awards for an accident of childbirth can run easily into the millions of dollars. One such award came to $12,000,000. Even half of that tax-free sum invested at 8% tax-free comes to $1315 a day. The people who indirectly but do actually pay for that (our patients) cannot afford that generosity. The present statute of limitations allows that a baby born today has until the age of majority (19) plus 2 years to file a suit against the doctor who delivered him. I am now 42 years old and if I continue to practice obstetrics as long as I would like I could be dead and either my widow or estate could have to deal with a suit in which I could not account for my performance. I do believe in the rights of minors, but I think you can understand why some obstetricians are opting for early retirement or are changing to gynecology only. I feel it's a shame to waste good physicians' skill and experience because of that prolonged period of liability plus the extended scope of liability as interpreted by our courts. When a doctor doesn't dare deliver a less than perfect baby without fearing a lawsuit for something for which there might not have been any knowledge or control I see very real problems for availability and affordability of health care. I also see real problems in the future of neonatal intensive care units where tiny infants born 3 months early are taken care of with great skill and caring but may not achieve a totally "normal" life. The people who have given of themselves to provide such care are sued because the child will not be able to enjoy a "normal" life, but without that care would simply have been dead if born five or ten years ago. You will not find doctors or nurses who will continue to give of themselves to this extent only to be come targets of a lawsuit and suffer the mental anguish that a suit itself gives. Life-saving vaccines may become either too expensive or even unavailable due to recent product liability suits. Imagine, polio and whooping cough epidemics again! I have never seen those diseases, thanks to the vaccinations. Any IUD will soon be impossible to obtain, regardless of whether or not one is willing to accept the risks that can accompany it's use.

I want to continue my practice of obstetrics as long as I'm able to perform with continued good judgement, state of the art methods, and with consultation when appropriate. However, when the time comes that I feel that the medical-legal atmosphere and emotional and monetary costs outweigh the satisfaction of being a part of one of the most gratifying events of life, then I'm going to stop. I think my patients will be disappointed. I feel that it will take solid tort reform to bring about a stable and predictable medical-legal atmosphere. I'm sure that there are several other physicians in the Valley who are of the same mind, but I cannot speak to their plans.

Any human being feels great sympathy toward a crippled or retarded child who cannot enjoy a normal life. Trial lawyers have found that "birth damaged infant" lawsuits can generate huge awards, and they have zeroed in on "birth damage" as a lucrative field, knowing full well that the sympathy of a well-meaning jury can mean large awards. Sympathy should not be the basis for an award; fault should be the basis for that.

Meaningful tort reform is essential soon but health care is only one small part of the whole picture. I would ask you, yourself, to imagine yourself on either side of a personal injury lawsuit, both as the injury victim and as the defendant, which any of you could easily become. See if SB 377 seems fair from both positions. See if your rights are still intact if you have a valid claim for a real injury. See if it weeds out the litigious

plaintiff who plans to capitalize on a misfortune. See if you can live with the changes proposed by this bill. Most of your constituents probably feel the same; they are fed up with the costs and threats of wide open litigation, which some folks call our "rights" as American citizens.

The proposed changes of SB 377 will funnel more of the award to the victim and less to the legal system, and should thus be more cost effective. Claims of less than $50,000 can be settled by arbitration, avoiding much of the legal cost. Larger awards will be itemized to reflect actual past and future losses, eliminating the tendency to award nice, round, (and inflated) figures. (Most of us have little appreciation for what a hundred thousand tax-free dollars really amounts to). It can be awarded in periodic payments, to put less burden on the uninsured defendant and be less costly to the insurance company (i.e. less costly to the payer of premiums also) An annuity could be set up to dispurse the monthly payments. The money would be more likely to go for the purposes intended. The sky will no longer be the limit for "pain and suffering" to pad an award where actual monetary damages have not occurred. The court will take into account other sources of compensation and insurance to avoid double payment. Contributory fault needs to be implemented. In obstetrics this is especially important for us when "failed" home deliveries occur and a mother with an undelivered infant appears at the emergency room entrance in serious trouble from lack of proper care. The doctor is then expected to produce good results, with a healthy mother and infant. If the physician cannot do so, he may be successfully sued. In this sort of case, the patient should have to assume much of the responsibility for the unfortunate results. You shouldn't be held responsible for injuries suffered by the the thief who joyrides in your car or burgles your school and falls through the skylight, either.

Apportionment of damages is necessary also. If I mismanage an obstetrical case and an obstetrician helps with an emergency C-section, but the baby does poorly, then the obstetrician who helped out should not be held liable for my poor management. Conversely, if I am called in the middle of the night to assist with an emergency operation and the surgeon is negligent, then I should not be held 100% liable for damages if the surgeon has little insurance or assets or even leaves the country. The present doctrine of joint and several liability allows any party to be sued for the full amount regardless of percentage of actual fault. This is called "deep pocket" and is not fair when I jump in and help out with a critical case. You wouldn't want to be a victim of this doctrine, either.

Verification of claims is important. Plaintiff's lawyers should persue a case only if it has real merit, and avoid the claims that consume time and money and are unlikly to succeed, but do manage to run up defense fees, cause the defendant emotional pain, and use up his time and mental energy better spent on other chores. Verification will require the plaintiff's attorney to do his homework well prior to filing a suit and not simply throw a net for defendants to dismiss them one by one as discovery progresses. Sometimes, defendants are named in the initial action in order to have the trial held in a location known to have liberal juries. Claims which are groundless or frivolous cannot be tolerated. Critics will say that this will deny poor victims access to their "day in court". I doubt that a case needs to go to court to determine whether or not it has sufficient merit. We feel that lawyers need to be as accountable as everyone else for their actions and that groundless litigation that turns a blameless person into a "victim-defendant" should not be tolerated.

The cap on pain and suffering needs to be held at $250,000 per event, and not be used as multiples of that amount to pad an award when no actual monetary damages occurred. The federal studies have recommended $100,000 as the cap. A tax-free $250,000 at 8% is $20,000 a year (tax free) without even spending any of the $250,000. That's a goodly amount, in my book.

Punitive damages will benefit society as a whole and will not be used as a threat to make a defendant settle for policy limits, (your liability policy

does not pay punitive damages).

Itemized verdicts will cause a jury to account for the actual usage and purpose of the award, causing more realistic figures to be reached.

Periodic payments will allow a defendant or his insurance company to make payments rather than be forced to pay a lump sum which may cause undue hardship. A defendant can undergo hardship just as easily as the plaintiff.

Contingency fees should be paid on a sliding scale. SB 377 needs to have this provision added.

Contributory fault is an essential provision. When the plaintiff's injury is 95% his own doing, the defendant should be responsible for 5% at the most. Present legal doctrine allows the defendant to be liable for 100% of the damages and that just plain isn't fair.

The statute of limitations somehow needs revision; I believe that California has a 6 year-3 year statute for minors but I could be wrong about the exact figure. Time of discovery is a difficult date to document and can be subject to abuse. Time from date of injury seems best. At least the insurance companies would have some sort of predictable risk when writing policies. Present product liability statute seems to have no limit at all. 21 years for me in my obstetrics is terribly long. It's a tough issue. It would seem that in only exceptional circumstances would any injury actually go undetected for more than several years though I would certainly expect that exceptions could probably be found. I feel strongly that a change in the statute of limitations needs to be added as a part of SB377.

I've said my piece: please support the concepts of the original SB 377 in it's entirety, with additions addressing contingency fees and restructuring the statute of limitations. SB 382 seems an attempt to continue the status quo under the guise of a tort reform effort, with non-economic damages in multiples of $750,000, continued joint and several liability, and a detailed provision allowing more than what the sliding scale for contingency fees allows. The U.S Attorney General's report of February 1986 gives a good analysis of the whole picture and it's eight recommendations are given as a basic beginning structure for meaningful tort reform. It does clearly state that meaningful tort reform as the only real long-range solution for our affordability/availability problem. We need more that a bandaid for this problem. Thank you, I appreciate your attention.

Yours truly,

David P. Werner, M.D.

Alaska State Legislature
House of Representatives

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REPRESENTATIVE
ALYCE HANLEY
DISTRICT 9, SEAT B

MEMBER
HEALTH EDUCATION AND
SOCIAL SERVICES COMMITTEE
LABOR AND COMMERCE COMMITTEE
PUBLIC SAFETY SUBCOMMITTEE

April 15, 1986

Senator Pat Rodey, Chairman
Senate Judiciary Committee
P.O. Box V, (M/S 3100)
Juneau, Alaska 99811

Dear Mr. Chairman:

The Health Association of Alaska sent me a copy of their April 14 letter to you regarding my amendment to House Bill 532. This amendment was added in the House Labor and Commerce Committee, and exempts hospital board members, among others, from certain liability.

My intent in suggesting this language was to address the growing problem of protecting members of the public willing to serve on the boards of hospitals, non-profit corporations, and schools.

The language suggested by Dennis DeWitt in his April 15 letter seems to clarify that intent. It is my hope that your committee will recognize the need for the amendments and consider them for adoption in Senate Bill 377.

With best regards,

Sincerely,

Alyce Hanley

cc: Senator Tim Kelly

STATEMENT OF PURPOSE

RS 12049C1

This bill will amend Section 41-335, Idaho Code, to require disclosure to the Department of Insurance of certain financial information maintained by insurance companies. The bill confers additional rule-making authority upon the Department of Insurance to require such statistical information and reports as the Department deems necessary to more adequately monitc -urance coverage, claims, and rates in the State of no.

The Statistical information currently being reported by the Insurance Industry to the Department of Insurance is incomplete and does not enable the Department of Insurance to evaluate questions of coverage, rates, claims, or losses within the industry.

FISCAL IMPACT

No Fiscal Impact on the general fund. This bill requires the Director of Insurance to include within the regulation currently existing under Section 41-401, the costs of administering this provision.

LEGISLATURE OF THE STATE OF IDAHO

Forty-eighth Legislature — Second Regular Session — 1986

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 460

BY BUSINESS COMMITTEE

AN ACT

RELATING TO STATISTICAL REPORTING OF INSURANCE CARRIERS; AMENDING SECTION 41-336A, IDAHO CODE, TO REQUIRE INSURANCE CARRIERS TO REPORT THEIR IDAHO EXPERIENCE AND OVERALL EXPERIENCE SEPARATELY, TO AUTHORIZE THE DIRECTOR TO PROVIDE FOR FORMS AND INFORMATION BY RULES AND REGULATIONS, AND TO ALLOW THE DIRECTOR TO COMPILE STATISTICS AND PREPARE REPORTS; AMENDING CHAPTER 3, TITLE 41, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 41-336B, IDAHO CODE, TO REQUIRE AN INSURER TO SUBMIT A DISPOSITION OF CLAIMS REPORT FOR CERTAIN TYPES OF CLAIMS, TO REQUIRE THE REPORTS BE MADE PUBLIC, AND TO PROVIDE IMMUNITY FROM SUIT FOR INSURERS AND THE DEPARTMENT FOR ACTIONS TAKEN PURSUANT TO THE SECTION; AMENDING CHAPTER 3, TITLE 41, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 41-336C, IDAHO CODE, TO PROVIDE PENALTIES FOR FAILURE TO REPORT; AND AMENDING CHAPTER 3, TITLE 41, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 41-336D, IDAHO CODE, TO PROVIDE FOR FEES AND MISCELLANEOUS CHARGES FOR THE ADMINISTRATION OF THE PROVISIONS OF SECTIONS 41-336A, 41-336B AND 42-336C, IDAHO CODE.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Section 41-336A, Idaho Code, be, and the same is hereby amended to read as follows:

41-336A. STATISTICAL REPORTS. (1) As a condition of doing business in the state of Idaho each insurer transacting insurance covering:

(a) Liability for malpractice of any person licensed under chapter 18, title 54, Idaho Code;

(b) Liability for malpractice of any person licensed under chapter 1, title 3, Idaho Code;

(c) Liability for the manufacture, design, production, processing or modification of any product; or

(d) Any other risk or risks, whether liability or otherwise, that the director of the department of insurance may specify;

shall report to the director such statistics as the director may designate by rule or regulation. The statistics shall be reported to the director annually, by the first day of March, for the preceeding year ending December 31. <u>The statistics shall separately address the experience of the state of Idaho and all other experience including the state of Idaho.</u>

(2) The reports required by subsection (1) above shall include, but shall not be limited to, the following for each insurer for each type of insurance for which a report is required:

(a) Number of exposures;

(b) Direct premiums written;

(c) Direct premiums earned;

(d) Direct losses paid

(i) amount,

(ii) number of claims;

(e) Direct losses incurred;

(f) Direct losses unpaid
(i) amount reported,
(ii) number of claims; and
(g) Net losses incurred but not reported.

(3) Reports required by subsection (1) of this section shall be made on forms required by the director and shall contain the information required by rule and regulation of the director.

(4) The director may annually compile and review all reports submitted under the provisions of this section. When reports are submitted representing no less than seventy-five percent (75%) of the premiums written for each reporting line of insurance for the reporting year, the director shall evaluate the premium rates in Idaho for each reporting line of insurance. The findings of such review and evaluation, and the reports required of insurers under this section, shall be made available to any interested citizen, insured or licensed insurer.

SECTION 2. That Chapter 3, Title 41, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 41-336B, Idaho Code, and to read as follows:

41-336B. DISPOSITION OF CLAIMS REPORT. (1) As a condition of doing business in the state of Idaho, each insurer transacting insurance subject to the provisions of section 41-336A, Idaho Code, shall report to the director annually by the first day of March, for each of the two (2) years next preceding the initial report and for one (1) year next preceding filing the report thereafter for each and every claim as defined in section 41-336A, Idaho Code, caused by the insured, for policies issued in the state of Idaho, if the claim resulted in:
(a) A final judgment in any amount;
(b) A settlement in any amount;
(c) A final disposition not resulting in payment on behalf of the insured.

(2) Reports required in subsection (1) of this section shall be made on forms required by the director and shall contain the information required by rule and regulation of the director.

(3) The director shall make reports required hereunder available to the public in a manner which will not reveal the names of any person, manufacturer or seller involved.

(4) There shall be no liability on the part of, and no cause of action shall arise against, any insurer reporting hereunder or its agents or employees, or the director or employees of the state, for any action taken by them in good faith compliance with the provisions of this section.

SECTION 3. That Chapter 3, Title 41, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 41-336C, Idaho Code, and to read as follows:

41-336C. FAILURE TO COMPLY -- PENALTIES. (1) Any insurance company required to file a report with the director under sections 41-336A or 41-336B, Idaho Code, which neglects to file such report in the form prescribed and within the time specified, or who neglects to fully and satisfactorily respond in any report timely filed, shall be subject to a penalty of one hundred dollars ($100) for each day in default.

(2) This penalty shall be in addition to any administrative penalty under

section 41-327, Idaho Code.

SECTION 4. That Chapter 3, Title 41, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 41-336D, Idaho Code, and to read as follows:

41-336D. FEES AND MISCELLANEOUS CHARGES. The director shall include within the regulation required in section 41-401, Idaho Code, the fees and miscellaneous charges required for the administration of the provisions of sections 41-336A, 41-336B and 41-336C, Idaho Code.

TORT REFORM

THE ROAD TO PREDICTIBILITY

A Position Paper

-By-

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TORT REFORM - THE ROAD TO PREDICTIBILITY

I. INTRODUCTION

An "availability and affordability crisis" in some lines of commercial insurance is a problem that now confronts the U.S. property/casualty insurance industry. Spiraling premium increases, reduced limits, large deductibles and, in some cases, a complete lack of coverage for some lines of insurance are becoming common occurrences. In short, there has been a complete market dislocation over the past year in some commercial property/casualty insurance lines.

As with any market disruption for any commodity or service, there are many causes. However, in the present commercial insurance crisis, one problem can be identified as playing a predominent role. The U.S. tort system, as interpreted and implemented by the courts at both the state and federal levels, has been tortured, abused and expanded in such a way that insurers can no longer predict or assess their exposure in insuring liability risks. In addition, those individuals and corporations that secure sufficient insurance coverage, are viewed simply as the "bank" or "deep pocket" from which monies are to be "drawn" to pay for any injury that occurs.

Our nation's tort system stems from the English common law and is our method of assessing legal fault and providing damages caused to one by the wrongful actions of another. Unfortunately, the present tort system has become derailed and turned into a compensation mechanism rather than a fault or true tort system. In recent years, the U.S court system appears to have shifted from a forum of adjudication to a forum for compensation where injury victims can appeal and obtain relief regardless of who is at fault or their degree of fault.

The court system does not operate in a vaccum, however. To a great extent, the changing court attitudes and the concurrent abberations in the nation's tort system mirrors changes in our society's values and outlooks.

First, advances in technology, science, medicine, etc. have produced a high standard of living for the vast majority of our citizens. As we continue to make further progress in these areas and the quality of our life increases, we also strive to reduce or eliminate the impact of adversity in our lives. For example, we have built "safety nets" to protect us from failures of our financial institutions. For the more unfortunate members of our nation, we have established welfare programs and our elderly have "social security." The country has also "bailed out" a number of failing business enterprises over the past ten years. As a society, we have rising expectations about the good life and, although impossible, we expect to live in a "riskless society."

Second, our expectations of being insulated from the adversities of life have resulted in a ubiquitous belief that each citizen is "entitled" to compensation from some source - any source - for every injury or loss experienced. Thus, compensation for any loss or injury, even if the victim is partially or totally at fault, is perceived today to be virtually an absolute right.

Third, to accomodate these rising expectations, the courts have evolved new theories of tort liability which shift the cost of injury or loss to "deep pocket" insurers, governmental entities or large corporations regardless of fault. Fault is no longer the issue since injury compensation is the goal.

Fourth, associated with this dramatic change, there has come a tremendous increase in litigation and transactional costs related to resolving disputes. As the courts become a forum for compensation of injuries irrespective of fault, the public has flooded the judiciary with disputes. Each individual dispute requires expensive lawyers, time consuming and costly procedures and often it results in inflated awards and settlements.

The 600 members of the National Association of Professional Surplus Lines Offices (NAPSLO) who provide high limit protection for both liability and property risks have been impacted by the problems of the civil justice system in the same manner and, possibly, to a greater degree than the general insurance industry. As the "deep pocket" theory of liability is applied, those organizations that supply high limits of coverage often find themselves being the targets of plaintiffs, lawyers and judges who view them as the resource to be used to compensate victims of injury or loss regardless of fault or cause.

The following are some reforms which NAPSLO believes could be instituted which would bring a balance to our civil justice system. These reforms would assist in solving both the availability and affordability problems which afflict the property/casualty insurance industry today by allowing insurers to accurately predict their exposure to risk.

II. GENERAL REFORMS

A. JOINT LIABILITY: Joint liability is the legal doctrine which makes every defendant in a group of defendants equally or solely responsible for damages when the other defendant(s) are unable to pay. This can occur regardless of a defendant's degree of culpulbility. Consequently, the defendant with greatest funds is often left "holding the bag" when other responsible parties default. The result is that those defendants that carry high insurance liability limits (deep pocket defendants) are often required to pay the entire cost of a judgment. While these defendants or their insurers can take court action to force the other defendants to pay their fair share, such action is expensive and time consuming and is ineffective against defendants who are "judgment proof" or whose resources are minimal.

The burden of joint liability is increased in those jurisdictions that abandon contributory negligence (a plantiff who is even partially responsible for his injury recovers nothing) and replace it with pure comparative negligence (damages are allocated purely by percentage and responsibility). Twenty-seven states either by legislative action or court edict have adopted pure comparative negligence. Consequently, in these states many plantiffs previously barred from a recovery now can secure an award. Thus, the "deep pocket" defendant is even more vulnerable to absorbing awards in excess of its responsibility.

A more reasonable and equitable approach in assessing damages is the doctrine of "several liability." Under several liability, defendants are only liable for their own tortuous conduct and are not required to pay the awards and judgments imposed on others. Therefore, NAPSLO urges all states to eliminate joint liability and hold defendants subject only to several liability.

To the extent that joint liability cannot be eliminated, NAPSLO supports the enactment of the "Uniform Contribution Among Tort Feasors Act" which establishes a system for all defendants to collect from one another without additional litigation when payments are made by a defendant which exceed that defendant's own individual responsibility.

B. CONTINGENCY FEES: The United States is the only major industrialized nation in which lawyers can be engaged exclusively on a contingency fee basis. In other countries, the contingency fee is either illegal, unethical or strictly regulated.

The contingency fee is a percentage of the client's recovery the lawyer receives for his or her effort. Thus, if no recovery is obtained, the lawyer does not get paid.

Theoretically, the contingency fee client need not be rich or even able to pay a lawyer. The only thing that is needed is a good case. The contingency fee has, therefore, been described as the "poor person's key" to the courthouse.

The reality of the contingency fee system, however, is somewhat different. Often, lawyers refuse to accept small cases regardless of their merit because the percentage of recovery will not be sufficient to cover the expenses of pursuing the case. In some personal injury cases, the lawyer may contract for as much as 50% of the injured claimant's recovery. This substantially reduces the total amount the client/victim receives.

While the contingency fee system encourages a lawyer's personal interest in the client's case and in obtaining the highest recovery possible for the client, there is no moderating mechanism within the contingency fee system that requires the lawyer to make reasonable and appropriate demands. Thus, it is in the lawyer's personal interest often to make an excessive demand knowing that a sympathetic jury may very well provide a recovery that is based upon the demand rather than upon the actual value of the loss.

Also, compensation on a contingency fee basis bears no relationship to the time, effort and skill a lawyer applies to the case. For example, cases in which hundreds of thousands of dollars of recovery are obtained may not require any more hours of skill or effort on the lawyer's part than a case in which a much lower recovery is secured. The contingency fee system, however, allows the lawyer to collect the same percentage regardless of the time, effort and skill put forth in the case. This actually discriminates against the plantiff with a meritious but low recovery case in favor of the client with a high recovery case and a "deep pocket" defendant that has purchased high liability limits. It also encourages demands to be inflated and discourages settlements.

NAPSLO recommends that the contingency fee system be modified so that contingency fees are based upon a declining percentage depending upon the amount of recovery. For example under this modified contingency fee approach, a lawyer could not accept more than 33.3% of the first $50,000 of recovery; 25% of the next $100,000; 15% of the next $200,000; and 10% of any recovery over $350,000.

Such a sliding scale will assure a greater share of the recovery will go to the injured party as well as reflecting a fair payment for the attorney.

C. PERIODIC PAYMENT OF DAMAGES: Traditionally, awards and settlements for personal injury cases have been paid on a "lump sum" basis. "Lump sum" payments for damages, however, have proved to be "expensive" and at times, inappropriate for both the victim who secures the payment and for the insurer that makes the payment. Lump sum payments provide no guarantee that the monies awarded to a victim, particularly a victim needing long term care or rehabilitation, will be available when actually needed to pay for medical and other necessary expenses. Lump sum payments need to be managed prudently and accident/injury victims, concentrating on their recovery, are not in the best position to manage large lump sum awards.

Seventeen states have enacted statutes that require or allow courts to award damage payments periodically rather than on a "lump sum" basis. Under these statutes, the defendants (or their insurers) must pay the victim's expenses as they occur rather than providing a speculative "up front" total award. In addition, such awards can also be structured to provide, when necessary, a stream of income.

By allowing periodic payments, liability costs are lessened because insurers can fund them at a substantially lower cost than a lump sum payment and the saving is passed on to the insured in the form of lower liability premiums. The recipient (victim) can be assured that the costs for which the award is given are paid and, when necessary, a steady stream of income can be provided. NAPSLO urges states to enact laws to provide for periodic payment of damages.

D. DISCOVERY ABUSE: "Discovery" is the means by which parties involved in litigation conduct a pretrial investigation. The purposes of discovery are: 1) to define the issues of a trial; 2) obtain evidence to be used in the trial; and 3) to find other additional evidence to be used in the litigation.

The process of discovery can be very time consuming and expensive. Both litigants (whether they be questioner or respondent) have found ways to frustrate the discovery process. Plantiffs often engage in "fishing expeditions" in which they ask extremely broad questions in order to uncover evidence of unrelated wrong doings for use at another trial. Defendants or respondents wishing to protect information "stall" by interpreting discovery requests in the most narrow terms possible. Thus, cases are delayed, settlement and litigation costs are increased and no one benefits.

Court rules and procedures must be rewritten to control discovery in order to reduce delays and trial costs. Therefore, NAPSLO recommends that legislation be adopted in the states which would allow courts to, on their own, weed out unmeritorious claims and defenses, sharpen the legal issues and impose sanctions against litigants who disobey pretrial orders and deviate from pretrial schedules.

E. STATUTE OF LIMITATIONS: Statute of limitations are limits imposed by law on the length of time following an injury that a victim has to file a lawsuit.

Statute of limitations are a recognition that stale claims are difficult to adjudicate. Over time, witnesses become hazy in their recollection and evidence disappears and is sometimes destroyed. Moreover, a statute of limitations provides

protection to defendants from having to defend suits which are filed many years after an injury occurs when advances in technology, science, education and manufacturing have changed the standard of conduct to which the defendant is to be held.

Every state has a statute of limitations applicable to general tort actions. In general, the time period for a statute of limitations begins to run when the injury is discovered or should have been discovered. However, many statute of limitations have been broadened by legislative actions in recent years. In addition, the courts have been interpreting statute of limitations in the broadest possible manner to allow claims which are based upon incidents that took place many years ago to be litigated. Simply, the desire to compensate victims has outweighed the spirit of fairness and the practical protection the statute of limitations affords.

NAPSLO supports statute of limitations that provide a reasonable time period in which a personal injury suit can be brought and urges legislative reform where judicial interpretations of a state's statute of limitations have unreasonably broadened the period of time in which suits can be brought.

F. COLLATERAL SOURCE RULE: The collateral source rule is a rule of evidence which prevents juries from receiving or considering evidence that a plaintiff has been compenstated from other sources such as workers compensation, health insurance, personal injury protection under no fault auto insurance, etc. Thus, plaintiffs with multiple insurance coverages often are able to get double and triple "dips" which are in essence "windfall" recoveries. Such multiple recoveries are unfair and costly to society and they increase the cost of insurance premiums to all consumers.

Juries should be given information as to other sources of recovery. Such information is crucial for a jury to determine the amount of a fair and proper award. Therefore, NAPSLO recommends the elimination of the collateral source rule in all jurisdictions.

An alternative to repealing the collateral source rule is implementing a mandatory offset against damage awards for all other compensation received by the victim which is related to the injury.

The Rand Corporation's Institute for Civil Justice has stated that the mandatory offset of collateral benefits against damage awards is one of the two tort reforms with the greatest impact on the size of awards. A ceiling or "cap" on awards is the other. The institute reports that in states where the collateral offset has been imposed, the severity of awards has dropped by 50% on the average within two years time.

NAPSLO recommends, therefore, that in states where the collateral source rule is maintained, a mandatory offset of collateral benefits against damage awards be enacted.

G. CLASS ACTIONS: One of the most complex and costly types of legal actions is the class action suit. Defense costs of a class acrion suit are enormous. In a class action suit, a defendant is required to identify and notify every plaintiff in the action and it must conduct a massive and costly investigation into thousands of individual plantiff situations.

Another problem with class action suits is that some attorneys have found the class action suit to be a very effective way to secure evidence for other litigation and file such actions for that purpose.

Class action law suits are an intimidating instrument. Defendants, when faced with a class action law suit are often willing to make generous settlements in order to avoid the burden and costs of lengthly litigation. NAPSLO recommends that all courts (federal and state) invoke rules that: 1) provide sanctions against lawyers who use the class action to seek evidence for other suits; 2) assure that members of class action plantiff groups receive an appropriate amount of the recovery; and 3) assure that fees are not excessive. Where courts can't accomplish these objectives, rules should act to provide these protections.

Finally, court rules should also be amended to: 1) prevent class action suits from being filed simply to coerce a defendant instead of trying to settle a dispute; and 2) to impose on the plaintiff its fair share of the costs related to the initial identification and notification process.

H. PAIN AND SUFFERING AWARDS: The pain and suffering award (non-economic award) is one area in which reform is vitally needed. Under the present system, juries have unlimited discretion in awarding damages for pain and suffering. The pain and suffering award is intended to "compensate" victims of bodily injury for mental, physical or emotional distress. However, such an award often reflects a jury's "sympathy" for the victim rather than its actual evaluation of the "loss." Actual economic losses can be determined but "pain and suffering" awards are in the realm of the "abstract" at best and can be inflated for any reason.

In recent years, pain and suffering awards have become volatile and unpredictable. In such an environment, insurers cannot predict their potential losses with any degree of precision and, thus, have reduced limits and eliminated coverage for many lines of liability insurance.

NAPSLO, therefore, urges states to place reasonable "caps" or ceilings on pain and suffering awards (non-economic awards). Alternatively, states should establish specific criteria and standards for awarding pain and suffering damages rather than leaving the entire amount to the discretion of the jury. Such action would at least provide insurers with some basis to accurately access their potential losses.

I. PUNITIVE DAMAGES: The purpose of punitive damages (exemplary damages) is to "punish" defendants for malicious and outrageous acts. Punitive damages were originally thought to be one method of controlling such "outrageous" behavior. However, in recent times they have become simply a way for plaintiffs to obtain "higher" awards and for attorneys to increase their fees.

In essence, punitive damages have become just another weapon in the arsenal of intimidation used by plaintiff lawyers to obtain higher settlements. Thus, rather than being a benefit to society, punitive damages do nothing but raise the cost of goods and services.

Both the reason and underlying purpose of civil punitive damages must be questioned. "Punishment", whether it be incarceration or monetary sanctions, is the responsibility of the criminal laws and criminal justice system not the civil courts. Those whose actions transgress the bounds of propriety, whether through negligence or intent, should be tried and punished by the criminal courts.

It is the criminal justice system that has been established to meet out punishment and it has created proper rules of evidence and safeguards to guaranty fair treatment for the defendant.

The theory that the fear of punitive damage judgments actually has a practical impact in controlling behavior is very doubtful. For example, punitive damages are quite often assessed in products liability cases. This has led to some ridiculous situations in which manufacturers and distributors have been "punished" several times as several suits are filed related to the same occurrence. However, the prospect of punishment, a multiple monetary punishment, in the civil courts is minimal and ineffective when compared to the "punishment" the marketplace can give a manufacturer or distributor of defective goods. It is the real fear of marketplace reaction rather than the threat of punitive damages that is the actual controlling factor in commercial behavior.

NAPSLO, therefore, recommends that punitive damage laws be eliminated or that action be taken to reform the abuses in punitive damages. Punitive damage reforms such as "caps" on awards, statutory definitions of the precise standard of conduct and proof required to justify a punitive damage award, and the elimination of multiple punitive damage awards in separate cases stemming from the same occurrence should be instituted. To avoid "windfalls" to plaintiffs, states should require that all or a certain percentage of punitive damage awards be used for public purposes. Also, lawyer's fees should be reduced or scaled back for any amount awarded under a punitive damage judgment. A lawyer's role is to represent the client and assure a fair result not to benefit financially from the punishment of others.

J. PREJUDGMENT INTEREST: Presently, twenty seven states by law add interest to the amount of an award in a civil suit. Such interest is added either from the date of the injury or the date the suit is filed. The purpose of such laws is to dissuade defendants from unnecessary delay and encourage prompt resolution of disputes.

These, of course, are very laudable goals. However, all that prejudgment interest laws have actually done is to provide a reason for plaintiffs to delay settlement since more delay will fatten the final award and to give plaintiff lawyers another "sword of intimidation" over the defendants to force them to "settle" questionable cases.

There can be no level of prejudgment interest that can be established that will eliminate delay by either plaintiff and defendant. Thus, the use of prejudgment interest laws to attain the prompt settlement of cases is futile.

NAPSLO, therefore, recommends the elimination of prejudgment interest laws.

As an alternative to prejudgment interest, NAPSLO suggests that court procedures be instituted that make the party that refuses to accept a reasonable pretrial settlement offer from the other party responsible for the other party's attorney fees and court costs. For example, if a settlement cannot be reached, the figure offered or demanded by each party would be a bench mark by which the court would later determine payment of attorney fees and costs. Under this approach, if a final trial judgment exceeds the amount demanded by a plaintiff at a settlement conference, the defendant would be required to pay the plaintiff's reasonable attorney fees. On the other hand, if the judgment is less than the defense counsel's offer, the plaintiff would be required to pay the reasonable

attorney fees and costs of the defendant. If the final judgment fell at or somewhere between the plaintiff's offer and the defendant's demand, neither side would be required to pay the attorney fees and costs of the other party.

Thus, when a plaintiff refuses a defendant's offer of $50,000 to settle the case and the final judgment is $20,000, the court would require the plaintiff to pay the defendant's attorney fees and costs. Such action penalizes the plaintiff for seeking unrealistic damage awards and causing an unnecessary trial. Conversely, if a final judgment is $75,000 and the defendant offered a pretrial settlement of $50,000, the defendant would be responsible for the plaintiff's attorney fees and costs. This punishes the defendant for an unrealistic settlement offer.

The institution of these procedures by the courts would encourage reasonable offers and demands as well as encouraging prompt settlement of cases.

III. SPECIFIC COVERAGES - TORT REFORM

Abuses in the U.S. Civil Justice System have been a fundamental cause of a decline in insurance capacity in certain commercial coverages. To some extent, the proposed general reforms discussed previously would serve to alleviate this problem through all lines of commercial insurance. However, there are some coverages in which specific reform can be taken that will directly impact and ease the present availability crisis.

A. DAYCARE CENTER LIABILITY: Daycare Center liability coverage was never an "easy" risk. The concentration of infants and young children in one facility for a period of time, creates a potential for substantial losses. Even in the best home environments, children can be seriously injured and at times fatalities occur. Thus, when the inevitable "minor" injuries associated with a large group of children are combined with the potential for large losses due to possible serious injury or death, daycare centers become a "difficult" risk to underwrite.

The endemic problems with daycare center liability insurance have been exacerbated recently by the publicity associated with sexual and physical abuse that has occurred in a few daycare facilities. As a consequence, underwriters expect both the severity and frequency of insurance claims to increase. Moreover, many suits may be "delayed" until children reach their age of majority and then take legal action on thier own. Thus, daycare centers offer great potential for major law suits to occur many years after an alleged incident takes place.

Tort Reform and Other Actions: Certainly stricter licensing, inspection and regulation by the state for family or home based daycare centers as well as the "professional" daycare provider would help make daycare facilities more appealing to underwriters. Many states are presently moving in that direction.

In addition, the implementation by daycare center operators of "risk management" and loss control techniques including better background checks of potential employees, disease control, physical hazard control, development and use of the specific supervision criteria based on the number and ages of children and an "open door" policy where parents are allowed to visit the facility at any time will go a long way in reducing the risks associated with daycare facilities.

Finally, one of the major problems with daycare liability insurance is its "long tail" nature. The potential of claims being filed years after the policy was written only adds to the fact that the risk is a difficult one in the first place. Some limitations or "caps" on the period of time in which claims can be filed against daycare centers, perhaps a five-to-seven year statute of limitations from the date of the alledged occurrence, would bring predictibility back into daycare center liability underwriting.

B. GOVERNMENTAL LIABILITY: The lack of governmental liability and, in particular, municipal liability insurance in today's insurance marketplace is directly related to the erosion of the doctrine of "sovereign immunity." Under this doctrine, the federal, state, and municipal governments as well as county, townships and unincorporated divisions of the state are immune from law suits from citizens.

However, both state legislatures and the judiciary, in recent years, have chipped away at the sovereign immunity doctrine particularly as it relates to municipalities. In some states, the state constitution has been amended or state statutes have been changed in a manner that partially or totally abolishes sovereign immunity as it applies to state and local units of government. Also, in some states where the legislature has eliminated the state's immunity, courts have ruled that the repeal also applies to all other political subdivisions of the state.

The courts have also applied a number of theories to circumvent the doctrine of sovereign immunity. Specifically, courts are holding that "governmental functions" are subject to immunity but "proprietary functions" are not. Also, courts have made distinctions between a governmental entity's general duty to the public and specific duty and responsibility to a specific citizen. This has provided individual citizens with the opportunity to sue governmental entities. Governmental entities have also been held liable for damages caused by highly dangerous acts and nuisances. In addition, the liability of municipalities has been expanded by the courts to include liability for violation of the constitutional rights of citizens. Finally, as the ultimate "deep pocket" defendant, municipalities often end up absorbing the full amount of damages under the doctrine of joint and several liability even though its responsibility for the damage was minimal.

Tort Reform and Other Actions: NAPSLO recommends the following measures be taken which will allow a viable market for municipal liability insurance to return:

1) Create state claims commissions to adjudicate claims against both the state government and local jurisdictions;
2) Adopt the Model Governmental Entity Claims Act which provides that governmental entities are liable for their torts but maintains immunity for certain governmental functions such as education, fire protection, utilities, welfare, taxation, crime control and the operation of recreational facilities;
3) Limit the amount of damages given to any one individual in a law suit against

a municipal entity or other state or local goverment jurisdiction;
4) Make certain high risk governmental activities immune from suit by giving immunity for actions involving defective highways, negligent operation of governmental cars, or dangerous or defective conditions of public buildings;
5) Provide that state legislatures and the governing bodies of other local jurisdictions can authorize the payment of claims without having to first waive their immunity;
6) Provide that government is not liable for "willful and wanton conduct" either directly or through actions for indemnity;
7) Allow for state of the art defenses in suits related to buildings and other projects undertaken by governments; and
8) Eliminate ad damnum clauses and introduce procedural reforms including a requirement that courts review attorney fees in cases where the suit is against the state or a political subdivision.

C. PROFESSIONAL LIABILITY: A severe crisis has developed in several areas of the country regarding both the availability and affordability of professsional liability insurance. In some lines of medical professional liability, particularly, prices have risen dramatically in recent months. In addition, reduced limits are common, increased deductibles are required and many insurers are switching to a claims made policy form in order to secure greater predictibility of risk. Specifically, insurance availability problems have arisen for a number of high risk medical specilities most notably obstetrics/gynecology, neurosurgery, orthopedic surgery and cardiology.

Nurse/mid-wives have had problems similar to those of physicians in regard to jury verdicts and, consequently, in obtaining liability insurance. There are other additional factors, nowever, specifically related to nurse/mid-wives that have made availability of insurance for them much more difficult. One such problem is the fact that the standard of care for a nurse mid-wife is less clear than it is for a physician. With this uncertainty as to what constitutes negligence, carriers are not anxious to write nurse/mid-wives. In addition, a lack of licensing standards in certain states and the broader practice for nurse/mid-wives in recent years has increased the risk particularly when licensed physicians are not present. This too makes insurers hesitant to underwrite this group of health professionals.

One reason for this insurance "crisis" among health related professions has been the excessive losses related to high and unreasonable verdicts in medical malpractic lawsuits.

Tort reform and strong peer review activities are the key to stabilizing prices and bringing back insurers into the professional liability marketplace.

Tort Reforms and Other Actions: Peer review activites and tough licensing criteria and procedures are vital in reducing the occurrence of medical malpractice. In order to bring about a more effective peer review and licensing mechanism, certain actions need to be taken:

1) Enactment by state legislatures of mandatory sanctions by peer review committees for certain types of inappropriate and unethical conduct. This would take the peer review committee's disciplinary actions out of the realm of discretion and put all professionals on notice that errant behavior will result in swift and sure disciplinary action;
2) Require doctors and other health care providers to report to their licensing authority their claims record (open and closed claims) including closed claims occurring prior to licensing;
3) Establishment by licensing authorities of criteria setting forth that a specified number of awards over a certain monetary amount within a certain period of time is a basis for license suspension, revocation or non-licensing of a physician or other professional;
4) Require hospitals to institute risk management programs meeting certain standards that the hospital will monitor the activities and claims records of all practioners using the facility. Thus, hospitals would be required to have every professional disclose his or her claims records including all judgments, settlements and pending claims before granting priviledges; and
5) Provide immunity by statute for all persons engaging in good faith in peer review activities.

NAPSLO recommends the following tort reform measures be enacted in the states:

1) Alternative dispute resolution mechanisms including arbitration, mediation and the institution of screening panels in regard to all medical malpractice cases;
2) Modification of the qualifications for expert witnesses in medical malpractice trials. Specifically, a requirement that only licensed practioners of the same speciality and from the same locality as the defendant practioner be qualified as experts;
3) A limitation or "cap" on non-economic damages regarding medical malpractice claims;
4) A requirement that malpractice awards be itemized with amounts being separated into the economic and non-economic damages and into present and future damages;
5) Imposition of sanctions for frivilous claims; and
6) Enactment of a "state of the art" defense or a statutory requirement holding physicians only to the standard of care in effect when the occurrence took place.

D. LIQUOR LIABILITY (DRAM SHOP LIABILITY): In recent years, the problem of alcohol and its dehabilitating effects on our society have become the focus of public concern. In particular, "drunk driving" has received wide spread attention and major efforts both socially and legally have been instituted to reduce the number of intoxicated drivers on our highways. The National Commission Against Drunk Driving estimates that half of the 43,918 motor vehicle fatalities in 1984 were alcohol related.

One means used to control drunk driving has been the establishment of "dram shop" laws in various states. These laws provide that the retail liquor establishment that serves alcohol to a minor or to an intoxicated person who later causes a motor vehicle accident is civilly liable for the damages. In states that have not enacted dram shop laws, courts have invoked common law liability principals which allow recovery against the establishment on the basis that the

establishment violated the state's liquor licensing law in serving a minor or an obviously intoxicated person. Presently, two thirds of the states have either dram shop laws or base "liquor liability" on common law principals. In order to protect themselves, those licensed establishments retailing liquor to the public must obtain liquor liability insurance.

Due to the tremendous public awareness in recent years of the dangers of drunk driving, the frequency of liquor liability lawsuits and dram shop actions has increased. Also, because of the mounting pressure to stop drunk driving, juries have been finding higher and higher amounts of damage in these types of actions.

Obviously, liquor liability has never been an easy risk to write. However, with the changing legal climate surrounding liquor liability, insurers find it even more difficult today to adequately determine their exposure under liquor liability policies.

The problems related to the availability of liquor liability insurance, in most states, is primarily centered on those liquor establishments that try to secure mono-line coverage (liquor liability insurance alone) rather than obtaining this coverage as part of a commercial lines insurance package. In many states, the monoline liquor liability coverage market has contracted dramatically and in some places, it is virtually non-existant.

Tort Reform and Other Actions: In order to alleviate the availability and affordability problems existing in liquor liability insurance market today, NAPSLO recommends the following reforms:

1) Set or retain financial responsibility requirements for liquor licensees at reasonable levels;
2) "Cap" damages under dram shop statutes and other liquor liability laws at reasonable levels;
3) Provide that where dram shop liability exists by statute, it is the exclusive remedy and no other common law theory of liability should be allowed against the retail liquor establishment;
4) Establish by law a responsible business practice defense for liquor licensees;
5) Establish by law a presumption that only the last licensed liquor establishment serving the last alleged intoxicating beverage to a person is liable in a dram shop action;
6) Exclude by law from the class of plaintiffs under a dram shop action the intoxicated person and guests (except for minor guests) in the automobile as well as the spouse and children of the intoxicated person;
7) Limit any cause of action for liquor liability to the "unlawful sale" which should be defined as a sale to one who is a minor or who is visibly drunk. Reliance in good faith by a retail liquor licensee on false identification cards should constitute immunity;
8) Strenghten criminal sanctions against retail liquor establishments that make unlawful sales and, therefore, eliminate punitive damages in a dram shop or liquor liability action;
9) Limit the statute of limitations for a dram shop or liquor liability action to one year;
10) Limit the action under a dram shop act or liquor liability law to vehicular accidents only;
11) Limit liability to the operator of the business not the owner of the premises (unless they are the same); and

12) Retain the intoxicated person as a defendant in all dram shop and liquor liability actions.

Also efforts must be made in the states to strenghten penalties for serving minors and for using false identification cards. Finally, states should require that all employees of a liquor establishment participate in a training program as part of the liquor licensing or relicensing procedure.

E. DIRECTORS AND OFFICERS LIABILITY: The availability of directors and officers liability insurance has become particularly difficult in recent months. Industries which are having particular difficulty in finding such coverage are financial institutions, electric (nuclear) utilities, "wild cat" oil and gas companies, real estate developers, chemical companies, steel companies, research and development enterprises and highly leveraged businesses.

Companies of larger size appear to be having more difficulty than smaller companies in securing directors and officers liability insurance. This is because the capacity constriction that the marketplace is now experiencing falls more heavily upon larger institutions needing high limits of coverage. The problem is also greater for profit making companies than for non-profit organizations. This is due to the fact that non-profit entities do not have the large exposure through dividend distributions, mergers, acquisitions and other financial transactions that profit making companies have. However, if the non-profit organizations begin to have difficulty in obtaining directors and officers liability coverage there will be more legislative/regulatory action in this area to assure a market.

The underlying problems responsible for the coverage limitations and rate increases for director and officers liability coverage stem from:
1) The well publicized financial management difficulties of many U.S. banks and savings and loans. Banks are suing their own managers and officers in some instances are attempting to collect on their own directors and officers coverage. Federal agencies that insure failed banks, in an attempt to make up their losses, are also suing former officers and directors for mismanagement;
2) The growing number of hostile takeovers and other business practices related to such activities as "poison pills," greenmail and golden parachutes; and
3) a growing perception among stockholders that directors and officers are not representing the interests of shareholders.

Tort Reforms and Other Actions: Positive reforms can be implemented through legislative action as well as specific policy exclusions. Such exclusions or legislative actions are:
1) The elimination of suits brought by the FDIC, FSLIC and other government regulatory agencies (the "regulatory exclusion");
2) The elimination of the right of corporations to sue their own officers and directors and the right of officers and directors to sue one another; and
3) The elimination of pollution and environmental claims.

F. POLLUTION LIABILITY: The lack of availability of insurance for pollution liability has been caused by a number of diverse yet related events.

For years, insurers offered coverage for "sudden and accidental" discharge through comprehensive general liability (CGL) policies. Later, insurers created an

environmental impairment liability (EIL) policy to cover the damage which gradual pollution incidents caused. However, as pollution cases were litigated, courts interpreted policy language to cover damages which insurers never intended to cover and for which they had collected no premium. The most significant example of this was the Jackson Township case in New Jersey. In this case, which dealt with the pollution of a number of wells, the New Jersey court:
1) Destroyed the use of the sudden and accidental coverage limitation as a way of limiting or defining pollution coverages; 2) found each contaminated well a separate occurrance with separate limits; and 3) broadened the coverage to include the costs of on-site clean up.

In addition to court created problems, federal and state legislatures have enacted various environmental laws. Specifically, the federal government in 1980 enacted the Comprehensive Environmental Response, Compensation and Liability Act (CERCLA), the "Superfund Law," which imposes retroactive and broad liability for the costs involved in the cleanup of toxic waste dumpsites. Forty states have enacted their own environmental protection laws which have been modeled after this Federal Superfund Act.

The Federal Superfund Law poses at least four major problems for insurers. First, the provisions of the law apply retroactively to generators and transporters of toxic waste and to owners and operators of toxic waste sites.

Second, the law imposes strict liability regardless of the fact that the responsible party's acts or omissions were not the proximate cause of any leak or the fact that the substance that is leaking was not actually deposited by that party. In essence, simply being involved in the dumping of waste at a site will create responsibility.

Third, a majority of the courts have held responsible parties jointly and severably liable for damages related to the cost of cleanup under the superfund law. Thus, a company only contributing 1% of the polution can be held responsible for the entire cost of the clean-up.

Fourth, the legal costs and attendent investigative costs involved in a "superfund action" are substantial and insurers, therefore, incur enormous transactional costs in superfund "actions".

Thus, problems with the superfund law and its administration by the Environmental Protection Agency (EPA) combined with state court decisions eliminating coverage limitations or exclusions in insurance policies regarding pollution liability has led to a withdrawal from the marketplace by the insurance industry.

Tort Reforms and Other Actions: NAPSLO recommends the following revisions to state and federal environmental pollution laws and to common law actions regarding environmental pollution liability to restore market stability and to increase predictibility for environmental pollution liability insurance:
1) A reinstitution of causation requirements and elimination of retroactive application of environmental laws;
2) A replacement of joint and several liability with several liability;
3) A replacement of strict liability with a negligence standard; and

4) The implementation of flexible financial responsibility requirements that are reflective of the risks involved rather than one standard for all generators, transporters, owners and operators of waste dump sites.

Asbestos: Included within the general framework of environmental "pollution" insurance problems are the difficulties asbestos contractors presently have in securing liability insurance. The great hazards asbestos poses to human beings has just recently been discovered. The demand by the public and the requirement by many state legislatures that asbestos be removed from schools and other public buildings as well as the growing commitment by private industries to eliminate asbestos from their facilities has resulted in a surging demand for asbestos removal contractors. The present demand far exceeds the supply of qualified and experienced contractors.

A number of new contractors have recently entered the asbestos removal business. Insurers, however, have elected to deny coverage to these inexperienced contractors. In addition, insurers concern about long latency diseases associated with asbestos, previous bad experience with asbestoes product claims, the lack of removal standards and the possibility that the state of the art performance will not be accepted as a legitimate defense in future action, all make insurers leary of providing coverage to asbestos removal operators.

Accepted standards for a removal of asbestos need to be developed. Strict licensing procedures also must be established for asbestos removal contractors and immunity or "hold harmless agreements" for contractors for "non negligent" actions which comply with established governmental standards also need to be developed and implemented. If these actions are taken, the problems in the asbestos removal liability insurance market would be eased.

IV. CONCLUSION

Major revisions in this nation's tort system are needed if many commercial lines of insurance are to remain available and affordable. If the U.S. tort system is not modified to a significant degree very soon, insurers will continue to be unable to predict or assess risks and, therefore, will be unable to provide insurance. This will have a devastating impact on the American economy for many businesses in this country will be unable to purchase necessary liability coverages to protect their assets.

There are those who charge that the present "availability and affordability crisis" in the property/casualty insurance market is directly attributable to the insurance industry and its failure over the past five years to apply prudent and proper underwriting and pricing policies. Such a comment simply "begs" the issue. How are insurers to employ prudent underwriting and pricing practices in the face of courts that alter policy wording and limitations; that apply liability retroactively; that sanction, if not encourage, expensive procedural delays; develop new theories of liability rather than seeking out justice; and view the insurance industry as a "banking system" to use whenever a claimant desires compensation? The answer is that the insurance industry can not institute any true underwriting or pricing practices in such an environment.

The tort reforms and suggestions NAPSLO has set forth in this paper are simply aimed at bringing about a tort/liability system that allows insurers to operate in a fair and predictable environment. If reforms are not made, what is now seen as a "crisis" will become a permanent condition.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date : _____

REQUEST

Bill/Resolution No. : CSSB 377(L&C)
Title :Relating to civil actions; amending Alaska Rules of Civil Procedure 49, 52, 58 68, and 82; and providing for an eff date"
Sponsor : Sen Kelly, et al
Requestor : _____
Date of Request : _____

FISCAL DETAIL

Agency Affected : Court System
BRU : _____
Components : _____

EXPENDITURES/REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	
CAPITAL	0	0	0	0	0	
REVENUE	0	0	0	0	0	

FUNDING : (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	

POSITIONS :

FULL-TIME	0	0	0	0	0	
PART-TIME						
TEMPORARY						

ANALYSIS : Attach a separate page if necessary

Prepared by: Michael Thill, Aide — Phone : 3844
Division : Senate Labor and Commerce Committee — Date : 4/1/86

Approved by Commissioner : Senator Zharoff, Chairman — Date : 4/1/86
Agency : Senate Labor and Commerce

Distribution (by Agency preparing fiscal note) :
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

10/25/85

SB 377

health association of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
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Morris Horning, M.D.
Anchorage

President
Dennis DeWitt
Juneau

FORMERLY
alaska state hospital association

April 14, 1986

Honorable Pat Rodey
Alaska State Senate
Pouch V (MS3100)
Juneau, Alaska 99811

Dear Senator Rodey,

The Health Association of Alaska wishes to indicate our support for the proposal to limit liability of directors and officers of our member institutions. It is important to our continued ability to recruit members of the public to serve in this important activity.

In response to your concern that corporate directors of any investor owned corporation be treated consistently, I would like to suggest an amendment to the proposed language which may resolve that concern. Amend 09.17.045(a)(2) to read: "a member of the board of directors of a public or nonprofit hospital or a community based advisory board of a hospital;". I believe that this language accomplishes the goal within the parameters you have suggested.

Thank you for your consideration in this matter.

Sincerely,

Dennis L. DeWitt
Executive Director

Enclosure

cc: Representative Hanley

Sec. 09.17.045. LIMITED LIABILITY OF CERTAIN DIRECTORS, OFFICERS AND SUPERINTENDENTS. (a) Unless the act or omission constituted gross negligence, a person may not recover damages for an act or omission to act, in the course and scope of official duties, from the following:

(1) a member of the board of directors or an officer of a nonprofit corporation;

(2) a member of the board of directors of a public or private hospital;

(3) a member of a school board or superintendent of a school district;

(4) an elected or appointed official of a political subdivision of the state.

(b) Notwithstanding (a) of this section, the duties and liabilities of a director or officer of a nonprofit corporation to the corporation or the corporation's shareholders may not be limited or modified.

ALASKA STATE LEGISLATURE
SENATE JUDICIARY COMMITTEE

SENATOR PATRICK RODEY, CHAIRMAN
SENATOR TIM KELLY, VICE-CHAIR
SENATOR JAN FAITH
SENATOR RICK HALFORD
SENATOR ROBERT ZIEGLER, SR.

POUCH V
JUNEAU, ALASKA 99811
(907) 465-3717

M E M O R A N D U M

To: Senator Rick Halford

From: Senator Pat Rodey

Date: April 9, 1986

Re: SB 443 - Surplus lines of insurance/brokers monthly reports.

We need a bill with an insurance related title in order to write a comprehensive insurance reform package as a Judiciary Committee Substitute.

Your SB 443 is now in the Senate Labor and Commerce Committee. Would you consent to modification of this bill to include this reform?

ALASKA STATE LEGISLATURE
SENATE JUDICIARY COMMITTEE

SENATOR PATRICK RODEY, CHAIRMAN
SENATOR TIM KELLY, VICE-CHAIR
SENATOR JAN FAIKS
SENATOR RICK HALFORD
SENATOR ROBERT ZIEGLER, SR.

POUCH V
JUNEAU, ALASKA 99811
(907) 465-3717

MEMORANDUM

To: Senator Fred Zharoff

From: Senator Pat Rodey

Date: April 9, 1986

Re: SB 443 - Surplus lines of insurance/brokers brokers monthly report.

We need a bill with an insurance related title in order to write a comprehensive insurance reform package as a Judiciary Committee CS.

The above-referenced bill is in your committee and would be an ideal vehicle. We would appreciate you moving the bill out of your committee with a Judiciary Committee referral.

ROBERT J. SAMUELSON

The Lawyering of America

We are now seeing the glimmers of a new legal crisis in America. It arises from the clamor over liability insurance and a vague unease that lawyers are exercising too much influence. The United States now has more lawyers (an estimated 675,000 of them in 1985) per capita than any other major nation. Since 1950, their numbers have grown twice as fast as the population. But our sense that lawyers are meddling too much sits awkwardly with the great American faith in law as a remedy for almost any ill. Or, as one book a few years ago put it, "Sue the B*st*rds."

The key to understanding this confusion—if not entirely dispelling it—is to grasp a basic truth. Lawyers and law firms are businesses, and their business is conflict. Creative lawyering often means exploiting or creating conflicts. Just as companies develop new products, so lawyers search for new legal theories on which to sue. Rights of action are lawyers' markets. But their economic self-interest—their legal innovations—may subvert their social usefulness. The civil-justice system's essential purpose is to resolve conflict, not to excite it.



The big danger is becoming an overly cautious, rigid society

It's often a pretense that lawyers represent other people's grievances rather than their own economic interests. There are thousands of cases where lawyers, not their supposed clients, are the main aggressors. In the early 1980s, for example, many new "high technology" companies sold stock to the public. Many of these admittedly speculative stocks subsequently collapsed. Now there are dozens of suits against these companies, their officers, accountants and insurance companies alleging that investors were misled. But the suits have been brought by a few law firms on a contingency-fee basis. The lawyers—who typically take 30 percent or more of a settlement or damages—stand to win the most.

Of course, a rising tide of lawsuits is not the only reason for more lawyers. Greater government regulation, complicated tax rules and expanding international business have all contributed. But the growth of lawsuits also has a big multiplier effect. It requires defense lawyers and lawyers to advise people and companies how to avoid being sued. Consider the evidence of more litigation:

- Since 1970, membership of the Association of Trial Lawyers of America has nearly tripled, to 60,000. (In the same period, all lawyers rose 90 percent.) To belong, half a lawyer's work must be representing people in personal-injury cases.
- The number of product-liability cases filed in federal courts has risen from 1,579 in 1975 to 10,745 in 1984. Although most cases are settled before trial, the volume of jury awards in product-liability and medical-malpractice suits roughly tripled between 1975 and 1984, says Jury Verdict Research Inc.
- Since the mid-1970s, suits against officers and directors of public corporations—from shareholders, employees, customers and others—have more than doubled, according to The Wyatt Co., a Chicago actuarial firm. Many of these cases are contingency-fee cases.

To be fair, the liability-insurance mess—complaints from doctors, cities, consulting engineers, day-care centers and others that insurance is too costly or unavailable—is not entirely the doing of lawyers. The insurance industry bears much of the blame. A few years ago companies lowered premiums to compete for business. They expected to earn lush profits by investing premium income at high interest rates. Declining interest rates wrecked that gamble and, combined with steep insurance losses, triggered premium increases and coverage cutbacks. But the insurers' blunder only mitigates the role of lawyers.

Side effects: If courts adopt expansive liability doctrines, then the costs—not just insurance—will be huge. The gravest danger is becoming a precautionary society. Unintended side effects are already emerging. The threat of suits has driven some drug companies from manufacturing vaccines; consulting engineers now refuse to work on hazardous sites for fear of suits. Companies are losing outside directors for lack of liability coverage. As attorney Peter Huber argues, courts deal poorly with the full social effects of products, like vaccines, whose public benefits overwhelm the risks. Courts see only mistakes. "Beneficiaries of risk-reducing products . . . do not litigate," he writes.

Stating the problem is easier than solving it. Lawsuits are an important discipline on corporate and individual irresponsibility. They do compensate victims. There is no neat dividing line between too much or too little liability. But we can impose self-restraint on the legal system by treating lawyers for what they are—businesses. We need legal rules with proper economic incentives. In damage suits, the losing side should always pay the other side's legal fees. This would deter weak suits by reducing the pressure for expedient settlements that are less than the cost of litigation. And a losing defense would ultimately pay if its delays ran up the other side's costs.

These common-sense ideas strike many lawyers as radical. They aren't. One inevitable complaint is that having losers pay would make it tougher for people of modest means to bring legitimate cases to court. This is nonsense. The reality is that the contingency-fee lawyer is already financing these cases. Strong cases would be more attractive under this system, because—aside from the contingency fee—the lawyer would also recover costs. But weak cases would be less attractive (the losing contingency-fee lawyer would pay the other side's legal fees), and they should be. The system exists to settle conflicts, not to generate lawyer caseloads. In a subtle way, commercial interests of lawyers now corrupt the law.

So let the lawyers grumble. If the current insurance mess leads to any good, it will be renewed political interest in our legal system. And that is as it should be. To paraphrase an old cliché: law is sometimes too important to be left to lawyers.

Must Reading

by Linda L. Castle

Juries hit corporate and government defendants hardest

Jurors returned one-third larger damage awards against corporate defendants than against individual defendants, and their verdicts went against blacks more often than whites, both as plaintiffs and defendants, according to a recent survey. The study, performed by the Rand Corp.'s Institute for Civil Justice, included more than 9,000 civil jury trials over a 20-year period in the Chicago area.

Rand terms its survey "the most sweeping and systematic analysis in the annals of U.S. law of juries' behavior in connection with different characteristics of litigants." The survey findings are reported in "Deep Pockets, Empty Pockets: Who Wins in Cook County Jury Trials," written by Rand staffers Audrey Chin, a social scientist, and Mark A. Peterson, a lawyer.

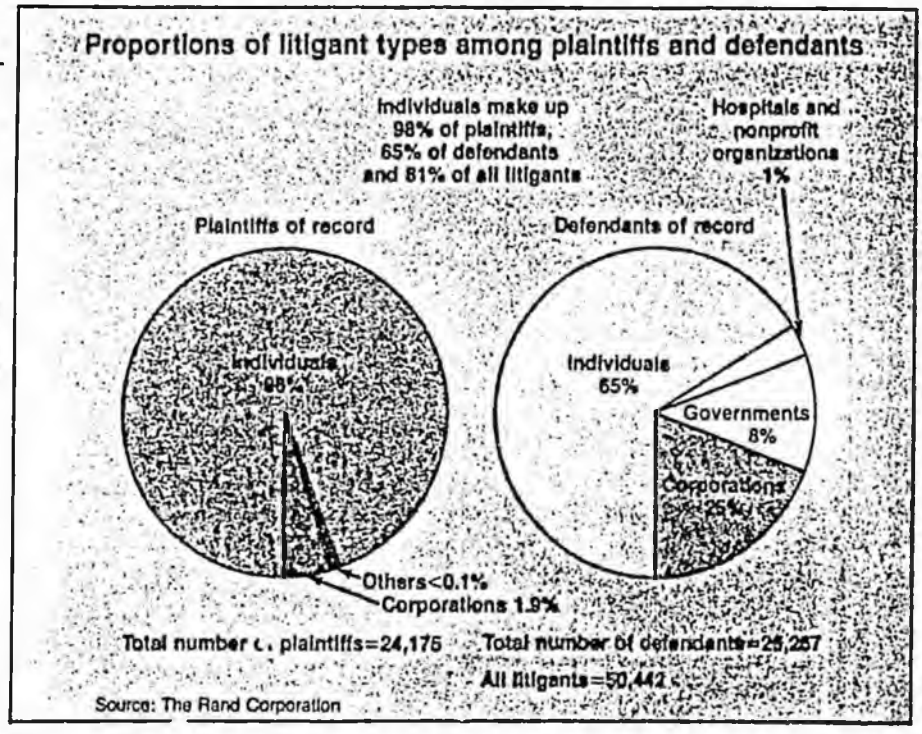
Chin and Peterson also report that:

- In lawsuits in which plaintiffs claimed severe injury, corporations not only had to pay higher damage awards "but were significantly more likely to be found liable in the first place."
- In lawsuits in which injuries were comparable in kind but less severe, however, government defendants paid more than corporations.
- Blacks lost more often than whites, both as plaintiffs and defendants, and black plaintiffs received smaller awards. Black defendants were assessed smaller damage awards than white defendants.

The authors point out that while their findings seem to indicate that juries treated types of litigants differently, it is possible that trials differed among types of defendants in ways not examined in the researchers' analyses—differences that also might have affected outcomes. Chin and Peterson nevertheless add that "while these limitations require caution in drawing conclusions, the results of our analyses are statistically robust, stable over time, and consistent with widely held expectations about how juries treat different types of litigants."

The authors also found that jury trials were an effective vehicle for compensation to ordinary citizens, contradicting the cynical view that the court system favors the wealthy and powerful.

Corporations made up 2 percent of the plaintiffs and little more than 25 percent of the defendants in the survey; government agencies accounted for 8 percent of defendants but only 13 government agencies were plaintiffs in civil jury trials. Defendants in lawsuits that produced the largest awards were usually "deep-pocket," or institutional, defendants.



Average award tops $120,000

Corporations were the most frequent defendants in high-stakes trials arising from workplace injuries, products liability and business or contract disputes, but only one-third of these corporations were named as a sole defendant, the authors found. The average award against corporate defendants was more than $120,000—$97,000 in the case of hospitals and other nonprofit organizations—while the average award against individual defendants was $18,500. "To some degree," the report says, "the average awards against corporations and hospitals were so great because of a few extraordinarily large awards."

Even routine awards against corporations were large, however, half of them more than $25,000. This was more than twice the median award against government defendants ($11,000), and more than four times that against individuals ($5,800).

The "deep-pocket" effect was most evident, the report shows [illegible] severely injured plaintiffs sued corporations, which paid 4.4 times more than was assessed individual defendants. "Where a government defendant might pay $75,000 and an individual defendant $50,000 to a severely injured plaintiff, a corporate defendant would pay $220,000," say Chin and Peterson.

"Long-shot" gambles

The authors found that malpractice trials were "long-shot" gambles for both plaintiffs and defendants. "Plaintiffs won only about one-third of the time, but received large awards when they did win," with hospitals and doctors treated like "deep-pocket" defendants.

Chin and Peterson conclude that their study might "improve lawyers' and litigants' understanding, so that particular types of potential litigants are neither discouraged from bringing lawsuits nor unwisely encouraged to go to trial."

("Deep Pockets, Empty Pockets: Who Wins in Cook County Jury Trials." Rand Corp., Publications Department, 1700 Main St., P.O. Box 2138, Santa Monica, Calif. 90406-2138. $10. (Report No. R-3249-ICJ).)

Racist joke in jury room kills death sentence

The Illinois Supreme Court ordered a retrial for a black man convicted of murder and sentenced to death by an all-white jury because three jury members said they read a racist joke in the jury room.

A courthouse janitor discovered a mimeographed copy of a racist joke and turned it over to the bailiff, who notified the trial judge. The trial court denied the defendant's motion for a mistrial, but the supreme court reversed.

Justice Goldenhersh held that prejudice to the defendant will be presumed in "such intolerable circumstances." He surmised that the failure of the jurors to bring the material to the attention of the court could be "indicative of either lack of appreciation for their responsibility as jurors, or that they did not consider it offensive."

The court refused to disseminate the "scurrilous material," saying "it suffices to note that it contains denigrating, racist comments which are insulting to black people."

(*Illinois v. Jones*, Feb. 6, 1985, 475 N.E. 2d 832.) —*Lauren R. Reskin*

California OKs cap on medical malpractice awards

A divided California Supreme Court has upheld the constitutionality of a state law limiting noneconomic damages in medical malpractice cases to $250,000.

Writing for the 4-3 majority, Justice Kaus rejected the arguments of an injured lawyer that the limit of the Medical Injury Compensation Reform Act of 1975 den s due process and equal protection. T measure is rationally related to the legitimate state interest in lowering costs of malpractice defendants and their insurers, Justice Kaus reasoned.

The court cited several possible legislative rationales for the $250,000 limit: it provides a more stable base on which to calculate insurance rates; it promotes settlements by eliminating the chance of huge awards for pain and suffering, which can "make litigation worth the gamble;" and it is fairer to malpractice victims to reduce only the very large noneconomic awards rather than the more modest recoveries in most of the cases.

Chief Justice Bird, joined by Justice Woods, dissented vehemently. "Insurance is a device for spreading risks and costs among large numbers of people so that no one person is crushed by misfortune. In a strange reversal of this principle, the statute concentrates the costs of the worst injuries on a few individuals," she said, lamenting that the majority opinion disregarded the court's duty "to apply the constitutional guarantee against irrational and invidious leglislative classifications"—crisis or no crisis.

Justice Mosk agreed with Bird's dissent but would have used an intermediate equal protection test.

(*Fein v. Permanente Medical Group*, Feb. 28, 1985, 695 P.2d 665.)

—*Lauren R. Reskin*

Contractor acts "under color of federal law"

The U.S. Court of Appeals for the District of Columbia Circuit has ruled that constitutional claims for damages

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CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

MEMORANDUM

TO: ALL LEGISLATORS

FROM: CITIZENS' COALITION FOR TORT REFORM

SUBJECT: FOR YOUR INFORMATION

Enclosed is a comparison of the current settlement practices versus the Citizens' Coalition for Tort Reform proposals under HB532.

The enclosed document in effect lays out the facts and numbers of a particular case to show how effectively the Coalitions proposals would work.

I believe you will find tort reform will work and that the proposals by the Citizens' Coalition will get more money to the injured client and reduce the cost of litigation while providing a substantial benefit to all injured parties.

Sincerely,

Al Tamagni, Sr.
Chairman

738 H Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-1135

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

Vol. I, No. 2 February 19, 1986

WE'RE MAKING NEWS

The Anchorage Board of Realtors News for February includes an article on the coalition's push for legislation, written by Marigale Compton, CCTR board representative for the Anchorage Realtors. Dr. Vince Haneman, P.E., has authored an essay on tort reform which will run in the Fairbanks News-Miner.

The successful Alaska Air Carriers convention in Juneau last weekend included a program on tort reform. CCTR was represented by Dr. Dave McGuire.

Dr. Peter Cannava spoke to the Kenai Chamber of Commerce earlier this month; by coincidence, Rep. Mike Navarre, chairman of the key House Labor and Management Commitee, was in the audience.

ENDORSEMENTS

In addition to the groups which have formally joined the Coalition, we now have the endorsements of the Sitka Chamber of Commerce and the Professional Engineers in Private Practice (PEPP).

JURY AWARDS: WHO LOSES?

The biggest losers in the current jury award lottery system seems to be corporations, governments and blacks, according to the Rand Corporation's Institute for Civil Justice. The survey findings are reported in "Deep Pockets, Empty Pockets: Who Wins In Cook County Jury Trials," a 20-year study of more than 9,000 civil jury trials in Cook County, Illinois.

Written by a social scientist and a lawyer, both Rand staff members, the report shows that:

In lawsuits in which plaintiffs claimed severe injury, corporations not only had to pay higher damage awards "but were significantly more likely to be found liable in the first place."

However, in lawsuits in which injuries were comparable in kind but less severe government defendants paid more than corporations.

Blacks lost more often than whites, both as plaintiffs and defendants, and black plaintiffs received smaller awards. Black defendants were assessed smaller damage awards than white defendants.

THE POLIO VACCINE: PAYS BETTER THAN A VEGAS SLOT MACHINE

In 1975, a Kansas farmer had his infant daughter vaccinated for polio with the Sabin oral vaccine. She spit some of it up on his hands. He came down with polio and claimed it was contracted from his daughter. He lost partial use of his arm and has some breathing problems as a result. His attorney, noted for winning record-breaking awards, managed to set a new Kansas record, when the jury awarded the farmer $2 million actual damages and $8 million in punitive damages. An attorney on the plaintiff's team termed the award "a civil penalty ... for wanton wrongdoing, more than simple negligence." The federal Center for Disease Control in Atlanta, Georgia, says that about 24 million doses of the oral vaccine are distributed each year. One in every 9.3 million results in polio. Among people coming into contact with a vaccinated child, the risk is 1 in 5.1 million. The CDC notes that in 1977, the vaccine's wholesale cost was 29 cents; as of February 1, 1986, it is over $8 per dose, minimum. The manufacturer, Lederle, issued a memo to doctors on January 28 saying "All indications are that Lederle may not be able to get any liability insurance coverage for vaccines after July 1, 1986."

If you are old enough to remember the last polio epidemics of the early 1950s, and iron lungs in which some youngsters lived out their short lives, you have to question the premise that the vaccine manufacturer was guilty of anything except saving thousands of lives, and preventing disabilities in thousands more.

CANDIDATE BOB RICHARDS SUPPORTS TORT REFORM

In a letter to CCTR Chairman Al Tamagni, gubernatorial candidate Bob Richards writes: "I am in complete accord with all of the provisions of the program proposed by the Citizens Coalition for Tort Reform and am prepared to aggressively pursue you objectives as governor."

738 H Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-1135

'FAMOUS CASES' IN THE LOTTERY GAME

CCTR speakers have been questioned by plaintiff's lawyers about some of the cases we have been citing. While we are not interested in doing their research for them, here are some court citations which you may want to memorize:

A 41-year old body builder entered a footrace with a refrigerator strapped to his back. The strap broke; he got hurt. He sued and won over $1 million. The case was Franko Colombo v. Transworld International, et al., C223 491 September 23, 1982; Los Angeles Superior Court. Prior to an appeal of the jury award, the case was settled in excess of $1 million; no specific figure available.

The hot air balloon in the dryer: A pair of balloonists decided to dry their wet hot air ballon in a commercial laundry dryer. The balloon and dryer blew up, destroying the laundry, and the men were hurt. They sued and won $885,000. Horan v. American Laundry Machinery Industries, Maryland Court of Appeals.

Remember the man who claimed that his Sears lawnmower was so hard to start, that it triggered a heart attack? That case was Frederick S. Share v. Sears Roebuck Co., Pennsylvania Common Pleas Court, Case No. 2984 PA.C April 27, 1984. Mr. Share already had a history of coronary problems. The jury awarded him $1.2 million plus damages for $550,000 for delays in settling the claim. Prior to Sears appealing the award, there was an out of court settlement for an undisclosed amount.

NEED MORE INFORMATION. WRITE OR CALL THE COALITION

The Citizens Coalition for Tort Reform
738 H Street, Suite 100
Anchorage, AK 99501
(907) 276-1135





Hon. Patrick Rodey
P.O. Box V
Juneau, AK 99811

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THE CITIZENS COALITION FOR TORT REFORM

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Alaska Dental Society
Alaska General Contractors
Alaska Chapter, American Optometric Association
Alaska Movers Association
Alaska Oil Marketers Association
Alaska Rental Association
Alaska Section, Fairbanks Branch, American Society of Civil Engineers
Alaska Society of Professional Engineers
Alaska State Health Association (Hospitals)
Alaska State Medical Association
Alaska Support Industry Alliance
Alaska Truckers Association
Alaska Visitors Association
Anchorage Board of Realtors
Anchorage Restaurant and Beverage Association (ARBA)
Cabaret Hotel and Restaurant Retailers (CHAR)
Childbirth Educators
Daycare Operators Association
Financial Managers
Hotel and Motel Association
Insurance Brokers and Agents Association
Nurse Midwives Association
Pension Consultants
Professional Physical Therapists Association
Risk Management Association
Southern Alaska Association of Life Underwriters

Alaska State Legislature

Senate

SB 377 file

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Juneau, Alaska 99811

MEMORANDUM

To: All Senators

From: Senator Tim Kelly TDK

Attached is a copy of an article from the Seattle Post-Intelligencer on the efforts of the Washington Legislature to address the tort reform problem.

Seattle Post-Intelligencer
A HEARST NEWSPAPER
Tuesday, March 11, 1986
25 Cents

Lawmakers OK limits on awards to injured

By Mary Rothschild
P-I Olympia Bureau

OLYMPIA — An extensive rewrite of state liability laws, with tight limits on damage awards for the injured, was approved 31-16 last night by senators convinced their actions will ease the insurance crisis.

In voting to concur with amendments already approved by the House, the Senate sent the bill to Gov. Booth Gardner, who must decide whether to sign it into law.

Senate opponents argued that the bill will not make liability insurance more available or affordable but will crush the rights of injured victims.

In emotional debate on a bill that has been the hottest issue of this legislative session, the Senate majority leader, Democrat Ted Bottiger of Graham, said he was so distressed he "thought very seriously" about resigning.

'Anti-victim'

"This is the worst thing I've ever seen in this Senate," he said.

Sen. Phil Talmadge, D-Seattle, said the bill will guarantee nothing more than years of "uncertainty, conflict and court challenge" and called it "the most comprehensive anti-victim legislation ever passed by the state of Washington."

But Sen. Alan Thompson, D-Kelso, argued, "If this is extreme, then this radicalism is sweeping the country."

Thompson, prime sponsor of the measure, was joined by Republican leader Sen. Jeanette Hayner of Walla Walla in contending the bill will reform the rules of liability and thus cut insurance costs.

The bill's main features include:

☐ Eliminating a rule called "joint and several" liability if the injured party is even partially at fault.

A rewriting of this rule, which had allowed a plaintiff to collect from any defendant regardless of the defendant's degree of fault, was the primary goal of the coalition sponsoring the legislation.

☐ Capping non-economic damages for "pain and suffering" at $573,000, with a minimum award of $117,000.

Compensation for lost wages and medical expenses still would be unlimited.

☐ Allowing damage awards to be spread out in installments

See SENATE, Page A-6

INSIDE

☐ The Legislature moved closer to adjournment by passing a supplemental budget of $102.9 million/A5

☐ Sen. H. A. "Barney" Goltz, president pro-tem of the state Senate, said he won't seek re-election/D2



DAVE EKREN/P-I PHOTO

Sen. Phil Talmadge almost seems to be praying for defeat of revisions of the state's liability laws, but the Senate later approved them. Talmadge argued that passage of what he called the "anti-victim legislation" would guarantee "uncertainty, conflict and court challenge."

Pay raise for state elected officials clears Legislature

OLYMPIA (AP) — State senators gave final legislative approval yesterday to give themselves and other state elected officials a pay raise.

The Senate passed the bill, 30-14, and sent it to Gov. Booth Gardner for signing, after agreeing to changes made by the House. Seven minority Republicans joined two dozen Democrats in voting for the measure.

Some elected officials, who haven't had a pay increase since 1980, would get raises of up to 80 percent.

Legislators would get step increases to raise their pay from the current $13,650 a year to $17,000 a year by Jan. 1, 1990. They would have to win re-election before they could get the pay increase.

Other elected officials would receive a raise Jan. 1, 1987, and another on Jan. 1, 1988. Here are current salaries followed by those two-step increase amounts:

☐ Governor, $63,000, $74,900, $86,800.

☐ Lieutenant governor, $28,600, $42,400, $53,800.

☐ Secretary of state, $31,000, $42,400, $53,800.

☐ Attorney general, $47,100, $55,450, $63,800.

☐ Superintendent of public instruction and land commissioner, $42,800, $53,300, $63,800.

☐ Auditor, treasurer and insurance commissioner, $37,200, $46,450, $55,700.

Salaries for legislators would rise to $14,500 on Jan. 12, 1987; $15,000 on Jan. 1, 1988; $16,000 on Jan. 9, 1989, and $17,000 on Jan. 1, 1990.

The vote:

Democrats for (24) — Bender, Bottiger, Conner, DeJarnatt, Fleming, Gorrell, Gaspard, Gaitz, Halsan, Hansen, Kreidler, McDermott, McManus, Moore, Owen, Peterson, Rasmussen, Rinehart, Talmadge, Thomsen, Vognild, Wojahn, Williams, Walgh.

Republicans for (7) — Bailey, Bluechel, Deccio, Johnson, Kiskaddon, McDonald, Metcalf.

Democrat against (1) — Bauer.

Republicans against (13) — Barr, Benitz, Crawford, Curtis, Hayner, Lee, McCaslin, Newhouse, Patterson, Pullen, Soling, von Reichbauer, Zimmerman.

Absent or excused, Conlu, R. Grenlund, Stratton, D.

Winds kill five

70 injured as storms rake three states

Associated Press

Tornadoes and winds up to 90 mph raked Indiana, Kentucky and Ohio yesterday, killing at least five people and injuring as many as 70, while cutting electricity to thousands of people and destroying dozens of airplanes at Cincinnati's airport.

About 40 people were injured in Newport, Falmouth and Erlanger, Ky., state police said. Eight to nine injuries were reported in Lexington and Bromley, Ky., 22 in Indiana and four in Ohio.

In nearby Covington, Ky., which is across the Ohio River from Cincinnati, officials declared a state of emergency and warned non-residents to keep out of the city after high winds knocked out power to most of the city and ripped roofs from dozens of buildings.

Trailer park hit

High winds "just wiped out" a trailer park on the west side of Indianapolis and caused heavy damage to several businesses, said a Marion County sheriff's dispatcher. No casualties were reported there.

The National Weather Service's Severe Storms Center in Kansas City reported at least 21 tornadoes, with 15 touching down in Indiana.

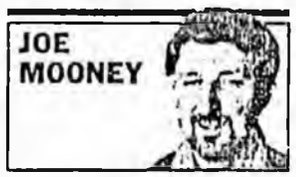
In Hancock County, Ind., a man was crushed to death when the barn in which he and his brother sought refuge collapsed under high winds. His brother suffered minor injuries.

Near Evansville, Ind., a man died when struck by a falling tree limb while working on a house, police said.

Roof drops man

In Jasper Township, Ohio, a

U.S. football gets rolling in China — think of the options



The estimated population of China in 1984 was more than 1 billion people — 1,034,907,000 to state it numerically, and somewhat more precisely.

It's almost impossible to appreciate a number that large. Consider this: If you had a billion dollars at the time of Christ and began losing $1,000 a day, you'd still be in business. You wouldn't be broke until sometime after the year 2,000.

Of course, if you had your heart set on blowing it all by the year 2000, it could be arranged. But you'd have to contrive some way to increase your losses to $1,369.86 a day.

As you can see, a billion dollars is a lot of money. And a billion people are a lot of people. A friend of mine, trying to impress me with the importance of opening up trade relations with China (which I now plan to do at my next opportunity), said, "Can you imagine the economic consequences to the Northwest if we just sold toilet paper to that many people?"

The Super Bowl

Well sir, I bring this up today not because we're about to sell toilet paper to China, but because we're about to sell something far more exciting: professional football.

In fact, it may already have been sold. Last weekend, amid a great deal of excitement, Super Bowl XX — the Chicago Bears against the New England Patriots — was shown nationwide on China Central Television, the state network.

Central Television has previously shown several National Football League games, but most Chinese are still unfamiliar with the sport, which in Chinese is translated as "olive ball."

What is plain from this is that the Chinese needed a crash course in something — either English or football. And as luck would have it, they got one — in football, compliments of the official Communist Party newspaper People's Daily.

'Crash course'

For those who want to "see ourselves as others see us," or *at both ends of the field is 10 yards wide.*

One side can score six points by reaching the gate area of the other side and score another point if the ball is kicked into the gate again.

Three points can be scored if the ball is kicked into the gate from outside the gate zone.

Each side has 11 players, and a side loses its chance to attack if its players cannot move ahead 10 yards during four attacks.

Potential enormous

I don't normally give financial advice in this space, but if I had some money to spare I think I'd put it into the helmet and shoulder pad industry. Not only is the sales potential enormous if the Chinese people take to the game, but the markup is also much greater than on toilet paper.

The question, of course, is whether olive ball can steal the Chinese heart. Nobody knows that for certain, but as one Chinese office worker said when he learned the game would be televised, "It's so much more exciting than Ping-Pong."

In the People's Republic, that's high praise.

* * *

The other day in this space I was talking about a friend of mine here at the P-I. I talked about his shiny Cadillac, which I said was gray. And I talked about his philosophy, which I said was sanguine. (Actually what I said was that he believes life is fair, that jerks always get it in the end.)

Here's an update, taken from a message I found when I got to work:

"It is silver, Joe. (He means the car.)

"And they always get it *during* (he means during their lives, not necessarily in the end) and they always do it to

Senate votes to limit awards

From Page A-1

rather than paid in one lump sum.

❑ Requiring medical malpractice suits involving children to be brought within three years of the negligent act or within one year of discovery.

Gardner, declining to say whether he will sign the bill, promised yesterday to have his staff and the attorney general's tort division "review it intensively."

The governor, who has remained outside the sometimes bitter lobbying battle waged by both sides, called limiting liability "an issue that came cascading out of the ocean — just one big tidal wave that caught everybody without a great deal of foreknowledge."

But Gardner conceded he believes the proposed changes will have some impact on reducing insurance rates.

That's what the powerful coalition of city and county governments, businesses, day-care operators, physicians and insurance companies supporting the bill have promised. Called the Liability Reform Coalition, their lobbyists wrote the final version of the bill.

All the coalition members have been hit hard by sharp rate increases in liability insurance. Some have seen their policies canceled, leaving them without any coverage.

If the limits to liability laws are found to be constitutional, coalition representatives predict reductions in their insurances premiums of up to 30 percent.

The coalition's efforts were opposed by an alliance of trial lawyers, labor unions and victims' groups such as Mothers Against Drunk Driving and the Church Council of Greater Seattle.

They ran a well-financed, highly organized media campaign against rewriting liability laws, arguing that insurance companies have created the rate crisis through their investment decisions.

But the coalition, which won bipartisan legislative support at the beginning of this 60-day session, proved to be a juggernaut that couldn't be stopped.

Talmadge failed in a procedural attempt to add new amendments to the bill, including a 15 percent limit on insurance premium increases.

He acknowledged that the move would have returned the bill to the House, where it would have to go through the hearing process. That would have killed the measure for this session.

"I believe there are needed changes in tort and civil justice," Talmadge said, but he argued for more time to work out a better agreement.

In the heat of nearly two hours of debate on the issue, Sen. Jim McDermott, D-Seattle, called the insurance industry a "500-pound gorilla" that had effectively deflected attention from itself by pitting day-care operators and small business owners against lawyers.

"Meanwhile, watch the stock market and they (the insurance companies) are doing pretty well," he said.

But Hayner insisted lawmakers could not "stand by and do nothing" on the issue of soaring insurance costs. "If we fail to do anything on this, we're putting our heads in the sand," she said.

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February 24, 1986

Senator Patrick Rodey
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

RE: TORT REFORM

Enclosed you will find two pamphlets entitled "The American Tort System: A Time to Rebalance the Scales of Justice" and "A Citizen's Guide to Tort Reform." These are provided to you with compliments from Richard E. Wagner, President of Alaska 100 Insurance in Fairbanks, Alaska.

If you wish to obtain extra copies of these brochures, please write to me at the address referenced above c/o Tort Reform.

Thank you for your support on these issues.

Sincerely,

Charlene Conway

Charlene Conway
Public Affairs

Allies, opponents clash over reforms

'Tort' laws would alter insurance compensation rules

by Mary Scarpinato
Times Business Writer

It's called "tort reform."

Translate that as a whole new way of who sues whom, over what, for how much under "tort law" compensation criteria for injured parties.

Specifically, on insurance claims.

Especially with an eye to putting a lid on the number of these cases that can get into court — and the award amounts that juries and judges can hand out after that.

The Alaska legislature now is considering a package of tort reform proposals. Roughly 30 states are considering or already have adopted similar provisions.

Tort reform is essentially a response to what currently is being called "the insurance crisis" in this country.

Everybody from day-care providers and air taxi operators to the Alaska Zoo and the Municipality of Anchorage are reportedly reeling under skyrocketing coverage rates.

Meanwhile, a number of businesses, particularly smaller ones, are either "going bare or going broke." That is, risking their assets as non-insured supply and service firms or simply closing shop for fear of non-insurable risks.

But is tort reform really the remedy to all this?

Well, maybe . . . later.

Tort reform promises no rate reductions, but it may increase coverage availability in the future for some higher-risk operations who now cannot find insurance "at any price."



Mike Schneider
. . .against tort reform

Its primary aid is for a national insurance industry that last year recorded $25 billion in underwriting losses, and $21 billion the year before that.

The industry itself — tort reform's leading lobbyist — claims added woe with a record-breaking rise in insurance suit filings and jury awards.

Relief from these arguably could reduce premium requirements on policy holders as an aftereffect.

However, anti-tort reformists — led by trial lawyer associations — see no reason for injury and accident victims' recovery rights to suffer.

Their argument is that the industry is only sitting in its own financial stew and crying for public bailout *a la* Chrysler Corp. but without the automaker's payback clause.

Even a U.S. Attorney General's policy group, which advocates tort reform, published a report in February, saying:

"These underwriting losses appear to be largely a result of coverage written in the late 1970s and early 1980s which may have been underpriced due to the industry's desire to obtain premium income to invest at the then-prevailing high interest rates."

Mike Schneider, a local attorney specializing in claimant representation, takes aim at the insurance industry for targeting jurors as a major source of its problems.

"The jury is being attacked by the industry and by legislators as being a random collection of bozos," says Schneider, who is actively involved in the anti-tort reform campaign.

High damage awards, which tort reformists like to label "outlandish" and "exorbitant," are "damned few here and they've all been for terribly injured people," he says, adding that the proposal to cap such awards can only hurt compensation possibilities for worst-case victims.

Bill Gee, an insurance agent here who is active in the tort reform drive, agrees that Alaska is not known for exceptionally high damage awards.

"The insurance companies make money in Alaska," admits Gee.

"But we constantly want to

See Insurance, page D-11

Insurance reforms might widen coverage but not cut costs

Continued from page D-5

separate Alaska from the rest of the world, and we can't," he adds. "The fact is that there's only so much money out there for the (nationwide) insurance companies to use."

In such a tight-finance situation, Gee says the industry logically will funnel itself toward the Lower 48 where climatic and geographic conditions make many ventures less-risky policy investments.

"None of the insurance companies are saying that rates will go down (if tort reform is adopted)," Gee clarifies. "But one thing it will effect is that more companies will be able to write (policies)."

"The long-term effect is what we're looking at," he says of a coverage situation that should improve for policy holders, or seekers, if the industry's financial status is improved.

Tort reformists also emphasize that the drive to hold down dollar verdicts is not in the area of actual damages (say, for medical expenses) but in that of "pain and suffering" and other non-economic compensation, which they claim often is inflated by juror sympathy in an emotional courtroom setting.

But opponents like Schneider say such a proposal again picks "victims like the young, poor and subsistence livers who don't have

Tort reformists also emphasize that the drive to hold down dollar verdicts is not in the area of actual damages but in that of 'pain and suffering' and other non-economic compensation, which they claim often is inflated by juror sympathy in an emotional courtroom setting.

a lot of W-2s (salary tax deduction statements) to prove economic damages."

Under these award restrictions, he says: "A 5-year-old boy can have his legs traumatically removed and get $20,000 in medical and $5,000 in pain and suffering. In my view, that's not reasonable and that's not fair.

"That kid can have his life literally crumpled up and trashed in front of him," Schneider continues.

But with no wages to show as lost and no dependents left without support, actual damages in such a case may make for a relatively minimal award.

Gee hears sorry stories at his desk daily, he says, but more from the home-provider family-supporter point of view.

He told of one client in the air carrier business whose coverage cost $8,500 two years ago, $24,000 last year, and is looking at $65,000 in premiums for policy renewal this year.

"His decision is that he's got to go without (insurance) or close his doors because he can't have a profit margin to make up for it (coverage costs)," explains Gee.

If verdict awards have not soared out of sight here, the sheer volume of case filings has certainly taken a dramatic upswing.

Although there is no way to calculate how many are insurance claims, general civil damage suits filed in Alaska Superior Court did take a rise from 1,305 in 1984 to 2,096 in 1985.

And much of the so-called insurance crisis is due just to Americans' ever-increasing willingness to sue, says Gee.

"I'll guarantee you," he says, "that if you slip and fall on the sidewalk in front of somebody's business, the first four people to stop will tell you to sue and the fifth will tell who's an attorney to call."

According to Gee, the notion that someone should be found to pay has replaced the one that individuals must sometimes accept responsibility for their own fates.

"For example," he says, "we live in a state with lots of ice and it's practically humanly impossible to make sure it's all kept cleared. So, maybe we do have the responsibility to at least learn how to walk on it."

Insurance companies might also do their part to make sure claim payments are prompt, he says, "so many good people don't end up getting bills (from cunning creditors) that drive them to get attorneys."

Tort reformists like to point out that the lawyers now challenging their proposals are the same professionals who earn their livelihoods with typical chunks of 30 percent or more out of claimants' case awards.

But Schneider says the insurance industry has been less than candid about the profits it pulls in, too.

Lawyers claim the industry has refused to break down and make public its profits and losses on a careful "line item" basis and has not offered more low-rate policies to clients with low-claim histories.

These attorneys also wish states across this country would take a closer look at Ontario, Canada, where many of the tort reform proposals being considered here already are in place.

According to a report compiled by a trial lawyers' lobby: "Pain and suffering awards (there) are capped at $185,000, punitive damages are virtually non-existent . . . Yet the insurance industry is raising its rates 400 percent and more, canceling policies in midterm and refusing to provide coverage at any price both in the U.S., which has not enacted the tort provisions the industry seeks, and in Ontario, where such provisions have long been in the law."





ON THE ARCTIC RIM

NEWSLETTER OF THE U.S. ARCTIC RESEARCH COMMISSION APRIL 1986

Kodiak and Anchorage Public Meetings

The sixth general meeting of the United States Arctic Research Commission (ARC) will be comprised of two separate parts. One is to be held in Kodiak on April 28, 1986; the other is scheduled to occur on the following day in Anchorage. The Kodiak sessions are planned to: (1) provide information about the mission and activities of the Commission, and (2) acquire input about fisheries ecosystem research needs as such work may relate to the Bering Sea and the Aleutian littoral zone. Kodiak has important commercial interests in both of these areas, and the acquisition of useful testimony on research needs concerned with harvesting, processing, marketing, and transporting the catch is expected. The public meetings in Kodiak are scheduled to start at 8:30 a.m. at the Community College. At midday and in the early afternoon of the 28th, the Commission will meet with the Kodiak Borough Assembly and the Kodiak City Council.

The Anchorage sessions start at 9:00 a.m., April 29, in the auditorium of the Anchorage Museum of History and Art, 121 West 7th Avenue. Dr. Oran Young, Northern Studies Center, Wolcott, Vermont, will present a public lecture entitled "Arctic Geopolitics and Their Impact on Research." A general understanding of northern geopolitical trends is important in making a long-range forecast of Arctic research needs. Other activities planned for Anchorage are a press conference and a business session of the Commission.

The Commission and its Activities

The Commission was established by the Arctic Research and Policy Act of 1984. Its duties are to:

1. develop and recommend an integrated national Arctic research policy;
2. assist the Interagency Arctic Research Policy Committee in establishing a national Arctic research program plan to implement the Arctic research policy;
3. facilitate cooperation between the Federal Government and State and local governments with respect to Arctic research;
4. review Federal research programs in the Arctic and suggest improvements in coordination among programs;
5. recommend methods to improve logistical planning and support for Arctic research as may be appropriate and in accordance with the findings and purposes of this title;
6. suggest methods for improving efficient sharing and dissemination of data and information on the Arctic among interested public and private institutions;
7. offer other recommendations and advice to the Interagency Committee as it may find appropriate; and
8. cooperate with the Governor of the State of Alaska and with agencies and organizations of that State which the Governor may designate with respect to the formulation of Arctic research policy.

No later than January 31 of each year, the Commission will (1) publish a statement of goals and objectives with respect to Arctic research to guide the Interagency Committee in the performance of its duties, and (2) submit to the President and to the Congress a report describing the activities and accomplishments of the Commission during the immediately preceding fiscal year.

In February 1985, President Reagan appointed Dr. James H. Zumberge, president of the University of Southern California, as Chairman of the Arctic Research Commission. The other two scientific members appointed were vice chairman Juan G. Roederer, Geophysical Institute, University of Alaska-Fairbanks, and Dr. A. L. Washburn, Quaternary Research Center,

U.S. Arctic Research Commission

3500 South Figueroa, Suite 114
Los Angeles, California 90007

On the Arctic Rim is published by the U.S. Arctic Research Commission, 707 A Street, Anchorage, Alaska 99501, (907) 263-0661 (Branch office). Requests for copies, submissions, and comments may be directed to Lyle D. Perrigo, editor, at above address.

The U.S. Arctic Research Commission was appointed in accordance with the Arctic Research and Policy Act of 1984. Our main address is: U.S. Arctic Research Commission, 3500 South Figueroa, Suite 114, Los Angeles, California 90007, (213) 743-0970.

University of Washington. Messrs. Elmer E. Rasmuson, Anchorage, and Oliver Leavitt, Barrow, are respectively presidential appointees to commission positions set aside for business/industry and the indigenous Natives of the American Arctic. Mr. Erich Bloch, director, National Science Foundation, is an *ex officio* member. W. Timothy Hushen serves as executive director.

The sister organization created by the Act is the Interagency Arctic Research Policy Committee. Its role is to establish and to develop a five-year program plan to integrate federal research activities in the Arctic. The Committee has representatives from all federal agencies, conducting research in the Arctic with the National Science Foundation serving as chair.

The Commission's accomplishments since it began operations in March 1985 include: (1) the acquisition of information on U.S. Arctic research needs through public testimony at meetings in Anchorage, Fairbanks, Barrow, Los Angeles, and Seattle; (2) the development of guidelines of U.S. Arctic Research policy; (3) the preparation of *National Needs and Arctic Research: A Framework for Action*, an overview of research needs and priorities to guide the Interagency Committee in its work; (4) the opening of an office in Alaska; (5) the publication of the annual report detailing fiscal year 1985 activities; (6) meetings with the governor, legislative committees, and key administrators in Alaska; and (7) signing agreements with Alaskan officials to promote national/state cooperation in information transfer and the identification of northern health research needs. (The signing of a similar agreement to form a joint group to identify Bering Sea fishery ecosystem research needs is pending.) Copies of the Commission's annual report may be obtained through the offices in Los Angeles or Anchorage.

Alaska Office

The Commission opened an Alaska office at 707 A Street, Anchorage, Alaska, 99501 in January 1986. This office is expected to provide local coordination of Commission activities with State and local research organizations, and serve as a place of contact in the North. Staff support is provided by Lyle D. Perrigo.

The Newsletter

On the Arctic Rim is the newsletter of the Arctic Research Commission (ARC). The purposes of this publication are: (1) provide an overview of ARC activities, and (2) disseminate information about related themes. Copies of the first edition are being mailed to: (1) those who testified before or otherwise contacted ARC, (2) state and federal officials responsible for Arctic research, (3) individuals conducting research in the Arctic, and (4) others who may have expressed an interest in following ARC activities. You may be added to the mailing list by writing to the editor, Lyle D. Perrigo, in Anchorage.

U.S. Arctic Research Commission
707 A Street
Anchorage, Alaska 99501

The Honorable Patrick Rodey
Chairman, Senate Judiciary
Committee
Alaska State Legislature
Capitol Building, Pouch V
Juneau, Alaska 99811

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DOUGLAS L. GREGG, Esq.
A PROFESSIONAL CORPORATION
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130 SEWARD STREET, SUITE 417
JUNEAU, ALASKA 99801

April 14, 1986

Honorable Patrick Rodey
Chairman, Judiciary Committee
Alaska State Senate
P. O. Box V
Juneau, Alaska 99811

Re: The Insurance Crisis and Tort Reform

Dear Senator Rodey:

I have practiced law in Juneau since 1959, am a former Assistant Attorney General, former Juneau City Attorney, and have a modest but respectable practice. Over the years I have handled a fair share of personal injury and a number of wrongful death cases for the victims and families of victims of negligence. I have no ax to grind because for the past year I have been gearing down to an even more relaxed practice, which obviously does not include a heavy litigation schedule. Nevertheless, I speak out strongly against legislation which would create a special class of people to be discriminated against: the victim of negligence.

As I wrote to Rep. Mike Miller a while ago, when you consider the many ideas afoot to alleviate the insurance crises, pause for a moment or two. In the life of a legislator many groups seek exemption. It may be from budget cuts, from taxes or the application of some law, rule or regulation. These requests for special treatment invariably involve money. The burden of one man's exemption is usually shared by all who pay taxes and is spread evenly.

Tort reform is different. It calls for payment by a class which already carries special burdens.

These Alaskans are a strange and pitiful lot. They are the brain-injured children struck by automobiles; the helpless passengers in the airplanes that should not have taken off that day; the pregnant women whose lives have perhaps been jeopardized by incompetent doctors; they are the maimed, the scarred, the blinded and the crippled. Include, also, in this group the survivors of those who were killed by acts of negligence.[1] Of all the people in society who ought NOT to be made to shoulder the burden of helping the insurance industry out of the doldrums, it is these survivors and these injured whom a jury has found entitled to recover.

---

1. I note that damages for the negligent killing of a person without dependents would be limited to $25,000 by the reform coalition. Why don't they say what they mean? They mean that $25,000 is the maximum payment for a child killed by a drunk driver. (That is less than some people pay for a car, a boat or even a horse.)

Today it is doctors who would deny the victim full compensation. But doctors are not the first nor will they be the last to seek emasculation of the legal system as a "quick fix." Ski areas, aircraft owners/operators, manufacturers of defective products, government entitities--these are examples of others who seek to limit their own liability. The one who will pay for that favored treatment is the faceless victim. I say "faceless" because we are speaking of the child, woman or man who does not know that tomorrow he or she will be chosen for tragedy. Tomorrow's victims are very real. They are as real as the awful numbers which measure the carnage. Since they have not yet been injured they cannot very well organize into a citizen's coalition.

The question you face is this: Will future maimed and injured Alaskans be made to pay, out of their compensation for injury, the cost of reducing insurance premiums?

Wealthy plaintiffs' firms are rare. Wealthy defense firms are well known in every major city in the State. The insurance lawyer is paid when he wins and he is paid when he loses. The Plaintiff's lawyer is only paid when he wins. The reason is simple: his clients cannot afford hourly fees. It is often hard to find a lawyer who will accept many of these cases--even at a 33-1/3% contingent fee. The coalition would reduce that fee even further. What a stroke of genius! It not only strikes a favorite target, the lawyer, but in so doing it also deprives the victim of representation.

I don't say there is no insurance problem. There surely is and for that reason all suggestions should be carefully considered--all but one, that is. You should reject out of hand the coalition's plans to undermine the common law tort system. You should steadfastly refuse to create a class of Alaskans whose ability to hire a good lawyer is compromised. You should vote "no" on legislation which would substitute the judgment of the legislature for the verdict of a jury as to what is fair compensation in any given situation.

The kind of "reform" I have been hearing about would be a high price to pay for the purpose of restoring profitability to an industry whose ethics (as well as profits) are in great doubt. I enclose a sampling of "twice told tales." These are some favorites of the news media--the Paul Harvey's of the world. Please take a few minutes to review the "rest of the story" behind these distortions. Thank you.

Very truly yours,

DOUGLAS L. GREGG

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Insurance "Crises"

The doctors are crying out in pain, because they are getting stung by the insurance industry. It is perhaps small comfort to them, but they are not alone. Just about anybody who does anything, from accountant to zookeeper, is being dogged by skyrocketing premiums, punitive policies, or difficulty in getting any insurance at all.

Have all of us, all of a sudden, become bad insurance risks? Of course not. Rather, the property/casualty insurance industry is creating an illusion of "crises" through the artful presentation of imprecise financial data. The insurers manufacture "losses" and blame them on our system of trial by jury. The industry pronounces itself virtually without fault as it searches, it seems, to get out of the business of insuring anything except profits. It blames these "crises" instead on the horribly injured victims of negligence, defective products, unsafe workplaces, faulty warnings, deficient safeguards, dangerous designs, and drunk drivers. It blames those who have suffered catastrophe and dare to exercise their right to go to court—the one place they have a fighting chance against the rich and powerful—and to seek a decision by a jury of fellow citizens.

Two things are primarily responsible for the shocking rise in insurance premiums: poor underwriting practices and exaggerated estimates of future losses by the insurers.

When interest rates are high, insurers slash premium prices in many commercial lines of insurance, getting back in investment income more than was lost through low-priced premiums. When interest rates fall, the tax-free money set aside to pay anticipated claims—a number that is only the insurers' estimate—earns less than expected. The insurers then proclaim a "crisis" and take actions they now are taking, raising premiums in all lines of insurance, even for those who have never had a single claim against them. As one insurance agent said recently, "Insurers are trying to recover five years of discounts in one year."

In 1984, the industry reported underwriting losses of $20.5 billion, according to Congress's General Accounting Office. Remember, these are not real losses; the sum largely represents invested, interest-earning, tax-free money reserved to pay estimated future claims. Even at that, insurers earned $30 million more in 1984 in investment income than their "losses" of $20.5 billion.

Wall Street knows that the property/casualty insurance industry is in sound shape. The stock index of property/casualty insurers rose by 50 percent in 1985, almost double the rise of the general stock market, according to the A. M. Best and Company index. Further evidence of health is the robust growth of the industry's assets. In 1984, these assets totaled $267.7 billion, up $15.6 billion from 1983, according to the Insurance Information Institute. The insurers try to tell us that they are paying out more than $1 in claims for every $1 they are taking in. How can this be, when their assets are growing, year in and year out?

Despite their profitability, the property/casualty insurers pay little federal income tax. From 1974 through 1983, according to the General Accounting Office, these companies had a total profit of about $72 billion, but they paid only $1.3 billion in federal income taxes. That's about 2 percent of their total profit for the period. ■

This is one of a series of articles prepared by the Public Affairs Office for you to submit to or use as resource material for articles or op ed pieces for your local paper.

WANTED: Discovery Abuse Sanction Materials

The ATLA Committee on Discovery Abuses and Protective Orders is collecting examples of court orders, transcripts of hearings, motions, supporting affidavits, memoranda of law, and anything else you have in your files regarding successful imposition of sanctions for abuse of discovery. The Committee is particularly interested in identifying chronic abusers. Once collected, the materials will be made available upon request. Send your examples to Discovery Exchange, c/o Kris Meyer, ATLA Education Department, P.O. Box 3717, Washington, DC 20007.

The Association of Trial Lawyers of America February 19

The Facts Behind the Horror Stories

The insurance companies, which oppose injured Americans' right to a jury trial, try to ridicule juries by parading before the media the same 6 or 7 stories of what they call "outrageous verdicts." Some of these cases are 6, 7, or 10 years old and have nothing to do with the truly outrageous premiums sought by the insurers today.

Nevertheless, insurers tell the tales to mislead the public into believing that juries give huge sums to undeserving victims and that this is driving up the cost of insurance.

Except for the injuries to the victims, close examination shows, there is nothing horrible about these "horror stories." Here are the anecdotes . . . and the facts.

THE PERFUME AND THE CANDLE

Among those citing this case is Victor Schwartz, chief lobbyist in Washington, D.C., for corporate and insurance interests. On the network news show "Nightline," Schwartz said recently: "A woman in Maryland recovered money when perfume was poured on a lit candle."

The Full Facts: First of all, Schwartz neglected to tell viewers that this case was decided 10 years ago and has nothing to do with today's issues. Second, the final award to the plaintiff was about $30,000, hardly enough to break an industry with assets of more than $267 billion. Third, the perfume was not poured on a lighted candle.

Nancy Moran, 15, was visiting a friend of the same age. There was a Christmas candle burning in a saucer. To give the candle fragrance, the friend poured cologne from a drip bottle into the saucer, not on the flame. The heat of the flame ignited the vapors rising from the cologne. The burning vapors torched the perfume in the saucer, causing it to explode into flame. Ms. Moran was seriously burned.

The jury verdict in *Moran v. Faberge, Inc.* was upheld in 1975 by the Maryland Court of Appeals, which ruled that the defendant knew or had reason to know that the cologne might come close enough to a flame to explode. The same product, sold in a spray bottle, contained a warning not to use it near a flame. A woman applying the cologne could experience the same result if she were to light a cigarette.

Had the plaintiff poured the cologne directly on the flame, there would have been no case, said Martin Freeman of Bethesda, Md., who handled the case. His number is (301) 951-1610.

THE REFRIGERATOR AND THE BODY BUILDER

Forbes Magazine in a July 1985 article and syndicated columnist Ernest Conine last November, among others, have cited the case of the "41-year-old body builder [who] entered a footrace with a refrigerator strapped to his back to prove his prowess. During the race, he alleged, one of the straps came loose and the man was hurt. He sued everyone in sight, including the maker of the strap. Jury award: $1 million." The quote is from *Forbes*.

The Full Facts: The recitation of this 8-year-old accident is wrong on several counts. In *Columbo v. Trans World International,* the plaintiff, Franco Columbo, was a world-champion body builder. In 1976, he won the "Mr. Olympia" contest. In 1977, he agreed to participate in a television show, "The World's Strongest Man," produced by Trans World International Corporation and aired on CBS television. The other defendants were MCA, the parent company of Universal Studios, where the event occurred, and Zuver Fitness Center, Inc., the manufacturer of the equipment used by the plaintiff.

The event was to have 10 participants, all well-known athletes, competing in "off-beat" contests. One event was a refrigerator race. Each contestant was to walk or run 40 yards with a 400-pound refrigerator on his back.

Before the event, each contestant was given a written contract guaranteeing that all the equipment had been tested for safety. Zuver Fitness Center developed the contests and prepared the equipment.

Mr. Columbo was in the first of five heats. All the other contestants were more than 6' tall; Mr. Columbo is 5'6" tall, and all the defendants knew that fact. After he had run 7 or 8 yards, he fell when the rack to which the refrigerator was attached struck the ground. For someone of his height to lift the rack and refrigerator off the ground, Mr. Columbo had to bend forward deeply. This caused his center of gravity to be thrown off, and he collapsed. He suffered a total knee displacement. His injuries required extensive surgery.

At the trial, the chief engineer for Zuver admitted that (1) the equipment had never been tested by anyone Mr. Columbo's size, (2) the equipment had never been tested by anyone who had run with it, and (3) he had told Trans World officials that he didn't think the equipment or the race itself was safe. Other experts testified that it was not humanly possible to do what was expected in the contest. (After Mr. Columbo's fall, all the other contestants walked the race.)

In 1982, a Los Angeles jury awarded $1,036,760 and Trans World settled for $1 million. The company was not insured, so this amount had no effect on insurance premiums. And the plaintiff never alleged that the strap broke; in fact, the maker of the strap was not sued. Attorney George Royce of Los Angeles represented the plaintiff. His number is (213) 552-7868.

THE HOT-AIR BALLOON AND THE LAUNDRY

Forbes, in its July 1985 article decrying the so-called current liability crisis, gave this ex-

continued on page 2

More Facts . . .

continued from p. 1

ample of "absurdly generous awards: Two Maryland men decided to dry their hot-air balloon in a commercial laundry dryer. It exploded, injuring them. They won $885,000 in damages from American Laundry Machinery, which manufactured the dryer." This tale is repeated, virtually word for word, in many places.

The Full Facts: Horan v. American Laundry Machinery Industries was decided in 1979. Mr. Horan owned a 60-foot, nylon, hot-air balloon used by his advertising agency. When it became extremely muddy, he took it to a friend in the laundry business, who advised him that his equipment was too small to launder the balloon. They then went to a local hospital, where the equipment was designed for industrial purposes, and began to launder the balloon. The laundry extractor began to vibrate violently, causing it to blow up.

Mr. Horan was badly injured; his friend's hand was nearly severed, requiring microsurgery at Johns Hopkins Hospital. At the trial, it was proved that the company had a patent on a device that would have automatically stopped the machine if it vibrated excessively. Nevertheless, evidence revealed, the company had decided before the accident not to install the device.

A Baltimore jury awarded $1,260,000 to the two men. Samuel O. Jackson, Jr., now retired, represented the plaintiff. The phone number for Mr. Jackson's firm is (301) 539-6633.

THE HORSE AND THE PINTO

In a speech last December, Richard Willard, assistant attorney general for the Civil Division, U.S. Department of Justice, told his audience a story repeated in many quarters.

"An Oregon jury awarded $1.5 million in damages to the estate of a woman who was killed when a horse fell through the roof of her 1980 Ford Pinto. The horse had been spooked by wolves or coyotes and broke through a triple-strand, barbed-wire fence onto the highway. The horse was hit head-on by the woman's car, was knocked into the air, and fell down onto the hood and roof of the car. Although Ford argued that the accident was a 'one in a million accident,' and that no car could ever withstand the impact of a horse, the jury found Ford liable."

The Full Facts: In *Green v. Ford Motor, Co.,* a Portland, Oregon, jury found Ford liable because of weakness in the design of the Pinto's roof. In 1982, Mr. Green was driving his 20-year-old wife and their newborn baby home from the hospital when a horse stepped into the road. The car hit the horse. The animal slid across the windshield and roof. The roof collapsed. Mrs. Green was struck in the temple and killed.

The National Transportation Safety Board requires that a vehicle withstand 5,000 pounds on impact from a rollover, which is close to what happened to the Greens' car. A simulation of the accident proved that the Pinto could withstand only 3,800 pounds. Furthermore, Ford employees testified, records of vehicles that had failed safety tests had been destroyed.

In addition, Oregon records show, a horse is involved in an automobile accident there every three days. So, this is hardly a "one in a million accident." Most important, however, the car should have been able to withstand the impact of the accident. Millions of people depend on the crashworthiness of their cars.

In June 1985, a jury brought a verdict of $1.5 million against Ford. Ford has appealed. The plaintiff's attorney is J. T. Baisch of Portland. His number is (503) 226-3232.

THE DRUNK DRIVER AND THE PHONE BOOTH

The Wall Street Journal, in a December 1985 editorial, said, "A man is injured when a drunk driver crashed into a telephone booth and California Chief Justice Rose Bird rules that the company that designed the booth is liable." (Willard also has cited this case.)

The Full Facts: In *Bigbee v. Pacific Telephone and Telegraph Co.,* Chief Justice Bird, along with five of the six other justices on the California Supreme Court, ruled in 1983 that the issue of liability in this case should be decided by a jury. A summary judgment had been granted to the defendant by the Los Angeles County Superior Court, and the Supreme Court was simply sending the case back to the lower court for trial. Bird wrote for the majority: "Where a telephone booth, which is difficult to exit, is placed 15 feet from such a thoroughfare, the risk that it might be struck by a car veering off the street, thereby causing injury to a person trapped within it, cannot be said to be unforeseeable as a matter of law."

The booth, which had been hit at least once before, was "difficult to exit," because its door was jammed, and the plaintiff was unable to flee the booth when he saw the drunk driver bearing down on him. The seventh justice, incidentally, while dissenting in part, wrote that the summary judgment was "properly reversed" on the question of the jammed door. This case, although sent back to the lower court in 1983, never went to trial. A settlement in this 1974 accident was reached, but attorneys for both sides are under a court order—requested by the defendant—not to discuss the amount. The plaintiff's attorney is Thomas Cacciatore of Los Angeles. His number is (213) 380-6330.

THE BURGLAR AND THE SKYLIGHT

The Wall Street Journal editorial stated, "An insurance company is ordered to pay $260,000 plus $1,500 a month to a plaintiff when he fell through a skylight while burgling a school."

The Full Facts: The insurance company in *Bodeine v. Enterprise High School District* was not ordered to pay anything; the case was settled. The man involved, Rick Bodeine, 19, had graduated from the high school in 1981. In 1982, as a lark, he and two friends tried to take a floodlight from the roof of the school to light

New "M" Club Members

Perry Abernethy	Thomas Guelzow	Stuart Pearlman
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George Andreos	Michael Haines	Scott Peters
William Anton	Joan Harlan	Thomas Popejoy
David Archuleta	John Harlin, Jr.	Terence R. Quinn
Patrick Armstrong	Thomas Hart III	Drew Ranier
Jeffrey Baker	Lex Hawkins	Thomas Reavely
William Ball	James P. Hayes	Gordon Reiselt
Carl Barbier	Arthur Hedberg	Charles Reynolds
David Baum	Jim Heslet	John Riccolo
Richard Beliles	William Hicks	Peter Riley
Victor Bergman	Albert Hofeld	James Roach
Thomas J. Bice	J. Roy Holliday	John James Rojas
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Charles Currier	Marjon Louis	J. Montjoy Trimble
T. A. Demetrio	Peter Mallery	Ronald VanAmberg
David Dekine	Alan Malott	Bette Velde

Legal Fictions



Alaska State Legislature
House of Representatives

4007 BRENTWOOD CIRCLE
ANCHORAGE, ALASKA 99502
(907) 243-7574

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811
(907) 465-4939

REPRESENTATIVE
ALYCE HANLEY
DISTRICT 9, SEAT B

MEMBER
HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE
LABOR AND COMMERCE COMMITTEE
PUBLIC SAFETY SUBCOMMITTEE

April 15, 1986

Senator Pat Rodey, Chairman
Senate Judiciary Committee
P.O. Box V, (M/S 3100)
Juneau, Alaska 99811

Dear Mr. Chairman:

The Health Association of Alaska sent me a copy of their April 14 letter to you regarding my amendment to House Bill 532. This amendment was added in the House Labor and Commerce Committee, and exempts hospital board members, among others, from certain liability.

My intent in suggesting this language was to address the growing problem of protecting members of the public willing to serve on the boards of hospitals, non-profit corporations, and schools.

The language suggested by Dennis DeWitt in his April 15 letter seems to clarify that intent. It is my hope that your committee will recognize the need for the amendments and consider them for adoption in Senate Bill 377.

With best regards,

Sincerely,

Alyce

Alyce Hanley

cc: Senator Tim Kelly

16 April 1986

Seward General Hospital
P.O. Box 365
Seward, Alaska 99664

The Senate Judiciary Committee
The Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Committee Member;

I urge you to support the issue of tort reform as presented in HB 532 (L&C) which includes amendments conforming to the principles set forth by the Citizen's Coalition on Tort Reform. Of particular interest is Rep. Alyce Hanley's amendment pertaining to a limitation on the liability of certain board members. Your support in this matter is appreciated.

Thank you for your time and consideration.

Sincerely,

Janet I. Trettner
Vice-Chairperson
Seward General Hospital Assoc.
Board of Trustees

cc: Sen. Patrick Rodey
Sen. Tim Kelly
Sen. Jan Faiks
Sen. Rick Halford
Sen. Robert Ziegler

DAVID T. MAYSCHAK, M.D.
P.O. BOX 1209
PALMER, ALASKA 99645
Telephone (907) 745-8100

April 9, 1986

Patrick Rodey
Chairman of House Judiciary Committee
Room 504, Capitol Building
Alaska State Legislature
Pouch 5 (MS3100)
Juneau, AK 99811

Dear Mr. Rodey:

As a practicing physician and surgeon in the Palmer and Wasilla area, I want to express my concern regarding problems with liability insurance. Traditionally, the majority of physicians have been dedicated to taking care of people and the surgeon especially delights in freeing people from pain and disease. Unfortunately, this practice of health care delivery is now being severely compromised by attitudes of fear, suspicions and anxiety engendered by the liability crisis. In this day and age, it is impossible to provide good health care without adequate liability insurance. However, without adequate reform of the tort system, I fear that the problem will continue to snowball and, as has happened elsewhere in the United States, professionals will escape from the vicious circle of liability problems by simply abandoning their profession. That probably is a better alternative than either compromising their principles of health care or, on the other hand, driving up the cost of health care simply to protect themselves from untoward suits.

Alas, even when a physician contemplates another profession that may be associated with lower risk, even those professions today are not immune from unrestricted and even indiscriminate liability suits.

The United States Attorney General Tort Policy Working Group Analysis (February 1986) recommends meaningful legislation that would make possible affordable and available liability insurance. It's recommendations are included in HB 532 and SB 377 in their original form. Accordingly, I strongly urge you to support those bills in their original form and in that way to help enact meaningful tort reform.

Sincerely,

David T. Mayschak, M.D.

DTM:lib

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

March 28, 1986

TO: ALL LEGISLATORS

Please note that the Citizens Coalition for Tort Reform continues to support the principles set forth in our original comprehensive solution. Those principles are contained in SSHB 532 and most of them are in SB 377. We appreciate the hard work and support which has been put forth in the effort to reform some of the tort practices which have developed in the past few years.

Al Tamagni, Sr.
Chairman of the Board

Gene Roguszka
Vice Chairman

David MacGuire, M.D.
Vice President;
President, Alaska State
Medical Society

David Zundel, Secretary;
Executive Director,
Alaska Air Carriers

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Don Redmond
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Association, Inc.

738 11 Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-1135

Marilyn Pierce-Bulger
Chairman, Alaska Chapter
American College of Nurse-Midwives

Martha A. Dearborn
Executive Director
Alaska Dental Society

T.J. Thrasher
Executive Director
Alaska Trucking Association

James E. Suttle
Chairman, Alaska Chapter
International Association of
Drilling Contractors

Marigale Compton
Liason, Anchorage Board of Realtors

Anita Farley
Childbirth Educator

Lynn J. Coon, O.D.
Legislative Chairman, Alaska Chapter
American Optometric Association

Dr. Vincent S. Haneman, Jr., P.E.
Immediate past President, Alaska
Society of Professional Engineers
and Dean of Engineering - University
of Alaska , Fairbanks

Nelson M. Franklin
Chairman, Professional Engineers
in Private Practice

Charles H. Selman
President, Caberet Hotel and
Restaurant Retailers (CHARR)

Mary Pierce
Risk Management Consultant

Michael W. Gordon
Board Member, (ARBA)
Anchorage Restaurant & Beverage Assoc.

Roy Robinson
Vice-President, Alaska Broadcasters
Association

Diane E. Ramey
Liason, Alaska Physical Therapy
Association

Dennis DeWitt
Executive Director, Health Association
of Alaska

ALASKA VISITORS ASSOCIATION

P.O. BOX 10-2220
ANCHORAGE, AK 99510
(907) 276-6663

Telex:
Within Alaska 25-147
Lower U.S. 090-25-147
Canada 0305-25-147
International 314-25-147

1984-85
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1975-1977
CHARLES CONWAY
1977-1978
JIM BINKLEY
1978-1979
MARTHA EDWARDS
1979-1980
ROLF KLUG
1980-1981
DAVE PALMER
1981-1982
CHRIS VON IMHOF
1982-1983
ROBERT H. BRENNAN
1983-1984

A RESOLUTION IN SUPPORT OF
TORT REFORM

WHEREAS, liability insurance is a necessary cost of doing business within the tourism industry in Alaska; and,

WHEREAS, liability insurance costs have continued to rise to prohibitive levels for many businesses: and,

WHEREAS, these higher costs result in a higher end product cost to the consumer; and,

WHEREAS, these higher costs of insurance are forcing many important visitor attractions out of business and prohibiting the entry of others,

THEREFORE BE IT RESOLVED that the Alaska Visitors Association make Tort Reform a Legislative priority and further direct the board and staff to work with the Citizen's Advocate Committee for Tort Reform and the Governor's Task Force on Insurance.

SUBMITTED BY: Jan Wrentmore, Suzanne Mullen, Bob Jacobsen, Lee Crane and Bob Englebrecht

PASSED October 12, 1985 by a vote of the membership at the Annual AVA Convention.

One the following five pages you will find a summary of the desired actions of the Citizen Advocate Committee for Tort Reform

Alaska MUNICIPAL League

TELEPHONE
(907) 586-1325

105 MUNICIPAL WAY, SUITE 301
JUNEAU, ALASKA 99801

To: Senator Patrick Rodey, Chairman
Members of the Senate Judiciary Committee SB 377

From: Scott A. Burgess, Executive Director

Date: March 26, 1986

Subject: CSSB 377 - Tort Reform

On behalf of the Alaska Municipal League, thank you and all the members of the 14th Legislature for recognizing that an insurance crisis exists, and for taking on, what has already proven itself to be, a difficult issue. The League, on behalf of the 116 municipalities it represents, directly, and all local governments in Alaska, offers its assistance in finding short-term and long-term solutions.

Attached is a copy of an AML resolution on the insurance and tort reform issue from the 1986 Policy Statement which was sent to you at the beginning of the year. Also, the following policy appears on page 8 of the Statement:

> F. TORT REFORM
> The League urges the Legislature to review tort reform and to work for a viable municipal insurance system.

These policies came out of the discussions and actions at the annual conference in Fairbanks. The Board of Directors chose finding solutions to the availability and affordability of insurance for municipalities as one of its top four legislative priorities for this year. While the League has been working for several years to assist municipalities with their insurance needs, it has been unable to address and fully understand the current crisis.

The League is in support of legislation allowing municipalities to create a self-insured risk pool. The current statutes allowing for municipalities to form reciprocals is unnecessarily burdensome and expensive. It requires municipalities to essentially create an insurance company rather than contracting with existing insurance and financial agencies; requires a heavy surplus deposit over and above the current high premiums; and, is subject to unnecessary regulation by the Division of Insurance.

The League is already helping municipalities with their insurance needs. The League has pursued setting up a self-insurance pool program for several years but have been thwarted by interpretations of existing law, and our attempts to change it. The League has a group insurance program which is providing insurance coverage to over 80 municipalities for workers compensation, general liability, business auto, and errors and

omissions coverage for law enforcement, public officials, and school board members. However, because of the market and our inability to pool, we are unable to improve the program and offer the coverage desired.

The League has not been able to research the current tort reform issue well enough to commit to supporting all the recommended changes to the Statues, or to make the direct connection between tort reform and the current insurance problem. Like you, local elected officials are equally concerned for both today's plaintiff and tomorrow's taxpayer. The Board of Directors is unsure whether the fault for the current insurance problems rest with a reckless society, the insurance industry, the justice system or State laws, or a combination of all. Therefore, the League is asking the Legislature for help to analyze the problem and develop reasonable solutions. Tort reform should be evaluated on whether it is good policy, and on the long term effects, not just as a possible solution to the current problem.

There is a problem. Municipalities, and others who will appear before you, are unable to obtain or afford insurance to protect themselves, their investments, and the public. The problem faced by municipalities is unique. Municipalities are regarded as high risk clients by insurance companies because they have a greater potential for being sued; therefore, they have, historically, been victims of paying higher premiums. This, itself, is not unique because the same applies to doctors. However, the fact that municipalities are in the business of providing high risk public services, such as fire and police, that they cannot stop providing just because of the cost or risk, is unique to municipalities. Secondly, municipalities are the victims of the "deep pocket" theory. Municipalities are named in suits, directly or indirectly, regardless of the degree of fault because there is a perceived unlimited ability to pay. A claim is not limited by the amount of insurance coverage but by assets, and juries perceive that municipalities need only raise taxes to pay the claim.

The League is currently collecting information through a survey of its 116 members on their recent insurance experiences. The survey is not complete; however, attached is the information from the communities that have responded to date. Also included is information from other municipalities in the AML Insurance Program, provided by our broker Frank B. Hall & Co. of Alaska.

Several bills are before the Legislature attempting to address the insurance problem in Alaska. We support the concept of allowing municipalities to form self-insured risk pools. An AML Legislative Subcommittee has reviewed the bills introduced this session and before your committee, and has no problem with the tort reform measures most completely covered in SB 377 and HB 532. However, the Subcommittee and the staff will follow the hearings and your deliberations closely to better understand all concerned before recommending any specific bill. The League, of course, is available to help you in any way we can to find short and long term solutions to the insurance problems faced by municipalities and others.

RESOLUTION OF THE ALASKA MUNICIPAL LEAGUE

RESOLUTION NO. 86-13

A RESOLUTION OF THE ALASKA MUNICIPAL LEAGUE URGING THE STATE LEGISLATURE TO INVESTIGATE TORT REFORM AND THE REASONS BEHIND THE UNAVAILABILITY OF CERTAIN LINES OF INSURANCE.

WHEREAS, insurance rates have increased astronomically and this has caused businesses to close and has created a financial burden on taxpayers in Alaska, and

WHEREAS, municipal insurance rates have increased as much as 500% in some areas, and

WHEREAS, day care operators, air carriers, truckers, contractors, CHAPP-affiliated businesses, doctors, and architects are in many cases unable to obtain any insurance, and

WHEREAS, the Alaska Municipal League feels strongly that an investigation into causes should be made and a solution to this problem must be found this year;

NOW, THEREFORE, BE IT RESOLVED by the Alaska Municipal League that the Office of the Governor and the Alaska State Legislature are urged to immediately pursue all avenues available to solve this problem and find a way to provide insurance in Alaska.

Adopted this 16th day of November 1985.

LEO B. RASMUSSEN, President

ATTEST:

SCOTT A. BURGESS, Executive Director

MUNICIPALITY	LAST YEAR PREMIUM/COVERAGE	THIS YEAR PREMIUM/COVERAGE	% of budget	JOIN/ SUPPORT POOLING
ALAKANUK	UNINSURED	UNINSURED	4%	YES
ALEKNAGIK	$ 4,500	$15,000	13%	MAYBE
BARROW	$ 4,100/$ 1 million	$10,000/$500,000		
BETHEL	$350,000	$600,000	10%	YES
CORDOVA	$ 21,000/$ 1 million	$ 31,850/$500,000		
EAGLE	$ 3,365/$500,000	$ 8,739/$500,000	6%	YES
FAIRBANKS	$212,876/$20 million	$514,167/$5 million	2.5%	NO
GALENA	REPEATED CANCELLATIONS/PREMIUMS UP 200%		5%	MAYBE
GAMBELL	$ 19,300/$1 million	$ 15,617/$500,000		
HAINES BOROUGH	$ 25,000	$ 34,797	3.5%	NO
HOONAH	$ 6,484/$1 million	$ 11,640/$500,000		
HOUSTON	$ 23,906	37,444	16%	MAYBE
JUNEAU	$518,000	$1,253,900	2%	YES
KAKE	$ 10,617/$1 million	$ 7,080/$500,000		
KENAI	$ 85,000/$10 million	$320,000/$10 million		NO
KODIAK	$ 90,083/$500,000	$155,725/$500,000	5%	YES
KOTZEBUE	$140,000	$280,000	5%	YES
LOWER KALSKAG	$ 2,500/$1 million	$ 5,000/$500,000		
McGRATH	$ 13,596	$ 41,063	7.5%	YES
NULATO	$ 4,500/$500,000	$ 12,000/$500,000	5%	YES
PALMER	$138,000/$10 million	$219,000/$1.5 million		YES
PELICAN	$ 7,457/$500,000	$ 15,908/$300,000	11.5%	YES
RUSSIAN MISSION	$ 2,580/$1 million	$ 5,000/$500,000		
St. MARY'S	$ 4,200/$1 million	$ 5,000/$500,000	10%	YES
SAND POINT	$ 45,000	$ 80,000	9%	YES
SITKA	$ 53,753/$10 million	$131,628/$5 million	3%	YES
SKAGWAY	$ 31,883/$1 million	$ 55,806/$ 1 million	6%	MAYBE
SOLDOTNA	$110,000/$10 million	$270,000/$10 million	6%	YES
TENAKEE SPRINGS	$ 13,670	$ 42,000	16%	YES
UNALASKA	$131,124/$14 million	$ 99,468/$4 million	10%	YES
WALES	$ 11,663	UNINSURED		YES
WASILLA	$ 11,000/$6 million	$19,000/$1.5 million	2%	MAYBE

** ALL INFORMATION COMPILED BY THE ALASKA MUNICIPAL LEAGUE BY SURVEY. BACK-UP IS AVAILABLE THROUGH THE AML 105 Municipal Way, Suite 301, Juneau, Alaska 99801

Trial Courts
State of Alaska

THIRD JUDICIAL DISTRICT
303 K STREET
ANCHORAGE, ALASKA 99501

GOLDEEN GOODFELLOW
Assistant Area Court Administrator/
Clerk of Court

(907) 264-0440

Memorandum

To: Karla Forsythe
Staff Counsel

From: Goldeen Goodfellow
AACA/Clerk of Court

Re: Personal Injury Statistics

Date: April 9, 1986

I had Sue and Melissa go through all of the Case Characterization Forms which we have in LeEllen's office at this time. They picked out the personal injury cases and put them into categories of (1) $100,000 and under, (2) more than $100,000 and (3) no amount indicated. They looked at a total of 188 Case Characterization Forms for personal injury cases. The breakdown is as follows:

$100,000 and under - 120 cases - 63.8%

more than $100,000 - 43 cases - 22.8%

amounts not indicated - 25 cases - 13.3%

If you want me to, I can continue to monitor the Case Characterization Sheets as they come in and add to the above figures.

cc: Douglas J. Serdahely, Presiding Judge
Albert H. Szal, Area Court Administrator

Allen R. Cheek
Attorney at Law
Northward Building, Suite 214-G
Fairbanks, Alaska
99701
907-456-8538

Tort

April 29, 1986

RE: LIABILITY INSURANCE CRISIS AND TORT REFORM LEGISLATION

Dear Legislator:

Please find enclosed information regarding the liability insurance crisis. My clients and your constituents are very concerned that spokesmen for the insurance industry have indicated that liability premiums will not be reduced if tort reform legislation is enacted. As is indicated in the article entitled "Taming the Latest Insurance 'Crisis'" printed in the New York Times, April 13, 1986 edition:

"Perhaps most significant, insurance companies have consistently refused to reduce their rates in exchange for legal limits on liability. If their problems were traceable to the civil justice system, then they should jump at the offer."

I strongly urge you to vote against any tort reform legislation unless and until the insurance industry comes forward with sufficient financial information with which to determine whether or not the present liability insurance crisis is in fact the product of the industry's own price-cutting policies of recent years. Additionally, any tort reform legislation which would of necessity limit the exposure of the insurance industry should be tied into a definite and substantial reduction in insurance premiums to the Alaskan consumer. It is further my opinion that all tort reform legislation should be tabled pending a further in-depth analysis of the extent of the problem and other possible solutions to this problem.

Sincerely yours,

Allen R. Cheek

ALLEN R. CHEEK

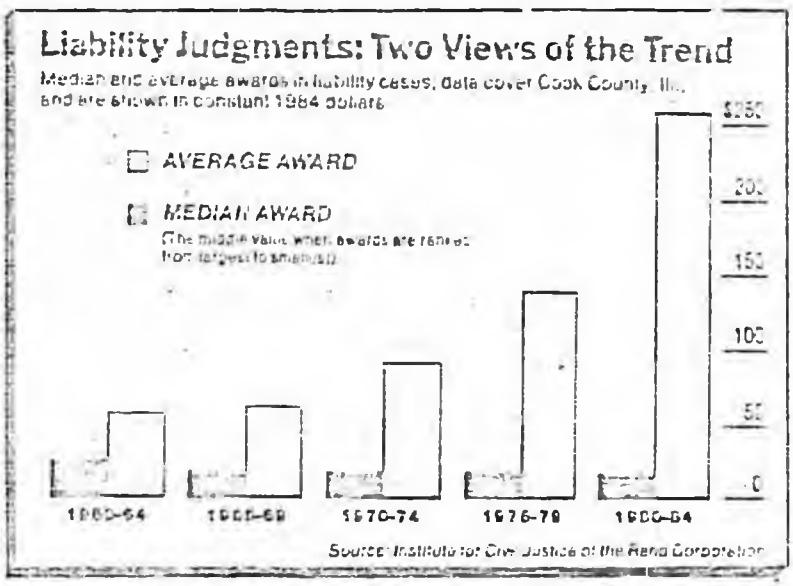
Enclosures
ARC/ej

Forum

REFORM INSURANCE, NOT LIABILITY LAW

Taming the Latest Insurance 'Crisis'

By ROBERT HUNTER



The latest liability insurance "crisis," like its predecessors, is widely attributed to overly generous juries and court decisions expanding manufacturers' liability. As in the preceding "crisis" in 1975, little is said about the fundamental cause — the sharp ups and downs of the insurance industry's profit cycle.

The gradual expansion of legal liability and the profit cycle are distinct phenomena and should be treated separately. The former has indeed caused rates to increase dramatically; the profit cycle has. Thus, limiting liability and restricting jury awards will not avert future insurance squeezes, but flattening the insurance cycle will.

Consider the roller-coaster ride the property insurance industry has taken us for in the last decade:

• 1975. The bottom. The industry earned 4 percent on equity, well below the average for all industry.

• 1976 to 1977. The ascent. The cost of insurance skyrockets by 300 percent or more for many doctors, manufacturers and others, as insurance companies' profits leap by more than 50 percent.

• 1978 to 1984. The fall. The high profits attract a flood of new capital. Insurers begin cutting prices and insuring poor risks, so as to obtain as many premium dollars as possible to invest at the high interest rates that prevail. Not surprisingly, the industry's profits decline, to a 2 percent return on equity in 1984.

• 1985 to 1986. A new ascent. As in 1976 and 1977, doctors, manufacturers and municipalities, this time joined by day-care centers and nurse midwives, find insurance costs rising by 300 percent and more — if they can get insurance at all. As the industry raises total premiums by $25 billion while reducing coverage, the stock prices of liability insurance companies rise by 50 percent, twice the rise of the Dow Jones industrial average. During the first quarter of 1986, insurance stocks rise another 22 percent.

Today, as in 1976, the insurance industry blames the legal system for the huge premiums. Their implausible claim is that judges and juries became generous in 1976, stingy for the next eight years and inexplicably generous again in 1985.

Actually, liability awards are remarkably consistent. In constant dollars, the median award has hovered around $20,000 over the last 25 years, according to the Rand Corporation's Institute for Civil Justice, although the average award has risen appreciably, reflecting the impact of a few huge settlements.

Legislated limits on liability awards have proved ineffective. Many cities and towns in Pennsylvania, for example, cannot get insurance even though the legislature virtually immunized them from liability the last time insurance rates shot up. The reason, simply, is that insurance rates and availability are determined by the profit cycle, not by juries.

Perhaps most significant, insurance companies have consistently refused to reduce their rates in exchange for legal limits on liability. If their problems were traceable to the civil justice system, then they should jump at the offer.

Certainly, the legal system is not perfect. Reforms, such as limiting fees for both plaintiff and defense lawyers and penalizing frivolous suits and frivolous defense delays, would enhance efficiency. But it would be unfair and nonsensical to limit compensation for injuries without proving that such a reform would work and providing an alternative.

Our experience with no-fault auto insurance is instructive. No-fault systems were enacted only after exhaustive studies showed that people with relatively minor injuries were overcompensated while people with severe injuries were undercompensated. Thus, a no-fault system for small claims made sense.

In contrast, the package of "reforms" sought by the insurers (and recently endorsed by President Reagan) not only involves no trade-offs — it takes away rights of injured people without giving them anything back — but is unsupported by any data about how victims fare under the current system, what drives up costs and how a given reform would affect victims or change system costs.

RECURRING insurance crises will be controlled only by insurance reform. Although insurance is a national, $310 billion business, it is regulated only by the states. But most state regulation is of consumer insurance; commercial insurance is almost entirely deregulated. Thus, deregulated commercial insurers are exempt from Federal antitrust laws and from oversight or prosecution by the Federal Trade Commission, and effectively exempt from Federal income taxes. Over the last 10 years, property/casualty insurers earned $75 billion but received a net tax refund of $125 million.

Last week, a special commission in New York proposed a plan that would restrict insurers' freedom to set rates and cancel coverage, and would give municipalities the right to form insurance pools. In return, insurers would get some protection against frivolous suits, the right to pay out settlements over several years and protection against one insurer paying the entire award when several parties share responsibility.

The plan, combined with Governor Cuomo's stipulation that limits on liability awards be accompanied by reductions in premiums, has much merit, and, if enacted, would be a constructive step and an excellent model for other states. But more needs to be done on the Federal level. Specifically, Congress should do the following:

• Repeal the insurance industry's antitrust exemption. Now, committees of the Insurance Services Office, a rate-making organization run by the insurance companies, set rates for most types of insurance.

• Create a Federal Office of Insurance to monitor the industry and establish minimum standards for state regulators.

• Repeal the insurance industry's exemption from Federal Trade Commission jurisdiction.

• Expand the Risk-Retention Act, which allows manufacturers — but not other businesses — to join together to self-insure or bargain for lower rates. This would pre-empt state laws.

The states could take several steps to bring down rates, starting with enforcing their own laws. Most states rely on competition to control rates, but competition cannot control prices when the periodic cartel pricing takes over. And states should follow New York's example and require insurers to give adequate notice of, and clear reasons for, cancellations or refusals of new coverage.

They should also build up their regulatory bodies — half do not even have actuaries, and few require consumer representation. One exception is New Jersey, where the public advocate may intervene in insurance rate cases, with the cost borne by the insurer seeking a price increase. This both discourages insurers from seeking exorbitant increases and minimizes public outlays.

The roller coaster is now reaching the top of the first big hill — the steep part of the ride, toward excessive profits. In a year or so, the downward trip will start, heading us toward a 1995 "crisis." To stop the roller-coaster ride, Congress should apply the brakes of insurance reform.

Robert Hunter, Federal Insurance Administrator from 1974 to 1978, is president of the National Insurance Consumer Organization, a consumer-oriented research organization.

April, 1986

Fact Sheet
Background/Key Findings of Rep. John LaFalce (D-NY)

John LaFalce on March 25 inserted in the Congressional Record a fascinating analysis of the current liability insurance crisis. LaFalce is undoubtedly one of the most informed members of Congress who as far back as 1977 held product liability insurance hearings covering 5 volumes, 75 witnesses on 16 separate days.

Some of LaFalce's findings back then were what we hear today: 500 to 1000% premium increases, companies "going bare", capricious increases bearing no relationship to claims experience.

Other findings were:

-Regarding the meaning of the word "loss": I quickly found out that in the insurance industry appearances can often be deceiving... You and I might think we know what a loss is: It means something that has been lost, rather simple. Not so in ...insurance... The definition of "loss" varies upon the context... If you use the word "loss" ...in finanical reporting to the States it means one thing. If you use the word.. in ratemaking it means something quite different... "Loss" also includes within its definition , reserves that have been set aside for claims that have been reported... and claims tnat the industry says probably have occurred, but which it has absolutely no knowledge or whatsoever.

- 90% of written product liability premiums were not primarily based on actuarily determined rates. A substantial portion were based on the subjective judgment of the underwriter... Now that's a fact, and a disturbing one.

- Any literature you read circa 1976-77 contains the truism that we had gone from a handful of product liability claims to the point where we had 1 million claims per year...But what was the reality? The best judgment of the Insurance Services Office or the number of product liability claims was from 60,000 to 140,000. The insurance underwriter's perception of reality was inflating reality by anywhere from 700 to 600%.

-In the media we read continually about multimillion dollar settlements and verdicts. The ISO reported in its

testimony that the average payment for bodily injury claims is $13,911. That's a tremendous difference from a million dollars. Not only did statistical gimmickery create a misleading average, but ISO also failed to factor in unsuccessful claims which were closed without any payment at all. If you use the true facts, you would see that the average payment... was not in the millions nor even $13,911. The average payment in reality was $3,592.

- IBNR figures - incurred but not reported- also require close scrutiny. In this area there is no effective way to monitor the insurance industry. When the IRS did study reserves subsequent to the medical malpractice crisis, it discovered the insurance industry was overreserving by approximately 30-45%. The lowest product liability reserving was 32% by Travelers, whereas Crum and Foster was the highest with its IBNR accounting for 71.4% of all its reported losses.

- History really does repeat itself- but this time it has done so with a vengeance... The picture is indeed bleak. Unfortunately, based on my previous experience with this issue, I am not confident that state insurance commissioners will be able to adequately handle the problem... Nothing has happened in the intervening period to alter this conclusion that a State-by-State approach to the insurance crisis simply is not adequate, and that a Federal response is warranted.

CAUTIONARY NOTE

John LaFalce is no tool of the trial bar. He has called for limited uniform federal product liability legislation as part of his package of reform. But so much of what he says is good that it is worth getting out his news.

MEMORANDUM STATE OF ALASKA

TO: John L. George, Director

DATE: March 17, 1986

FILE NO.:

THRU:

TELEPHONE NO.:

SUBJECT: 1985 Underwriting Results
Other Liability

FROM: Donald DeMuth
Chief Financial Examiner

You have asked me to review the underwriting results of approximately the 10 leading writers of the line "Other Liability" "(17)" in the State of Alaska. The results of my study follow.

You will note that I have actually supplied statistics on 13 companies. The reason for the three additional companies are: You stated that you did not want companies like "State Farm" - companies that are not traditionally considered to be writers of Other Liability included. For this reason, I did not know if you wanted ARECA Insurance Exchange included or not. I added one company and you may exclude "ARECA" if you wish. I also question the accuracy of the Continental Insurance Company's Alaska direct losses incurred figure, and both noted a probable aberration in schedule "P" figures and am aware that CIGNA made some big reserve adjustments which may well be without basis at year-end, and which may have skewed Alaska Pacific Assurance Company's figures. You may, hence, eliminate the figures for these two companies if you wish and still be left with the statistics on 10 companies. I also eliminated the figures for the Insurance Company of North America as their page 14 figures for this line are probably erroneous and meaningless.

The first area of experience that I looked at was the company's direct underwriting results in Alaska. The results are summarized as follows:

Rank by Premium Written In Alaska		Alaska Direct Premium Written	Alaska Direct Premium Earned	Alaska Direct Losses Paid	Alaska Direct Losses Incurred	Alaska Loss Ratio
12	Federal Insurance Company	$ 759,348	$ 556,132	$ 4,380	$ 32,347	5.8%
13	The Continental Ins. Co.	552,533	558,869	299,050	(387,299)	*
10	Pacific Marine Insurance Co. of Alaska	792,416	808,528	150,530	245,804	30.4%
2	Alaska National Ins. Co.	3,938,343	2,703,705	1,581,666	2,173,774	80.4%
1	AK Pacific Assurance Co.	4,148,556	4,329,380	1,845,266	2,960,272	68.4%
7	Freemont Indemnity Co.	1,581,809	1,600,374	283,530	856,617	53.5%
9	ARECA Insurance Exchange	975,398	975,398	50,849	175,312	18.0%
6	Providence Washington Insurance Co. of Alaska	1,827,910	2,424,073	4,275,334	2,817,529	116.2%

5	Industrial Indemnity Company of Alaska	1,838,269	1,842,175	1,236,617	1,423,207	77.3%
4	Alaska Insurance Company	1,870,196	1,539,729	576,349	896,926	58.3%
3	Nat'l Union Fire Ins. Co.	3,732,736	2,636,895	170,668	577,159	21.9%
11	Employers Insurance of Wausau, A Mutual Company	759,889	675,147	124,435	992,116	147.0%
8	General Accident Ins. Company of America	1,004,405	996,593	22,857	723,766	75.7%
		$23,781,808	$21,049,998	$10,621,731	$13,437,538	62.3%

* Meaningless

The column above entitled "Alaska Direct Losses Paid" is not of much significance. I included it only to illustrate the great disparity between losses paid and losses incurred in certain cases. There are a number of possible reasons for this disparity, but I cannot identify which reason is responsible for the cases reflected in the above exhibit.

For comparative purposes, I attempted to develop the same information for the same companies on a national basis. The companies are not required to provide this information on a national basis, but a few companies volunteer and, hence, complete page 14 of the annual statement on a national basis. The results of this comparative study does not reveal very much information, but the results are as follows:

Rank by Premium Written In Alaska		National Direct Premium Written	National Direct Premium Earned	National Direct Losses Paid	National Direct Losses Incurred	National Loss Ratio
12	Federal Insurance Company	Information not available.				
13	The Continental Ins. Co.	Information not available.				
10	Pacific Marine Insurance Co. of Alaska	Information not available.				
2	Alaska National Ins. Co.	Information not available.				
1	AK Pacific Assurance Co.	Information not available.				
7	Fremont Indemnity Co.	$31,645,042	$34,211,163	$25,679,707	$53,934,431	157.6%
9	AAACA Insurance Exchange	National experience same as Alaskan experience.				
6	Providence Washington Insurance Co. of Alaska	Information not available.				
5	Industrial Indemnity Company of Alaska	Information not available.				
4	Alaska Insurance Company	National experience same as Alaskan experience.				
3	Nat'l Union Fire Ins. Co.	Information not available.				
11	Employers Insurance of Wausau, A Mutual Company	Information not available.				
8	General Accident Ins. Company of America	Information not available.				

In an attempt to get some kind of comparative information - Alaska vs. National - I then decided to take a look at the same companies' net national business. This is not a direct comparison due to the fact that net business is net of assumed and ceded reinsurance, but the annual statement does not reflect direct national premium earned, only written, so I had no choice.

The result of this study is as follows:

Rank By Premium Written In Alaska		National Net Premium Written	National Net Premium Earned	National Net Losses Paid	National Net Losses Incurred	National Net Loss Ratio
12	Federal Insurance Company	$223,854,784	$166,392,450	$ 42,483,524	$ 85,539,884	51.4%
13	The Continental Ins. Co.	38,783,790	32,026,227	19,576,743	30,850,173	96.3%
10	Pacific Marine Insurance Co. of Alaska	Not Applicable				
2	Alaska National Ins. Co.	2,077,778	1,547,010	222,217	1,051,634	68.0%
1	AK Pacific Assurance Co.	3,834,456	3,271,679	3,995,018	5,151,751	157.5%
7	Fremont Indemnity Co.	33,624,745	26,542,239	11,277,702	36,844,816	138.8%
9	AIECA Insurance Exchange	823,895	823,895	50,649	175,312	21.3%
6	Providence Washington Insurance Co. of Alaska	Not Applicable				
5	Industrial Indemnity Company of Alaska	Not Applicable				
4	Alaska Insurance Company	Not Applicable				
3	Nat'l Union Fire Ins. Co.	357,841,310	283,621,245	80,724,018	228,277,500	78.4%
11	Employers Insurance of Wausau, A Mutual Company	112,716,611	104,759,066	73,570,268	73,177,983	69.9%
8	General Accident Ins. Company of America	31,868,701	29,249,804	10,955,921	20,886,903	71.4%
		$805,656,070	$648,233,815	$242,856,260	$475,756,156	73.4%

I also felt that it might be interesting to make a similar review on an accident year basis rather than on a calendar year basis. The reason for this comparative review is that reserve changes made during 1985 applicable to prior year business is reflected in the calendar year 1985 experience, but not in the 1985 accident year experience. The accident year business only reflects the company's experience on accidents that actually happened during 1985. The result of this review is as follows:

Rank By Premium Written In Alaska		Nat'l Net 1985 Accident Year Premium Earned	Nat'l Net 1985 Accident Year Loss Payments	Nat'l Net 1985 Accident Year Losses Incurred	Nat'l Net 1985 Accident Year Loss Ratio
12	Federal Insurance Company	$166,392,450	$ 8,109,100	$ 77,210,574	46.4%
13	The Continental Ins. Co.	32,026,247	1,618,902	24,550,326	76.7%

10	Pacific Marine Insurance Co. of Alaska	Not Applicable			
2	Alaska National Ins. Co.	1,547,010	34,420	1,012,476	65.5%
1	AK Pacific Assurance Co.	3,271,679	414,259	2,790,689	85.3%
7	Fremont Indemnity Co.	26,542,239	1,606,638	26,435,512	100.0%
9	ARECA Insurance Exchange	823,895	30,435	362,361	44.1%
6	Providence Washington Insurance Co. of Alaska	Not Applicable			
5	Industrial Indemnity Company of Alaska	Not Applicable			
4	Alaska Insurance Company	Not Applicable			
3	Nat'l Union Fire Ins. Co.	283,821,245	7,168,480	211,149,406	74.4%
11	Employers Insurance of Wausau, A Mutual Company	104,759,072	6,085,504	80,311,511	48.0%
8	General Accident Ins. Company of America	29,249,801	1,126,201	16,247,129	55.6%
		$545,233,636	$ 26,182,939	$410,070,584	63.3%

Overall, in spite of all the tears that the insurance industry is shedding, it appears to me that the insurance industry is doing quite well for this line. Unfortunately, accident year direct statistics are not available for Alaska, but I would guesstimate that if they were, they would reflect a loss ratio down around 50%. I also note that the paid loss ratio for accident year 1985, on a national basis, is down around 4%. Fat city on investment income coming up in 1986, particularly in those states that do not allow pre- and postjudgment interest.

I would suggest that you have your market conduct "rate section" follow-up on this memo - perhaps doing some research work in some of the companies offices. I hope to take a look at Providence Washington Insurance Company of Alaska and Industrial Indemnity Insurance Company of Alaska shortly, as both are overdue for an examination.

I would also suggest that you have your rate people perhaps take a look at 1984 experience for comparative purposes. It might also be interesting to do a policy year review of the same companies for 1984. This information should now be available but it is not reported in the annual statement. It would entail a special statistical call.

All figures reflected in this memo were taken from filed annual statements, but I have no idea how accurate the information is.

DD/mst3523m
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ALASKA ACADEMY OF TRIAL LAWYERS

1015 W. 7th Ave.

Anchorage, AK 99501

FOR IMMEDIATE RELEASE

April 22, 1986

FOR MORE INFORMATION CALL:

Ames Luce 276-1191

STATE MEMO SAYS INSURANCE COMPANIES VERY PROFITABLE IN ALASKA

Counter to unsubstantiated claims by the insurance industry, a memo written by the state's Chief Financial Examiner for insurance indicates that Alaska insurers are in excellent financial shape. The top 13 regulated insurance companies doing business in the state maintained loss ratios 20% better than the conventional break-even point for the "Other Liability" line during 1985, and performed better in Alaska than they did nationally. The businesses most hard hit by the recent round of rate increases are covered by "Other Liability" line policies.

"Overall, in spite of all the tears that the industry is shedding, it appears to me that the insurance industry is doing quite well for this line," concluded Donald DeMuth, author of the memo. DeMuth also called on Division of Insurance Director John George to conduct followup investigations on company rate-setting.

— more —

"The greediness of the insurance industry in this state appalls me," asserted Ames Luce, an Anchorage attorney. "The figures indicate that companies were making sizeable profits BEFORE they began imposing massive increases. Businesses and consumers have been bludgeoned by rate hikes in the last 6 months, and all that money is going straight into the companies' pockets."

"I want to know why the industry is trying to pull off this charade, I want to know why the Division of Insurance continues to approve the rate increases without adequate substantiation, and I want to know when Alaskans can expect rate relief on insurance policies," Luce said.

The Division of Insurance memo indicates that the top 13 insurance companies had an average "loss ratio" of 62.3%, compared to a national average for those companies of 73.4% during calendar year 1985. (The "loss ratio" is the industry benchmark for profitability and is calculated by dividing "losses incurred" by "premiums earned". According to industry analysts, a company breaks even, including a healthy profit, with a loss ratio of 70%. Lower loss ratios mean higher profits for the company.)

A more accurate picture of the industry's health is found if statistics are compiled on an accident year basis (accidents that actually occurred in 1985). The same 13 companies averaged a

— more —

63.3% loss ratio if nationwide business is taken into account, while DeMuth "guesstimates" that their Alaska business alone generated a very profitable 50% loss ratio.

"The insurance industry has nearly two dozen lobbyists in Juneau pushing to reduce wrongdoers' responsibility, pushing to reduce victims' rights and pushing to increase company profits," said Luce. "I think it's time our legislators called a halt to this charade."

The line of insurance analyzed in the memo covers municipalities, day care centers, non-profit boards of directors, errors and omissions insurance for architects and engineers and malpractice insurance for attorneys. Excluded are auto, Workers' Compensation, aircraft and medical malpractice insurance.

-END-

COALITION FOR CONSUMER JUSTICE

WHAT HAPPENS TO INSURANCE RATES

WHEN "TORT REFORM" LEGISLATION IS ENACTED?

Virtually every "tort reform" measure the industry is seeking is currently the law in Ontario, Canada. Yet the insurance industry is raising premiums by 400 percent, cancelling coverage in mid-term and refusing to provide coverage at any price in Ontario, Canada just as it is in the United States. For Example:

* The insurance industry has refused to provide insurance at any price for Ontario day care centers.

* The insurance industry has refused to provide insurance at any price to all but 1 of 121 Canadian School Boards responding to a questionaire.

* The insurance industry has refused to provide liability insurance for Toronto and many other cities.

* The insurance industry has raised premiums 1000 percent and at the same time reduced coverage for the Ontario intercity bus industry.

* Hospitals in Toronto can still get insurance, but only at "greatly increased" premiums.

* An insurance company renewed the Ontario School Bus Operators Association's policy on December 1, 1985 -- at 400 percent more than it charged the year before.

If any of the organizations denied coverage were ever sued -- and many of them have never been sued in the past -- they would be sued under the laws of Ontario, where pain and suffering awards are capped at $185,000, punitive damages are virtually non-existent, contingency fees are prohibited and the plaintiff must pay the defendant's attorney's fees if he loses. Yet the insurance industry is raising its rates 400 percent and more, cancelling policies in mid-term and refusing to provide coverage at any price both in the U.S., which has not enacted the tort provisions the industry seeks, and in Ontario, Canada, where such provisions have long been in the law.

215 Pennsylvania Ave., S.E., Washington, D.C. 20003, (202) 546-4996

FACT SHEET ON THE INSURANCE CRISIS

1. The insurance crisis is due primarily to the cyclical nature of the insurance industry.

Insurance companies cut their prices when interest rates, and thus their income from investing the premiums they collect, are high; they raise their prices when interest rates, and thus investment income, are low. They overreact at both the top and the bottom of the cycle. (See Chart 1.)

Wall Street understands the insurance industry cycle: while the price of insurance rises and falls, insurance stock prices just keep on rising. For example, since 1975 the property/casualty insurance stock index rose almost 500%, while the Dow Jones Industrial Average did not even double. And during 1985, as insurers complained of their dire financial condition, the property/casualty index rose by 50%, almost twice the rise in the Dow. (See Chart 2.)

2. The special privileges enjoyed by the insurance industry are largely responsible for the insurance cycle. For example:

A. <u>The insurance industry is exempt from the antitrust laws</u>. This allows insurance companies to agree to raise their prices without fear of antitrust prosecution. Executives in other industries who act in concert to raise prices can go to jail.

B. <u>The insurance industry is exempt from federal regulation</u>. In all other cases, when the federal government exempted an industry from the antitrust laws it substituted regulation for antitrust enforcement, as it did with trucking, railroads and utilities. The insurance industry is unique: that it is exempt from <u>both</u> antitrust enforcement and federal regulation, leaving the federal government impotent to deal with the dramatic price rises, mid-term cancellations and refusals to insure at any price so prevalent today.

C. <u>The insurance industry is protected from competition by state regulation</u>. Many state laws prohibit businesses, as well as consumers, from joining together to buy insurance at a lower rate, and state and federal laws prohibit other financial institutions from selling insurance.

D. <u>The insurance industry is exempt from Federal Trade Commission scrutiny</u>. In 1979, after the FTC published a study critical of the life insurance industry, Congress prohibited the FTC from ever again studying -- let alone prosecuting -- any sector of the industry.

3. The property/casualty insurance industry is exempt from federal taxation.

According to the General Accounting Office, the property/casualty insurance industry earned a profit of $75.2 billion during the period 1975-84, yet paid no federal income tax. The industry's tax exemption is due primarily to three insurance industry accounting privileges; the most significant such privilege is the provision allowing insurance



In my opinion

by L. Ames Luce

IT IS UNFORTUNATE that Brad Bradley in his "Assembly report" of April 2 has chosen to utilize his column to advocate "tort reform" and to support such advocacy with half-truths and innuendos and a total absence of objectivity. This perhaps is not surprising considering his acknowledged source of information — that being the "Citizens Coalition for Tort Reform," a group supported and principally funded by the insurance industry and other vested interests.

In the March 10 issue of Business Week, a publication dedicated to a reporting of activities within the United States business community, in a lead editorial on page 140 the following comments are found, which factually summarizes the reason for our "insurance crises."

"For many years, insurance carriers slashed premium prices and wrote as much insurance as they could get. Many companies abandoned traditional underwriting standards and competed fiercely for premium dollars they could invest in high-yield debt. This so-called cash flow underwriting is probably responsible for most of the damage to company balance sheets today.

"With careful management, these mistakes can be corrected. But instead, the industry has spent most of its time and energy lately mobilizing attacks on the U.S. tort system. . . .

"It is likely that the risks that society agrees must be insured will gradually be spread among insurance carriers, insurance users, and where appropriate, government. That is a better way to deal with liability claims than restricting the rights of injured people to their day in court."

MR. BRADLEY ASSERTS that some of the causes of the problem are the increasing trends for larger non-economic awards, the lottery mentality of injured plaintiffs and that contingency fee arrangements encourage frivolous lawsuits. Neither fact nor reason support such assertions.

The extensive hearings which have recently been concluded by the House Labor and Commerce Committee in Juneau did not disclose that jury verdicts in Alaska were running wild, or have even exceeded inflation during the past five years. Reason further asks, if a plaintiff's counsel is to be only compensated under the contingency fee system if he wins, how then does such a system induce him, or his client, to file frivolous lawsuits? Only if payment is to be made to the attorney by the hour, as insurance defense lawyers are compensted by their masters, is frivolous activity monetarily rewarded.

Mr. Bradley then proceeds in his "Assembly report" to catalog his remedies to the "tort crises" which have been drafted and sponsored by the insurance industry, and which are the most comprehensive assault on the rights of injured people in our state's history. These solutions are a rehash of SSHB532 and provide:

- Structured payments — This would allow an insurance company to pay an injured victim damages which a jury would award, not in a lump sum, but over time, ignoring the eroding fact of inflation and putting the investment proceeds from the delay in paying the victims award into the insurance company's own pocket.
- Attorneys fees — This would restrict plaintiff's attorneys fees so that in many cases claims which would be expensive to pursue, such as those resulting from product liability or medical malpractice, could not be maintained, placing no limitations on the amount that an insurance company could spend for its attorneys.
- Punitive damages — This would require the recovery of all punitive damages by a plaintiff to be paid to the state. Since no plaintiff would derive benefit from receiving such damages, they would never again be sought.
- Death benefits only to be paid to economic dependants — This would deny a mother's right to recover for the death of her child killed by a drunken driver (the mother is not a dependent of her child), but allow the mother to be compensated for the death of a family dog killed in the same accident, because the dog would be considered as property.
- A two-year statute of limitations from the time of the act or omissions. Such a restriction precludes recovery in many accidents where a defect in design or manufacture of a product more than two years old caused the accident.

IN EACH SECTION out of SSHB532, there is a systematic and devastating assault upon the rights of the citizens of this state which will not only affect their interests, but the interests of their children and their children's children.

We are experiencing an insurance crisis, and legislation is urgently needed to correct the many insurance abuses which have caused this problem, and which are presently being permitted to go unchecked.

The question is simple. Do we, as citizens, wish to continue in our democratic society to place our confidence and trust in our fellow citizens? These citizens are the members of our juries who decide what is fair and just compensation. Or do we wish that those decisions be made for us by the insurance industry and other vested-interest groups?

The answer to this very important question will probably be resolved by our legislature before it recesses this session. If the citizens do not now make their wishes heard, the decision will be made for them by the hoards of insurance lobbyists who have now descended upon our legislators in Juneau.

L. Ames Luce is a member of the Board of Governors of the American Trial Lawyers, a member of the Alaska Academy of Trial Lawyers, and a 20-year resident of Alaska.

Quotes

"America geared up to meet the Soviet challenge of being the first into space, then pursued an all-out effort to go to the moon. Unfortunately the momentum of the Apollo program was not sustained, resulting in what has been called the lost decade of progress."

— From a report on the future of the U.S. space program by business and education leaders

Anchorage Times 4/5/86

Chugiak-Eagle River
Chamber of Commerce

P.O. Box 770353 / Eagle River, Alaska 99577

"PLACE OF MANY PLACES"

April 11, 1986

Senator Tim Kelly
Post Office Box V
Juneau AK 99811

Dear Senator Kelly,

On April 11th the Chugiak - Eagle River Chamber of Commerce Board of Directors unanimously approved the following resolution:

> "Be it resolved the District 15 Legislators be requested to vote against C.S.S.S.H.B. 532."
>
> "Be it further resolved that legislation which lessons the rights of injured persons should only be approved if there are guarantees that the reduction of these rights will substantially reduce liability premiums."

I am submitting this letter at the direction of the Board of Directors and request that you keep the Chamber advised on developments.

Respectfully,

Edgar W. Smoot
President

EWS:azh

A look at the other side of liability loss

WASHINGTON—In recent months the insurance industry has launched an impressive campaign of public relations. The idea is to justify the industry's role in what is widely described as "the crisis" in liability coverage. There's another side to the story—the lawyers' side. It deserves a fair shake.

The industry contends that in 1984 it suffered an underwriting loss on property/casualty policies of more than $20 billion. Its experience last year was better, but not much better. The industry's position is that two factors have compelled a sharp increase in premiums: Sympathetic juries, overwhelmed by persuasive lawyers, have awarded undeserved millions of dollars in damages. In what is known as "long tail liability," companies face huge outlays in cases involving toxic wastes or time-delayed drugs. The industry is lobbying Congress and state legislatures to put ceilings on damages and to make other changes in the area of "tort reform."

What about all this? The Association of Trial Lawyers of America is fighting back.

The lawyers contend, to begin with, that the insurance lobby has clouded the industry's books with blue smoke. Insurance companies, derive their income from two broad sources—premium payments and investments. If one looks only at the operating side, yes, the companies have suffered operating losses. But when account is given to investment income, and to capital gains from the sale of stock, a quite different picture emerges. Over the past 30 years, the lawyers observe, property and casualty assets have grown from $22 billion to $365 billion—a growth that hardly suggests an industry in terrible trouble.

What about these multimillion-dollar judgments? The insurance lobby quotes figures from Jury Verdict Research Inc., of Solon, Ohio, indicating an average award in product liability cases in 1984 of $1.07 million and an average award in malpractice cases of $950,000.



Views expressed here do not necessarily represent those of the Daily News-Miner.

The data show 360 verdicts in 1984 alone of more than $8 million.

The lawyers respond that the statistics are seriously flawed. They are not based on a random sample of awards nationwide. They are not confined solely to property/casualty cases. The data do not reflect reductions on appeal. Neither do these "averages" take into account the great majority of claims that are settled out of court. Studies in Wisconsin, Massachusetts and California provide no confirmation for the high averages reported by Jury Verdict Research.

In any event, the trial lawyers contend, the rare multimillion-dollar verdicts are abundantly deserved. The awards given to victims of permanent paralysis, permanent brain damage, multiple amputations or painfully wrongful death. In such cases a surviving plaintiff's life has been ruined, the death of a young and successful breadwinner imposes painful hardship on a family. To "cap" awards for pain and suffering, the lawyers say, is grossly unfair in these instances.

The insurance industry suggests that trial lawyers are more concerned with their high "contingent fees" than with the pain and suffering of their clients. These fees typically range from 30 percent to 50 percent of an award. The lawyers respond by saying that if the defendant wins, the plaintiff's lawyer gets nothing—and doctors win about 75 percent of the malpractice suits brought against them. If lawyers are denied generous compensation when they win a plaintiff's case, honest lawyers will take the client's case only if the facts, manufacturer and prognosis will be overly protected.

Who's right? My own conclusion is that "the crisis" for whatever reason, is real. Liability insurance in many fields has become virtually unavailable at any affordable cost. The evidence persuades me, as it persuaded an advocacy commission in New York, that the insurance industry's wounds "are largely self inflicted." The industry recently competed for cut-rate business when interest rates were high; now that interest rates are falling, their investment income is insufficient to offset operating losses. Much tighter state supervision of the insurers will be required.

Some proposals for reform of tort law strike me as desirable, but I put them off for another day. The insurance industry has had its day in the court of public relations. The trial lawyers deserve a hearing in their own defense.

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House of Representatives

SOLUTIONS TO THE LIABILITY INSURANCE CRISIS

Mr. LAFALCE. Mr. Speaker, it is not often that a problem reaches crisis proportions, but thousands of businesses, municipalities and individuals across the country will attest to the existence of an insurance liability crisis. Without insurance, many segments of our society cannot function. Yet, during the past year, premium costs have escalated to the point where liability insurance has become unaffordable to many. And, even those who can afford liability insurance find that they cannot buy it at any price. Unless this crisis, and that is exactly what it is, of affordability and availability is resolved, we will soon find ourselves in a state of economic paralysis.

Crises in the insurance industry are neither new to me, nor surprising. As early as 1978, I stated that "we have seen severe problems with medical malpractice insurance; today we are having difficulties with product liability insurance. Tomorrow, we are likely to have problems in other lines of insurance." Tomorrow is today. The next crisis in the insurance industry has arrived.

Our constituents are demanding relief, and rightfully so. They are caught in an insurance crunch, which leaves them either completely without coverage, or coverage that is obtainable only at astronomical premiums. There is no single solution to a problem of this magnitude. Rather, what is required is a comprehensive multifaceted approach which acknowledges the complexity of the problem. The package of reforms that I am introducing today offers precisely such an approach.

During my time today, I would like to address the following topics: my previous involvement with this issue as chairman of a Small Business Subcommittee, the problems within the insurance industry which my subcommittee uncovered, and proposed solutions which I am introducing in this Congress.

A. SUBCOMMITTEE INVESTIGATION INTO THE INSURANCE CRISIS—LATE 1970'S

If we put these issues into a historical perspective, it quickly becomes apparent that what we are facing today is essentially a replay of a similar insurance crisis that occurred a decade ago. Indeed, it was during the fall of 1976 that I first became aware of the problem of product liability insurance, and insurance coverage generally, when I started receiving complaints concerning unbelievably high premium increases from small businesses within my congressional district in western New York.

Several months later, in February 1977, I was elected chairman of the Small Business Subcommittee on Capital, Investment and Business Opportunities. In that capacity, I started receiving complaints similar to that which I had been receiving from my constituents regarding premium increases, only this time not just from western New York, but from across the country. I then decided to initiate a series of hearings regarding the impact that the product liability insurance shortage was having on the small business person. I did so, and to make a long story short, conducted 16 days of hearings, gathering 5 volumes of testimony from over 75 witnesses.

During the course of this investigation, I also worked very closely with the interagency task force on product liability, led by the Department of Commerce, whose chairman was Prof. Victor Schwartz.

My subcommittee heard testimony from trade associations representing all types of businesses, and the story was always the same: Their members were experiencing not 100-percent increases, but very often 500-percent increases, 1,000-percent increases, and even 10,000-percent increases in their premiums. Many companies were simply unable to afford the extraordinary high premiums for product liability insurance, and chose to "go bare," that is, without coverage. If these stories sound familiar, they should.

Invariably, these trade associations claimed that premiums charged were arbitrary, capricious and unfairly high; and that they bore no relationship either to historical experience or to quality control standards. They also proposed "the solution." In a unanimous vote, they stated, "we need tort reform; we must have drastic changes in our tort laws."

Although certain changes in tort law, for example, uniform product liability standards, seemed to make sense, tort reform alone did not seem likely to achieve a solution. The premiums being charged were unfair, arbitrary and capricious, and this situation could not be rectified through tort reform, but rather required an indepth examination of the insurance industry itself.

B. PITFALLS OF THE INSURANCE INDUSTRY

My inquiry took me through the looking glass, so to speak, because I quickly found out that in the insurance industry appearances can often be deceiving. I quickly found out that the vocabulary of the insurance industry differs markedly from the vocabulary that you and I ordinarily use. Their definition or use of a word would often differ from our definition of that same word. For example, the word "losses." You and I might think that we know what a loss is: It means something that has been lost, rather simple. Well, not so within the insurance industry.

In the insurance industry, the definition of "loss" varies depending upon the context in which it is used. If you use the word "loss" in connection within financial reporting to the States, it means one thing. If you use the word "loss" in connection with ratemaking, it

means something quite different. Thus, when the insurance industry for purposes of State financial reporting uses the word "loss," it means that which it paid out in settlement of a given claim or jury verdict. But the industry also means that which it has set aside as reserves for those claims that have been reported to it. In other words, "loss" in this context includes not just what is actually paid out, but estimates of future pay outs as well.

Furthermore, the insurance industry also includes within its definition of "loss," reserves that have been set aside for claims that it says probably have occurred, but of which it has absolutely no knowledge whatsoever. It calls these losses IBNR (incurred but not reported). However, when it uses the word "loss" within the context of ratemaking, it does not include IBNR because it is deemed statistically unreliable—and that's putting it mildly. We'll get back to IBNR a little bit later, but I merely wanted to set the stage for the importance of examining with a critical eye and ear virtually every piece of information you get from the insurance industry.

Gaining an appreciation of insurance industry vocabulary was not all that my subcommittee learned from its exhaustive hearings. We also learned that less than 10 percent of all product liability premium dollars were manually derived—that is, based upon a manual for which there is some actuarial predicate for the rates. This means that in excess of 90 percent of the premium dollars for product liability insurance were not primarily based on actuarially determined rates. Of this 90 percent, a substantial portion were based on the subjective judgment of the individual insurance underwriter. Now that's a fact, and a disturbing one at that.

In determining whether premiums not based primarily on actuarial data are fair or arbitrary and capricious, we have to look at whether the insurance industry's subjective judgment that is both adequately and appropriately informed.

Hopefully, our perception of reality and reality itself are one. Subjective judgments can often be good judgments, informed judgments, even appropriate judgments. If there is a difference, however, between our perception of reality and the reality itself, then the judgment may be erroneous, perhaps arbitrary, even capricious.

One of the most important factors that the underwriter must consider is the frequency of claims—the number of claims that are occurring per exposure unit. Any [illegible] you read circa 1976 and 1977, co[illegible] in it the truism that we had gone [illegible] a handful of claims in the late 1960's and early 1970's, to the point where we then had 1-million product liability claims per year. Information put out by the Insurance Information Institute and the testimony of many of the trade associations that came before my subcommittee, started out with the fact that there were now 1-million product liability claims per year. That was the perception of reality. But what was reality?

The Insurance Services Office (ISO), a ratemaking and service organization with 4,000 employees, owned by all the major insurance companies—they're able to do this because of the antitrust exemption for the insurance industry under the McCarran-Ferguson Act—made a closed-claim study. It studied approximately 24,000 claims that were closed during an 8½-month period spanning 1976 and 1977. It said that in its judgment this study represented 70 percent of all claims that were closed in the United States during that timeframe. And it was the best judgment of the Insurance Services Office that the range of product liability claims per year was from 60,000 to 140,000. The insurance underwriter's perception of reality was inflating reality by anywhere from 700 to 800 percent.

About 4 months after ISO testified before my subcommittee on this point, two insurance companies—Aetna and Crum Forster—ran advertisements in national journals still using the 1-million figure. However, when you look to the number of claims, you can see that the perception of reality and reality itself differed markedly. And it is on the basis of reality, not anecdotal conjecture, that the insurance industry should set rates and Congress should legislate.

A distinction between reality and the insurance industry's perception of reality regarding the fairness or unfairness of the law also exists. Even though I favor a uniform Federal product liability law because the present law is too murky, I do not subscribe to the view that tort law as presently construed is responsible for escalating premium costs. Indeed, of all claims going through to verdict, in 75 percent of the cases where the law was applied to the facts by a jury, the plaintiff got no recovery. And this was not based on conjecture, but upon the insurance industry's own ISO closed-claim study.

The amount of the award constitutes another factor that goes into the judgmental process. In the national media, we read continually about multimillion dollar settlements and verdicts. Yet, the ISO reported in its testimony before my subcommittee that of all those 24,000 claims that were closed, the average payment for bodily injury claims is $13,911. That's a tremendous difference from millions of dollars, or even hundreds of thousands of dollars. This $13,911 figure did not receive widespread publicity, so few people even knew of it. But even this low figure was, upon very close analysis by my subcommittee, most misleading.

Although the study was a closed-claims one, that $13,911 did not prepresent the average payment that was made. It was a figure that used trended data. That is, what would be paid in the future as if the accident happened today. In determining their trended data, the insurance industry also used an inflation factor of 25 percent per year. The use of these statistical devices greatly inflated the so-called "average" payout figure. Not only did statistical gimmickery create a misleading average, but the ISO also failed to factor in unsuccessful claims which were closed without any payment by the insurer whatsoever.

If you use the true facts, you would see that the average payment for a bodily injury claim was not in the millions, nor even $13,911. In a study that included 70 percent of all the product liability claims closed in the United States, 24,000 during an 8½-month period, the average payment for bodily injury claims was in reality, $3,592. If you compared the amount that was actually paid out in claims with the total amount of premiums paid in to purchase product liability insurance policies, you would find an excessively large spread in favor of the industry.

The insurance industry's IBNR figures—losses incurred but not reported—also require close scrutiny. In this area, there is no effective way to monitor the insurance industry. Formerly, the IRS was able to do at least some monitoring of the reserves since they were audited on a line-by-line basis. When, however, the IRS did this subsequent to the medical malpractice crisis, it discovered that the insurance industry was overreserving its medical malpractice line by approximately 30–45 percent.

Regrettably, the IRS procedure has now changed. It no longer audits on a line-by-line basis so it can make no determination as to the validity of reserves for any given line—including that with the product liability experience, an area which no State insurance department in the entire United States monitors. Finally, in a detailed questionnaire that I sent out to the insurance industry, I discovered wide variations in IBNR among insurers. The lowest percentage of losses attributable to IBNR was 32 percent by Travelers, whereas Crumm and Foster was the highest, with its IBNR accounting for 71.4 percent of all its reported losses.

In short, the frequency of claims, the size of the payouts, the misleading use of statistics and various accounting devices which overstate actual loss experience all indicated that the premiums you and I were being charged were unfair, arbitrary and capricious and should have been lowered.

C. THE INSURANCE CRISIS TODAY

History really does repeat itself—but this time it has done so with a vengeance. The crisis which I addressed years ago was primarily centered on problems identified with product liability insurance. Today, those problems remain, but the crisis has now spread throughout the liability insurance industry.

The parameters of the 1986 crisis are boundless. Far more than manufacturers are affected this time. The unavailability or unaffordability of insurance coverage has permeated every sector of society. It determines whether our children can participate in after-school activities; whether we will have day care centers open to care for the young of working parents; and even whether doctors will be able to deliver babies.

This litany does not even come close to describing the disaster that this situation has created for small businesses across America. Because these companies are forced to "go bare," they are extremely vulnerable to big lawsuits or jury awards. Large corporations are also experiencing dramatic increases in premium costs or outright cancellation of coverage. Service sector businesses such as restaurants, bars and ski resorts are also feeling the insurance crunch.

Across the country, businesses of all sizes are facing premium increases ranging from 25 percent to more than 1000 percent for property and casualty insurance—if they can get any coverage at all. Experts predict that the escalating crisis in the availability of insurance will consid[illegible]ably worsen in the months ahead.

Surveys of members of small business organizations reveal high percentages of business owners who have had their policies canceled or have been refused coverage—30 percent of NSB members. Ninety-two percent of the companies surveyed which were able to renew their policies had their rates increased. All this despite the fact that 81 percent of the respondents have never had a case against them.

The picture is indeed bleak. Unfortunately, based on my previous experience with this issue, I am not confident that State insurance commissioners will be able to adequately handle the problem. Generally, State regulatory schemes focus principally on assuring the solvency of insurers; they are not designed to deal with overpricing, or the unavailability of insurance for consumers or businesses. In fact, in 1979, officials from the General Accounting Office testified before my subcommittee, citing their study of the State regulation of the insurance industry. The study found "serious shortcomings in state laws and regulatory activities with respect to protecting the interest of insurance consumers." Nothing has happened in the intervening period to alter this conclusion that a State-by-State approach to the insurance crisis simply is not adequate, and that a Federal response is warranted.

B. PROPOSED SOLUTIONS

The package of bills which I am introducing today is aimed at the many components of the insurance crisis. This comprehensive approach, much of which is based on reforms which I advocated 6 years ago, will serve to stimulate debate as to what Federal response is required to aid the businesses and individuals that are so desperately in need of assistance.

1. FEDERAL INSURANCE COMMISSION

First, to address the inadequacies of State regulatory schemes in dealing effectively with this issue, many of which were revealed by the GAO several years ago, I have proposed the establishment of an agency within the Federal Government with expertise in insurance that can adequately guard against future difficulties. A Federal Insurance Commission will, in general, defer to continued State regulation of the insurance industry, but would retain the power and duty to act in those instances where State regulation is deficient. The Commission will be structured along lines similar to the Federal Trade Commission, and will be given the broad grant of powers needed to perform its role.

Under this legislation, the FIC would be able to prevent persons from engaging in unfair insurance practices. More specifically, the Commission will have the authority to issue cease and desist orders to those insurance companies whose activities are not in the public interest and not necessary to promote their solvency. These powers will prevent insurers from charging excessive premiums and from canceling insurance contracts without justification. As such, the Commission will be able to address directly the principal factors that have contributed to the current crisis of unaffordability and unavailability.

2. REEXAMINATION OF THE MCCARRAN-FERGUSON ACT

Second, I am also calling for a reexamination of the McCarran-Ferguson Act, which exempts the insurance industry from Federal anti trust laws and oversight. The 1945 act was hastily conceived and was enacted with scant legislative history. Thus, the McCarran-Ferguson Act has been the source of much justified criticism. I am introducing five alternative bills which merit careful scrutiny. The bills would: First, repeal the McCarran-Ferguson Act; second, amend the act to require effective State regulation to qualify for an exemption from Federal oversight; third, clarify that the exemption from Federal regulation pertains only to insurance matters—not to extraneous matters such as advertising, investment, and so forth; fourth, eliminate those portions of the McCarran-Ferguson Act that exempt the insurance industry from Federal oversight, but retain the part of the act that permits State taxation of the industry; and fifth, define the business of insurance.

The broad-based exemption from the anti-trust laws accorded the insurance industry has long been subject to serious criticism. In 1976 and 1979, the National Commission for the Review of the Antitrust Laws and Procedures concluded that the immunity granted by the McCarran-Ferguson Act is overly broad and should be repealed.

As the Commission noted, "where members of a competitively structured industry are allowed collectively published industrywide rates—often without effective State supervision—in an regulatory environment that encourages uniform pricing, insurance premiums are likely to be higher than under a system that relies more heavily on independent pricing decisions." My proposed legislation will bring the antitrust laws to bear upon the insurance industry, thereby permitting competition to drive down the exhorbitant premiums which have so contributed to the current crisis.

3. FEDERAL PRODUCT LIABILITY ACT

Third, product liability tort reform will also promote a resolution of the insurance crisis. However, I am fearful that this cannot be brought about at the State level, where any changes are likely to be overly restrictive of the rights of injured persons. My proposal for Federal Product Liability Law would achieve equity, but not at the expense of an injured party, by creating a much needed single cause of action.

Right now a plaintiff can proceed on theories of breach of warranty, negligence, strict liability, absolute liability, and any of a number of different defenses might or might not be applicable. A single cause of action distinguishes among liability arising out of a defect in construction—that is, where a product is not manufactured in accordance with the manufacturer's own specifications—and liability arising out of other unsafe conditions or situations where appropriate warning or instructions were allegedly not given.

In all three classes, liability will result for bodily injury proximately caused by a defect. In the latter two cases, however, where liability arises from unsafe conditions or the failure to provide appropriate warnings, the trier of fact will be required to balance the foreseeability and seriousness of the injuries proximately caused, with the utility of the product to society, and the cost that would have been incurred by the manufacturer to have avoided the risk.

My bill also calls for a statute of limitation that would expire 3 years after the time the claimant discovered or should have discovered harm. Some industry spokesmen have argued that the statute should run from the date of manufacture or sale, rather than the date of injury. In my judgment, such an approach would be harsh and unreasonable. However, in order to alleviate what is a real problem, I have proposed an amendment to the statute of limitations that would provide that 10 years after the product has been in use, the burden of proving fault should rest exclusively on the plaintiff, without the benefit of any presumptions such as the failure to comply with ordinances or statutes, and such doctrines as res ipsa loquitor.

Finally, my proposal would clarify that the state of the art of the time of manufacture is relevant to the unsafe condition of the product. Moreover, we would clarify that the court would have the power to appoint its own expert witnesses. It would also provide for pure comparative responsibility. Responsibility would be apportioned among plaintiff and all defendants. These proposed reforms will provide a new degree of rationality, consistency and balance to our tort laws. They recognize the need to provide uniformity and certainty to those manufacturers whose products are sold not totally, but in interstate commerce. They do not, however, unfairly restrict the rights of individuals to seek redress through the courts for injuries caused by the negligent conduct of a manufacturer.

4. EXPANSION OF THE PRODUCT LIABILITY RISK RETENTION ACT

Fourth, in 1981, President Reagan signed into law the Product Liability Risk Retention Act of 1981, a bill based on one I had introduced in past Congresses. The stated purposes of this law were to ensure the prompt payment of legally valid claims, to promote competition among providers to product liability coverage, and to reduce the outflow of capital to offshore captive insurance companies. One additional feature of the act was that it had the effect of preempting State laws which prohibited selling product liability insurance to fictitious groups. Removing this impediment greatly facilitated the ability of groups of manufacturers to obtain insurance in the commercial marketplace.

In light of our current liability insurance crisis, we need to enact amendments to this law which will expand its coverage to general liability insurance rather than exclusively product liability, and I am introducing a bill that will do just that.

5. CONCLUSION

Mr. Speaker, the liability insurance crisis will continue to haunt us if we don't act responsibly and take action now. The insurance crisis which I investigated during the late 1970's has returned, and will continue coming back unless something is done to bring effective accountability to the insurance industry.

My proposed reforms are a starting point. For example, the Federal Insurance Commission will ensure, for the first time, effective regulation of the insurance industry. Repeal of or amendments to the McCarran-Ferguson Act will stimulate needed competition in the industry. A uniform Federal product liability statute along the lines I have suggested will provide predictability and certainty to business, while not unfairly infringing upon the rights of injured individuals. Finally, expansion of the Product Liability Risk Retention Act to cover all lines of liability insurance will create new options for those businesses that are unable to obtain insurance in the current market.

I hope that my colleagues have the courage necessary to stand up for their constituents in the face of admittedly heavy opposition. I invite each of you to join with me in a search for lasting solutions to the liability insurance crisis.

Congress must be willing to admit that this problem is beyond the ability of the States to handle, and initiate debate on the subject.

Wall St Jn
3/24/86

Enterprise Liability

The cable tram to Roosevelt Island in New York City stopped for two weeks recently because the insurance company refused to renew the policy. It looked like another victim of the litigation explosion set off by activist judges. But the residents of the island got the New York State Legislature to become the new insurer. The tram is running again. Now it's the taxpayers who are being taken for a ride.

So it goes in the world of American torts, or personal injury, law. There hasn't been a single accident in the 10 years of operating the tram, but insurance companies fear the possibility of multimillion-dollar verdicts even where there is no fault. Insurers are getting out of underwriting entire activities, like trams, day-care centers and midwifery. Consumers pay the bill, either through taxes as in the tram case, or through higher prices or through the unavailability of goods and services. Faced with this litigation explosion, about half the states are considering bills to get tort liability under control.

A Justice Department report on torts last week said that reinstituting the fault standard was the single most needed change. The current Journal of Legal Studies, published at the University of Chicago, describes how fault has been replaced by a notion called "enterprise liability." This scheme, devised by liberals in the early 1960s, says that business enterprises should be responsible for *any* injuries caused by products they introduce into commerce, no matter if the products were as safe as technology allowed or were misused. This is entirely different from the age-old view of the common law that with few exceptions there is no liability without fault.

George Priest, a Yale law professor, traced the history of enterprise liability to a desire on the part of some academics and judges for torts to become a system of national insurance, not just a forum for fairly resolving disputes. Mr. Priest says the impetus for holding defendants strictly liable was the New Deal notion of law as "social justice." Liberal judges embraced broader liability to pick the deep pockets of corporate defendants.

The judges appointed themselves as income redistributors. Canadian lawyer Ernest Weinrib points out that it's only in the U.S. that judicial fiat could create strict liability. Elsewhere, courts are supposed to resolve disputes between the opposing parties, not redistribute wealth according to their idea of social justice. Mr. Weinrib described how the Australian High Court refused to abandon the fault standard. Strict liability should be adopted "if at all, openly and after adequate public inquiry and parliamentary debate and not worked towards covertly, in the course of judicial decision, by the adoption of policy factors which assume its desirability as a goal."

Judges make lousy social engineers. Costs of goods rise with insurance premiums, hurting the poor and defeating the very purpose of the judicial activism. The result can be that only industries with wealthy consumers survive huge new premiums. A modest ski lodge in Tennessee may not be able to pay its premiums, but you can bet the slopes will still be full in Aspen. It may be hard to find an insured family doctor in Harlem, but richer Americans can still pay higher fees to cover higher premiums.

When judges start acting like politicians, it's time for the politicians to remind them of the separation of powers. State legislators can undo strict liability by passing statutes requiring that a party actually be at fault to be held liable for damages. This would not be revolutionary. It is the common law in the rest of the world, and was our law until the Great Society invaded the courts.

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ADMINISTRATION GIVES A PREVIEW OF ITS TORT REFORM VIEWS

Assistant Attorney General Richard Willard last week gave the Federal Bar Association a preview of the Reagan administration's review of tort law problems. Willard heads the interagency task force which is producing a series of reports, the first of which is due in mid-March.

He said the current liability insurance crisis is due to two factors: insurers' cash-flow underwriting in the past and the "explosion of civil liability." The latter is due to the combined effects of three changes in the law: the trend to no-fault liability; the erosion of the doctrine of causation, including the rise of joint liability; and sharp increases in the size of damage awards. He warned that "tort liability cannot be a constantly expanding concept" and indicated that the Justice Department will recommend efforts to change overall public attitudes rather than pursue specific tort reform proposals.

The task force is not likely to recommend indemnification of federal contractors, because that would merely transfer the cost rather than solve the tort law problem, Willard said. It is looking at the liability problems of federal government employees and also the impact of federal civil rights laws on local government liability. While endorsing federal product liability law in concept, the administration is not embracing any specific legislation at this point.

PRODUCT LIABILITY LEGISLATION DEBATED

Insurers, consumer groups, manufacturers and attorneys last week presented to the Senate Commerce Committee their views on new product liability legislation. The bill (S.1999), introduced by Committee Chairman Sen. John C. Danforth (R-MO), will establish a uniform federal liability standard which would incorporate a no-fault victim compensation system. Danforth admitted that his bill is "not perfect and leaves room for improvement." Consumer advocates said they would favor an incentive system which would award those manufacturers who work out a prompt settlement with victims and punish those who carry on with unreasonable litigation.

Federal Team Urges Tort Law Reforms

Liability Lawsuits Seen Prime Cause Of Insurance Crisis

A top level federal government policy working group issued a list of recommendations March 19 calling for extensive reform of the country's tort laws in order to alleviate the current liability insurance crisis.

The group, made up of representatives from 10 federal agencies and headed by U.S. Assistant Attorney General Richard K. Willard, was appointed by Attorney General Edwin Meese last October and asked to take a close look at the crisis in liability insurance affordability and availability.

The investigation led the group to the conclusion that insurance industry losses alone are not the cause of the recent massive increases in premiums. "To the contrary, indications are that developments in tort law are a major cause of the sharp premium increases," the report stated.

The federal study team said it "was

(See TORT REFORM, p. 5)

ort Reform

(Continued from page 1)

ticularly struck by the extraordiy growth over the last decade of number of tort lawsuits and the rage award per lawsuit." For exam-, it cited a survey of punitive nage awards in Cook County, Ill., icating the average personal injury nitive damage award increased m $40,000 in 1970-74 to $1,152,174 1980-84.

he group said its information emonstrates that the insurance ustry was selling coverage at con-nt or even reduced cost over a iod of years during which tort lia-ity was undergoing a dramatic ansion."

This suggests that a major factor derlying the availability/affor-ility crisis is the industry's attempt ring premiums quickly back into with rapidly growing liability s," it added. "The high — and in e areas unaffordable — insurance miums reflect the fact that tort law ows placing a massive compensa-burden on the private sector."

One serious contributing factor is fact that the "rules of the game" in law standards for liability and sation continue to change rapidly, ecting "tremendous uncertainty" thus making it virtually impossi-for insurers to assess future risks y may face, the group reported.

t recommended a series of eight tort law reforms that it "should significantly alleviate the crisis in insurance availability and affordability." These are:

- Return to a fault-based standard for liability. For non-product liability cases, negligence should remian the applicable standard of liability.
- Base findings of causation on credible scientific and medical evidence and opinions.
- Eliminate joint and several liability in cases where defendants have not acted in concert.
- Limit non-economic damages (such as pain and suffering, mental anguish or punitive damages) to a fair and reasonable maximum dollar amount.
- Provide for periodic — instead of lump sum — payments for damages for future medical care or lost income.
- Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery.
- Limit attorneys' contingency fees to reasonable amounts figured on a sliding scale.
- Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

At a press conference last week, Mr. Willard said: "The working group does not at this time recommend how these reforms should be implemented — whether at the federal or state level, or through legislative or judicial modification of the law — nor are these reforms meant to be an exhaustive list of potential reforms."

The study group rejected the concept of federal government-provided insurance coverage as unaffordable and unworkable. It also said it "found nothing to support the suggestion that this crisis should be remedied through federal regulation of the insurance industry or of state insurance regulators."

The group warned that "significant, long-term reform cannot and should not come solely from the federal government. Ultimately, state governments and courts must address the current excesses of tort law. Their active participation is essential to finding workable solutions to the increasingly debilitating problems of tort law."

City, seawall engineers sued for $1 million over summer drowning

by Bobbie Garthwaite

Arvin Dull, representing the estate of Abraham James, is seeking in excess of $1 million in a wrongful death suit filed this month against the city of Bethel and the engineering firm of Galliett & Silides.

Seventeen-year-old Abraham James fell into the Kuskokwim River from a floating dock below the intersection of First and Main on July 28, 1985 and drowned. He was reportedly with two female co... ions at the time, and the women later said that he had been pretending to throw one of them into the water when he and one of the women fell in.

The other woman reportedly jumped into the water and both women attempted to assist James, but could not. His body was recovered later that day.

Police Chief Kevin Clayton said that at the time of the accident, the young women said that they and James had been drinking.

In the suit, Dull states that the dock is attached to the Bethel seawall and is owned and operated by the city of Bethel.

He further states that the dock and seawall were designed by Galliett and Silides.

And, he claims that neither the seawall nor the floating docks had life rings, life ropes, guard rails, or warnings to the public concerning the use of the docks.

"As a direct and proximate result of the negligent design, construction, and maintenance of the Bethel Seawall and the floating docks, Abraham James drowned," Dull claims in the suit.

Dull is asking the court to award in excess of $1 million to the estate of Abraham James. James was Dull's brother-in-law, according to Dull's attorney, Cathleen Connolly of the Angstman Law Offices.

Attorneys, who have been at odds with Congress over federal product liability legislation, remained firmly opposed to any changes in the current system. Manufacturers, while acknowledging their reservations about the bill, generally favor the idea of a uniform law in the hopes it would improve the affordability and availability of liability insurance. Les Cheek of Crum & Forster offered specific suggestions for changes in the legislation, indicating that the standard of liability in the alternative claims mechanism was unworkable.

HIGH COURT LETS CITIES OFF THE ANTITRUST HOOK

The Supreme Court last week eased the threat of antitrust lawsuits against local governments that regulate economic activities. In an 8-to-1 decision, the Court said municipal rent control laws do not violate federal antitrust statutes. By extension, the ruling also validates local zoning laws, taxicab regulation, cable TV franchises and other rules that were under legal challenge. The decision clarifies a 1978 case in which the Court ruled that local governments could be held liable under antitrust law for economic regulation that exceeded authority granted to them by the state. The latest decision came in Fisher vs. City of Berkeley (Docket No. 84-1538).

HAZARDOUS WASTE OPERATORS DEBATE INSURANCE DEADLINE CHANGE

Representatives of the hazardous waste management industry last week presented opposing views on legislation (HR.3917) which would extend the period allowed for compliance with federal financial responsibility requirements. Testifying before the Senate Environmental Pollution Subcommittee, small hazardous waste management companies said the unavailability of adequate liability insurance made it impossible to meet the Nov. 1, 1985, deadline. Extending the deadline, they added, would allow them to develop alternatives to commercial insurance. Technically, those not in compliance are operating illegally.

Representatives of larger companies noted, however, that the insurance problem will not disappear in a year and that granting an extension will not help resolve the problems of those who are unable to comply with financial responsibility requirements. They said an extension of the deadline would be unfair to those companies which did meet the compliance deadline. The bill was passed by the House of Representatives last December and awaits action by the Senate.

PENNSYLVANIA GOVERNOR VETOES BILL TO RETAIN GENDER-BASED RATING

Insurers are considering their options following Pennsylvania Gov. Dick Thornburgh's veto of a bill (HB.452) which would have retained gender-based rating for auto insurance (see ExL 2/18/86). The governor said he could not support legislation "which affords less protection against unfair sexual classifications than is (legally) afforded against unfair classifications

based upon race, religion or national origin." He said what should be identified are underlying rating factors which better reflect actual variations in driving and safety records of many males and females. "While such factors might coincide with the sex of the insured, rates should be based on those underlying factors and not per se on sex."

Since the bill was passed by more than a two-thirds margin in both houses and a veto can be overturned by such a majority, insurers may lobby for that to be done. Another possibility is lobbying for Senate concurrence with the House-passed bill (SB.1037), which would, among other things, postpone implementation of unisex rating for 18 months while the State Government Commission -- a legislative body -- develops a plan for implementation. Some insurers believe the commission might find that the problems of unisex outweigh the supposed benefits, resulting in a commission recommendation for a modification of the unisex directive. The governor said he could support legislation to delay unisex implementation while a "legislative-executive inquiry" seeks alternative methods for determining auto insurance rates, but his veto message seems to flatly rule out use of sex as a rating classification.

COOK COUNTY SUIT AGAINST ASBESTOS MANUFACTURERS DISMISSED

A Cook County Circuit Court (Chicago) judge has dismissed lawsuits filed by 34 school districts in Illinois against dozens of asbestos manufacturers seeking to force the companies to pay the cost of removing the substance from school buildings. Judge Richard Curry rejected the suits (Cook County Circuit Court 85-CH-811, 812 and 3905) ruling the school districts, including the Chicago school system, failed to prove the companies knew of the dangers of the substance when they sold it to the schools. The cost of removing the asbestos, he ruled, should be paid by the school districts or the state under the Illinois Asbestos Abatement Act. Only about $3 million has been appropriated for the act, however, significantly less than the $55 million expected cost for removal of the asbestos from the schools. The suits were filed last year against 78 firms that mine, manufacture, sell and install the material. An appeal is expected.

INSURERS AND INDUSTRY CRITICS CLASH AT ICAN MEETING

Industry critics such as Ralph Nader, Robert Hunter and several trial lawyers clashed with insurance industry representatives in Los Angeles Feb. 21 and 22 at a meeting of the Insurance Consumer Action Network (ICAN). Most of the approximately 100 persons attending were plaintiff attorneys, with representatives from government and insurance companies and some consumers also present. Insurance Information Institute spokespersons represented the industry on two panels: one dealing with insurance company profits, and another dealing with auto insurance questions including territorial rating and compulsory insurance. ICAN, which bills itself as "a network of consumer insurance

advocates ... dedicated to defining and protecting insurance consumers' rights," received its start-up funds from a past president of the California Trial Lawyers Association.

TRIAL LAWYER TOURING COUNTRY TO PROMOTE BOOK

William M. Shernoff, a past president of the California Trial Lawyers Association and a force behind the Insurance Consumer Action Network (see item above), is on a 15-day tour promoting through television appearances his new book, "Payment Refused." Published by Richardson & Steirman of New York, the book reviews in detail "bad faith" claims brought by Shernoff involving all lines of insurance. The Insurance Information Institute and the American Council of Life Insurance are arranging for industry representatives to appear with Shernoff, as was the case last week in New York City where he kicked off his tour with appearances on two stations.

MICHIGAN'S AUTO LAWS GET MODIFIED

Efforts to modify the auto insurance provisions of Michigan's Essential Insurance Act (EIA) appear headed for success. Unlike last year's package, the 1986 version apparently has Gov. James Blanchard's support. The major thrust of the reform measure is to relieve the onerous rating provisions of the old law, allowing rates outside of Detroit to be set competitively while retaining some restrictions on Detroit rates.

The law also mandates a 20% discount for personal injury protection rates after Feb. 1, 1987, to reflect the state's seat belt usage law. Other sections of the proposed law deal with auto theft, including the establishment of an auto theft authority.

R.I. GOVERNOR NAMES INDUSTRY PANEL ON AVAILABILITY

Rhode Island Gov. Edward D. DePrete has established a 25-member Governor's Insurance Council, made up of insurance industry executives, to address problems of availability and affordability in the current insurance market. The governor, a former insurance agent, has targeted three main purposes for the Council: to ensure that the needs of the insurance consumer are being met; to establish communications between the insurance industry and state government; and to retain existing jobs as well as to create new employment.

VERMONT BANKING AND INSURANCE COMMISSIONER NAMED

Vermont Gov. Madeleine Kunin has named Thomas P. Menson, former executive vice president and chief operating officer of the Bank of Vermont, as the new banking and insurance commissioner. He succeeds David Bard, who resigned to become president of the New England IBM Credit Union.

Carl C.A. Lee, Editor

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ALAKANUK	UNINSURED	UNINSURED	4%	YES
ALEKNAGIK	$ 4,500	$15,000	13%	MAYBE
BARROW	$ 4,100/$ 1 million	$10,000/$500,000		
BETHEL	$350,000	$600,000	10%	YES
CORDOVA	$ 21,000/$ 1 million	$ 31,850/$500,000		
EAGLE	$ 3,365/$500,000	$ 8,739/$500,000	6%	YES
FAIRBANKS	$212,876/$20 million	$514,167/$5 million	2.5%	NO
GALENA	REPEATED CANCELLATIONS/PREMIUMS UP 200%		5%	MAYBE
GAMBELL	$ 19,300/$1 million	$ 15,617/$500,000		
HAINES BOROUGH	$ 25,000	$ 34,797	3.5%	NO
HOONAH	$ 6,484/$1 million	$ 11,640/$500,000		
HOUSTON	$ 23,906	37,444	16%	MAYBE
JUNEAU	$518,000	$1,253,900	2%	YES
KAKE	$ 10,617/$1 million	$ 7,080/$500,000		
KENAI	$ 85,000/$10 million	$320,000/$10 million		NO
KODIAK	$ 90,083/$500,000	$155,725/$500,000	5%	YES
KOTZEBUE	$140,000	$280,000	5%	YES
LOWER KALSKAG	$ 2,500/$1 million	$ 5,000/$500,000		
McGRATH	$ 13,596	$ 41,063	7.5%	YES
NULATO	$ 4,500/$500,000	$ 12,000/$500,000	5%	YES
PALMER	$138,000/$10 million	$219,000/$1.5 million		YES
PELICAN	$ 7,457/$500,000	$ 15,908/$300,000	11.5%	YES
RUSSIAN MISSION	$ 2,580/$1 million	$ 5,000/$500,000		
St. MARY'S	$ 4,200/$1 million	$ 5,000/$500,000	10%	YES
SAND POINT	$ 45,000	$ 80,000	9%	YES
SITKA	$ 53,753/$10 million	$131,628/$5 million	3%	YES
SKAGWAY	$ 31,883/$1 million	$ 55,806/$ 1 million	6%	MAYBE
SOLDOTNA	$110,000/$10 million	$270,000/$10 million	6%	YES
TENAKEE SPRINGS	$ 13,670	$ 42,000	16%	YES
UNALASKA	$131,124/$14 million	$ 99,468/$4 million	10%	YES
WALES	$ 11,663	UNINSURED		YES
WASILLA	$ 11,000/$6 million	$19,000/$1.5 million	2%	MAYBE

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THE INSTITUTE FOR CIVIL JUSTICE

Civil Justice Roundtable

Vol. 3, No. 12 **March 1986**

Civil Justice Roundtable is a monthly newsletter from The Institute for Civil Justice. It is, in part, an "opinion exchange" for policymakers, practitioners, and researchers concerned with problems of the civil justice system. *Roundtable* also provides brief updates on the ICJ's research and reactions to it, and announcements of future activities. We invite letters expressing opinions from diverse perspectives that contribute to the informed debate of civil justice issues. *Roundtable* is mailed to nearly 7,000 business executives, judges, lawyers, legislators, court executives, researchers, and federal, state, and local government leaders. We welcome your contribution to the debate and offer this forum for your opinions— excerpts from letters we receive may be reproduced to facilitate communication among ICJ's diverse audiences.

ROUNDTABLE DISCUSSION

On February 27, 1986, ICJ researcher Deborah Hensler testified before the **U.S. Senate Commerce Committee** on the results of ICJ research relevant to the **tort liability system**. Below we reprint portions of that testimony; the full report on which this statement was based will be available as P-7210-ICJ.

The ICJ has assembled a statistical database that tracks the results of all civil jury trials held in Cook County, Illinois and San Francisco, California from 1960 to 1979. Analyses of these data show that: The typical jury award for personal injury cases is modest in amount (less than $20,000 in recent years). Amounts awarded for typical cases remained roughly the same over the twenty year period. The typical award for seriously injured plaintiffs doubled or tripled, and the typical wrongful death award doubled during the 1970s. Juries increased awards in medical malpractice, defective products and street hazard cases, regardless of the seriousness of injuries. The changes in the amount of money awarded for serious injuries and the amount awarded for medical malpractice, product liability and street hazard cases contributed to a growing number of exceptionally high awards. The amount of money litigants could expect to win or pay out depended on their own characteristics. When sued, businesses paid 1 1/2 times the amount paid by individual defendants. Jury awards also appeared to be sensitive to the race of the litigant. In Cook County, during the 1970s, blacks lost more frequently than whites; when they were successful, they received less than white plaintiffs. The number and size of punitive damage awards increased substantially during the past twenty-five years. Typical punitive damage awards remained small. Most awards involved intentional torts rather than personal injury cases.

Punitive damage awards against businesses increased in number and amount, particularly in recent years. A substantial number of punitive damage awards are reduced after trial, as a result of settlement or judicial action.

In 1982 the ICJ conducted a study on how the current product liability system affects corporate behavior. The study involved interviews with corporate product safety officials in nine large manufacturing firms generally recognized as leaders in the safety field. The researchers drew the following conclusions:

"It is clear from these interviews that . . . product liability is the most significant influence on product safety efforts. Product liability, however, conveys an indistinct signal. The long lags between the design decision and the final judgment on product liability claims (frequently five or more years), the inconsistent behavior of juries, and the rapid change in judicial doctrine in the area, all tended to muffle the signal. . . . That is to say, firms learned little from the results of particular litigation about either specific design decisions or the process of design decisionmaking. The frequency of suits and the level of awards provide some idea of the costs of failing to design a safe product and hence the level of effort that should be devoted to assuring a safe design. Nevertheless, considerable uncertainty remains about the most appropriate method of assuring safety in product design."

According to ICJ studies, an estimated $320 million was expended nationwide in federal and state trial courts to process personal injury cases in 1982. The typical public expenditure to try a personal injury suit in the federal courts was about $9200. The costs in state trial courts varied substantially depending on judge salaries and other expenses; costs ranged from about $4000 to $8000 per case. Public costs to process cases depend not only on whether a case goes to judge or jury trial but on the amount of judge time spent hearing discovery and other motions and presiding over pretrial conferences.

An ICJ study of the largest and one of the busiest state trial courts in the nation, the Los Angeles Superior Court, found that the civil caseload is increasingly dominated by complex personal injury litigation that places heavy demands on judge time. By comparison with earlier periods, current civil cases are characterized by a greater use of discovery as well as more papers filed, appearances made, and motions requested. This increased activity means that even cases that settle rather than go to trial take longer to reach settlement than in earlier years. It is these increases in case complexity, rather than an increase in litigiousness, that have contributed to increased congestion and delay on the civil calendar.

The ICJ's studies of asbestos personal injury litigation highlight the problems posed by mass toxic torts. These studies have shown that: Most courts have had serious problems disposing of cases; plaintiffs wait a minimum of three years and as long as five or more years until their cases are resolved. The costs of asbestos litigation are higher than for any other kind of personal injury case for which transaction costs have been estimated; about $1 billion was paid to compensate and litigate asbestos claims between 1970 and 1982. The latent nature of asbestos-related diseases and the manufactuing context in which they occurred raise issues on the timing of filing claims, determining causation, determining liability and apportioning damages that have been dealt with inconsistently by various state appellate courts and local trial courts, resulting in increased uncertainty in case value, delays in processing, increased transaction costs, and inconsistent outcomes.

Finally, the ICJ has conducted a series of studies on the outcomes of court-annexed arbitration programs in state trial courts. Thes studies consistently indicate that such alternatives to traditional settlement and trial can provide acceptable outcomes to plaintiffs and defendants with a reduction of time and litigation expense, and that such procedures may be perceived by litigants to be as fair as the traditional system.

ICJ UPDATE

The **Thirteenth Semiannual Meeting of the Board of Overseers** was held on February 21. An overview of the Institute's research agenda was presented by ICJ Deputy Director Stephen Carroll, and five research briefings were featured: *Bad Faith Punitive Damages; Wrongful Termination; Private Costs of Civil Litigation; New Research Issues in Civil Jury Verdicts;* and *Judicial Arbitration in New Jersey.*

ICJ researcher James Hammitt spoke on "Modeling Compensation for Auto Accidents" at the February 21 conference of the **Insurance Consumer Action Network** and the **National Insurance Consumer Organization** in Los Angeles. On February 27, ICJ Director Gustave Shubert testified in Topeka before the **Insurance Joint Subcommittee of the Kansas State Legislature** considering the **problems of availability in insurance**. On the same day, he addressed the **Kansas Tort Reform Coalition** in Topeka. On March 5, Stephen Carroll, Gustave Shubert, and ICJ researcher Mark Peterson testified before the **White House Tort Policy Working Group** in Washington. Marianna Smith, Executive Director, and Robert Habush, President-Elect, of the **American Trial Lawyers Association** visited the ICJ on March 6 to discuss possible collaborative research efforts. Stephen Carroll addressed a meeting of the **Council of Medical Specialty Societies** on March 10 in Chicago. Mark Peterson will testify before the **Subcommittee on Oversight of the House Ways and Means Com e** hearings concerned with the costs and availability of ... insurance on March 13 in Washington. Stephen Carroll will testify before the **National Commission on Jobs and Small Business** on March 14 in San Francisco. ICJ consultant Patricia Danzon will testify on March 26 in Washington before the **Senate Judiciary Committee** hearings on tort reform. Her topic will be "The Effects of Tort Reform on the Frequency and Severity of Medical Malpractice Claims." ICJ researcher Allan Lind contributed an article, "Alternative Dispute Resolution in the Federal Courts: Public and Private Options," to the March issue of the *Federal Bar News and Journal.*

The Institute for Civil Justice, established within The Rand Corporation in 1979, performs independent, objective policy analysis and research on the American civil justice system. The Institute's principal purpose is to help make the civil justice system more efficient and more equitable by supplying policymakers with the results of empirically based, analytic research.

For information on the Institute's program, and for published research findings as they become available, please contact:

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A RAND NOTE

LIMITING LIABILITY FOR AUTOMOBILE ACCIDENTS: ARE NO-FAULT TORT THRESHOLDS EFFECTIVE?

James K. Hammitt, John E. Rolph

October 1985

N-2418-ICJ

Prepared for

The Institute for Civil Justice

Rand
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The Institute for Civil Justice

The Institute for Civil Justice, established within The Rand Corporation in 1979, performs independent, objective policy analysis and research on the American civil justice system. The Institute's principal purpose is to help make the civil justice system more efficient and more equitable by supplying policymakers with the results of empirically based, analytic research.

Rand is a private, nonprofit institution, incorporated in 1948, which engages in nonpartisan research and analysis on problems of national security and the public welfare.

The Institute examines the policies that shape the civil justice system, the behavior of the people who participate in it, the operation of its institutions, and its effects on the nation's social and economic systems. Its work describes and assesses the current civil justice system; analyzes how this system has changed over time and may change in the future; evaluates recent and pending reforms in it; and carries out experiments and demonstrations. The Institute builds on a long tradition of Rand research characterized by an interdisciplinary, empirical approach to public policy issues and rigorous standards of quality, objectivity, and independence.

The Institute disseminates the results of its work widely to state and federal officials, legislators, and judges, to the business, consumer affairs, labor, legal, and research communities, and to the general public.

PREFACE

This Note is a reprint of an article that appeared in *Law & Policy*, Volume 7:4, 1985. Using insurance claims data, the authors analyze the effectiveness of no-fault tort thresholds in limiting the number of automobile accident victims who seek compensation through the tort system.

The analysis contained in this Note is described in greater detail in the first two volumes of a four-volume study on automobile accident compensation, conducted by the authors for The Institute for Civil Justice. These four reports are included in a listing of current ICJ publications at the back of this Note and can be obtained from the Institute.

Limiting Liability for Automobile Accidents: Are No-Fault Tort Thresholds Effective?

JAMES K. HAMMITT and JOHN E. ROLPH*

"No-fault" automobile insurance plans are designed to supplant the tort system by requiring motorists to purchase no-fault insurance and allowing victims to file liability insurance claims and tort suits only if their injuries exceed a legislated "tort threshold." While thresholds vary among states, many are satisfied if the victim incurs medical expenses as low as a few hundred dollars. Using insurance claims data, we estimate the effectiveness of several states' thresholds. We find that tort thresholds are surprisingly effective: modest tort thresholds reduce the number of successful tort claimants by half, and the strictest thresholds may exclude nine-tenths of potential claimants. Moreover, we find little evidence of claimants "padding" their claims to exceed the dollar thresholds.

No-fault compensation plans for automobile accident victims were developed to replace the traditional tort liability system. Early no-fault advocates criticized the tort system under which the motorist who is legally at fault or his liability insurance company compensates the accident victims as providing "too little, too late, unfairly allocated, at wasteful cost, and through means that promote dishonesty and disrespect for the law." (Keeton and O'Connell, 1965: 3). In contrast, no-fault plans establish mandatory "no-fault" insurance that reimburses the policyholder, his passengers, and any pedestrians he may injure, without regard to who "caused" the accident. No-fault insurance is intended to provide quicker and more certain compensation, at less cost, because there is no need to ascertain legal responsibility for the accident.

No state has yet adopted a no-fault plan that totally replaces the tort system. All no-fault states attempt to prevent certain automobile accident victims—those with less severe injuries—from using the tort law to obtain compensation, but allow more seriously injured victims to pursue tort compensation in addition to collecting no-fault insurance benefits. The two classes of victims are defined by whether their injuries exceed a "tort threshold," which may be either a "dollar" or "verbal" threshold.[1]

Under a dollar tort threshold, accident victims are not entitled to tort compensation unless their medical expenses exceed the threshold value.

* The Institute for Civil Justice, The Rand Corporation. We thank Joseph Ferreira, Robert Houchens, Sandra Polin, Timothy Quinn, Donald Segraves and three anonymous reviewers for their contributions to this research.

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Thresholds range from $200 (net of hospital and diagnostic expenses) in New Jersey to $4,000 in Minnesota. To breech a verbal threshold, victims must have suffered one of a specified set of injuries. Verbal thresholds are typically quite stringent, requiring permanent and significant disfigurement, disability, or death. In a few states, however, the verbal threshold is satisfied by less serious injuries: a fracture (Massachusetts), or any injury not confined to soft tissue (New Jersey).[2]

All states with dollar thresholds also have verbal thresholds, but three no-fault states (Florida, Michigan and New York) have only verbal thresholds. In these states, regardless of medical expenses incurred, a victim is not entitled to tort compensation unless his injuries exceed the stringent verbal threshold.

Whether an accident victim is entitled to tort compensation or must be satisfied with no-fault insurance benefits can have a substantial effect on the amount of compensation he or she receives. No-fault insurance pays only for a victim's economic losses (called "special damages"), primarily medical expenses and lost wages.[3] In contrast, under tort law the victim can potentially collect compensation for "pain and suffering" and other nonpecuniary losses (called "general damages") as well as for special damages. Although payments for general damages differ widely between accident victims, they often exceed the victim's special damages. For automobile accident victims with $500 in medical expenses the median payment for general damages in our data (described below) is about $1,000. For those with $5,000 in medical expenses the median payment for general damages is about $6,500. (Hammitt, 1985, see figure 1.) Thus the lure of compensation for general damages provides a substantial incentive for a victim to seek tort compensation if another motorist is arguably liable for his injuries.

Because payments for general damages can be so large relative to the compensation a victim can obtain from no-fault insurance, one would expect accident victims to file lawsuits or claims against another driver's liability insurance in all but minor cases. Indeed, one might expect that some victims would attempt to circumvent the tort threshold either by fraudulently claiming medical expenses in excess of the dollar threshold, or by incurring additional, unnecessary, medical treatment in order to surmount the threshold. In some cases accident victims do receive liability insurance payments, including compensation for general damages, even though their injuries may not have exceeded the tort threshold. These payments are made because almost all automobile liability claims are settled without recourse to trial. In cases where it is not clear whether a claimant could prove that his injuries exceed the tort threshold the liability insurer may offer some payment to settle the claim and avoid further expense.

Because the possible gain in seeking compensation from a liability insurer is so large, there is some debate about how effectively tort thresholds, especially low-to-moderate dollar thresholds, reduce the

number of victims who file liability claims.[4] In this article we present an analysis of insurance claims data designed to address this issue. In the states studied, we find that even relatively weak thresholds appear to prevent a large proportion of accident victims from obtaining tort compensation. For example, we estimate that the $500 tort threshold in Massachusetts reduces the number of victims who are paid under automobile liability insurance there by more than half. Stricter tort thresholds, such as the verbal one in Michigan, appear to prevent about 90 percent of auto accident victims from obtaining tort compensation. We surmise that the much smaller chance of recovering compensation if one's injuries do not exceed the tort threshold discourage large numbers of victims from filing liability claims and lawsuits. Interestingly, we find no evidence to suggest that victims systematically exaggerate their expenses, or incur additional medical expenses, to surmount dollar tort thresholds.

We turn now to describing the closed automobile insurance claims data that we analyze. We then describe our two methods for estimating the proportion of automobile accident victims excluded from tort claims by the tort threshold. Finally we present our analysis of claims to determine whether they have been padded or exaggerated in an effort to surmount the tort threshold.

DATA

The data we analyze consists of claims paid by automobile insurers under the Bodily Injury (BI) and Personal Injury Protection (PIP) coverages. BI insurance is liability insurance; it pays damages to a third party (the accident victim) for which the policyholder is liable. PIP insurance is no-fault insurance; it pays benefits to the policyholder, his passengers, and pedestrians without regard to legal fault.

The data were collected by the All-Industry Research Advisory Council (AIRAC), an insurance-industry association, and include all claims that were closed with some payment to the claimant by the participating insurers during a two-week period in autumn, 1977; claims that were denied payment are not included. At the time of the survey, the twenty-nine participating insurers had a 62 percent share of the national market for private passenger automobile insurance. For each closed claim, insurance company claims adjusters and supervisors provided detailed information on the claimant's personal characteristics, medical and other economic losses, type and severity of injury, and the payment made by the insurer. The data are described more fully in AIRAC (1979).

As part of a study of compensation under tort and no-fault rules (Hammitt, 1985; see also Rolph et al., 1985), we selected four no-fault states for analysis—Massachusetts, New Jersey, Pennsylvania and Michigan. Generalization of results from one state to another is always problematic; however, based on the frequency with which claimants retain attorneys and file

Table 1. Cumulative Distribution of Total Payments

Payment Less than	Personal Injury Protection		Bodily Injury	
	Michigan	Massachusetts[a]	California	Massachusetts
	Percentage of Claimants Paid			
$100	34	40	12	6
$300	59	65	29	13
$500	69	72	37	18
$1,000	80	82	51	28
$5,000	95	100	89	74
$15,000	98	100	98	93
$50,000	100	100	100	100
	Percentage of Dollars Paid			
$100	1	4	0	0
$300	5	12	1	0
$500	8	18	3	1
$1,000	15	32	7	2
$5,000	42	94	42	32
$15,000	64	100	70	64
$50,000	100	100	88	100

[a] PIP policies in Massachusetts are required to provide for medical benefits of at least $2,000; additional coverage is available as an option.

lawsuits, these four states appear to be more litigious or claims-conscious than most other states. Consequently the proportions of accident victims that the thresholds prevent from recovering tort compensation in these states is likely to be smaller than the proportion that similar thresholds would bar in other, less claims-conscious, states.[5] There may be other states however, that are even more claims-conscious than the four we analyze. For example, knowledgeable insurance industry followers assert that the original $1000 tort threshold in Florida had almost no effect on the number of BI claims paid there; it was not until Florida established an entirely verbal threshold, and an anti-fraud bureau, that the number of victims receiving tort compensation declined (Personal communication; see also O'Connell, 1977: 159–60, and U.S. Dept. of Transportation, 1977). Thus there may be some states where our conclusions do not hold. However, we believe our analysis is based on assumptions that apply in all but exceptional circumstances.

Table 1 presents an overview of claims payments under both PIP and BI insurance, for three representative states. The majority of claims are quite modest; as shown in the first panel of the table, more than half the PIP claimants are paid less than $300, while about four-fifths receive less than $1,000. BI payments are somewhat larger, because they usually include payments for general damages in addition to economic loss. Even so, half of the California BI payments are less than $1,000. The Massachusetts BI payments are much higher than the California payments, because the Massachusetts tort threshold excludes claimants with relatively mild injuries.

As a result, only 28 percent of Massachusetts BI payments are less than $1,000.

The second panel of the table reveals that the distribution of dollars paid by insurers is dominated by the larger claims. While most claims payments are modest, these account for only a small share of total payments. As shown in the second panel, both the two percent of Michigan PIP claimants and of California BI claimants who were paid more than $15,000 each received about one-third of the total dollars paid.

METHODS

Our strategy for estimating the effect of tort thresholds in each of the four states studied is to generate independent estimates for each state. When we compare these states to states without tort thresholds using the "BI-file method" (described below), we also generate independent estimates for each comparison pair of states. This disaggregated estimation approach is appropriate here in view of the diversity of the states we are comparing. The alternative of simultaneously estimating the effects of tort thresholds for all states with a statistical model (like regression) that shares information about relationships across states is not feasible without comprehensive and comparable data for litigation affecting factors in each state. Such data are needed to statistically adjust for differences between states that might affect how tort thresholds operate. We have not been able to locate such sufficiently comprehensive data.

We estimate the fraction of accident victims who are denied tort compensation because of tort thresholds using two different methods and compare the results. First, we use the "PIP-file method" to compare the number of PIP claimants who are eligible to obtain BI compensation (as reported by the survey respondents) to the number who would have been eligible prior to the adoption of the tort threshold in their state. Since PIP pays all victims without regard to fault or injury severity the PIP claims file includes most types of accident victims (the main exception is uninsured motorists and their passengers). The fraction of PIP claimants who would have been eligible for BI payments prior to the threshold, but who are no longer eligible, is our PIP-file method estimate of the effect of the tort threshold in reducing the number of successful BI claimants in that state. Note that this method estimates only the number of potential claimants that are no longer entitled to tort compensation, but does not account for their likelihood of actually filing BI claims.

Our second method, the "BI-file estimate," is based on a comparison of the populations of claimants who are paid by BI insurance in the no-fault state and in a reference state that has no tort threshold. The validity of this estimate depends on the extent to which the distributions of accident victims in the no-fault and the reference state are similar, with respect to economic loss, type of injury, legal fault, propensity to file insurance claims

and to retain an attorney, and other factors that might affect the number of successful BI claimants. We attribute the difference between the numbers of successful BI claimants to the tort threshold. Unlike the PIP-file method, the BI-file method does account for victims' likelihood of filing BI claims. However, it does not allow for the estimation of any separate effect (in addition to the tort threshold) that the existence of no-fault insurance has on the number of liability insurance claims filed. (Since victims can almost always collect under PIP, they may be less likely to also file a BI claim.) However, since the results of both of our estimation methods are in general agreement, we conclude that tort thresholds are the primary cause of fewer liability insurance claims in no-fault states.[6]

To determine the accuracy of the BI-file method we generate independent estimates of the tort-threshold effect using several different reference states. If the potential-claimant populations are distributed identically in all states, the estimates would be the same for all reference states up to statistical fluctuations. The extent to which the choice of reference state affects the estimate is an indication of the degree to which the populations differ, and thus is a measure of the precision of the method.[7]

Some commentators have suggested that the adoption of a no-fault system will increase the number of automobile accidents, since drivers may be less careful when the deterrent of tort liability is removed.[8] Others doubt such an adoption will have a significant effect, since the tort deterrent is largely diluted by liability insurance, and other factors are probably more important influences on driving behavior. Our estimates do not take account of this effect, should it exist. We estimate the change in the proportion of accident victims who are paid by BI insurance; if the adoption of a no-fault plan increases the number of accident victims our estimates will overstate the reduction in BI claims paid. We describe both our methods and results in more detail below.

ANALYSIS AND RESULTS

A large proportion of accident victims in the four no-fault states we studied did not seek or were denied payment under BI insurance because of a tort threshold. Our estimates of the fraction affected by the threshold vary, depending on the method used and the reference state chosen. But, as shown below, the order of the estimates is consistent with the order defined by the apparent stringency of the thresholds.

Table 2 gives our estimates of the proportion of BI claimants excluded by the thresholds using both the PIP-file method and the BI-file method with our four reference states. The New Jersey threshold ($200 medical loss, net of hospital and diagnostic expenses) was the weakest of the four.[9] We estimate that roughly half of the potential claimants were excluded by this threshold. Stated another way, the number of accident victims obtaining compensation from another motorist's liability insurance company

Table 2. Estimated Percentage of Potential BI Claimants Excluded by Tort Thresholds

No-fault State (threshold)	PIP-file Method	BI-file Method			
		Reference State			
		California	Washington	North Carolina	Maryland
New Jersey ($200)	48%	39%	51%	66%	41%
Massachusetts ($500)	60%	50%	64%	76%	69%
Pennsylvania ($750)	72%	—	—	—	—
Michigan (verbal)	89%	—	—	—	—

Note: We did not calculate BI-file estimates for Pennsylvania and Michigan because too few BI claimants were paid in those states to generate reliable estimates.

would have been about twice as large if there were no threshold. We estimate that Massachusetts' $500 threshold excluded roughly 60 percent of potential claimants, Pennsylvania's $750 threshold excluded about 70 percent, and Michigan's verbal threshold excluded almost 90 percent of all victims who would otherwise have been paid under BI.[10] (We did not calculate BI-file method estimates for Michigan and Pennsylvania because the number of BI claimants in our sample is too small to give reliable estimates.)[11]

While there is substantial variability among the estimates for each state, the relative ordering of the no-fault states is the same for each set of estimates. The exact percentages differ with the method, but all of our estimates suggest that even modest tort thresholds have a large (if not precisely known) effect on the number of BI claims paid.

Large decreases in the number of BI claims paid do not, however, translate to equally large effects on total BI payments. Because the claimants who are prevented from making claims are those with the smallest economic losses and least serious injuries, they account for a relatively small share of all BI payments. By comparing the total BI payments to reference-state claimants, classified by whether or not they exceeded the no-fault states' thresholds, we estimate that total BI payments are about 7 to 16 percent lower in New Jersey (compared to 39 to 66 percent of claimants excluded) and 15 to 31 percent lower in Massachusetts (compared to 50 to 76 percent of claimants excluded), than they would be in the absence of a threshold.[12] Moreover, because of inflation in the costs of medical care, the fixed-dollar thresholds in New Jersey, Massachusetts and Pennsylvania are undoubtedly less effective in reducing both the number of BI claims and claims costs today than they were in 1977, the year to which our estimates apply. We turn now to a discussion of the details of each of the analyses.

PIP-FILE ESTIMATES

The PIP-file method for estimating the number of potential claimants who were denied BI compensation because of a state's tort threshold is based on data for victims who filed claims under a no-fault (PIP) policy. For each PIP claimant, claims adjusters reported 1) whether the claimant qualifies for a BI or tort payment under his state's current no-fault law, and 2) whether the claimant would have qualified prior to the imposition of that law. Although the instructions that accompanied the survey forms do not define "qualification," respondents seem to have interpreted the question as asking whether the claimant would be likely to obtain some payment if he filed a BI claim.[13]

The PIP-file estimate of the proportion of potential BI claims that were either denied or not filed because of the tort threshold is the number of PIP claimants no longer qualifying for BI recovery divided by the number who would have qualified before the threshold was imposed. That is:

$$\text{PIP File estimate of fraction denied} = 1 - \frac{\text{Number of PIP claimants eligible for BI with threshold}}{\text{Number of PIP claimants eligible for BI without threshold}}$$

Although a claimant who qualified for BI recovery would not necessarily have filed a BI claim, the direction in which this factor would bias our estimate is unclear. Our PIP-file estimate is based only on victims who filed PIP claims. The incentives to file BI claims are in some respects stronger than the incentives to file PIP claims, and in other respects weaker.[14] On balance, we believe that the PIP-file estimates are more reliable than the BI-file estimates since they rely solely on data for the particular no-fault state in question. As a comparison of the two sets of estimates shows, however, the two methods produce roughly consistent results.

BI-FILE ESTIMATES

To estimate the proportion of potential claimants denied payment because of a tort threshold using the BI-file method we categorize potential BI claimants in no-fault states into three groups, as illustrated in Figure 1. Claimants in Group 1 have injuries greater than the tort threshold and are paid by BI insurance. Claimants in Group 2 have injuries that are not serious enough to breach the threshold, but nevertheless these claimants also obtain BI payments, presumably because the BI insurer would rather make some payment to settle the claim than continue to defend it. Claimants in Group 3 have injuries that do not exceed the threshold and are unable to obtain BI payments. As a result, Group 3 claimants are not included in our sample; it is their number that we estimate.[15]

The successful BI claimants in a reference (tort or add-on) state include all three groups, though we cannot, of course, distinguish between Group 2

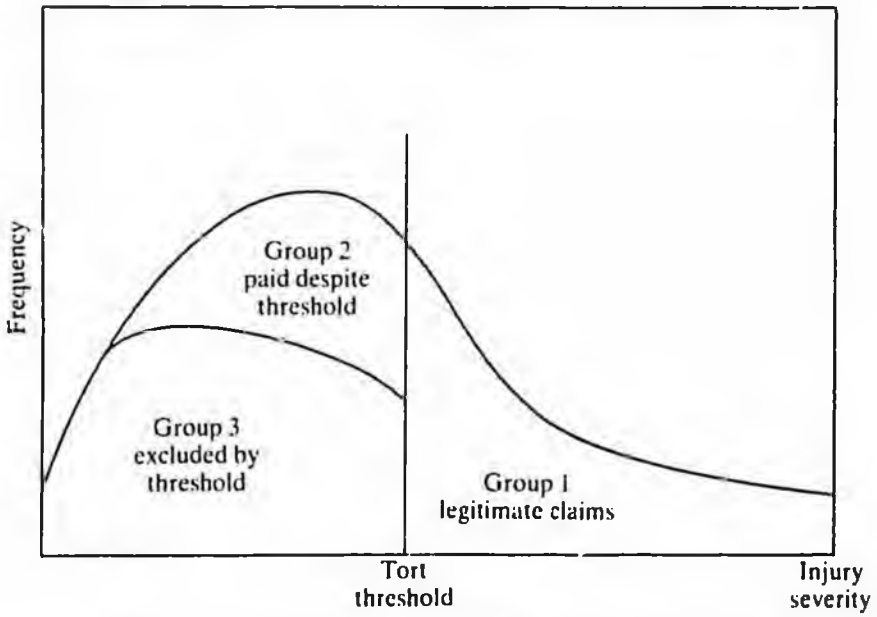


Figure 1. BI Claims Excluded by the Tort Thresholds

and 3 claimants in these states. If the populations of potential claimants are distributed similarly in the no-fault and reference states, the ratio of the number of successful no-fault-state claimants whose injuries exceed the threshold (Group 1) to the total number of potential no-fault-state claimants (all three groups) is equal to the corresponding ratio in the reference state. We use this relationship to derive our estimate of the size of Group 3, the claimants excluded by the threshold.

Table 2 above presents our estimates of the proportion of all potential no-fault state claimants (Groups 1, 2 and 3) that are excluded by the tort threshold (Group 3). We calculate these estimates as follows. Let r be the proportion of paid reference-state claimants whose injuries exceed the no-fault state's tort threshold r is equal to the ratio of the number of Group 1 claimants to the total number in Groups 1, 2 and 3 in the reference state). Similarly, let p be the proportion of no-fault-state claimants in our data whose injuries exceed the tort threshold p is equal to the number of Group 1 claimants divided by the number of Group 1 and Group 2 claimants in the no-fault state). Let x be the unknown ratio of the number of Group 3 claimants to the number of paid (Groups 1 and 2) no-fault state claimants. We wish to estimate ß, the proportion of all potential claimants excluded by the threshold (the ratio of the number of Group 3 claimants to the total number in all three groups), where

$$\beta = \frac{x}{1+x}. \qquad (1)$$

We assume that the distribution of injuries in the no-fault and reference states is the same, or, more specifically, that the proportion of potential

claimants in each state whose injuries exceed the no-fault state's threshold is the same,

$$r = \frac{p}{1 + x}. \tag{2}$$

Combining equations (1) and (2), we obtain our estimate

$$\beta = \frac{x}{1 + x} = 1 - \frac{r}{p}.$$

As shown in Table 2, the estimates using different reference states differ by as much as 27 percent, reflecting differences between the potential-claimant populations in the different states. These differences arise for various reasons, including differences between states in the mix of accident types, victim characteristics, and the cost of medical care. In addition, potential BI claimants may be less likely to file BI claims in a state such as Maryland where PIP insurance is required if they can more easily obtain compensation from their PIP coverage. If this effect were large, it could affect the estimates of tort-threshold effects that use Maryland as the reference state. As Hammitt (1985) reports, however, comparisons between BI-claimant populations do not provide any evidence that the availability of PIP benefits in Maryland reduces the number of BI claimants in that state, and the tort-threshold estimates that use Maryland as the reference state are comparable to those derived using other reference states.

In addition to differences between accident-victim populations in different states, our BI-file estimates are affected by the difficulty of determining which reference-state claimants would have satisfied a particular tort threshold, that is, distinguishing Group 1 claimants from the others. For the no-fault-state claimants, the survey forms record whether the tort threshold was exceeded, allowing us to distinguish between Group 1 and Group 2 claimants. But for the tort-state claimants we had to estimate, using reported medical expenses and injury severity, whether the claimant's injuries would have exceeded the no-fault state's tort threshold. In order to make the comparison between tort and no-fault states consistent, we considered claimants in both states to have exceeded the threshold (Group 1) only if their recorded injuries exceeded the threshold.

We could not determine unambiguously whether a claimant exceeded the tort threshold from the recorded injury descriptions. For example, the Massachusetts threshold is exceeded if the claimant suffers permanent and serious disfigurement, but the questionnaire we used does not ask about the severity of a permanent disfigurement. Somewhat arbitrarily, we define all claimants with permanent disfigurement to have exceeded the threshold.[16]

We check the accuracy of this classification procedure by comparing the proportions of no-fault-state claimants recorded as having exceeded the threshold to the proportions estimated by our method of classifying claimants using their reported injuries; this is presented in Table 3. Our classification procedure labels more claimants as being over the threshold in both

Table 3. Percentage of All Paid BI Claims that Exceed the Tort Threshold

	NJ	MA
Recorded over threshold	88%	76%
Classified over threshold	89%	80%
Either recorded or classified over threshold	97%	88%

New Jersey and Massachusetts. However, the differences between proportions are small—at most 4 percent. The discrepancies probably result from two factors. First, our classification procedure counts too many claimants over the threshold because of the ambiguity in the injury descriptions (some of the permanently disfigured claimants were not sufficiently disfigured to exceed the threshold). Second, the proportion recorded in the questionnaire as having exceeded the threshold is probably too small. The multiple-choice question from which this proportion is derived asks how the claimant exceeded the threshold but does not ask whether he did so. We assume that all claimants for whom no answer was given (and whose medical expenses did not exceed the dollar threshold) did not exceed the tort threshold, but there are surely some claimants who exceeded the threshold but for whom, for whatever reason, the question was not answered.

Although our classification procedure is not perfect, the effect of the imperfections on our estimate of the proportion of claimants excluded by the tort thresholds is unclear. Since we use the same classification method for both no-fault and reference states the errors should be offsetting. The similarity of the BI-file and PIP-file estimates suggests that the effect of the classification errors is not large, relative to the other inaccuracies of the procedure.

CIRCUMVENTING THE TORT THRESHOLD

Do claimants in some no-fault states inflate their medical expenses, either by incurring needless treatment or by claiming (perhaps with the assistance of an unscrupulous doctor) to have incurred such treatment? We find no evidence of such padding in our data.

Claimants face a strong incentive to breach the threshold because doing so enhances the possibility of their receiving payments for general damages, which are not covered by PIP insurance. Moreover, by breaching the threshold, claimants may be able to recover for their economic losses twice: once from their PIP insurers, and once under their BI claims. This double recovery may be possible if the PIP insurer does not require reimbursement from the BI payment, or if the insurer fails to enforce the reimbursement provision.

If a significant number of claimants whose injuries do not exceed the threshold manage to obtain BI payment by "padding" their claims, we would expect to find a "hump" in the distribution of medical losses—a dis-

proportionately large number of claimants whose reported medical expenses exceed the tort threshold by only a little. To assess how many Massachusetts and New Jersey claimants overcome the tort thresholds by padding their medical expenses, we compare the proportion of claimants whose injuries exceed the dollar threshold by no more than $100 and $500 to the proportion predicted in each of the four states without thresholds. In total, we make sixteen comparisons (two no-fault states times two medical expense intervals times four reference states). In twelve of the sixteen cases, fewer claimants have recorded medical expenses in the interval just above the threshold than predicted. In the other four cases, using the above method, the estimate of the number of paid claimants who exaggerate their injuries in order to breach the threshold is between 2 and 16 percent of all claimants who appear to exceed the threshold.[17]

Because twelve of our sixteen comparisons provide no evidence of padding, we conclude that the data give little support to the notion that claims are systematically padded to circumvent tort thresholds. Further, since these states are more litigious than most, as discussed above, we would expect to find more evidence of padding claims here than in most other no-fault states. Alternatively, the effect of any padding that does occur may be offset by other factors such as other claimants' reluctance to file BI claims when they have already been compensated under PIP, or their uncertainty about the definition of the tort threshold and whether they are eligible to make BI claims.

SUMMARY

Contrary to what one might expect, modest tort thresholds appear to have a substantial effect on the number of accident victims who obtain compensation from liability insurance, at least in the states we studied. The availability of first-party insurance benefits probably contributes to this reduction, but our data do not allow us to estimate this effect separately in the four no-fault states.[18] Stringent tort thresholds, like the Michigan verbal threshold, deny tort compensation and, with it, compensation for pain and suffering to nine out of ten automobile accident victims. Also, contrary to some reports, we find little evidence in the states studied to support the view that many accident victims incur unnecessary medical treatment as a means of circumventing the tort threshold. The thresholds appear to serve their purpose of acting as gates to limit the number of automobile accident victims who enter the tort system and they thereby defeat the no-fault reforms.

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NOTES

1. States are classified as tort, add-on, and no-fault. No-fault insurance is not sold in tort states. In add-on states, insurers are required to offer and motorists may be required to buy no-fault coverage. In no-fault states, motorists are required to buy no-fault insurance and accident victims are not entitled to tort compensation unless their injuries exceed the tort threshold.
2. In 1983 New Jersey adopted a law allowing automobile insurance buyers to choose the threshold to which they will be subject if injured. Buyers can elect either the $200 threshold which applied to all motorists from 1973 to 1983, or a new, higher threshold of $1500 in medical expenses, net of hospital, x-ray and other diagnostic expenses, to be adjusted annually in accordance with the Consumer Price Index. The verbal portion of the new threshold is also stricter than the old. Under the old threshold, a victim could sue for tort compensation if his injuries were not confined to "soft tissue," but this language has been omitted from the new threshold.
3. Most no-fault plans further limit compensation for each type of loss. Maximum policy limits on medical benefits range from $2,000 to unlimited, while wage-loss policy limits on benefits are often 75 or 85 percent of lost wages, up to only $100 or $200 per week.
4. An accident victim may file a claim directly with another party's liability insurer, may file a lawsuit against the other party and/or his insurer, or do both. Because of filing fees and other costs, only about one-fifth of those who file liability claims (primarily those with larger claims) also file suit (see Hammitt, 1985).
5. The proportion of claimants denied BI compensation in a claims-conscious state will be a lower bound for the proportion that would be denied in a less claims-conscious state if claims-consciousness disproportionately increases the number of claims filed by victims with relatively mild injuries, that is, if severely injured victims in the less litigious state are as likely to file claims as those in the more litigious state.
6. Using a similar method, we estimate that the availability of no-fault insurance alone has little effect on the number of liability claims filed in Maryland, an add-on state that requires motorists to carry no-fault insurance (see Hammitt, 1985).
7. As reference states, we used the four other states—California, Washington, North Carolina, and Maryland—that we had selected for our larger study (Hammitt, 1985). The first three are tort states, while Maryland is a mandatory add-on state, meaning that motorists are required to carry PIP insurance.
8. Landes (1982) analyzed fatal accident rates across states and years. She asserts that, after controlling for other factors, fatalities are more numerous in states with higher thresholds, and that comparatively strict thresholds may increase the fatal-accident rate by 10 to 15 percent.
9. The New Jersey tort threshold was $200 at the time the claims data were collected, but was changed in 1983. See note 2 *supra*.
10. The tort thresholds are defined as follows:
    New Jersey: (1) $200 medical expenses net of hospital and diagnostic expenses, (2) death, (3) permanent disability, (4) permanent significant disfigurement, (5) partial or total loss of body member, (6) any injuries not confined to soft tissue.
    Massachusetts: (1) $500 medical expense, (2) death, (3) loss of body member, (4) permanent serious disfigurement, (5) loss of sight or hearing, (6) any fracture.
    Pennsylvania: (1) $750 medical expense net of diagnostic x-ray and rehabilitation costs in excess of $100, (2) death, (3) serious permanent injury, (4)

permanent, irreparable, severe cosmetic disfigurement, (5) total disability exceeding 60 days.
Michigan: (1) death, (2) serious impairment of bodily function, (3) permanent, serious disfigurement.

11. Our estimates are consistent with those available from other sources. According to a study by Thomas Jones, then Michigan Insurance Commissioner, BI claims in that state declined 87 percent after no-fault insurance was adopted. It is not clear whether this figure refers to claims filed or paid (see Widiss et al., 1977: 383). The U.S. Department of Transportation published ratios of paid BI claims to insured cars for fourteen no-fault states covering the years 1969 to 1975. These data were obtained from the State Farm Insurance Companies, which had a 14 percent national market share at the time. By comparing the average paid claim frequencies for all reported years before and after no-fault was adopted, we calculate that BI claims declined 62 percent in New Jersey, 82 percent in Pennsylvania, and 88 percent in Michigan (see U.S. Department of Transportation, 1977: 26–28).
12. The share of total BI payments made to claimants whose injuries do not exceed the New Jersey tort threshold is 7 percent in California, 8 percent in Maryland, 9 percent in Washington, and 16 percent in North Carolina. The share of payments to claimants whose injuries do not exceed the Massachusetts threshold is 15 percent in California, 18 percent in Washington, 25 percent in North Carolina, and 31 percent in Maryland. These estimates assume that none of the claimants whose injuries do not exceed the threshold would be paid, and that they consequently overstate the reduction in claims payments. In contrast, our procedure for estimating the number of claimants that are excluded because of the threshold accounts for the fact that some are paid, even though their injuries do not exceed the threshold (see the "BI-File Estimates" subsection). As shown by Table 3 *infra*, as many as one-quarter of paid claimants in the no-fault states may have injuries that do not exceed the threshold.
13. See AIRAC (1979) for the actual questionnaire. Although all claimants would "qualify" before the threshold was established, in the sense that they were not barred from filing a claim because of a tort threshold, only those to whom another motorist was likely to be liable were described as qualifying for recovery. Thus drivers in single-car accidents were not included in this definition. Because PIP compensation is available to nearly all accident victims the proportion of PIP claimants who would have qualified for BI compensation prior to the imposition of the tort threshold is an estimate of the proportion of accident victims who are injured in circumstances that allow compensation under tort liability. The proportion is close to two-thirds in each of our four no-fault states: Michigan—56 percent, Pennsylvania—64 percent, Massachusetts—65 percent, New Jersey—69 percent.
14. Filing a BI claim will not affect one's own insurance rates, as filing a PIP claim might, and the victim may file a BI claim as retribution. On the other hand, a victim may feel that he must retain an attorney to handle a BI claim, he may find it more unpleasant to negotiate with an adversary insurance firm, or he may pity the at-fault driver.
15. There is also a fourth group—accident victims whose injuries exceed the threshold but who do not file BI claims, or whose claims are denied for other reasons. Because we are interested in the number of potential claimants excluded by the threshold, this group does not concern us. We assume that the number of eligible claimants who do not file claims, or whose claims are incorrectly denied, is the same fraction of claims that are properly paid in each state. That is, we assume that no claims are incorrectly denied for not exceeding the threshold when the claimant's injuries do exceed the threshold.

16. The tort thresholds are reported at note 10 *supra*. We assume that the claimant exceeded the Massachusetts threshold if his medical expenses exceeded $500, he died, or he suffered permanent disability or a fracture. The New Jersey threshold is deemed to be satisfied if medical expenses net of hospital and x-ray expenses exceeded $200, the claimant suffered permanent disability or a fracture, or he died.
17. More precisely these are estimates of the percentages of "excess" claimants—the data do not indicate the reasons. In Massachusetts, the estimates of the percentage of "excess" claimants between the dollar threshold ($500) and $100 higher ($600) is 13, 2 and 2 percent using California, Washington and Maryland respectively as reference states. In New Jersey the corresponding percentage is 16 percent using a $500 range and California as the reference state.
18. As described at note 6 *supra*, using our BI-file method we found little evidence that the availability of PIP benefits alone significantly reduces the number of BI claims in Maryland.

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R. B. Victor, L. Cohen, C. Phelps
1982

R-2922-ICJ
The Pace of Litigation
Conference Proceedings
J. W. Adler, W. F. Felstiner, D. R. Hensler, and M. A. Peterson
1982

R-2979-ICJ
Workers' Compensation and Workplace Safety
The Nature of Employer Financial Incentives
R. B. Victor
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R-2985-ICJ
Costs of the Civil Justice System
Court Expenditures for Various Types of Civil Cases
J. S. Kakalik and R. L. Ross
1983

R-3002-ICJ
Managerial Judges
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Comparative Justice
Civil Jury Verdicts in San Francisco and Cook Counties, 1959-1980
M. G. Shanley and M. A. Peterson
1983

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Civil Jury Verdicts in Cook County
M. A. Peterson
1984

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New Tools for Reducing Civil Litigation Expenses
M. A. Peterson
1983

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Designing Safer Products: Corporate Responses To Product Liability Law and Regulation
G. Eads and P. Reuter
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R-3032-ICJ
The Selection of Disputes for Litigation
G. L. Priest and B. Klein
1984

R-3042-ICJ
Costs of Asbestos Litigation
J. S. Kakalik, P. A. Ebener, W. L. F. Felstiner, M. G. Shanley
1983

R-3050-ICJ
Automobile Accident Compensation
Volume I: Who Pays How Much How Soon
J. E. Rolph, J. K. Hammitt, R. L. Houchens, and S. S. Polin
1985

R-3051-ICJ
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Volume II: Payments by Auto Insurers
J. K. Hammitt
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R-3052-ICJ
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R. L. Houchens
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Automobile Accident Compensation
Volume IV: State Rules
J. K. Hammitt, R. L. Houchens, S. S. Polin, and J. E. Rolph
1985

R-3071-ICJ
Simple Justice
How Litigants Fare in the Pittsburgh Court Arbitration Program
J. W. Adler, D. R. Hensler, C. E. Nelson, and G. Rest
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Regulating the Content and Volume of Litigation
An Economic Analysis
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Variation in Asbestos Litigation Compensation and Expenses
J. S. Kakalik, P. A. Ebener, W.L.F. Felstiner, G. W. Haggstrom, M. G. Shanley
1984

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Managing the Unmanageable
A History of Civil Delay in the Los Angeles Superior Court
M. Selvin and P. A. Ebener
1984

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Introducing Court-Annexed Arbitration
A Policymaker's Guide
E. Rolph
1984

R-3249-ICJ
Deep Pockets, Empty Pockets
Who Wins in Cook County Jury Trials
A. Chin, M. A. Peterson
1985

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Asbestos in the Courts
The Challenge of Mass Toxic Torts
D. R. Hensler, W.L.F. Felstiner, M. Selvin, P. A. Ebener
1985

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Court-Administered Arbitration: An Alternative for Consumer Dispute Resolution
D. R. Hensler and J. Adler, with the assistance of Rest
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Jury Awards and Prejudgment Interest in Tort Cases
S. J. Carroll
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N-2096-ICJ
California Enacts Prejudgment Interest: A Case Study of Legislative Action
A. Lipson
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Court-Annexed Arbitration: The National Picture
P. A. Ebener, D. R. Betancourt
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N-2342-ICJ
Punitive Damages: Preliminary Empirical Findings
M. A. Peterson
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D. R. Hensler
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D. R. Hensler
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D. R. Hensler
1984

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D. A. Waterman and M. A. Peterson
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G. Eads and P. Reuter
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The Impact Of Fee Arrangement on Lawyer Effort
H. Kritzer, W.L.F. Felstiner, A. Sarat, D. Trubek
1986

P-7189-ICJ
Some Observations on the Need for Tort Reform
G. H. Shubert
1986

A special bibliography (SB 1064) provides a list of other Rand publications in the civil justice area. To request the bibliography or to obtain more information about The Institute for Civil Justice, please write the Institute at this address: The Institute for Civil Justice, The Rand Corporation, 1700 Main Street, P.O. Box 2138, Santa Monica, California 90406-2138, (213) 393-0411.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: May 7, 1986

REQUEST
Bill/Resolution No.: House CS for SSSB 377 (JUD)
Title: An act relating to civil actions, etc.

Sponsor: Kelly, Abood, Bennett, et al.
Requestor:
Date of Request: May 7, 1986

FISCAL DETAIL
Agency Affected:
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS	-0-	-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary House CS for SSSB 377 (JUD) removes or modifies the original bill language to delete any fiscal benefit to the State of Alaska's estimated ultimate loss and loss expense, i.e., "noneconomic damages" limit changed from $250,000 to $1,000,000, "punitive" damages not mentioned in revised bill, "periodic payment" provision changed, "joint and several" provision change, "release or covenant not to sue" provision change, "offers of judgment" provision change.

Prepared By: Donald Hitchcock, Director
Phone: 465-2180
Division: Risk Management
Date: May 7, 1986

Approved by Commissioner: Eleanor Andrews
Date:
Agency: Department of Administration

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Rev. 11/8/85

8/9K1/0507-03

Original sponsors: Kelly, Abood,
Bennett, et al

IN THE SENATE BY THE JUDICIARY COMMITTEE

CS FOR SENATE BILL NO. 377 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to civil actions; amending Alaska Rules of Civil Procedure 49, 52, 58, and 68; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS AND PURPOSE. (a) Tort law in this state has generally been developed by the courts on a case-by-case basis. While this process has resulted in some significant changes in the law, including amelioration of the harshness of many common law doctrines, the legislature has periodically intervened in order to bring about needed reforms. The purpose of this Act is to enact further reforms in order to create a more equitable distribution of the cost and risk of injury and increase the availability and affordability of insurance.

(b) The legislature finds that boroughs, cities, and other governmental entities are faced with increased exposure to lawsuits and awards and dramatic increases in the cost of insurance coverage. These escalating costs ultimately affect the public through higher taxes, loss of essential services, and loss of the protection provided by adequate insurance. In order to improve the availability and affordability of quality governmental services, comprehensive reform is necessary.

(c) The legislature also finds comparable cost increases in professional liability insurance. Escalating malpractice insurance premiums discourage physicians and other health care providers from initiating or continuing their practice or offering needed services to the public and contribute to the rising costs of consumer health care. Other

professionals, such as architects and engineers, face similar difficult choices, financial instability, and unlimited risk in providing services to the public.

(d) The legislature also finds that general liability insurance is becoming unavailable or unaffordable to many businesses, individuals, and nonprofit organizations in amounts sufficient to cover potential losses. High premiums have discouraged socially and economically desirable activities and encourage many to go without adequate insurance coverage.

(e) It is the intent of the legislature to reduce costs associated with the tort system, while ensuring that adequate and appropriate compensation for persons injured through the fault of others is available.

* Sec. 2. AS 09 is amended by adding a new chapter to read:

CHAPTER 17. LIMITATIONS ON CIVIL LIABILITY.

Sec. 09.17.010. NONECONOMIC DAMAGES. In an action to recover damages for personal injury based on negligence, damages for noneconomic losses shall be limited to compensation for pain, suffering, inconvenience, physical impairment, disfigurement, loss of enjoyment of life and other nonpecuniary damage.

Sec. 09.17.020. PUNITIVE DAMAGES. (a) Punitive damages may not be awarded in an action, whether in tort, contract, or otherwise, unless supported by clear and convincing evidence. Fifty percent of any punitive or exemplary damages that may be adjudged against the party defending the claim shall be awarded to the benefit of the state and when paid deposited in the general fund.

(b) The amount of punitive damages awarded to the state shall be considered a part of the amount recovered by the claiming party for purposes of calculating an award of attorney fees.

(c) Except for purposes of seeking execution on a judgment, the state may not bring or be joined in an action based on punitive

damages that may be awarded under this section.

Sec. 09.17.025. DAMAG S RESULTING FROM INTOXICATION OR COMMISSION OF A CRIME. A person who suffers personal injury or death may not recover damages for the personal injury or death if the person is determined by the fact finder to be more than 50 percent responsible for the injuries or death and the person was

(1) intoxicated or under the influence of a controlled substance listed in AS 11.71.140 - 11.71.190; or

(2) engaged in the commission of a felony, if the felony was causally related to the injury or death in time, place, or activity; however, nothing in this paragraph shall affect a right of action under 42 U.S.C. 1983.

Sec. 09.17.030. ITEMIZED VERDICTS. In every case where damages for personal injury are awarded by the court or jury, the verdict shall be itemized between economic loss and noneconomic loss, if any, and economic loss shall be further itemized by category. Itemization of economic loss by category includes: (1) amounts intended to compensate for reasonable expenses that have been incurred, or which will be incurred, for necessary medical, surgical, x-ray, dental, or other health or rehabilitative services, drugs, and therapy; (2) amounts intended to compensate for lost wages or loss of earning capacity; and (3) all other economic losses claimed by the plaintiff or granted by the jury. A verdict shall further determine the amounts intended to compensate for injury or losses incurred before the verdict and amounts intended to compensate for losses that will be incurred in the future.

Sec. 09.17.040. VERIFICATION OF CIVIL CLAIMS. The party or the attorney of the party filing a complaint, answer, cross-claim, or counterclaim shall sign and verify the pleading and shall state in

the verification that the signatory believes the statements made in the pleading are true. If the court finds that the signatory knowingly made a false statement in the pleading, upon motion of a party, the court shall order the signatory to show cause why the signatory should not be held in contempt of court.

Sec. 09.17.050. EFFECT OF CONTRIBUTORY FAULT. In an action based on fault seeking to recover damages for injury or death to a person or harm to property, contributory fault chargeable to the claimant diminishes proportionately the amount awarded as compensatory damages for the injury attributable to the claimant's contributory fault, but does not bar recovery.

Sec. 09.17.055. COLLATERAL BENEFITS. (a) After the fact finder has rendered an award to a claimant, and after the court has awarded costs and attorney fees, a defendant may introduce evidence of amounts received or to be received by the claimant as compensation for the same injury from collateral sources that do not have a right of subrogation against the claimant by law or contract.

(b) If the defendant elects to introduce evidence under (a) of this section, the claimant may introduce evidence of

(1) the amount that the actual attorney fees incurred by the claimant exceed the amount of attorney fees awarded to the claimant; and

(2) the amount that the claimant has paid or contributed to secure the right to an insurance benefit introduced by the defendant as evidence.

(c) If the total amount of collateral benefits introduced as evidence under (a) of this section exceeds the total amount that the claimant introduced as evidence under (b) of this section, the court shall deduct from the amount awarded the claimant, the amount by which

the value of the benefits under (a) of this section exceeds the amount of payments under (b) of this section.

(d) Notwithstanding (a) of this section, the defendant may not introduce evidence of

(1) benefits that cannot be reduced or offset by federal law;

(2) a deceased's life insurance policy; or

(3) gratuitous benefits provided to the claimant.

Sec. 09.17.060. APPORTIONMENT OF DAMAGES. (a) In all actions involving fault of more than one party to the action, including third-party defendants and persons who have been released under AS 09.17.-070, the court, unless otherwise agreed by all parties, shall instruct the jury to answer special interrogatories or, if there is no jury, shall make findings, indicating

(1) the amount of damages each claimant would be entitled to recover if contributory fault is disregarded; and

(2) the percentage of the total fault of all of the parties to each claim that is allocated to each claimant, defendant, third-party defendant, and person who has been released from liability under AS 09.17.070.

(b) In determining the percentages of fault, the trier of fact shall consider both the nature of the conduct of each party at fault and the extent of the causal relation between the conduct and the damages claimed. The trier of fact may determine that two or more persons are to be treated as a single party if their conduct was a cause of the damages claimed and the separate act or omission of each person cannot be distinguished.

(c) The court shall determine the award of damages to each claimant in accordance with the findings, subject to a reduction under

AS 09.17.070, and enter judgment against each party liable. The court shall also determine and state in the judgment each party's equitable share of the obligation to each claimant in accordance with the respective percentages of fault.

(d) The court shall enter judgment against each party liable on the basis of joint and several liability, except that a party who is allocated less than 50 percent of the total fault of all the parties may not be jointly liable for more than twice the percentage of fault allocated to that party.

Sec. 09.17.070. EFFECT OF RELEASE. A release, covenant not to sue, or similar agreement entered into by a claimant and a person liable discharges that person from liability to the claimant, but it does not discharge another person liable upon the same claim unless the release, covenant not to sue, or similar agreement provides for discharge. However, the claim of the releasing person against other persons is reduced by the dollar amount of the release, covenant not to sue, or similar agreement.

Sec. 09.17.900. DEFINITION. In this chapter "fault" includes acts or omissions that are in any measure negligent or reckless toward the person or property of the actor or others, or that subject a person to strict tort liability; the term also includes breach of warranty, unreasonable assumption of risk not constituting an enforceable express consent, misuse of a product for which the defendant otherwise would be liable, and unreasonable failure to avoid an injury or to mitigate damages; legal requirements of causal relation apply both to fault as the basis for liability and to contributory fault.

* Sec. 3. AS 09.10 is amended by adding a new section to read:

Sec. 09.10.075. ACTIONS THAT MUST BE ARBITRATED. A person may

not bring an action for damages based on injury to person or property when the amount in controversy is less than $75,000, exclusive of costs, interest and attorney fees, unless the controversy is first arbitrated under AS 09.43.

* Sec. 4. AS 09.30.065 is amended to read:

Sec. 09.30.065. OFFERS OF JUDGMENT. At any time more than 30 days before the trial begins [ON OR BEFORE THE 60TH DAY FOLLOWING THE FILING OF AN ANSWER IN A CIVIL ACTION, AND ON THE FIFTH DAY FOLLOWING THE DAY DISCOVERY CLOSES AS ORDERED BY THE COURT], either the party making a claim or the party defending against a claim may serve upon the adverse party an offer to allow judgment to be entered in complete satisfaction of the claim for the money or property or to the effect specified in the offer, with cost then accrued. If within 10 days after the service of the offer the adverse party serves written notice that the offer is accepted, either party may then file the offer and notice of acceptance together with proof of service, and the clerk shall enter judgment. An offer not accepted within 10 days is considered withdrawn and evidence of that offer is not admissible except in a proceeding to determine the form of judgment after verdict. If the judgment finally entered on the claim as to which an offer has been made under this section is not more favorable to the offeree than the offer, the interest awarded under AS 45.45.010(a) and accrued up to the date judgment is entered shall be adjusted as follows:

(1) if the offeree is the party making the claim, the interest rate shall be reduced by five [TWO] percent a year;

(2) if the offeree is the party defending against the claim, the interest rate shall be increased by five [TWO] percent a year.

* Sec. 5. AS 09.30.070 is amended by adding a new subsection to read:

(b) Except when the court finds that the parties have agreed otherwise, prejudgment interest accrues from the day the cause of action accrues.

* Sec. 6. AS 09.43.110 is amended to read:

Sec. 09.43.110. CONFIRMATION OF AN AWARD. Upon application of a party, the court shall confirm an award unless

(1) within the time limits imposed by AS 09.43.120 and 09.43.130 grounds are urged for vacating or modifying or correcting the award, in which case the court shall proceed as provided in AS 09.43.120 and 09.43.130; or

(2) an appeal is taken under AS 09.43.160(c).

* Sec. 7. AS 09.43.160 is amended by adding a new subsection to read:

(c) An award made as a result of arbitration required by AS 09.-10.075 may be appealed to the proper court. The appeal shall be filed within 60 days after notice of an award is made under AS 09.43.080. The court shall grant a trial de novo if an appeal is filed under this subsection.

* Sec. 8. AS 09.55.548 is repealed and reenacted to read:

Sec. 09.55.548. AWARDS. Except as provided in AS 09.17, damages in a malpractice action shall be awarded in accordance with principles of the common law.

* Sec. 9. AS 09.60.010 is amended by adding a new subsection to read:

(b) The court may, upon petition by a party to a civil action, determine the reasonableness of that party's attorney fee agreement. The court shall take into consideration

(1) the time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) the likelihood, if apparent to the client, that the

acceptance of the particular employment will preclude other employment by the attorney;

(3) the fee customarily charged in the locality for similar legal services;

(4) the amount involved and the results obtained;

(5) the time limitations imposed by the client or by the circumstances;

(6) the nature and length of the professional relationship with the client;

(7) the experience, reputation, and ability of the attorney or attorneys performing the services;

(8) whether the fee is fixed or contingent;

(9) whether the fixed or contingent fee agreement was in writing and whether the client was aware of the right to petition the court under this section.

* Sec. 10. AS 09.60 is amended by adding a new section to read:

Sec. 09.60.035. COSTS AND ATTORNEY FEES ALLOWED FOR ARBITRATION APPEAL. If a party appeals an award made as a result of arbitration required by AS 09.10.075, and the appellate court increases or decreases the award by more than 10 percent, the prevailing party on appeal shall also be awarded actual costs and attorney fees incurred as a result of the appeal.

* Sec. 11. AS 22.10.020(d) is amended to read:

(d) The superior court has jurisdiction in all matters appealed to it <u>(1)</u> from a subordinate court<u>; (2) by a party to an arbitration award under AS 09.43.160(c);</u> [,] or <u>(3) an</u> administrative agency when appeal is provided by law. The hearings on appeal from a final order or judgment of a subordinate court or administrative agency shall be on the record unless the superior court, in its discretion, grants a

trial de novo, in whole or in part.

* Sec. 12. AS 22.15.030(a) is amended to read:

(a) The district court has jurisdiction of civil cases and proceedings as follows:

(1) for the recovery of money or damages when the amount claimed exclusive of costs, interest and attorney fees does not exceed $25,000;

(2) for the recovery of specific personal property, when the value of the property claimed and the damages for the detention do not exceed $25,000;

(3) for the recovery of a penalty or forfeiture, whether given by statute or arising out of contract, not exceeding $25,000;

(4) to give judgment without action upon the confession of the defendant for any of the cases specified in this section, except for a penalty or forfeiture imposed by statute;

(5) for establishing the fact of death of any person in the manner prescribed in AS 09.55.020 - 09.55.060;

(6) for the recovery of the possession of premises in the manner provided under AS 09.45.070 - 09.45.160 when the value of the property or of the arrears and damage to the property does not exceed $25,000;

(7) for the foreclosure of a lien when the amount in controversy does not exceed $25,000;

(8) for the recovery of money or damages in motor vehicle tort cases when the amount claimed exclusive of costs, interest and attorney fees does not exceed $25,000;

(9) over civil actions for taking utility service and for damages to or interference with a utility line filed under AS 42.20.-030;

(10) over cases involving injunctive relief for domestic violence under AS 25.35.010 and 25.35.020;

(11) over an appeal by a party to an arbitration award under AS 09.43.160(c) when the amount claimed exclusive of costs, interest, and attorney fees does not exceed $25,000.

* Sec. 13. AS 09.16.010, 09.16.020, 09.16.030, 09.16.040, 09.16.050, and 09.16.060 are repealed.

* Sec. 14. AS 09.17.030 and 09.17.060 enacted in sec. 1 of this Act have the effect of amending Alaska Rule of Civil Procedure 49 by requiring the jury to answer the special interrogatories listed in AS 09.17.060 regarding the amount of damages and the percentages of fault to be allocated among the parties and to itemize the verdict regarding economic and noneconomic loss as specified in AS 09.17.030.

* Sec. 15. AS 09.17.060 enacted in sec. 1 of this Act has the effect of amending Alaska Rule of Civil Procedure 52 by requiring the court to make specific findings regarding the amount of damages and the percentages of fault to be allocated among the parties.

* Sec. 16. AS 09.17.030 and 09.17.060 enacted in sec. 1 of this Act have the effect of amending Alaska Rule of Civil Procedure 58 by requiring the court to include a specific item in its judgment.

* Sec. 17. AS 09.17.040 enacted in sec. 1 of this Act has the effect of amending Alaska Rule of Civil Procedure 11 by requiring verification of pleadings.

* Sec. 18. AS 09.30.065 as amended by sec. 4 of this Act has the effect of amending Alaska Rule of Civil Procedure 68 by providing that prejudgment interest accrues from the day the cause of action accrues.

* Sec. 19. APPLICABILITY. Sections 1 - 13 of this Act apply to all causes of action accruing after the effective date of this Act.

* Sec. 20. This Act takes effect immediately in accordance with

AS 01.10.070(c).

MEMORANDUM State of Alaska

TO: John L. George, Director

DATE: March 17, 1986

FILE NO.:

THRU:

TELEPHONE NO.:

SUBJECT: 1985 Underwriting Results
Other Liability

FROM: Donald DeMuth
Chief Financial Examiner

You have asked me to review the underwriting results of approximately the 10 leading writers of the line "Other Liability" "(17)" in the State of Alaska. The results of my study follow.

You will note that I have actually supplied statistics on 13 companies. The reason for the three additional companies are: You stated that you did not want companies like "State Farm" - companies that are not traditionally considered to be writers of Other Liability included. For this reason, I did not know if you wanted ARECA Insurance Exchange included or not. I added one company and you may exclude "ARECA" if you wish. I also question the accuracy of the Continental Insurance Company's Alaska direct losses incurred figure, and both noted a probable aberration in schedule "P" figures and am aware that CIGNA made some big reserve adjustments which may well be without basis at year-end, and which may have skewed Alaska Pacific Assurance Company's figures. You may, hence, eliminate the figures for these two companies if you wish and still be left with the statistics on 10 companies. I also eliminated the figures for the Insurance Company of North America as their page 14 figures for this line are probably erroneous and meaningless.

The first area of experience that I looked at was the company's direct underwriting results in Alaska. The results are summarized as follows:

Rank by Premium Written In Alaska		Alaska Direct Premium Written	Alaska Direct Premium Earned	Alaska Direct Losses Paid	Alaska Direct Losses Incurred	Alaska Loss Ratio
12	Federal Insurance Company	$ 759,348	$ 556,132	$ 4,380	$ 32,347	5.8%
13	The Continental Ins. Co.	552,533	558,869	299,050	(387,290)	*
10	Pacific Marine Insurance Co. of Alaska	792,416	808,528	150,530	245,804	30.4%
2	Alaska National Ins. Co.	3,938,343	2,703,705	1,581,866	2,173,774	80.4%
1	AK Pacific Assurance Co.	4,148,556	4,329,380	1,845,266	2,960,272	68.4%
7	Freemont Indemnity Co.	1,581,809	1,600,374	283,530	856,617	53.5%
9	ARECA Insurance Exchange	975,398	975,398	50,849	175,312	18.0%
6	Providence Washington Insurance Co. of Alaska	1,827,910	2,424,073	4,275,334	2,817,529	116.2%

5	Industrial Indemnity Company of Alaska	1,838,269	1,842,175	1,236,617	1,423,207	77.3%
4	Alaska Insurance Company	1,870,196	1,539,729	576,349	896,926	58.3%
3	Nat'l Union Fire Ins. Co.	3,732,736	2,636,895	170,668	577,159	21.9%
11	Employers Insurance of Wausau, A Mutual Company	759,889	675,147	124,435	992,116	147.0%
8	General Accident Ins. Company of America	1,004,405	996,593	22,957	733,765	75.7%
		$23,781,808	$21,649,998	$10,621,731	$13,497,538	62.3%

* Meaningless

The column above entitled "Alaska Direct Losses Paid" is not of much significance. I included it only to illustrate the great disparity between losses paid and losses incurred in certain cases. There are a number of possible reasons for this disparity, but I cannot identify which reason is responsible for the cases reflected in the above exhibit.

For comparative purposes, I attempted to develop the same information for the same companies on a national basis. The companies are not required to provide this information on a national basis, but a few companies volunteer and, hence, complete page 14 of the annual statement on a national basis. The results of this comparative study does not reveal very much information, but the results are as follows:

Rank by Premium Written In Alaska		National Direct Premium Written	National Direct Premium Earned	National Direct Losses Paid	National Direct Losses Incurred	National Loss Ratio
12	Federal Insurance Company	Information not available.				
13	The Continental Ins. Co.	Information not available.				
10	Pacific Marine Insurance Co. of Alaska	Information not available.				
2	Alaska National Ins. Co.	Information not available.				
1	AK Pacific Assurance Co.	Information not available.				
7	Freemont Indemnity Co.	$31,645,042	$34,211,163	$25,679,707	$53,934,431	157.0%
9	ARECA Insurance Exchange	National experience same as Alaskan experience.				
6	Providence Washington Insurance Co. of Alaska	Information not available.				
5	Industrial Indemnity Company of Alaska	Information not available.				
4	Alaska Insurance Company	National experience same as Alaskan experience.				
3	Nat'l Union Fire Ins. Co.	Information not available.				
11	Employers Insurance of Wausau, A Mutual Company	Information not available.				
8	General Accident Ins. Company of America	Information not available.				

In an attempt to get some kind of comparative information - Alaska vs. National - I then decided to take a look at the same companies' net national business. This is not a direct comparison due to the fact that net business is net of assumed and ceded reinsurance, but the annual statement does not reflect direct national premium earned, only written, so I had no choice.

The result of this study is as follows:

Rank By Premium Written In Alaska		National Net Premium Written	National Net Premium Earned	National Net Losses Paid	National Net Losses Incurred	National Net Loss Ratio
12	Federal Insurance Company	$223,854,784	$166,392,450	$ 42,483,524	$ 85,539,884	51.4%
13	The Continental Ins. Co.	38,763,790	32,026,227	19,576,743	30,650,173	95.7%
10	Pacific Marine Insurance Co. of Alaska	Not Applicable				
2	Alaska National Ins. Co.	2,077,778	1,547,010	222,217	1,051,834	68.0%
1	AK Pacific Assurance Co.	3,884,456	3,271,879	3,995,018	5,151,751	157.5%
7	Freemont Indemnity Co.	33,824,745	26,542,239	11,277,702	36,844,816	138.8%
9	ARECA Insurance Exchange	823,895	823,895	50,849	175,312	21.3%
6	Providence Washington Insurance Co. of Alaska	Not Applicable				
5	Industrial Indemnity Company of Alaska	Not Applicable				
4	Alaska Insurance Company	Not Applicable				
3	Nat'l Union Fire Ins. Co.	357,841,310	283,621,243	80,724,018	222,277,500	78.4%
11	Employers Insurance of Wausau, A Mutual Company	112,716,611	104,759,066	73,570,268	73,177,983	69.9%
8	General Accident Ins. Company of America	31,868,701	29,249,804	10,955,921	20,886,903	71.4%
		$805,656,070	$648,233,815	$242,856,260	$475,756,156	73.4%

I also felt that it might be interesting to make a similar review on an accident year basis rather than on a calendar year basis. The reason for this comparative review is that reserve changes made during 1985 applicable to prior year business is reflected in the calendar year 1985 experience, but not in the 1985 accident year experience. The accident year business only reflects the company's experience on accidents that actually happened during 1985. The result of this review is as follows:

Rank By Premium Written In Alaska		Nat'l Net 1985 Accident Year Premium Earned	Nat'l Net 1985 Accident Year Loss Payments	Nat'l Net 1985 Accident Year Losses Incurred	Nat'l Net 1985 Accident Year Loss Ratio
12	Federal Insurance Company	$166,392,450	$ 8,109,100	$ 77,210,574	46.4%
13	The Continental Ins. Co.	32,026,247	1,618,902	24,550,326	76.7%

10	Pacific Marine Insurance Co. of Alaska	Not Applicable			
2	Alaska National Ins. Co.	1,547,010	34,420	1,012,476	65.5%
1	AK Pacific Assurance Co.	3,271,879	414,259	2,790,689	85.3%
7	Freemont Indemnity Co.	26,542,239	1,605,638	26,435,512	100.0%
9	ARECA Insurance Exchange	823,895	30,435	362,961	44.1%
6	Providence Washington Insurance Co. of Alaska	Not Applicable			
5	Industrial Indemnity Company of Alaska	Not Applicable			
4	Alaska Insurance Company	Not Applicable			
3	Nat'l Union Fire Ins. Co.	283,621,245	7,168,480	211,149,406	74.5%
11	Employers Insurance of Wausau, A Mutual Company	104,759,072	6,085,504	50,311,511	48.0%
8	General Accident Ins. Company of America	29,249,801	1,126,201	16,247,129	55.6%
		$548,233,838	$ 26,192,939	$410,070,584	63.3%

Overall, in spite of all the tears that the insurance industry is shedding, it appears to me that the insurance industry is doing quite well for this line. Unfortunately, accident year direct statistics are not available for Alaska, but I would guesstimate that if they were, they would reflect a loss ratio down around 50%. I also note that the paid loss ratio for accident year 1985, on a national basis, is down around 4%. Fat city on investment income coming up in 1986, particularly in those states that do not allow pre- and postjudgment interest.

I would suggest that you have your market conduct "rate section" follow-up on this memo - perhaps doing some research work in some of the companies offices. I hope to take a look at Providence Washington Insurance Company of Alaska and Industrial Indemnity Insurance Company of Alaska shortly, as both are overdue for an examination.

I would also suggest that you have your rate people perhaps take a look at 1984 experience for comparative purposes. It might also be interesting to do a policy year review of the same companies for 1984. This information should now be available but it is not reported in the annual statement. It would entail a special statistical call.

All figures reflected in this memo were taken from filed annual statements, but I have no idea how accurate the information is.

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TORT REFORM

Workload Impact on the Court System

[CSSB 377 (L & C)]

OVERALL IMPACT

Increased litigation. Could require the equivalent of one judge and related staff in Anchorage alone, which would increase the time to trial in civil cases from 3 to 4 years (assuming no new judge position).

Provisions which will result in more hearings.

1. Periodic payments for awards of $50,000 or more will be mandatory if requested by the judgment creditor (09.17.030(a) - page 2). Requires court to find debtors in contempt if they show a pattern of failing to make payments (.030(c)). Puts court in position of monitoring installment payments. Many new hearings when defaults occur. Defendant will have right to jury trial on contempt issue. Paragraph (c) also requires court to determine damages related to failure to make timely payments. This is yet another issue to be litigated.

2. Apportionment of damages between parties (09.17.050 - page 3) including persons who have been released from liability. Litigation will result as defendants attempt to transfer liability to persons who have previously settled and who are not present at trial.

3. Mandatory arbitration for claims under $100,000 (09.10.075 - page 5). Bill provides for a trial de novo, leading to duplicative hearings (09.43.160 - page 6).

Provisions which raise interpretation problems and therefore will be extensively litigated

1. Periodic Payments. Bill provides that when judgment debtor dies, payments must be made to "persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before death." (09.17.030(b) - page 2). Litigation will result because it is unclear how this provision relates to probate of an estate and to a judgment debtor's will.

2. The bill abolishes joint liability. It requires the court to determine each party's "equitable share of the obligation" (09.17.050(c) - page 4). This phrase is open to interpretation and will lead to litigation.

3. Definition of fault (09.17.900(1) - page 4). The definition includes concepts which are not traditionally associated with fault, such as strict liability and breach of warranty. This whole section will lead to litigation.

Provisions which diminish the incentive to settle a case

1. $250,000 cap on non-economic loss (09.17.010(b) - page 1). Does not create an incentive to settle, because bulk of damages in large monetary cases come from lost wages, not non-economic loss.

2. Periodic payments diminish the present value of an award because the award is paid out over time. This will encourage defendants to go to trial, since it will be economically beneficial to make payments over time rather than settle for a lump sum.

3. The bill eliminates attorney's fees unless the party at fault acted with malice, in bad faith or with reckless disregard of the rights of another (09.60.010 - page 6). Attorney's fees are an incentive to settle.

Other Problems

1. Periodic payments. Inappropriate for court to be in position of monitoring these payments, because it puts the court in the collection business.

2. Arbitration. Many problems in this area. Who pays costs for indigent parties? Who are the arbitrators? There are very few potential arbitrators in rural areas. Even in urban areas, the pool of experienced litigation attorneys is quite small. Arbitration also means that a final decision in a case will be greatly delayed.

3. Litigation challenging constitutionality. Judge Serdahely believes there may be constitutional problems with the $250,000 cap on non-economic loss and that a constitutional challenge will be mounted.

KF/kl

TORT REFORM AND RELATED INSURANCE ISSUES

FOR DISCUSSION IN CONNECTION WITH SB 377

I. Background

The prime impetus behind the escalating plea for "tort reform" on both a national and state level is the rapidly increasing cost of insurance premiums. In some cases, premiums have risen 500 to 600% to renew coverage with the same carrier and as much as 800% if a new carrier is chosen. The impact on the business insurance consumer ranges from a decreased ability to compete in the marketplace to a decision to forego coverage or terminate the business enterprise.

Insurers admit that to some extent the higher premiums reflect the industrywide decision several years ago to cut radically premium prices in light of the substantial interest income then being realized on their investments. With the fall in interest rates, the industry suffered substantial losses which it is now seeking to recover.

In addition, aspects of the civil justice system, including contingent attorney's fees, large lump-sum non-economic awards, and the doctrine of joint and several liability among tortfeasors, have been identified as potential contributors to the current problem. The

insurance industry stresses a need for "predictability" in designing its rates which is hampered by the existing system.

Delineated below are a list of potential areas of "tort reform" which might be considered in addressing the issue. Alternatives to traditional insurance coverage, such as a state reinsurance program or the use of reciprocals are also listed.

II. Potential Areas for Change in the Civil Justice System Highlighted in CS SB 377 (L & C)

A. Non-economic damages. Proposal to cap the award at a specific figure, e.g., $250,000 to $500,000, or to set it at a percentage of the annual wage and life expectancy of the claimant. See Washington State Senate legislation, SB No. 4630, Sec. 301.

B. Itemized verdicts. A requirement that juries itemize each verdict in which an award of economic and non-economic damages is rendered.

C. Periodic payments. Various proposals to allow the plaintiff, the defendant or the court to provide for the periodic payment of damages over the life of the claimant rather than as a lump sum at the time of award.

D. Comparative fault. A proposal to reduce or eliminate the claimant's right of recovery based on his degree of fault. Under a "pure" comparative system, if the plaintiff were 25% responsible for his injury, he could recover no more than 75% of his damages from the defendant. Under the "modified" comparative system, the plaintiff could recover even if he is partially negligent, but only if he is no more negligent than the defendant.

E. Joint and several liability. Under current law, in cases of multiple tortfeasors, a defendant who is only 1% responsible for a claimant's damages may be required to pay 100% of the award, if his co-defendants are insolvent. This so-called "deep pocket" rule is viewed as the main reason plaintiffs' lawyers seek to bring the state or a municipality into a lawsuit as a defendant.

A proposal to reduce the utility of the "deep pocket" rule is a combination of the comparative fault rule and modified use of the joint and several liability concept. For example, a claimant 25% responsible for his damages could only recover a total of 75% of his damages. Assume two defendants, one of whom is 65% responsible but is insolvent, and the other who is 10% responsible but a "deep pocket." Under one version of the proposal, the 10% responsible defendant would pay no more than 50% of the damages for which the claimant was not responsible. Thus,

in this example, 50% of 75% = 37.5% of the total damage sustained by the plaintiff. Although still skewed in favor of the plaintiff, a procedure of this type would substantially reduce liability of "deep pockets."

F. Effect of release. A proposal to reduce the plaintiff's potential damage award from non-settling defendants by the amount of the released defendant's equitable share of the obligation.

G. Arbitration requirement. A proposal to require arbitration of tort claims prior to instituting a civil action when the amount in controversy is less than a specific dollar amount, e.g., $100,000. A further proposal is to require arbitration of contribution claims among joint tortfeasors.

H. Offers of judgment. One proposal eliminates prejudgment interest from the date of a settlement offer if the plaintiff refuses the offer and ultimately collects less damages at trial. A second proposal involves modifying the interest rate on an award depending upon who prevails at trial following a rejected settlement offer.

III. Other Areas of Potential Civil Justice Reform

A. Attorney contingent fee awards. Proposals to limit the amount of a plaintiff's attorney's fees. Suggestions include a limit of 1/3 of the total award, with specific approval by the court to exceed that amount, and a graduated system, e.g., 50% of the first $50,000, 25% of the next $100,000, and 15% of anything exceeding these amounts. Another proposal simply requires judicial approval of the party's attorney's fees. See, Washington State Senate legislation, SB 4630, Sec. 201.

B. Collateral source rule. To the extent a plaintiff recovers damages from a source other than the named defendants, his damage award for economic losses should be reduced, e.g., self-insurance.

C. Verification of claims. Proposal to have claimants sign their complaints under penalty of perjury.

D. Penalty for frivolous suits or motions. Proposal for a penalty for non-meritorious lawsuits or motions.

E. Punitive damages. Proposals range from elimination of punitive damages to payment of these awards to a state fund rather than to the claimant.

F. Repeal of Civil Rule 82. This rule was adopted to apply in certain public interest lawsuits and allows the court to increase attorney's fees up to 10% above the agreed upon level.

G. Plaintiff's intoxication. If a plaintiff's intoxication or illegal drug use is more than a 50% cause of his damages, he should be barred from recovery.

IV. Changes in the Insurance Industry

A. Disclosure of information. Proposal to require insurance companies to disclose data to the Division of Insurance on a closed claim basis.

B. Premiums based on experience. Proposal to have insurance premiums based on the insured's track record. Premiums should be higher for repeat claimants than for those who never make claims. Alternatively, premiums could be lowered for those who maintain claimless records.

C. Notice for cancellation of policies. Notice for cancellation of policies should be increased to sixty days and unused premiums simultaneously returned to the premium holder to provide the consumer a reasonable opportunity to obtain other coverage. See SB 404.

D. Insurance premiums. Proposal for a limitation on increases in premiums on an annual basis, e.g., 10%.

E. Information on claims of professionals. Proposal to have either the Division of Insurance, the relevant insurance company or the insured provide information concerning the number and amount of successful claims against him to the relevant professional licensing board.

V. Alternatives to Traditional Insurance Coverage

A. State reinsurance program. Establishment of a state reinsurance plan such as that incorporated in HB 589 with respect to state disability insurance.

B. Reciprocal insurance arrangements. Establish reciprocal insurers which consist of unincorporated groups of subscribers operating collectively through an attorney-in-fact to provide reciprocal insurance among themselves, e.g., the Alaska Timber Exchange.

C. Pooling arrangements. Establish pooling arrangements among groups such as municipalities or school districts.

SB

377

(FILE 2)

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SB 377

March 24, 1986

Senator Pat Rodey
Senate Judiciary Committee
Room 504, Capitol Building
Juneau, Alaska 99811

Dear Senator Rodey:

Please do not be fooled by the insurance industry. Our tort laws protect innocent victims who do not have a lobby. These laws should not be tampered with.

Enclosed find an editorial from one of the most objective and well-respected magazines in the aviation community. It accepts no advertising and speaks only after thorough investigation. It found that the insurance industry is perpetrating a sham crisis; that their earnings are as high as ever; and that the lawyers, juries, and judges are being made into scapegoats.

Please read the enclosed editorial and vote against tort changes. Don't hurt our innocent accident victims who have no voice and no choice.

Very truly yours,

Raymond A. Nesbett

Raymond A. Nesbett

RAN:pm
Enclosure

Editor

The Aviation Consumer

Product Liability: Who's the real villain?

Seldom has a single issue aroused so much indignation as product liability. You've heard the figures—$70,000 an airplane, just so the builders can pay the insurance tab.

A proper villain has been identified for tar-and-feathering. It is our "litigious" society—the courts, the juries and their grossly large awards, and the greedy lawyers who thrive in the system. Every group and publication in aviation is screaming for legal reform. But wouldn't it be a surprise if some other villain were getting away scot-free in all the commotion?

Well, there is persuasive evidence that the insurance industry may be a bigger culprit than the legal system, but has erected a facade of innocence and neatly dodged all the responsibility. How indeed do they get away with huge hikes in premiums, and even refusing to provide coverage? Who holds them accountable? (No federal agency, certainly, and only weak state agencies, according to critics.)

Their reply is that they have been devastated by a spate of natural catastrophes (floods, hurricanes, etc.) and man-made ones (crashing jumbo jets) that has drained their coffers and made them church-mouse poor. The insurance industry at the end of last year claimed it suffered a record $5.5 billion loss in 1985. But according to an industry watchdog group, the National Insurance Consumer Organization, and Ralph Nader, the insurors conveniently omitted tallying in capital gains and federal tax credits to the tune of $8.4 billion. If you add $2.1 billion of dividends paid to stockholders labeled losses (according to a debatable accounting procedure) the overall insurance *earnings* amounted to $5 billion.

The insurance industry claims the high cost of litigation and awards are behind much of their recent losses, but have not, to our knowledge, come up with any plausible proof. Indeed, the Institute for Civil Justice reports jury verdicts have remained about the same over the last quarter century (accounting for inflation), the number of lawsuits filed *per capita* has stayed constant, and jurors have found for defendants about as often as for plaintiffs.

Add to all this a chronic industry habit of *underpricing* premiums during cyclical periods of high interest rates on investments, and *overpricing* them on the low swing, as now, and there's good reason to figure the insurance people have set themselves, and us, up for a lot of unwarranted grief. Maybe we ought to ask to see what's up the sleeves of these "good hands people" before we slap the tar and feathers on the wrong villain.

Richard B. Weeghman

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FEBRUARY 1986 $2.50

Small Firms And Social Security

Which Business Ads Are Best?

John Naisbitt On The Future Of Franchising

Nation's Business®

The liability insurance crisis is the most serious threat to business today.

Companies risk bankruptcy by paying soaring premiums or going without insurance. The results include lost jobs and higher prices. Experts blame a litigation explosion in which there is a private civil lawsuit for every 15 Americans. Many of those suing count on a trend of fat awards that assume wrongdoing by business. Page 22.



COVER STORY

Liability: Trying Times

By Harry Bacas

An overweight man with a history of coronary disease has a heart attack while trying to start a lawn mower. In a suit against the manufacturer, he argues that pulling the starter rope required excessive effort. A jury awards him $1 million in damages—plus interest.

A drug dosage administered by hospital personnel to a child who then suffers brain damage exceeds the manufacturer's specifications. The child's parents nevertheless sue the manufacturer—and are awarded $22 million.

A motorcyclist, injured when he runs off the road into a parked truck, sues the truck's owner. A mediation board, citing the motorcyclist's own role in the accident, limits a damage award to $20,000. The case goes to a jury, which increases the award to $4.2 million.

Those examples of recent damage awards are not isolated instances but are part of a cycle that is pulling more and more businesses, particularly smaller and medium-size ones, into what has become one of the most serious problems facing business today—the liability-insurance crisis.

The crisis begins with damage awards in cases that are frequently based on thin legal grounds. It moves to the insurance companies that raise premiums—or limit or deny coverage—to stem losses caused by the swollen awards. It ends up with the businesses that face massive cost increases or are unable to obtain coverage at any price.

For that reason, reform of the civil justice system is a key goal of business organizations that want to ease the liability crisis. A second goal is adoption of a federal product-liability law to replace the present patchwork of individual state laws that require manufacturers and retailers to comply with many different and often conflicting statutes or face lawsuits.

In discussing the overall liability cri-

Jack Hayes, a free-lance writer based in Roswell, Ga., also contributed to this article.

"We are reaching the point where we can no longer afford product liability insurance," says Maynard B. Weaver, president of an Omaha company that makes man-lift cranes. He saw his insurance payments rise 500 percent in one year and his coverage limits go down.



PHOTO: MAX WINTER—PICTURE GROUP

David and Ruth Hampe—paying bills for their Somerset, Pa., auto salvage yard—needed a bank loan after their liability insurance premium nearly doubled.



PHOTO: LYNN JOHNSON—BLACK STAR

ance agent who is also current president of the Independent Insurance Agents of America, says, "My customers think I'm nuts suggesting they are lucky to renew at double last year's premiums."

It is becoming more and more apparent, he says, that "price is no longer the issue. It's a question of availability, of just finding the coverage."

Joseph Prendergast, American Ski Federation president, says ski resort operators are facing premium increases ranging to 500 percent. He adds that companies that sell roller skis—which have wheels and are used on nonsnow surfaces—are unable to obtain any coverage.

David Hampe had filed no claims under the liability insurance on the wrecker and dump truck he uses in his auto salvage business in Somerset, Pa., but recently received notice his premiums had nearly doubled. He did not have the cash needed to pay the bill and took out a bank loan so he could.

Edward Cone, chief executive officer of Graco Children's Products, Elverson, Pa., says the deductible on his basic-coverage policy went from $25,000 to $150,000 in 1985, and he had to canvass five sources to get the $500,000 coverage he needed before anyone would sell him an excess risk policy. And that provided one fourth the coverage at a cost five times greater than his previous policy. "We have not had any large claims," he says. "Our claims experience does not nearly justify those rates. But, because of the cost, we will have to evaluate our product lines, and we may get out of some." One of those lines is children's car seats.

All 50 states require use of special car seats for tots, Cone notes. "They have to meet federal standards," he says. "It is not a product that is likely to be used for any other purpose than the one it's designed for. Yet, in our court system, that won't mean a thing to a jury. They see an injured child, and they say, 'Somebody has to pay.'"

He cites a $10 million claim against another car-seat manufacturer resulting from an accident in which a passenger not wearing a seat belt was thrown against a baby strapped into a car seat.

Long-range trends, as well as awards in specific cases, spotlight the connection between the litigation explosion in the nation's courts and the insurance crisis.

In 1984 there was one private, civil lawsuit for every 15 Americans. The number of personal injury cases with awards of $1 million or more is now more than 13 times the 1975 total. A record 12 million lawsuits were filed in state courts between 1978 and 1983. The average product liability award has increased from $345,000 to more than $1 million in 10 years, and the number of product liability suits filed in federal courts alone has tripled since 1960.

There are three times as many lawyers practicing now as there were in the 1950s, and it costs 37 times more to run the tort system than it did then.

Chief Justice Warren Burger says the American public "has an almost irrational focus—virtually a mania—on litigation as the way to solve all problems."

Richard K. Willard, an assistant U.S. attorney general, asks of the fast-growing insurance crisis that is affecting more and more businesses: "How did we get into this mess?" He continues: "I believe the answer lies in recent legal movements by activist judges and tort lawyers who see no bounds to the ever increasing expansion of tort liability."

The traditional basis of tort liability is fault—one individual's actions have caused harm to another individual, who seeks recompense. But under the current trend, Willard says, tort law is increasingly invoked to punish those who have done nothing wrong but have resources to pay damages.

Rick Berman, executive vice president of Dallas' S&A Restaurant Corporation and chairman of the Liability Crisis Steering Committee recently created by the U.S. Chamber of Commerce to coordinate lobbying and other efforts in behalf of reform, says that curbing tort system abuses "is the main road to solution of this problem."

The Chamber committee, he explains, was established as a catalyst to bring together the many interested groups seeking a solution to the insurance crisis. Among other activities, he points out, the committee operates a clearinghouse "to share information and to inform the public of the dimensions of the liability problem."

And the impact of the problem on the general public is much greater than is generally realized.

Huge jury awards and a patchwork of laws are principal reasons for a scary insurance crisis into which business has been plunged.

sis at a recent congressional hearing, the U.S. Chamber of Commerce declared:

"A preliminary survey . . . indicates that businesses in every region of the country have experienced extreme hardship. In fact, there have been business closures due to the dramatic increase in premium payments. Each day, we learn firsthand of another segment of our economy which has been affected by this crisis. There seem to be no boundaries."

Testifying for the business organization, William C. Wyer, president of the Delaware State Chamber of Commerce, added: "Small businesses are bearing the brunt of the present crisis."

Evidence from businesses across the country supports that statement:

Maynard B. Weaver, president of Elliott Equipment Corporation, an Omaha manufacturer of man-lift cranes, reports that his liability insurance payments are $18,000 a month, up 500 percent from 1984, though his coverage has been reduced. "We are reaching the point where we can no longer afford product liability insurance," he says.

The Amigo Company, a family-owned manufacturer of motorized wheelchairs, has never had a successful insurance claim brought against it. But General Manager Alden Thieme says that, because of the insurance crisis, he does not know whether the company can stay in business.

Amigo, which has offices in Albuquerque, N.M., and a factory in Bridgeport, Mich., was told last year that its insurance premiums were being raised from $30,000 to $150,000.

Though Thieme obtained coverage from a Bahamas broker for $45,000, Amigo expects its 1986 liability insurance costs to be $100,000 to $120,000. "The liability crisis is getting completely out of hand," he says. His company experienced the problem firsthand when it had to face a type of lawsuit becoming increasingly common—those in which the defendant is chosen on the basis not of fault, but ability to pay.

Alden Thieme manages a company that manufactures motorized wheelchairs in Bridgeport, Mich. Although it has never lost a liability suit, its insurance premiums are skyrocketing. Thieme blames a legal system that encourages litigation and allows huge jury awards.

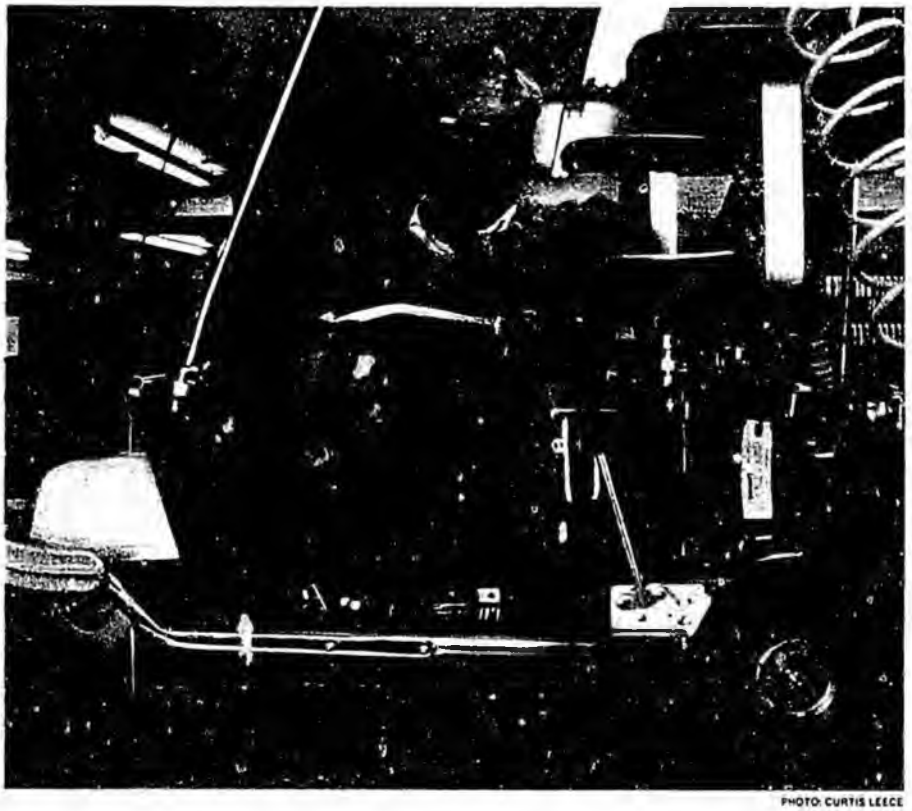


PHOTO: CURTIS LEECE

Thieme recalls that a woman in a wheelchair, accompanied by her husband, was killed when struck by a car that had run a red light on a California street. "The driver had no insurance, so the husband sued us," Thieme says. "The case dragged on for two years before we won. But it cost us $170,000 to defend ourselves."

The company, founded by Thieme's brother, Allen, has 120 employees, does $10 million a year in sales and is the leader in its field. Allen Thieme was named national Small Business Person of the Year in 1981 for successfully launching the firm. His brother and general manager now says that if insurance premiums continue to soar, "it will wipe us out. If we keep adding to our costs, we will price ourselves out of the market."

Vernon Hayes, president of Hayes and Stolz, which makes grain-processing machinery in Fort Worth, Tex., operated without insurance for several weeks last year after his primary policy was canceled. "What do you do?" he asks. "Everybody in America can't shut down. And it's hard to put 70 people out of work." By paying an 800 percent premium increase, he finally obtained a new policy, but it did not provide as much coverage as the canceled policy.

Dick Taylor, a Salt Lake City insur-

Of the 13 U.S. firms making football helmets a few years ago, only three are still in production. The others dropped out because of insurance costs.

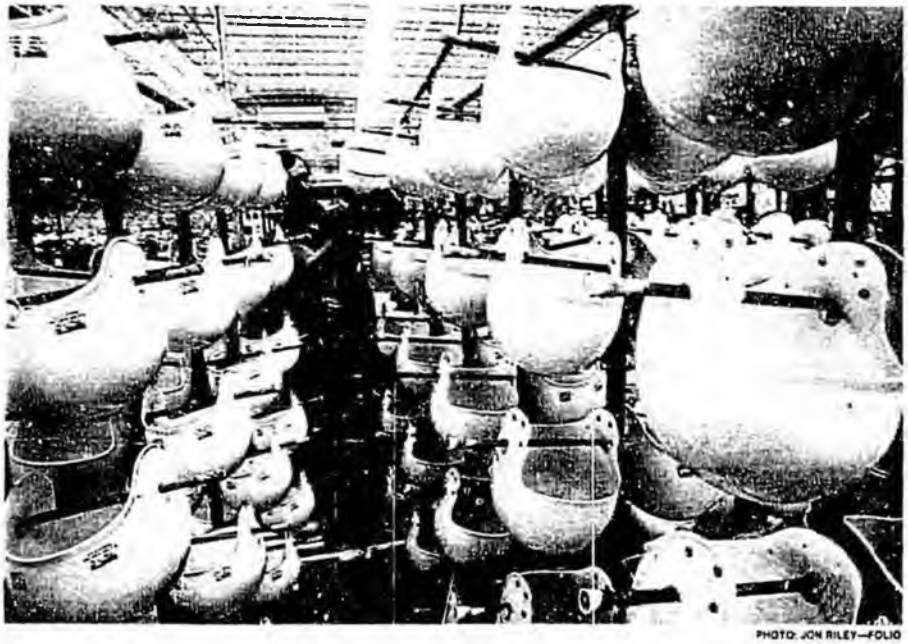


PHOTO: JON RILEY—FOLIO

Rick Berman, of Dallas' S&A Restaurant Corporation, heads a business group seeking state changes in the legal tort system and uniform product liability standards.



PHOTO: C. THATCHER

Malpractice awards against physicians reached an average $950,000 in 1984, and the costs of liability insurance for medical practitioners generally are changing the way many of them approach their patients. The trend to defensive medicine involves additional—and often costly—tests and procedures by physicians concerned that failure to go those extra lengths could lead to allegations of negligence.

But the combination of higher insurance costs and defensive medicine is raising the nation's medical bills an estimated $2 billion to $4 billion a year, an expense being felt mainly by employers who provide health insurance to workers.

Consumers can no longer purchase the drug Bendectin, which had been the only safe and effective treatment for persistent nausea in pregnant women. The manufacturer took it off the market when liability insurance reached $10 million a year, more than 80 percent of annual sales. A nationwide shortage of vaccine to protect children from diphtheria and whooping cough developed when all but one of several companies manufacturing it halted production in the face of mounting liability insurance costs.

Insurance rate boosts are showing up in the price of goods. Twenty percent of the cost of a stepladder now represents the manufacturer's expenses for liability insurance. There is also an effect on employment. Of the 13 U.S. firms making football helmets a few years ago, only three still are. The others dropped out because of insurance costs.

Owners and managers of smaller businesses could face problems beyond the immediate question of insurance coverage, says Jan E. Smith, president of a Bradenton, Fla., business-investment firm. "If banks find a company has lost its liability insurance, they may start asking, 'What about those operating loans we made to that company?' And they may not renew those notes. Banks may require liability insurance before they will make a loan."

Each day, we learn firsthand of another segment of our economy which has been affected. Small businesses are bearing the brunt of this [liability] crisis.

—William C. Wyer, president, Delaware State Chamber of Commerce

In his testimony to Congress for the U.S. Chamber, William Wyer said: "Perhaps this crisis will reserve ultimately its harshest consequences for American consumers. When obstetricians withdraw from their profession, it is the quality of health care for all of us which suffers. When sporting goods manufacturers go overseas, it is the American worker who becomes unemployed.

"And when . . . firms announce price increases primarily to cover rising insurance costs, it is all of us who will pay more through higher prices."

The actual and threatened problems of the liability crisis have spurred a wide range of reactions by those most affected—individual business and professional people, their trade organizations, the insurance industry and the legal profession.

These are among steps being taken on the business side:

- Business people in all fields are shopping more aggressively for coverage by obtaining quotes from several brokers. They are also accepting higher deductibles and are self-insuring when they can afford to.
- Many businesses are hiring consultants to conduct risk audits and help them analyze their insurance needs more carefully. Consultants are also showing companies how to minimize exposure to large damage awards by keeping detailed records on product-safety management programs with an eye toward impressing juries if they ever face them.
- Some companies unable to meet massive premium increases or even to obtain coverage are, like Vernon Hayes of the Fort Worth machinery-manufacturing company, taking the ultimate step of "going bare"—operating without liability insurance and hoping for the best.
- Contractors are setting up subsidiaries without assets to work in high

Ski resort operators have more than weather to worry about. They are paying liability insurance premiums that have increased up to 500 percent in a year.



PHOTO: MICHAEL PHILIP MANHEIM—FOLIO

liability areas like cleanup of hazardous waste and asbestos removal.

- Engineers and architects are writing contracts that require clients to share the risks or indemnify them against claims.
- Organizations are establishing special programs to help member companies and individuals curtail exposure to risk. The American Medical Association, for example, is showing physicians how to avoid or correct situations that might invite lawsuits. The National Restaurant Association is teaching members how to lower their vulnerability to lawsuits stemming from later conduct of customers who have been served drinks.

In addition to such specific steps, there is the drive by many business organizations for long-term reforms in the civil justice system and in basic laws on liability.

The National Association of Independent Insurers, American Insurance Association and Alliance of American Insurers have joined in supporting three tort system reforms they say will improve the affordability and availability of liability insurance:

1. Fair application of the "several liability" doctrine, which assigns damages based on the defendant's determined share of negligence, rather than on ability to pay.

2. Abolition of punitive damages in civil liability litigation on the ground that they excessively drive up settlements and awards.

3. Adoption of "state of the art" rules that will limit product, professional and municipal liability claims to standards prevailing at the time a damaging act takes place, rather than at the time of litigation.

In addition to the Steering Committee, the U.S. Chamber of Commerce is establishing a Blue Ribbon Civil Justice Action Group to recommend legal system changes that would reduce the extent and cost of litigation and would increase the availability and affordability of liability insurance.

One area of top concern to those seeking reform of the civil justice system is the practice of compensating lawyers through contingency fees, which are based on the amount of damage awards they win for their clients. Critics say that policy encourages lawyers to encourage clients to file lawsuits on a no-lose basis—the client incurs no costs if the lawyer does not win an award.

Tim Reath, chief executive of the eastern division of Jardin Insurance Brokers and past president of the National Association of Insurance Brokers, says, "Within a couple of years, we're going to see some serious reform activity in this area. We definitely need to get off the contingency system."

There is a division within the legal profession on the system. The American Bar Association published in its journal recently a debate on the contingency approach, with one lawyer terming it an "indispensable delivery device ... for the use of the civil law as a hammer in support of consumer interests." But another attorney asserted that "the pro-plaintiff trend of the last 25 to 30 years" has made the contingency fee a luxury that "must be controlled or modified in some way if the American system of justice is to be preserved."

Peter Perlman, president of the Association of Trial Lawyers of America, argues that the contingency fee system cannot be blamed for the surge in personal injury suits.

"Under the contingency fee system," he argues, "victims may have an incentive to bring weak claims, because they risk nothing. But, conversely, the contingent-fee lawyer has no such incentive, because the compensation for a weak claim is likely to be zero."

What about the argument that sharply increased advertising by lawyers seeking clients has been a factor in the litigation explosion? Joel Hyatt, whose 30-second television commercials have made him one of America's best-known lawyers and his law firm the nation's second largest, says advertising by lawyers has contributed little to increasing case loads of damage claims.

"The injury area of the law was already being served by the legal profession," he says. Hyatt, whose firm has 575 attorneys in 200 offices, says their work is mostly in divorce cases, bankruptcies and probate law. Less than 5 percent is in injury cases, he says.

But he does have a recommendation for the insurance industry. The current problem, he says, is not the large jury awards that receive much attention, but "the far greater number of small cases that should never have been brought to court."

Hyatt says some lawyers created "a whole frivolous lawsuit industry" after insurance companies made the "bad mistake" of deciding "that, if the cost of litigating a case was greater than the amount insurers could settle for, they would make the economic decision to buy those cases off—pay $5,000 to settle rather than $8,000 to fight the case." He says insurers should take the long view by fighting the bad cases regardless of the expenses involved.

Some insurance companies have begun to do that and to defend themselves in other ways. Increasingly, they are writing policies to cover only claims made during the life of the policy, excluding retroactive claims. Some are also limiting how much they will pay for legal defense of the insured company and for punitive damages.

Though the tort system and the cur-

Franklin W. Nutter, president of the Alliance of American Insurers, says the availability of affordable insurance depends on a climate of "legal and regulatory stability."



PHOTO: T. MICHAEL KEZA

rent, fragmented product liability laws are viewed as the principal pressures on insurance rates, insurance companies concede that part of the problem represents a delayed reaction to early 1980s pricing and investment policies. Interest rates were so high that the companies competed intensely for funds to invest. To attract premiums that could be used as investment capital, the entire industry engaged in what was termed "cash-flow underwriting." A former marketing vice president with one of the 10 largest property-casualty insurers says, "The theory was that, if you could sell a dollar's worth of risk protection for 50 cents and still end up with a dollar and 5 cents after investments, you'd be ahead of the game."

But, in 1984, as losses overtook investment returns, insurers became far more careful about what risks they would take at what price, and premium increases, limitations and even cancellation of coverage followed.

Another factor that put pressure on premium costs was the shrinkage of the reinsurance market, where underwriters spread risks they have insured. Andre Maisonpierre, president of the Reinsurance Association of America, told a congressional hearing recently: "Insurance policies and reinsurance contracts written in the 1950s and 1960s for relatively low premiums are now responding—pursuant to court decisions or retroactive legislation—to claims which were never anticipated under the contracts. The resulting impact on reinsurance has been traumatic."

Maisonpierre says the withdrawal of foreign reinsurance capital has reduced the property-casualty industry's capacity by about $5 billion, or approximately 7 percent. "We can foresee that 1986 will be much more difficult for U.S. reinsurers than 1985, simply because the funds are not going to be available," he adds.

Some critics accuse the industry of overreacting to its revenue problems. J. Robert Hunter, president of the National Insurance Consumer Organization and a former federal insurance administrator, joined with Ralph Nader at a recent press conference to argue that industry loss reports were "misleading and fraudulent." They held that the $5.5 billion loss cited for last year did not reflect tax credits and the increased value of investments and listed dividends as expenses.

Franklin W. Nutter, president of the Alliance of American Insurers, replied that the criticism was based on "voodoo accounting." He said the reports were based on requirements of state insurance regulators who, among other things, specify that dividends be carried as expenses. Hunter said insurance companies do not willingly withhold coverage: "We are not in the business of not selling insurance."

Resolution of the problem is not expected to come quickly. The insurance industry still faces difficulties. Final 1985 figures are expected to show a premium/cost ratio of 116 for the year, compared with 118 for 1984. (The ratio uses a base of 100, meaning that for every dollar of premiums in 1985, the industry paid $1.16 in costs and claims.)

At the same time, the dimension of the problem and business demands for action are getting attention. Mary Jane Fisher, Washington-based correspondent for the insurance industry publication, *National Underwriter*, says, "The members of Congress are getting heat from their constituents who want something done about availability and pricing of liability insurance."

Though the campaigns for civil justice reform and a uniform product liability law continue to be pressed, and the insurance industry is working its way out of its financial problems related to investment policies of recent years, many individual businesses worry that they will sooner or later face the dilemma of Maynard Weaver of Omaha's Elliott Equipment Corporation:

"We'll go broke if we pay the premiums. If we go bare, we risk product liability suits shutting us down. We're just sitting here bleeding to death." NB

To order reprints of this and the following article, see page 77.

Insurance Industry Gains And Losses

The U.S. insurance industry collects $249 billion a year in premiums. That is 6.9 percent of the gross national product and an average of $972 for every man, woman and child in the country.

There are 5,600 insurance companies, with nearly 2 million employees (a third of them agents and brokers) and assets of $985 billion.

The Insurance Information Institute says that 48 percent of the world's premiums are collected in the United States, followed by Japan, 13 percent, and West Germany, 8 percent.

Property-casualty insurance in this country, most of it written by 900 companies, takes in $118 billion in premiums, about half of it in personal auto and homeowner policies and half in business lines.

For two years, property-casualty insurers have had net operating losses. In 1984 the total loss was $3.8 billion; in 1985, $5.5 billion. Critics charge that those losses are overstated, but the industry denies that accusation, stating that 1985 was the worst year for insurance since the San Francisco earthquake of 1906.

The companies have been paying out $1.18 in claims settlements and expenses for every $1 they collected in premiums.

Of the payout, 88 cents goes for claims and adjustment expenses, 25 cents for sales and administrative expenses, 2 cents for dividends to policyholders and 3 cents for taxes.

Losses in some lines were much larger than the overall loss. General liability policies cost the companies $1.51 for every $1 they got in premiums. Commercial auto liability cost $1.42. Medical malpractice cost $1.61.

New Directions In Liability Laws

Safeguards for business that are uniform nationwide—those are reformers' goals

Product liability law in this country is a confusing patchwork. Only 31 states have statutes, and no two are the same. Congressional bills establishing uniform nationwide standards have been stymied repeatedly, with trial lawyers leading the lobbying.

The result is confusion for businesses, insurers and injury victims alike. A case that would be won in one state would be lost in another.

With lawsuits increasing more than 500 percent in a decade, courts have become clogged. Decisions are delayed.

Litigation takes years to run its course before victims are compensated, and then legal costs often take more than half the money paid in claims. A Rand Corporation study of asbestos liability cases showed that lawyers' fees consumed 63 percent of all damage awards. Since the 1950s the population has grown 60 percent, the number of lawyers 200 percent and the cost of the tort system, adjusted for inflation, 700 percent.

Although liability law arises from the tort system—a person who wrongs another must compensate him for the wrong—in recent practice it has been moving in new directions.

Questions of negligence and fault ("Did someone do wrong, and did it cause this injury?") have grown nearly irrelevant. Instead, courts have moved toward a concept of entitlement to injury compensation: "A person has been hurt, and somebody has to pay. Who involved has the deepest pockets?"

The judge in the celebrated Agent Orange case pressured the seven chemical company defendants to pay $180 million to Vietnam veterans and their families even though, he said later, he did not believe there was any medical evidence to support their claims.

In this effort to find compensation for victims, judges have created a doctrine of "strict liability." This means that manufacturers are responsible for more than doing their best to produce products without defects. They are also responsible for creating product designs whose usefulness outweighs all possible hazards, and they must foresee ways in which a product might be misused and warn against them.

U.S. Asst. Atty. Gen. Richard K. Willard (left) blames lawyers and judges who have tried to compensate all plaintiffs at the expense of anyone with deep pockets.



PHOTO: T. MICHAEL KEZA

The limits on manufacturers' liability have been steadily expanded.

Biro Manufacturing Company in Marblehead, Ohio, is being sued for a hand injury caused by a hamburger grinder the company sold 27 years ago. Originally sold to the Air Force, the grinder was privately owned and in commercial use when the accident took place. Its safety guard had been removed.

H.B. Rouse & Company in Chicago is being sued for injuries on a bench milling machine it sold in 1947. The machine, still owned by the original purchaser, was being used by a new operator in an obviously unsafe manner.

Business people generally want laws that assure a reasonable balance between rights of plaintiffs and defendants.

Some have proposed that product liability be removed from the area of tort and a new no-fault compensation system be created that would operate like workers' compensation. The system, supported by business taxes, would use administrative shortcuts to avoid courts, guarantee victims speedy relief from economic losses and protect manufacturers from suits.

Other business people, and the Reagan administration, see the answer in reforming present liability laws. A coalition of business groups has advanced the following as goals of such reform:

- A fault-based standard for judging the adequacy of product design and the appropriateness of safety warnings.
- A statute of limitations on the time period during which manufacturers can be held liable for a defective product.
- A standard limiting the number and size of punitive damage awards for injuries from a particular product defect.
- A standard requiring that damages reflect the extent to which plaintiffs contributed to their injuries.
- A clear presumption that government contractors are not liable for injuries resulting from equipment or systems that they have built to government specifications.

Sen. Robert W. Kasten (R-Wis.), author of the best-known reform bill, says enactment would "put money for injuries back into the hands of the victims rather than in the pockets of lawyers."

He says uniform nationwide liability standards, "by placing clear responsibility on people who make unsafe products, will bring about the manufacture of safer products . . . and do so without one cent spent for additional regulation."

—Harry Bacas

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March 25, 1986

Senator Patrick Rodey
Alaska State Legislature
Box V
Juneau, Alaska 99801

Re: HB 532 and SB 377 - Tort Reform

Dear Legislator:

I am writing to you as a 28-year Alaskan resident who is entering my 18th year of professional practice as a civil engineer and the 9th year of business practice.

I urge your support and passage of legislation on tort reform, in particular House Bill 532 and Senate Bill 377. I support these bills as well as the Citizens Coalition for Tort Reform. I believe passage of these bills are vital to our business climate.

My company's professional liability insurance premium for $1 million coverage limit rose from $12,000 annual premium to $16,000, to $24,000 in three policy years. THEN, the 1985 "indicated" premium quote (an actual quote was never received; previous insurance company "left" Alaska) was $130,000 +. This was a fivefold increase on the same volume of claims-free business.

A single quote for $500,000 policy coverage limit was received for a $55,000 annual premium - still an effective increase of more than four times.

In view of apparent volatility of the insurance market, sky-rocketing premiums, and declining economy, all coupled with the fact that none of our existing or previous contracts have required professional liability insurance, we elected not to re-insure for "errors and ommissions". Our favorable claims experience aided in this decision.

Also, nowhere in our wildest expectations did we budget for a fivefold increase in E & O premiums. Predictability! Affordability!

A recent survey of Alaskan architect-[illegible]neer firms, which an A/E ad hoc committee on professional li[illegible] insurance commissioned through the accounting firm of Peat, Marwick, Mitchell & Co., indicates an average 2 times increase in 1985 premiums for A/E firms with more than $5 million in annual revenues. This rate of increase rose to more than 4 times the 1984 premium. for small A/E firms in the range of $100 to $200 thousand annual revenues! Bear in mind that these are averages. A copy of this survey, in which 43 Alaskan firms responded, is attached for your information.

I know of several design firms who did not or could not renew their professional liability insurance policies for the same reasons. Several of these firms also have a favorable claims experience. We are one of those firms.

We are now faced with the situation where clients who did not previously require professional liability insurance are now requiring such coverage. One notable example is the Municipality of Anchorage who are themselves un-insured due to unavailability or unaffordability of liability insurance!

The Municipality has been without liability insurance since the first of the year, and now have a firm requirement for professional liability insurance for all professional design services where they have not previously required such in the past.

Meetings with Jack Coyne, Assistant Municipal Attorney, and Dave Berry, Director of Property and Facility Management, June 1985 and March 1986, respectively, indicate the Municipality of Anchorage has not experienced any claims or otherwise had a loss history on its civil projects (i.e., streets and roads, drainage, water and sanitary sewer line improvements).

A January 23, 1986 memorandum from the Municipality's Risk Management Division to all Municipal departments requires $500,000 E & O coverage for professional services for ALL projects with construction values up to $1 million, and $1 million E & O coverage for projects exceeding this construction value.

A recent Municipal request for proposal for civil design services lists several projects in the range of $50,000 to $65,000 construction value. Based on our single quote received last spring, our professional liability insurance premium will equal or exceed the construction value of these projects which might have a design fee of 6% to 10% of the construction value!

This recent request for proposals, which were due to Municipality yesterday, covered a list of twelve water and sewer projects, of which only two had estimated construction values in excess of $1 million. None of these projects are "Eklutna Water" or "Bradley or Susitna Hydroelectric" projects, either. I wonder if there are twelve "local Alaskan" engineering firms in Anchorage who still have professional liability insurance in force.

I have several real concerns regarding this problem. The first, obviously enough, concerns my own ability to be able to continue working. The second concern is that more and more of this design work will be awarded to "outside" engineering firms who have "branch" offices in Alaska. I feel strongly that profits, as well as payroll, made on Alaskan projects should stay in Alaska and continue to be spent in Alaska! I wonder how many of these "outside" firms, like the insurance companies, are also going to "pull-out of Alaska" when the economic climate is no longer beneficial to them.

Another concern, though perhaps less direct, is the State subsidy of the student loan and other programs. Why bother!

Alaska's student loan program helped me through my undergraduate and graduate studies at the University of Alaska in Fairbanks (money spent in Alaska!). The purpose of the student loan program is purportedly to train and educate Alaskans to live and work in Alaska. Why bother when the Alaskan work cannot be awarded to Alaskan firms who cannot obtain/afford liability insurance, and the work "goes outside" anyway.

On the short-term, the architect-engineer community is attempting to work with the Municipality of Anchorage to resolve some of these insurance requirements, but in the long-term I believe tort reform is required to provide some predictability in the courts for the insurance companies and predictability and affordability for us Alaskans attempting to do business in Alaska.

I'm not trying to paint the insurance industry as being lily white, I doubt that any of us are that, but I do believe that they, and we, need help in modifying the climate of extremely liberal awards that presently seems to be prevalent in our courts.

I attended a professional liability seminar in Texas in early 1984, and was told by the speaker, an attorney for a major underwriter of professional liability insurance - one of two companies still writing in Alaska, that the courts in Alaska are so consumer-oriented that "you guys don't have a chance up there".

Where there were more than twelve insurance companies writing professional liability insurance in Alaska two years ago, we are told there are now two, possibly three underwriters now.

I sat as a juror on a personal injury/product liability case in 1983. I have seen the attitude that not only do we need to make someone well, we have to "make it up to them", and "somebody" has to pay. Unfortunately, no amount of money is ever going to replace a limb or a loved one.

I support every one of the elements in these two bills and the Citizen's Coalition for Tort Reform. I am not trying to limit victims rights and no one that I know is. Just as victims should be compensated in an appropriate and JUST manner, neither should they profit by their unfortunate experience.

I understand that the 13-point HB 532 is one of the more comprehensive tort reform bills in the nation. Many of these reforms have already been passed by other states "in South America" and many of these have been upheld as constitutional in the respective state supreme courts.

Again, I urge you to pass HB 532 and SB 377, and support other companion legislation.

I would suggest to you that if these bills are not passed, at the rate insurance companies are leaving Alaska, victims may lose rights due to the unavailability of insurance. After all, if there is no insurance in force, there may be no "deep pocket" to compensate victims with valid claims.

This started out to be a 50-word Public Opinion Message, but since I've exceeded the limit slightly, I guess a letter will have to do. While these are my opinions, discussions with others, both within and without the design community, indicate that many share these opinions.

If I can be of any assistance to you or provide any information, please do not hesitate to contact me.

Very truly yours,

Stephen D. Shrader
House District 11
Senate District G

Encl: E & O Survey, dtd 2/27/86

SDS/cs

PEAT MARWICK

RMS ✓
SD ✓
MC ✓

Peat, Marwick, Mitchell & Co.
Certified Public Accountants
Alaska Mutual Bank Building
601 West Fifth Avenue, Suite 700
Anchorage, Alaska 99501
907-276-7401

January 23, 1986

Dear Participant:

Attached are the results of the November, 1985 Errors and Omissions Insurance Survey conducted by the American Institute of Architects, Alaska Chapter, and the Alaskan Society of Professional Engineers. Fifty-five companies responded to the survey; however, only 43 companies provided information that could be utilized to compare changes from 1984 to 1985.

Exhibit I lists the individual responses of the 43 companies used in the survey. In addition, companies were categorized into six groups, based upon their 1984 revenue, and averages have been provided for each group. No significant changes in classification would have occurred if the companies had been categorized based upon their 1985 revenues.

Exhibit II provides a summary of comments made by respondents.

Several companies did not indicate whether their 1985 data was actual or quoted amounts; as such, the data for 1985 may not be the actual coverage, deductible and premium selected by a company.

If you have any questions please feel free to call me.

Very truly yours,

PEAT, MARWICK, MITCHELL & CO.

Larry L. Laughman

Larry L. Laughman
Senior Manager

LLL:BM
Enclosure

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AMERICAN INSTITUTE OF ARCHITECTS, ALASKA CHAPTER
and the
ALASKA SOCIETY OF PROFESSIONAL ENGINEERS

Errors and Omissions Insurance Survey

November 1985

Exhibit 1

AMERICAN INSTITUTE OF ARCHITECTS, ALASKA CHAPTER
and the
ALASKA SOCIETY OF PROFESSIONAL ENGINEERS

Errors and Omissions Insurance Survey

November 1985

1984 Revenues	Company	Coverage 1984	Coverage 1985**	Deductible 1984	Deductible 1985**	Premium 1984	Premium 1985**	Multiplier
Less than $200,000	1	$ 1,000,000	1,000,000	5,000	5,000	3,000	13,104	4.37
	2	100,000	100,000	5,000	5,000	2,500	7,172	2.87
	3	100,000	250,000*	5,000	5,000	1,500	8,500	5.67
	4	500,000	500,000	5,000	5,000	4,800	13,700	2.85
	5	1,000,000	1,000,000	2,500	10,000*	3,000	36,500	12.17
	6	250,000	150,000*	5,000	5,000	4,000	21,000	5.25
	7	500,000	500,000	5,000	5,000	3,973	17,272	4.35
	8	500,000	500,000	5,000	5,000	6,868	10,387	1.51
Average		$ 493,750	500,000	4,687	5,625	3,705	15,954	4.31
$200,001 to $499,999	9	$ 1,000,000	1,000,000	5,000	5,000	7,696	21,898	2.85
	10	1,000,000	1,000,000	5,000	10,000	7,902	33,154	4.20
	11	---"Not Provided"---		5,000	5,000	6,500	31,000	4.77
	12	1,000,000	500,000*	10,000	15,000*	8,425	30,000	3.56
	13	1,000,000	1,000,000	10,000	10,000	26,000	130,000	5.00
	14	500,000	500,000	5,000	5,000	5,000	17,000	3.40
	15	---"Not Provided"---		5,000	5,000	7,785	19,995	2.57
	16	1,000,000	1,000,000	5,000	10,000*	11,058	37,844	3.42
	17	500,000	500,000*	40,000	40,000	17,952	11,560	.64
	18	100,000	100,000	10,000	10,000	8,714	66,750	7.66
Average		$ 762,500	700,000	10,000	11,500	10,703	39,920	3.73
$500,000 to $999,999	19	$ 1,000,000	1,000,000	25,000	25,000	18,000	54,000	3.00
	20	1,000,000	1,000,000	10,000	10,000	19,000	29,000	1.53
	21	500,000	1,000,000*	10,000	10,000	23,602	40,000	1.69
	22	1,000,000	1,000,000	7,500	10,000*	6,500	96,000	14.77
	23	1,000,000	1,000,000	15,000	15,000	26,180	28,756	1.10
	24	1,000,000	1,000,000	15,000	15,000	7,800	22,500	2.88
	25	100,000	100,000	10,000	10,000	12,000	16,000	1.33
	26	1,000,000	250,000*	15,000	15,000	39,062	63,147	1.62
	27	1,000,000	1,000,000	20,000	20,000	21,446	74,491	3.47
Average		$ 844,444	816,666	14,167	14,444	19,289	47,099	2.44
$1,000,000 to $1,999,999	28	$ 500,000	500,000	10,000	20,000*	15,500	44,500	2.87
	29	1,000,000	1,000,000	25,000	25,000	24,000	130,000	5.42
	30	---"Not Provided"---		10,000	20,000*	17,000	44,000	2.59
	31	500,000	500,000	5,000	10,000*	11,892	46,972	3.95
	32	---"Not Provided"---		10,000	20,000*	34,931	79,374	2.28
Average		$ 666,666	666,666	12,000	19,000	20,665	68,969	3.34
$2,000,000 to $5,000,000	33	$ 1,000,000	1,000,000	40,000	50,000*	30,000	130,000	4.33
	34	1,000,000	1,000,000	50,000	50,000	44,937	127,000	2.83
	35	1,000,000	1,000,000	25,000	50,000*	27,934	110,012	3.94
	36	2,000,000	2,000,000	50,000	50,000	70,000	114,000	1.63
	37	2,000,000	2,000,000	100,000	100,000	45,392	66,952	1.47
	38	1,000,000	1,000,000	10,000	25,000*	65,809	147,475	2.24
	39	2,000,000	2,000,000	50,000	75,000*	133,528	119,544	.90
Average		$ 1,428,571	1,428,571	46,429	57,143	54,657	116,426	1.95
Over $5,000,000	40	$ 1,500,000	1,500,000	100,000	100,000	55,000	220,000	4.00
	41	2,000,000	2,000,000	50,000	75,000*	190,000	365,000	1.92
	42	---"Not Provided"---		25,000	25,000	30,000	35,000	1.17
	43	---"Not Provided"---		50,000	250,000*	50,000	150,000	3.00
Average		$ 1,750,000	1,750,000	56,250	112,500	81,250	192,500	2.37

* Quote at 1984 level not provided.
** Actual or quotes.

Exhibit 2

AMERICAN INSTITUTE OF ARCHITECTS, ALASKA CHAPTER
and the
ALASKA SOCIETY OF PROFESSIONAL ENGINEERS

Errors and Omissions Insurance Survey

November 1985

The following is a summary of comments by respondents:

- The triple cost of premiums made it unfeasible for a small firm, such as ours, to continue to carry this coverage.

- New policy with new carrier - they would not cover prior acts, so the retroactive date became the date of the new policy. I am still trying to find insurance for my prior acts.

- Coverage was not renewed for 1985 due to an increase in premiums of over 400%.

- We are doing without errors and omissions insurance. In ten years of practice, we have never litigated a claim. In view of our reduced practice and low-risk projects, the premium increase is unconscionable. The insurance industry has a problem, not us, but they want us to pay for it.

- Applications were submitted to five firms. So far, two have declined, one pulled out of Alaska, one said its gross income was too small and still no response from the fifth. Did offer suggestions of a higher deductible and instead of the $500,000 limit, suggested even $250,000, but so far no response.

- The firm is now, in essence, uninsurable as the project insurance contract was canceled. The current practice of the insurance industry is an apparent deliberate method of putting the small businesses in this country either out of business entirely or at an uncompetitive disadvantage for lack of ability to obtain required insurance coverage.

- My old insurance broker sold the company to another broker who in turn sold to an Eastern company this year. At the same time, our insurance was due for renewal and the old insurance underwriter would not renew A&E liability insurance in Alaska. We had to find a new broker who filed applications with three companies but was having trouble getting quotations. In the meantime, the State DOT&PF terminated a contract we were working on for some time due to the fact that we did not have insurance coverage for a short period of time.

AMERICAN INSTITUTE OF ARCHITECTS, ALASKA CHAPTER
and the
ALASKA SOCIETY OF PROFESSIONAL ENGINEERS

Errors and Omissions Insurance Survey

- Errors and omissions insurance may not be affordable for us next year.

- Did not renew because of the cost. One of my clients is requiring $500,000 in errors and omissions insurance. I am trying to get a new quote without prior acts coverage.

- Half the coverage for almost four times the premium -- that is an 800% increase. The carrier already told us we can expect a 20% to 30% increase for next year. This may tap us to the limit, that is, fold our doors. It is about time the federal government and the Alaska State legislature did something positive to keep small business firms in business. It is getting extremely difficult to compete with the big boys, especially with these dramatic insurance increases!

- In 1985, dropped coverage from $1,000,000 with $7,500 deductible to $500,000 with $10,000 deductible and the premium paid was $34,000. Don't remember the May 24, 1985 questionnaire. Since my coverage runs from August 31 to August 31, it was easier to give you the actual amounts as they appear on my application for errors and omissions insurance. Basically, when considering we are paying five times the premiums for half the coverage, that represents a 1000% increase!

March 21, 1986

Senator Patrick Rodey
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Rodey:

I am writing to you regarding House Bill 532. First off, I am not in favor of House Bill 532, in that I feel it is taking away rights of future-injured individuals, and they have absolutely no in-put into the loss of their rights to be compensated when they are injured through no fault of their own. The problem of "tort reform" is that it is minimizing or totally eliminating the responsibility of the physician, manufacturer, company, etc., and penalizing the injured person for getting up that morning and doing whatever he was doing when he became injured.

In Alaska, the medical profession, specifically, is working very hard to pass this legislation to totally eliminate their responsibility. Many doctors in our state go bare, and many more will go bare that now are carrying insurance if "tort reform" is passed. The doctors put their assets in trust or in other individual's names, so they are not subject to judgments. Doctors are pushing particularly to do away with joint and several liability because everytime an uninsured doctor injures or kills someone, the hospital which gave him privileges to practice is also named in the suit, and it ends up paying the settlement or judgment because the doctor has hidden his assets. I feel both the hospital and the doctor are responsible, and it doesn't hurt my feelings a bit if the hospital ends up paying because the physician is hiding his assets and refusing to carry medical negligence insurance.

The hospital can put a stop to this in a flash, like they do in other parts of the country, by requiring every

physician practicing at their institution to show proof of insurance prior to getting hospital privileges. In Alaska, we have a good old boy medical association that allows this pathetic situation to exist. Where does the Governor go to have medical treatment? Well, it sure isn't to Anchorage, Alaska, because he knows as well as other individuals if you can afford it, you go outside and get competent help by competent physicians, at competent hospitals that have insurance to cover accidents or mistakes. That's why you and I buy automobile insurance. It's to protect people as a result of an accident or negligence.

In passing this legislation, you are guaranteeing that there will be more doctors going bare in Alaska because they will know now that the hospital will not be tapped but for a very small percentage, and they have essentially eliminated their financial responsibility to those that are injured at their hands.

As a public representative, and an individual who has been entrusted with their constituents' best interest, I cannot see how you could support H.B. 532 that is so devastating to the general public. This is victimizing the victim a second time, and you and yours may be the next victims.

What can be done? (1) Make the insurance industry, through legislation, set up risk management departments that oversee the medical profession which have the expertise and the power to take away an Alaskan physician's license if it has been shown that he is incompetent. (2) Have the risk management department or state licensing department have the powers to reduce a doctor's privileges to areas that will keep him out of trouble. (3) Require that all hospitals doing business in the State of Alaska and certified by the State of Alaska require each and every physician to show proof of medical negligence insurance before they obtain privileges. (4) Require the Commissioner of Insurance to be an actuary or to have an actuary on his staff. (5) Require the insurance industry be estopped from wholesale price increases that are illegal in the State of Alaska, since each price increase has to be submitted to the Insurance Commissioner and justified (and all of the tremendous increases from 100 to 1,000 percent that have happened in the State of Alaska this year have happened without the formal proceeding set up to protect the public). (6) Set up reinsurance pools or insurance pools for industries that have been singled out by the insurance industry. (7) To disallow insurance companies to arbitrarily cancel an individual's insurance, but to give them adequate notice and adequate reason. In Alaska, as in other parts of the United

States, there are companies that have had absolutely perfect records and their insurance has been either cancelled or increased to such an amount that it is prohibitive. Insurance premiums should be on the basis of claims made history, so that if you have a company which is historically bad, it should pay a higher premium than the company that is concerned and has a good safety record. (8) Make it so that the Commissioner of Insurance cannot get into the insurance business until five years after he terminates with the State of Alaska.

The insurance industry in 1975 did a dry run for the 1985 "insurance crisis." If you will remember, throughout the United States, they targeted the physicians who in our country have a lot of political clout and money; and they have again targeted them, as well as other professions and companies such as day cares, bars, and recreational providers. By doing this, the insurance industry knew they would directly impact millions of individuals through either higher costs or the loss of a service--recreation.

I am sure you have heard that the insurance industry goes in a 10 year cycle, and as I noted previously in 1975 we had a dry run for the industry falling flat on its face again in 1985 and blaming that strictly on the tort system in America and not on their bad business practices and corporate greed. Just in case you have not kept up with this aspect of the "crisis," the insurance industry during the time of high interest rates put all of their moneys in large interest-bearing funds, gaining interest at 20 percent, cut prices ridiculously so to undercut their competition to get a larger share of the market, and then failed to put the appropriate amounts of money in reserves to cover losses that were forecast by their own actuaries. When the interest started going down, they started earning less money; and with the failure of adequate reserves, they had to start paying out large losses from natural disasters, airplane crashes, hotel fires, and the like; and they went flat on their faces as an industry. This is when they started yelling, "tort reform," "tort reform," and blaming the whole problem on the judicial system.

"Tort reform" is happening nationwide, and the insurance industry has orchestrated this "insurance crisis" and the Insurance Information Institute of New York is sending out packets called "The Civil Justice Crisis" which tells the recipient of the packet how to get tort reform legislation passed, and it is a step-by-step instructional book with examples and fliers, etc. On first blush, you may raise your eyebrow at a conspiracy theory, but once you look at this

packet, it is quite clear what they are doing, and that it is not something they have just casually set out to do.

I want to thank you for your time. I want to again strongly urge you to oppose House Bill 532 and any other bill that is going to penalize the individual who has already been injured by taking their rights to recovery away for the injury caused by a third party.

Sincerely yours,

Leonard J. Hackett

Leonard J. Hackett

LJH:amm

2468A

P.S. Please also oppose S.B. 377. Please support Insurance Reform & Fooling legislation!

Alaska State Legislature

Senate

Committee on Labor & Commerce

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 24, 1986

TO: Senator Rodey, Chair
Senate Judiciary Committee

FROM: Senator Zharoff
Chair, Senate Labor and Commerce Committeee

RE: Tort Reform legislation

By request, I am forwarding to you a proposal related to tort reform legislation, sent by a Kodiak constituent. We were not able to accomodate every request regarding the tort reform bill while it was in the Labor and Commerce Committee, but I promised I would bring this to the attention of the Senate Judiciary Committee. Thank you.

Kermit D. Reppond
1616 Selief Lane
Kodiak, AK 99615

Senator Fred Zharoff
Box V
Juneau, AK 99811

March 5,1986

Dear Senator Zharoff:

I have enclosed a copy of a bill passed last year in Idaho which prohibits so-called "wrongful life" suits. In such suits, parents of a handicapped child claim a doctor was at fault for not preforming prenatal tests that would reveal the handicap so they could have the child aborted. The idea being that death is preferable than living with a handicap. Other enclosed material gives additional data on such legislation. It is obvious why pro-life people favor the bill but it should have support among all physicians as it is really for their protection. This would be especially true of pro-life doctors who are ethically opposed to abortion. This bill could be part of any tort reform legislation. Nothing in the bill hinders prenatal testing for birth defects or abortion. I would appreciate it if you would look over this idea.

Thank you for your recent letter concerning state program for prenatal services. It is my hope that the legislature will soon see the hypocricsy of claiming to be "pro-choice" while funding only one choice in the abortion question.

Sincerely,

Kermit D. Reppond

Kermit D. Reppond

STATEMENT OF PURPOSE

RS 11142

Rs 11142 precludes a cause ~~to~~ of action based on the claim that, but for the negligence of another, a woman would have had an abortion. It only precludes an award of damages; it does not prevent a woman from having diagnostic tests performed to detect a handicap, nor does it prevent any woman from obtaing an abortion.

The bill represents a public policy choice favoring childbirth and refusing to encourage or facilitate abortion, infanticide, bad medical practice and unequal treatment of the handicapped.

FISCAL IMPACT

There is no fiscal impact to state agencies.

RS11142

LEGISLATURE OF THE STATE OF IDAHO

Forty-eighth Legislature — First Regular Session - 1985

IN THE _____

_____ BILL NO. _____

BY _____

AN ACT

RELATING TO PROCEEDINGS IN CIVIL ACTIONS; AMENDING CHAPTER 3, TITLE 5, IDAHO CODE, BY THE ADDITION OF A NEW SECTION 5-334, IDAHO CODE, TO PROVIDE THAT A CAUSE OF ACTION SHALL NOT ARISE, AND DAMAGES SHALL NOT BE AWARDED, ON BEHALF OF ANY PERSON, BASED ON THE CLAIM THAT BUT FOR THE ACT OR OMISSION OF ANOTHER, A PERSON WOULD NOT HAVE BEEN PERMITTED TO HAVE BEEN BORN ALIVE BUT WOULD HAVE BEEN ABORTED, AND TO PROVIDE CAUSES OF ACTION THIS ACT SHALL NOT PRECLUDE; AND DECLARING AN EMERGENCY.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. That Chapter 3, Title 5, Idaho Code, be, and the same is hereby amended by the addition thereto of a NEW SECTION, to be known and designated as Section 5-334, Idaho Code, and to read as follows:

5-334. ACT OR OMISSION PREVENTING ABORTION NOT ACTIONABLE. (1) A cause of action shall not arise, and damages shall not be awarded, on behalf of any person, based on the claim that but for the act or omission of another, a person would not have been permitted to have been born alive but would have been aborted.

(2) The provisions of this section shall not preclude causes of action based on claims that, but for a wrongful act or omission, fertilization would not have occurred, maternal death would not have occurred or handicap, disease, defect or deficiency of an individual prior to birth would have been prevented, cured or ameliorated in a manner that preserved the health and life of the affected individual.

SECTION 2. An emergency existing therefor, which emergency is hereby declared to exist, this act shall be in full force and effect on and after its passage and approval.

Sunday 2-3-80 Front Page The Spokesman-Review

ill to shield doctors from wrongful-birth suits u

By DAVID NEWMAN
staff writer

BOISE — Idaho's anti-abortion ivists are urging lawmaker sup- t this year for a bill that would ld doctors from "wrongful h" malpractice lawsuits.

'ear of such lawsuits coerces doctors into performing risky and expensive prenatal tests on their patients to diagnose potential handicaps, pro-life advocates contend.

When tests show a birth defect is certain or likely, prospective parents choose to abort the pregnancy in more than 60 percent of such cases, according to a Chicago doctor aiding the lobbying efforts of Right to Life of Idaho.

"It makes physicians a hit squad for those people who morally favor abortion as an alternative for society's obligation to care for the handicapped," said Sandpoint Democrat Rep. Steve Herndon, a devout supporter of the pro-life agenda.

The test in question is amniocentesis, in which a long needle is used to penetrate the draw a sample of The fluid is culture mined to reveal th makeup.

"It's used as a stroy [illegible]," said R the legislative direc Life of Idaho. "It's

(Continued on

Doctors

(Continued from page 1)

Down's Syndrome or spina bifida, neither of which can be completely cured."

Wrongful-birth lawsuits typically are filed by the parents of a handicapped child. They contend a physician was negligent because he failed to perform diagnostic tests that would have revealed the handicap and perhaps convinced the parents to terminate the pregnancy rather than care for the child.

"With that as a cause of action, you place the medical community in a position where they have to test for every birth defect imaginable," said Herndon, who is a lawyer. "You're exposing the phy- cians to liability for damages th did not cause."

Such lawsuits are becoming increasingly common as legal precedents are set in more and more states, according to pro-life advocates, medical experts and malpractice insurance carriers.

A September 1984 decision by the Idaho Supreme Court in Blake vs. Cruz appears to have opened the door to wrongful-birth actions in this state, according to Uhlenkott.

In that case, Dr. Amado J. Cruz failed to diagnose or order a test for a case of German measles in a Kamiah woman who subsequently gave birth to a severely handicapped daughter.

"A physician whose negligence has deprived a woman of the opportunity to make an informed decision whether her fetus should be aborted should be required to compensate her for the damage he has . . . caused," the court said.

It's not clear how common such lawsuits are in Idaho. No reliable information on wrongful-birth actions is available from the Idaho Medical Association, the state Board of Medicine or the state Insurance Department.

"They're on the rise," said Barbara Reynolds, a spokeswoman for St. Paul Fire & Marine. The Minneapolis-based insurance company is the nation's largest malpracuce insurance carrier, with 14.6 percent of the U.S. market.

Legislation aimed at stopping the rise emerged here Thursday. House Bill 120 provides that there shall be no cause for legal action, and no damages awarded, for a doctor's failure to perform tests, reveal a handicap and provide information that leads parents to select abortion rather than a live birth.

"It only affects tests that would be used only to end the life of the child," said Dr. Steven Zielinski of Chicago, who is lobbying Idaho lawmakers and is affiliated with the Americans United for Life Legal Defense Fund.

"They (doctors) will never get off the hook if their actions are truly negligent," Zielinski said.

The bill would not prohibit prenatal diagnostic tests; a pregnant woman still could elect to have them performed.

But the decision to administer tests would be made on clinical grounds, rather than upon economic grounds, Zielinski said. Fear of wrongful-birth lawsuits forces doctors to administer the tests to nearly all their obstetric patients — whether or not they have high-risk pregnancies — as they build evidence to combat potential malpractice suits.

Pro-life interests believe such blanket testing not only encourages abortions of handicapped children, but carries other health hazards and economic consequences.

Amniocentesis carries an 8 to 10 percent risk of injury to the fetus, according to Zielinski.

"You may wind up creating handicaps which would not have existed otherwise," he said.

Uhlenkott noted the test also carries a 2 percent risk of spontaneous miscarriage, while mothers age 40 have only a 1 percent risk of bearing a child who suffers from Down's Syndrome. The risk of Down's Syndrome is lower for younger mothers.

Uhlenkott was citing statistics from a 1983 article by Dr. Hymie Gordon, a Mayo Clinic genetic researcher, that appeared in a newsletter published by the American Life Lobby.

Uhlenkott further noted that abortions performed because of information revealed in the test occur late during the pregnancy — at the 24th or 25th week — when risk of injury to the mother is high.

As for economics, spokeswoman Reynolds of St. Paul Fire & Marine cautiously said wrongful-birth actions contribute to increases in the cost of malpractice insurance.

Her company Friday imposed a 25 percent boost in the cost of such insurance for obstetricians and other doctors who administer prenatal care and deliver children.

In Idaho, St. Paul's new annual premium is $26,846 for an obstetrical malpractice policy affording $1 million protection. The company's rates for similar coverage range from $6,316 per year in Arkansas to $45,722 in Dade County, Fla., Reynolds said.

The December 1983 average nationwide for her company's obstetrical policy was $33,400, she said, and is higher now.

Idaho Medical Association Executive Director Don Sower said costs for malpractice insurance cover a wide range. He cited another obstetric policy that costs $12,000 per year, but noted that carrier has notified Idaho doctors to expect a rate boost of not loss than 30 percent in June.

Rep. Dean Sorensen, R-Po se, is a surgeon and past president of t IMA, and also sits on th [illegible] tee considering HB120.

Sorensen estimates at malpractice insurance add $500 to $1,000 to the patient's c st for a typical delivery.

"The pro-life people look at this a little differently than physicians," said Sorensen, who said he's heard of obstetrical malpractice rates rising as high as $80,000 per year in some states.

The effect of high insurance rates is not limited to increased health-care costs Sorensen said it also is forcing some doctors out of the baby business. That is particularly true for general practitioners and rural doctors, he said, who can buy cheaper insurance if they omit obstetrical care from their services.

"Of all the medical specialties, this is the one that's having the real problem," he said.

If the bill becomes law, Sorensen said, "I think most responsible obgyn people will still go through the motions of advising patients. I don't think it will change the methods of practice."

IMA director Sower said his group has taken no position on the bill, but it is before the board of directors for consideration.

"The abortion issue aside, most of them (doctors) support reducing doctors' liability," said Sorensen, who predicted the medical community will remain neutral or support the bill.

HB120 rests now with the House Judiciary, Rules and Administration Committee. Chairman Rep. Larry Harris, R-Boise, said the bill probably will come up for committee debate during the week of Feb. 11.

TORT

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

TO: ALL LEGISLATORS

FROM: CITIZENS' COALITION FOR TORT REFORM

SUBJECT: ENCLOSED DATA FOR YOUR USE AND REVIEW

Thanks,

Al Tamagni, Sr.
Chairman

738 H Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-7135

Who is the Citizens Coalition for Tort Reform?

The Citizens Coalition for Tort Reform is an organization composed of representatives from a broad cross section of Alaskan businesses and professions.

They include these companies, associations and agencies:

Alaska Air Carriers
Alaska Broadcasters Association
Alaska Chapter, American Institute of Architects (AIA)
Alaska Dental Society
Alaska General Contractors
Alaska Chapter, American Optometric Association
Alaska Movers Association
Alaska Oil Marketers Association
Alaska Rental Association
Alaska Section, Fairbanks Branch, American Society of Civil Engineers
Alaska Society of Professional Engineers
Alaska State Health Association (Hospitals)
Alaska State Medical Association
Alaska Support Industry Alliance
Alaska Truckers Association
Alaska Visitors Association
Anchorage Board of Realtors
Anchorage Restaurant and Beverage Association (ARBA)
Cabaret Hotel and Restaurant Retailers (CHAR)
Childbirth Educators
Daycare Operators Association
Fairbanks North Star Borough
Financial Managers
Hotel and Motel Association
Insurance Brokers and Agents Association
Nurse Midwives Association
Pension Consultants
Professional Physical Therapists Association
Risk Management Association
Southern Association of Life Underwriters

The Citizens Coalition for Tort Reform, Inc.

738 H Street, Suite 100
Anchorage, AK 99501

(907) 276-1135

TORT REFORM -- A COMPREHENSIVE SOLUTION TO THE INSURANCE CRISIS

Introduction

THE TAX THAT SKIRTS THE TAX COLLECTOR

A tort is literally a wrong. Tort actions seek to redress wrongs in a court of law. A close look at how the tort reparations system works 1986 reveals that it's not working. The system is mired in inefficiency, punctuated with greed and demonstrably unable to deal with the great bulk of its caseload in a timely and fair manner.

It often takes three to five years to settle a case. Only 30 to 40 per cent of the costs of reaching a settlement go to victims, and that does not include costs of the court system.

The economic costs to society are staggering and difficult to precisely quantify. It is clear that the hefty increases in insurance rates affect the price of nearly every product or service we purchase. *It is a tax -- a tax imposed by default, without full political and social evaluation of its impact.*

A society that can send men to the moon ought to be able to settle liability claims in a more effective way. Most other western countries do.

THE COMPREHENSIVE SOLUTION

The tort reparation system needs a thorough overhaul. Alaska can no longer afford the luxury of having its courts administer a giant lottery where a victim may win a fortune, but more likely will find the pot at the end of the rainbow empty.

Alaska and other states have been tinkering with the tort system for ten or 15 years and there is adequate evidence major changes in the tort reparations system is essential. *The fundamental goal of tort reform is to restore predictability to the tort system.*

All manner of solutions to insurance crisis have been proposed including tighter regulation of insurance companies, state-backed insurance funds and reform of the tort system. More regulation may be useful and a state-supported fund may provide temporary relief to some. However, *without stopping the flagrant abuses of the tort system, liability will continue to be a serious problem for business, government and consumers.*

The following proposals address the major faults of the tort system. They are intended to restructure the process to allow more efficient and effective dispute resolution. These reforms should get a higher proportion of damage payments into the hands of plaintiffs while protecting the rights of defendants and the public which ultimately pays the bills.

THE CITIZENS COALITION FOR TORT REFORM
738 H Street, Suite 100
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(907) 276-1135

News Media Contact:
Beverly or Ed Isenson
(907) 276-4600

JANUARY 1986a

ITEMIZED JURY AWARDS

Juries awards for damages should specify amounts for monetary losses, non-economic losses, future losses, past expenses and other losses. *This will help to eliminate arbitrary awards based upon showmanship or prejudice and introduce an element of rationality in award construction.* An itemized award which is grossly unfair to either the victim or defendant can be more effectively appealed than a lump-sum award.

RULE 82

Rule 82 is unique to Alaska. It is a device to increase attorneys' fees above the agreed level by order of the court. The rule was originally adopted to apply in certain public interest lawsuits, but it has been extended to cover most liability suits. *It simply adds up to 10 percent to the cost of awards without serving the originally intended public purpose.*

ARBITRATION

Tort litigation is time consuming and expensive. Claims under $50,000 should be required to go to arbitration before being heard in Superior Court. Either party would be free to appeal the arbitration decision to the courts, however the results of the arbitration could be admitted in evidence at any subsequent trial. *Experience indicates that the effect would be to reduce the number of cases going to court, lower the costs of resolution and ultimately get more money into the hands of victims without great delays.*

NOTICE OF POLICY CANCELLATION

Individuals, businesses and professionals have been suddenly cut off from their insurance programs. *Companies should be required to give 60-day notice of changes in coverage.* This would avoid drastic disruptions in people's ability to earn a living.

PRE-JUDGMENT INTEREST

Interest is often paid on awards. It should accrue from the date an action is filed. Currently, interest accrues in many cases from the date of the occurrence - even if no claim is filed for years. *A defendant should not be required to pay interest covering that period of time when he may have had no knowledge of his liability.*

WRONGFUL DEATH STATUTE

Where there are no dependents, wrongful death monetary awards should be limited to $25,000. *A wrongful death is always unfortunate, but it is questionable public policy which permits -- even encourages -- distant relatives and lawyers to reap a windfall at the expense of other policy holders and the public.*

A COMPREHENSIVE LEGISLATIVE SOLUTION TO THE INSURANCE CRISIS

JOINT AND SEVERAL LIABILITY

If more than one defendant is found partly responsible for an injury, each can be held "jointly and severally" liable for all damages. This means that if one defendant is unable to pay, the other defendants must pay the entire award. *Responsibility should be apportioned according to the degree of fault and each defendant's requirement to pay damages should reflect his share of responsibility for the injury.*

NON-ECONOMIC AWARDS

Non-economic awards compensate a victim for intangible loses -- loss of consortium, pain and suffering, traumatic experiences and other things for which no established economic value exists. *A limit on this kind of arbitrary award will help establish consistency and fairness in this no-man's land. We suggest a maximum award of $250,000 per incident.* **The U.S. Supreme Court has upheld such a law in another state.**

STRUCTURED SETTLEMENTS

Damages awarded for predicted future loses should be computed at their present economic value. The injured party would have an option to accept lump-sum payment at present value or accept structured payments running over a period of years and equal to the total award. *This guarantees financial support and care for a long time, often for life.*

COLLATERAL INCOME SOURCES

Insurance payments which have been made to an injured party should be disclosed to the jury and should be protected from recovery in the event the victim receives an award. *Under current rules, juries cannot be told about existing medical or other insurance coverage.* If the injured party receives an award, the insurance companies which have fulfilled their obligations may sue for repayment from the victim.

SLIDING CONTINGENCY FEES

Plaintiff attorneys today can take upwards of 40 percent of a total award verdict. A sliding scale will increase the proportion of the award which actually goes into the victim's pocket as the size of the award increases. *Where the sliding scale is now in effect, lawyers still work on contingency fees, but victims recover a greater share of awards.* **The U.S. Supreme Court has upheld this principle.**

PUNITIVE DAMAGES

Punitive damages is the civil justice system's way of punishing defendants for conduct particularly offensive to society., therefore, punitive damages should be paid to the State of Alaska. *Society as a whole should share the benefits of punitive damages (which are rarely covered by insurance).*

STATUTE OF LIMITATIONS

The current statutes of limitation must be clarified to make sure that lawsuits are brought within a reasonable time. Recent court decisions make it possible to file suits in the distant future, making risks totally unpredictable. **The alternatives to a functional statute of limitation are insurance devices which effectively establish these limits without benefit of public policy considerations.** *These devices (claims-made policies) can cause severely reduced public protection and even reduced availability of some goods and services.*

FRIVOLOUS SUITS/UNTRUE ALLEGATIONS

An Indiana woman purchased a box of Cracker Jacks. The usual prize was not in the box, so she filed suit against the manufacturer. Someone had to defend the suit, even if it was only to ask for dismissal. A responsible legal system should require that plaintiffs attorneys certify that the facts have been reviewed and there is reasonable and meritorious cause for filing the action. This certification should be made in writing. **Rules have been adopted by the U.S. Supreme Court and ten states to curb these abuses of our court system.**

FULL DISCLOSURE

Essential data should be made available to state regulatory authorities on a quarterly or semi-annual basis, to allow proper regulation of regulated companies regarding reserves, premium rates, loss ratio, investment and other data so as to properly protect people of Alaska.

by MORTIMER B. ZUCKERMAN
Chairman and Editor-in-Chief of *U.S.News & World Report*

THE NATIONAL LOTTERY

An epidemic of costly litigation is sweeping the country, and the time to halt it is now.

Witness the efforts of lawyers after any disaster, such as an airplane crash or the tragedy at Bhopal, India. They rush to the scene and descend upon the distraught survivors and relatives. They rent movie houses and auditoriums to make their pitch for clients. In law offices all over the country, lawyers are hard at work finding and convincing people to file suit. It used to be that lawyers tried to persuade their clients to settle disputes. No longer.

The pot of gold for lawyers is a huge fee or a participation of up to 50 percent in court awards. Staggering court awards in cases whose results seem to violate common sense have made it worthwhile for the lawyers. Recently, a man attempted suicide by jumping in front of a New York subway train. He sued the Transit Authority because the train stopped in time to save his life but not quite soon enough to avoid some physical damage to him. He collected more than $600,000.



And what about the tenant, celebrating his birthday on a Sunday afternoon, who drowned when he drunkenly tried to walk along the bottom of his apartment-house swimming pool in the full view of his wife and 15 close friends? His wife successfully sued the landlord's insurance company.

The result? Soaring premiums for liability insurance to cover this increased and indeterminate financial exposure. Legal costs and insurance have become an increasing component of the price of goods and services. Even the availability of some consumer services is being curtailed.

Personal-injury awards, especially jury awards, are out of touch with reality. They are often based on estimates of how much money the defendants have rather than whether they are at fault. The awards have become a means to redistribute wealth rather than a measure of fault or a deterrence to undesirable conduct. It may appear to a jury that an insurance company, individual, corporation or government with "deep pockets" is paying the claim. The truth is that millions of "little pockets" are actually paying the cost either through higher prices for products and services or through higher insurance bills.

It is time to re-examine the manner in which the nation's judicial system deals with injured parties.

First, a method must be developed to tilt the judicial system against increased litigation. One approach would be to compensate a successful defendant for the cost of the defense against an unsuccessful plaintiff. The obvious benefits would be a more serious and thoughtful analysis of a claim prior to bringing a lawsuit and a reduction in the number of frivolous claims. It would also bring pressure to bear on achieving a reasonable settlement of the matter prior to running up large legal fees.

Second, the states should follow the example of California in limiting contingent fees to lawyers. These fees theoretically balance economic power for those who cannot afford the cost of bringing a case on an hourly basis. In practice, however, contingent fees have fostered an atmosphere of a no-cost lottery for clients. The California bill caps the contingency fees at 40 percent of the first $50,000 of the settlement, ranging downward to 10 percent of any award above $200,000.

Third, damages awarded for "pain and suffering" and other noneconomic losses should be capped. California has set a limit of $250,000, controlling the awards in medical-malpractice suits for such vague matters as grief, mental distress, etc.

One of the great principles of American jurisprudence has been access to justice through the court system. But the right to swing your arm stops at the point of another man's chin. The right to access to the courts must not be permitted to bury our society under a mountain of legal pleadings that raise insurance bills for all. To permit this abuse is to turn the courts into a national lottery in which the winning names are the lawyers and certain plaintiffs who are picked by judges and juries, while each of us, every day, is the loser. ■



MALPRACTICE BATTLES
Surgeon Donald Stewart has fought off six suits



BARTENDER RISKS
High premiums forced Washington, D.C., bar owner Jim Stiegman to go without insurance



HOMEOWNER WOES
Helene Harris's pet nearly cost her insurance coverage

Sky-high damage suits

The impact on consumers, business and professions

A seriously injured California gymnast wins $14.7 million in a suit against an exercise-mat manufacturer.

Half of the 10 doctors doing obstetrics work in Montrose, Colo., stop delivering babies when insurance rates soar.

A New Jersey couple must pay $72,500 to a woman hurt when a man who had been drinking at the couple's home smashes his truck into her car.

In Minnesota, a farmer cancels a live Nativity scene when an insurer asks a $540 premium in case someone is injured by a donkey and horses carrying Mary and the Wise Men.

It seems that everyone is liable these days. Juries return costly verdicts against homeowners, million-dollar awards against professionals and huge assessments against manufacturers. A new national study by Ohio-based Jury Verdict Research, Inc., reports the dollar amount of awards in personal-injury cases up 15 percent in 1984. Courts issued 401 verdicts exceeding $1 million that year, the latest for which statistics are available. A sampling shows liability suits filed in state courts jumping by 20 percent or more over seven years, according to the National Center for State Courts.

"We are in the midst of an unprecedented liability crisis," says Barry Bauman of the U.S. Chamber of Commerce. To cope, insurance firms have been raising premiums sharply since 1984—sometimes by 1,000 percent or more at a clip—drastically reducing coverage and sometimes pulling out altogether. Companies in turn are abandoning lines of business, operating without insurance or hiking prices of products to cover premium costs. "Companies don't pay the cost of product-liability suits—consumers do," says Martin Connor, Washington, D.C., attorney for General Electric Company. Manufacturers say 20 percent of the cost of a $25 stepladder goes to insurance. A similar proportion in the airplane industry was one reason Beech Aircraft Corporation quit making a small training aircraft.

Meanwhile, obstetricians and surgeons are walking away from their practices rather than paying insurance premiums of up to $50,000 or more a year. States, cities and school districts spend large sums to satisfy judgments and drop risk-laden services such as recreation programs.

The turmoil springs from changes in the law and society. No longer is the decisive question whether the party sued—the defendant—negligently harmed someone. The question now centers on how much the plaintiff ought to be compensated for injuries. Judges constantly expand "common law" to create new grounds for suits, and citizens in a more impersonal world look to courts to solve problems. They are aided by a corps of 700,000 lawyers—roughly 1 for every 350 Americans—who collect some $55 billion a year in fees. The spread of liability insurance also has led to a mind-set that no one really gets hurt by the barrage of suits since insurers will pick up the bill.



Critics contend that the system has gone out of control. Richard Willard, chief of the Justice Department's civil division, charges that some judges and lawyers are utilizing the courts in such a way as "to restructure





◄ Dr. Daniel O'Keeffe, far left, no longer delivers babies and complains about "practicing with a gun at your head"

◄ Consumer advocate Ralph Nader says rate hikes for liability insurance amount to a "ripoff"

► Doctors, trying to avoid litigious patients, can check computer file of malpractice claims

society and administer a massive scheme for the redistribution of wealth."

Trial lawyers and consumer spokesmen such as Ralph Nader argue that the problems spawned by expanded liability have been exaggerated. The real villains, they say, are property and casualty insurers who are trying to use an attack on the courts to line their own pockets. "What we are witnessing is a manufactured crisis, intended to bloat insurer profits and reduce victim rights," contends J. Robert Hunter, president of the National Insurance Consumer Organization.

Some consumers argue, too, that the spurt of damage claims serves as a warning that providers of goods and services must maintain high standards—or suffer the consequences. "The liability system ought to hurt. It ought to encourage people to modify their behavior," says Gary Schwartz, a law professor at the University of California at Los Angeles.

Whichever side is correct, liability will be a major issue this year in Congress and many state legislatures.

Liability's lengthening shadow

Anyone from Uncle Sam to Uncle Harry is open to suit, now that the mood of society is to seek a cure for all of life's mishaps.

A New Jersey court said merchants could be held liable if a customer's dog bit another patron, and a Philadelphia insurer, fearing legal action over an allegedly vicious dog, threatened cancellation of Helene Harris's homeowner's policy. A Maryland court held that handgun makers could be forced to pay damages resulting from a shooting. A California policeman agreed to pay damages when the woman who bought his house complained he hadn't disclosed five murders committed there 12 years earlier. After a man flying on a charter flight made a mock announcement that the plane would crash, a passenger won damages in Minnesota for emotional distress.

Employes injured on the job, no longer satisfied with workers' compensation, now often sue not only their employers but also the makers of the equipment involved in the accident. Companies complain that they are caught in a bind when faced with a claim over machinery made years ago that may have been altered or poorly maintained. "How do you design something to last forever?" asks Gary Bell, product-safety administrator of Toledo-based DeVilbiss Company.

Lawsuits over industrial machinery are just a tiny part of a vast arena of litigation. The number of product-liability suits filed in federal courts has jumped from 1,600 in 1974 to 13,554 last year. A major source of product-liability cases is chemicals and drugs said to cause harm that may not be detected until years after exposure. More than 30,000 damage claims for lung ailments and cancer allegedly caused by asbestos have piled up around the country. Millions of dollars in damages already have been paid out, and the threat of other pending cases has sent the huge Manville Corporation into a bankruptcy reorganization.

Filing a similar bankruptcy claim was Virginia-based A. H. Robins Company, which has set aside $1 billion to satisfy claims by 15,000 women over damage caused by the intrauterine contraceptive device called the Dalkon Shield.

For professionals: A malpractice meat grinder

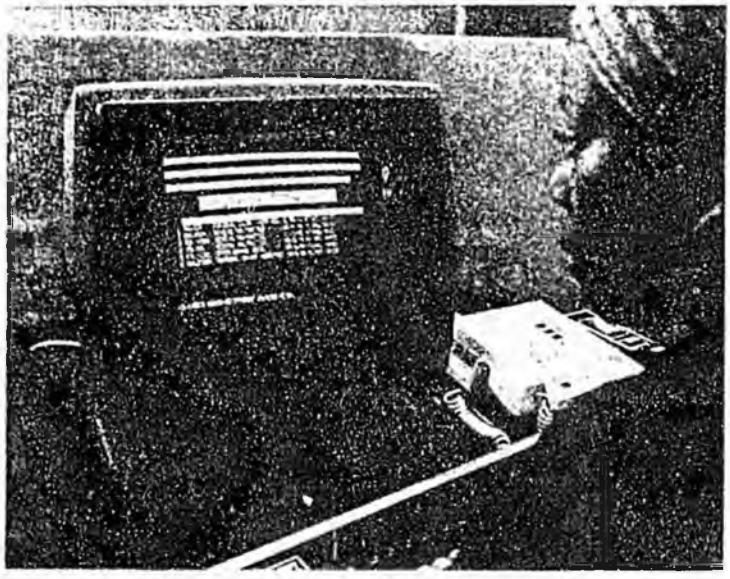
Major corporations usually have vast resources to draw upon in combatting the litigation wave, but few doctors, lawyers, accountants or other professionals dragged into court have that cushion. Malpractice claims against physicians have more than doubled in a decade, reports the American Medical Association. Although more than half are dismissed, there have been 367 verdicts of a million dollars or more against doctors over the years, and the average settlement costs defendants $330,000. Malpractice-insurance premiums exceed $2 billion annually.

The irony is that improvements in the quality of care can encourage lawsuits. Defense lawyer James Ludlam of Los Angeles notes that "infants with severe brain damage who would have died three years ago now live, but the parents—or society—are faced with lifelong care. I can't think of anything more expensive."

Obstetricians in New York State saw their malpractice premiums increase by an average of $21,635 last year, amounting to 16 percent of their gross income. Some have decided to quit. After four suits were filed against him, obstetrician Daniel O'Keeffe of Glens Falls, N.Y., said enough was enough. He hasn't lost a case, but, O'Keeffe says, "I decided that at age 64 I did not wish to expose my personal assets and life savings to a mishap that would wipe me out. There is also the emotional factor: Practicing with a gun at your head."



Syracuse neurosurgeon Donald Stewart has successfully defended six suits in 15 years. He is dismayed by the expectations of today's patients, recalling one 16-year-old boy who remarked to his father during an examination, "Think how much money you'd get if he screws up."





To sniff out proclivities toward suing, some doctors are attempting to screen their patients. In Los Angeles, some now use a computerized service called Physicians' Alert to identify patients who have filed malpractice claims. Tit for tat, lawyers are setting up a hot line warning patients about the lawsuit records of doctors.

Trial lawyers argue that malpractice litigation reflects rising medical negligence. But a recent study by a Pennsylvania committee comprising doctors and lawyers laid the problem to a combination of things, including an inability by the medical profession to discipline repeat offenders and excessive damages awarded in a few cases.

When lawyers aren't suing other professionals for malpractice, they may be defending themselves against it. In October, a court affirmed a $26 million judgment for actress Doris Day in a suit accusing her former attorney, Jerome Rosenthal, of an investment and legal-fee swindle. More-typical suits allege foul-ups such as failing to pursue worthy cases and missing deadlines for filing court papers.

No profession seems immune, from accountants and architects to teachers, therapists and even clergymen. The Big Eight accounting firms paid nearly $200 million in the past five years in malpractice suits and face $2 billion more in claims. A San Jose, Calif., minister faces a $5 million suit by a woman who charges that he violated her privacy by disclosing her confession that she had embezzled church funds. Last year, the Vermont Supreme Court held a therapist liable for the burning of a barn by a patient who had told her he wanted to get back at his father. The court said she had a duty to protect third persons.

Legal theory opens the floodgates

The big verdicts stem almost in equal measure from a loosening of standards for proving liability and the ever growing resourcefulness of lawyers in finding new places to collect damages. Rules that shielded defendants from liability have eroded as judges have given persons filing suits the benefit of the doubt. At the same time, the growth of insurance has encouraged juries to award huge sums in the belief that someone else will end up paying the bill.

Plaintiffs now win damages by linking products to health problems even when there is no proof that the products caused harm. Thousands of Vietnam War veterans charged

NEIGHBOR VS. NEIGHBOR

From playmate to plaintiff

Staten Island, N.Y. What started as a pleasant summer day of child's play in 1972 at Morris and Rosalyn Friedman's house turned into a nightmare of lawsuits that lasted a decade.

Neighborhood children had a standing invitation to play with the Friedmans' five children in the back yard of their modest, ranch-style home. One of the visitors—9-year-old Sylvia Ashwal—was being pushed on a swing by playmates Deborah and Lisa Rosenberg when somehow she broke her leg. Rosalyn Friedman took her to a hospital and thought the episode would be forgotten.

But three years later, the Friedmans were surprised to be cited in a lawsuit. "We were shocked," remembers Morris Friedman. "We had thought things were over and done with."

The Friedmans weren't the only ones sued. The Rosenberg children also were named, as were Sears, Roebuck, which sold the swing, and Turco Manufacturing Company of Illinois.

From the vantage point of Joseph and Eva Ashwal, seeking recompense for their daughter's injury became the logical option when the fractured leg stopped growing. Even an operation on her good leg couldn't prevent a limp and back problems.

"I was in pain all the time," Sylvia says. "I still can't sit or stand very long. I get fidgety and have a lot of back pain."

The pretrial maneuvering dragged on. Sylvia's legal team—led by New York trial lawyer Fred Queller—contended that the swing was so poorly designed that Sylvia's leg easily became caught between the seat and a platform below.

Turco and Sears both countered that the accident was Sylvia's fault: She was standing up when she shouldn't have been and fell down. The Friedmans and the Rosenberg children maintained that they didn't cause the mishap.

In the end, an accident that occurred in seconds took three weeks to sort out before a jury in November, 1984. The verdict: $2.5 million for Sylvia, mostly to cover medical care. Turco was ordered to pay 80 percent, Sears 20 percent. The neighbors were cleared. To avoid a long and costly appeal process, the companies chose to settle the matter last summer by paying the Ashwals $1.35 million—a third going to attorney Queller.



Suit over backyard injury shocked the Friedmans

The defendants regard the ordeal as Exhibit A of modern-day litigation run amok. Friedman, who worried about losing his home if a verdict exceeded his $100,000 insurance policy, says, "I now carry a $10 million policy. I don't take chances any more."

James Lysaught, attorney for the Rosenbergs, says they had to endure "the horror of the incident and the horror of being sued."

Harold Berel, Turco's lawyer, believes the many years it took to bring the case to trial made jurors sympathetic to the injured plaintiff. As for Sears: "It was an outrageous verdict," says attorney Suzanne Hyer.

by Dan Collins

that the defoliant Agent Orange had caused birth defects in their children. Chemical firms agreed to pay $180 million even though the judge noted that there was no conclusive evidence that the chemical was responsible.

Others are found at fault, in effect, just for being in a particular line of business. In Michigan, for example, 16 drug firms have agreed to share in payments to 240 women who suffered abnormalities because their mothers took a drug called DES years earlier. Too much time had elapsed to determine which firm made the DES taken by any individual, so all the companies were dragged in. "The plaintiff can sue the bunch, and it's up to them to prove they weren't involved," says Detroit lawyer Charles Nichols.

Workers in chemical plants are winning claims based solely on the fact that the risk of becoming ill has increased. Employes of firms where asbestos was prevalent have won cases alleging that their chances of contracting serious lung ailments are much greater, even if they do not suffer now. Some lawsuits charge that the fear of becoming ill is so terrifying that recompense is warranted.

A statute aimed at organized crime—called the Racketeer Influenced and Corrupt Organization Act, or RICO—provided litigation fodder when lawyers discovered its language is so broad that suits can be filed against just about any corporation if they claim a pattern of illegal activity such as fraud. Triple damages are authorized—a payoff that has encouraged thousands of claimants to march into court. Few judgments have yet been awarded, but suits are pending against such firms as Shearson Lehman Brothers and Price Waterhouse.

Personal-injury lawyers also are adept at finding "deep pockets" with resources to pay big judgments. With a campaign against drunk driving gathering steam, the number of cases being pursued against bars and restaurants over damage caused by intoxicated patrons has gone up 300 percent in the last year, reports Massachusetts lawyer Ronald Beitman. Laws in 35 states hold liquor purveyors liable for such injuries. Last year, insurers of a Clarkston, Mich., café agreed on a $1 million settlement to families of three teenagers killed in an auto accident with a café patron. Noting that insurance costs have tripled in the last year, café owner Don Hayes says he now cites the case when refusing drinks to tipsy customers.

Supreme courts in Iowa and New Jersey have gone a step further by holding private hosts liable for injuries caused by guests, and the Michigan Supreme Court held a bar responsible for a patron's death in a car crash.

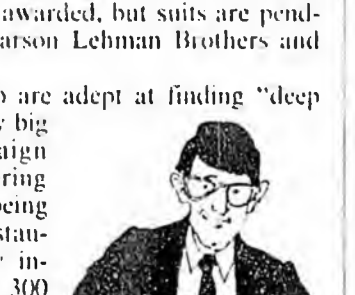
High crime rates have spawned suits by victims against hotels, apartment landlords and stores blamed for providing inadequate security. Spurred by the $1.5 million award that singer nie Francis won from a motel where she was raped, sec cases are so widespread that they produced more than million in damages in the last three years, reports Vir lawyer Frank Carrington.

Whenever new concerns develop in society, they us end up in court. The latest example is AIDS. An al lover of the late actor Rock Hudson has sued his esta the ground that Hudson failed to disclose that he ha deadly disease. Suits also have been brought against pe for spreading herpes and other infectious ailments.

Another rapidly expanding tactic is to go beyond pensation for actual harm—such as payment for me bills and missed work—and to demand damages for tional distress. States for years have allowed money aw



Agent Orang



Before you file suit . . .

Another motorist hits your car, sending your child against the windshield. The bill for medical care: $6,500. Your lawyer promises a hefty recovery, but discussions with the other party's insurance representative go nowhere. You're tempted to go to court, but your child may be in college before you recover a penny. Then, too, because of legal costs involved, it often does not pay to pursue in court a claim of less than $10,000. Just what are the alternatives?

In 22 states, no-fault auto insurance eliminates most auto-injury litigation and provides more compensation faster. In 16 states, your case, as well as other civil disputes in which damages are under $15,000-$25,000, probably would go to an arbitration proceeding with your right to trial preserved if you didn't accept the award.

If the other driver were uninsured, your policy might call for a hearing by the American Arbitration Association. The group also promotes mediation of auto-injury disputes and reports settlements in 90 percent of such cases. In other states, such as Illinois, court-appointed mediators steer both sides toward a settlement.

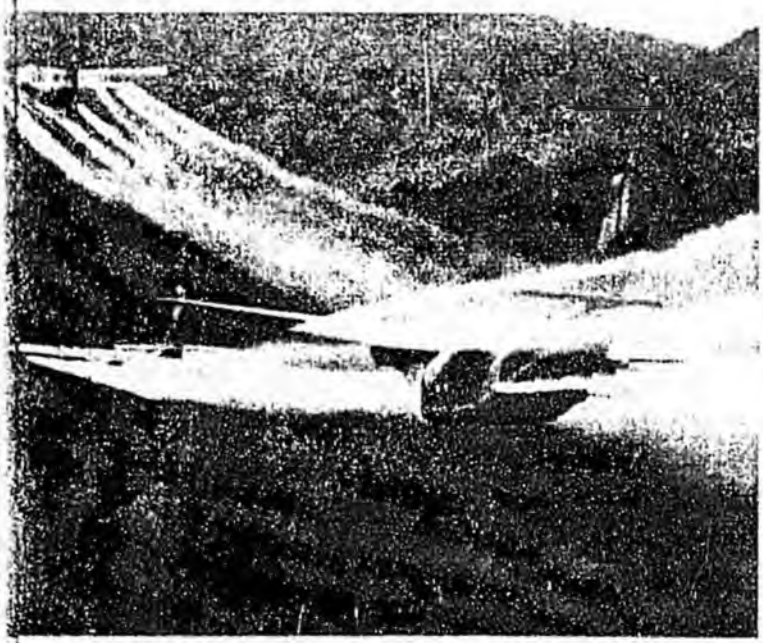
Private firms, such as EnDispute of Washington, D.C., offer another option. For a $200-to-$425 fee per party, the company will help arrange a private, voluntary settlement conference before a neutral adjudicator, usually a retired judge. Federal District Court Judge Thomas Lambros of Cleveland has designed the "short jury trial"—copied elsewhere—featuring a half-day trial before six jurors, who hear arguments from both sides with no live testimony by witnesses. Most parties settle on the basis of the jury's advice.

If you get sued . . .

As often as not, people are caught by surprise when a liability suit hits. Some guidelines for action:

- Call your insurance agent immediately, since your auto or home coverage is your first line of defense.
- Don't talk to the plaintiff's lawyer. You could make a mission damaging to your Report any contacts by th er side to your insurer.
- Keep any notes or p that you may have taken time of the incident leadi the suit. If it was an auto dent, get as much inform as you can about the d and cars.
- If you have no insuran your insurance does not the matter for which you a ing sued, you need to find own lawyer. Ask friends a sociates for their recomm tions and interview your spective lawyer, discu





Vietnam and prompted lawsuits against chemical makers

for "pain and suffering," a term encompassing a victim's anguish that is not reflected in a doctor's bill.

Now, it is common for lawsuits to make claims for mental harm resulting from a mishap even if the plaintiff was not injured. Family members are suing over the trauma of witnessing an accident in which a loved one was killed or injured. The Ohio Supreme Court ruled that a claimant need not even be at the scene. Suffering distress over a family member's fate may be enough to sue those responsible.

A change of attitudes in society

Why do new theories win such support? One reason is that Americans have become more insistent on finding remedies whenever anything goes wrong. "People want to get back at whoever they perceive is the cause of injustice," says Bruce Wackowski of the Research Institute of America.

In years past, people tended to resolve disputes informally, whether the argument was with the corner dry cleaner or the family doctor. In today's more complex and more mobile society, there are more demands that the law settle disputes in all facets of life. Big damage awards and new remedies create fresh demands. "At the end of the process, what people come to expect is a higher level of justice—social justice, life justice," says Prof. Lawrence Friedman of Stanford University Law School in a new book, *Total Justice.*

In situations where many used to accept adversity, the first move now is to call a lawyer. Legal help is easier to get these days than ever. With an explosion of the lawyer population has come a scramble for business that often includes newspaper and broadcast advertisements or mail solicitations. Also, notes Professor Schwartz of UCLA, "the ability of plaintiffs' lawyers to prove their cases has greatly improved, and in mass injury cases they have learned how to collaborate."

Leading the campaign for expanded liability concepts is the Association of Trial Lawyers of America, a Washington-based organization of 60,000 attorneys for plaintiffs. The group helps lawyers exchange tips on promising subjects of lawsuits and techniques to win them. A convention the group is holding in late January features such programs as "the expanding responsibility of hospitals" and "enforcing landlord's duty to protect tenants from crime."

The largest legal group, the American Bar Association, also supports the way courts handle personal-injury suits. An ABA committee last year praised the "resilience" of the law in responding to social change, a development credited in part to "imaginative lawyering."

To critics, some of this innovation is reaching absurd proportions. They cite a suit by a California tree trimmer who charged that eating Hostess cupcakes and similar products had given him "toxic-junk syndrome." A Pennsylvania mother whose baby choked on peanut butter alleged that the makers should have warned of the danger to infants.



Legal scholars note that what may seem farfetched now may be routinely accepted later. "A black's

your case and the fees. Lawyers typically charge $50 to $150 an hour to defend personal-injury cases. If the case goes to trial, expect to pay upward of $10,000.

An ounce of prevention, however, can save you a fortune. For example:

- Consider buying "umbrella" liability insurance that would kick in after your auto or homeowner's policy limits have been reached. Such coverage is relatively inexpensive—$80-$120 annually for a million-dollar policy—and covers both home and auto-related incidents.
- Use vigilance and common sense. Inspect your property for hazards. If your child invites friends over, you're responsible for their safety. If you serve cocktails to guests, you could be liable if they drive drunk and have an accident. And keep your animals under control. The "one free bite" allowed by law in many states is fading fast.

Take a bureaucrat to court

Gloomy reports of government red ink haven't stopped many people from viewing the bureaucracy as a rich target. Here are three recent cases.

- A disabled weather buoy off Massachusetts failed to send a storm warning. A judge ordered the U.S. to pay $1.2 million to families of fishermen lost in the maelstrom.
- Police in Torrington, Conn., didn't step in to prevent an estranged husband from beating his wife. She sued the city and won nearly 2 million dollars.
- A speeder in Antioch, Calif., hit a light polo. An injured rider argued that the pole should have broken on impact and won a $400,000 settlement.

A key reason for the trend is a series of court rulings and laws reducing immunity from suits that government long has enjoyed. As a result, states and cities face huge insurance-premium increases. Oak Park, Ill., schools now pay $24,303 annually, four times the price two years ago. Plymouth, Calif., closed its swimming pool and fired its two-person police force for fear of lawsuits.



In the face of premium hikes as high as 1,100 percent, 32 California cities now insure themselves. Cities in nine states have organized insurance pools to share the risk.

At the federal level, claims against agencies total $277 billion, including thousands of cases of World War II shipyard workers exposed to asbestos.

Liability insurance bills

Typical annual premiums—

- Big Eight accounting firm in New York, $5 million
- Wisconsin dairy, $1.5 million
- Illinois bank, $1 million
- California law firm, $700,000
- Georgia engineer, $24,000
- Maryland surgeon, $17,000
- Pennsylvania auto-body shop, $13,000

charge in 1950 that segregated schools were unconstitutional would have been considered frivolous," remarks Prof. Ronald Allen of Northwestern University Law School. Others point to the asbestos cases, regarded as questionable when they were first filed two decades ago. Now, they are threatening the financial health of major corporations.



Lawyer Melvin Belli has earned fame in injury cases

In the jaws of a money machine?

Defendants are quick to scoff at any notion that a higher justice is being served by the liability crunch. They see themselves as victims of a system geared more to encourage giant verdicts than to weigh fault. The public seems to agree. A new Roper survey found that nearly half of Americans believe that courts tilt toward injured persons. About one third believe the system is fair to both sides. Only 5 percent say defendants have the edge.

Most businesses and professionals insist they will compensate persons they harm. But they assail unpredictable behavior of judges and juries, and a costly and time-consuming legal system that may force them to settle cases even when blameless—driving up insurance rates.

At dozens of White House conferences around the nation on small business, liability has emerged as "just about the biggest issue," reports coordinator Robert Leitao. In Willard, Ohio, Glen Ward was forced to run his Thundering Wheels Skating Arena "bare" after his insurance expired in December. Although Ward has never been sued, the lowest rate he could obtain was for $17,000, more than seven times his old price. In Des Moines, Iowa, Dwayne Van Oort reports that profits in his Northwest Erection Services construction business have been "wiped out" by a $250,000 increase in insurance premiums. Van Oort is tacking 5 percent onto current bids to cover the added costs. "Liability insurance is not a luxury item but a necessary expense," says Frank Swain of the Small Business Administration, who predicts that some firms will reduce payrolls or limit expansion to pay the bill.



Are these big bills warranted? Many consumer advocates contend that they are not. "It's a staggering ripoff," says consumer activist Nader, who insists that when items such as capital gains and tax credits are factored in, the industry made a $5 billion profit in 1985, a year in which insurance stocks rose by more than 50 percent.

Insurers declare that the increases are justified, pointing out that property and casualty firms reported record pretax operating losses of $5.5 billion last year. The industry is in "rather fragile financial condition," contends Mavis Walters of the Insurance Services Office.

To keep big verdicts from driving rates still higher, defendants are fighting lawsuits with a variety of tactics, chief among them an aggressive stance in court. For example, a Tennessee judge and a California jury were convinced that cigarette makers were not to be held accountable for smokers' illnesses.

Losers often appeal and get big verdicts tossed out. A Yale University study found that U.S. appeals judges void lower-court judgments in nearly half the cases. Over all, reversals do away with 51 percent of verdicts favoring plaintiffs but only 20 percent of defendants' verdicts.

Another tactic is to sue insurers for "bad faith" in jacking up premiums or refusing to pay claims. In one such case, insurers wouldn't pay off after a fire at the MGM Grand in Las Vegas killed 87 and injured hundreds. The hotel and victims recovered $76 million in a settlement.

More businesses and professionals are forming their own "captive" insurance companies. Nurse-midwives, whose underwriters abandoned them, will open one such firm in April. A consortium of 33 corporations, including IBM, General Electric and Shell Oil, is doing likewise. But success is not guaranteed. Some "bedpan mutuals" created by doctors in a malpractice crisis a decade ago are now close to insolvency.

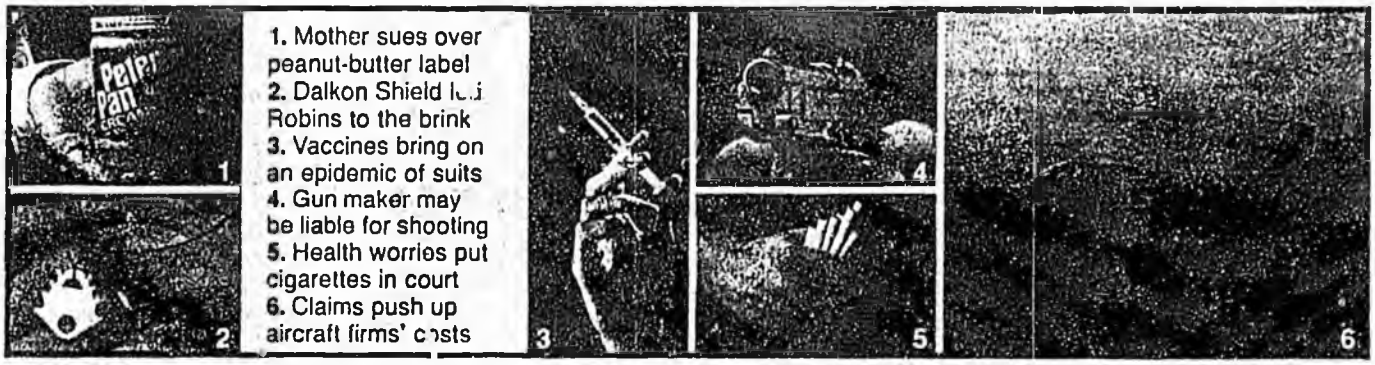
The search for solutions

When insurers, businesses and professionals aren't litigating, they are lobbying. They have massed to storm Congress and statehouses, seeking an array of changes in the law.

Capitol Hill debate centers on a plan to set national rules for product suits. A Senate panel deadlocked over the bill last year after trial lawyers opposed it. A new version stands a better chance. It gives victims the option of collecting damages out of court without proving a firm at fault and is backed by consumer groups who say the first bill favored business.

Most of the furor is erupting in the states. Says Colorado

Targets of legal opportunity



1. Mother sues over peanut-butter label
2. Dalkon Shield led Robins to the brink
3. Vaccines bring on an epidemic of suits
4. Gun maker may be liable for shooting
5. Health worries put cigarettes in court
6. Claims push up aircraft firms' costs



Senate President Ted Strickland. "It affects every walk of life."

Among remedies being considered by states are ceilings on jury awards and fees of plaintiffs' lawyers. The U.S. Supreme Court upheld California laws dating from the 1970s. The Court affirmed a limit of $250,000 on damages in malpractice cases for anything beyond out-of-pocket expenses, as well as limits on legal fees. Montana limited "punitive" damages—assessments by juries to punish defendants for wrongful acts and to serve as deterrents. Other reforms under study:

- Calculating interest on damages from the day a case is filed to discourage defendants from stalling.
- Forcing losers of cases that judges consider weak to pay the winner's legal fees and court costs.
- Fining those who pursue frivolous cases. The Supreme Court ordered an Indiana lawyer to pay a $500 penalty for backing a worker's challenge of salary withholding for taxes.
- Stopping payments for medical care when a victim dies. A Virginia doctor is appealing a $2.5 million award for the care of a brain-damaged girl who died a month after the verdict.

Insurance practices may also be overhauled. Some states will regulate insurers more carefully to keep rates sound.

Interest groups are increasing their activities. Insurers have helped set up "civil-justice reform" drives in a dozen states to build support for new laws, and a coalition of groups hardest hit by lawsuits announced a national campaign on January 16. Defendants are expecting help from the Reagan administration, where Atty. Gen. Edwin Meese has named a panel that is likely to offer proposals this year that coincide with many being circulated by business owners.

Lawyers, who have the most to lose from changes in the legal system, are becoming more involved, too. They fear that the increasing number of "horror stories" about big verdicts and canceled insurance may turn the tide against them. To counter anecdotes suggesting never ending liability, lawyers cite a new study for the American Insurance Association showing that overall costs in personal-injury cases over the last 50 years have risen at about the same rate as workers'-compensation payments and health-care costs and less than half as fast as Social Security.

Despite such moves, no one expects quick solutions to a crisis that took decades to build. In the meantime, juries will continue issuing verdicts that make millionaires of some Americans while sending others into bankruptcy. ■

by Ted Gest and Clemens P. Work with the magazine's domestic bureaus

Should lawyers' contingency fees be limited?

PRO

Interview with Grant DuBois, chairman, National Coalition for Litigation Cost Containment

Q Mr. DuBois, why limit the contingency fees that lawyers receive in liability suits?

Contingency fees, which can amount to 40 percent or more of the money awarded to plaintiffs, are principally responsible for the explosion of huge verdicts and the logjam in our courts. The principle of strict liability allows lawyers to collect hundreds of thousands of dollars for what often amounts to very little work.

We run the risk of creating an insuranceless society because the threat of liability suits has caused insurers either to drop coverage or charge sky-high rates.

Q What reforms is your group proposing?

One example is a California law on medical malpractice, recently upheld by the U.S. Supreme Court. The statute provides a scale of maximum fees a lawyer can collect—40 percent of the first $50,000, 33 percent of the next $50,000, and so on.

Q Would lawyers refuse to take cases if fees were limited?

Some would, but the oversupply of lawyers assures that someone would take the case. If there is a reluctance, it might be a sign to the plaintiff that the case does not have sufficient merit.

Q Aren't chances for limiting lawyer fees rather slim?

Reform won't be easy, but the public has finally awakened—thanks to the publicity surrounding such developments as U.S. lawyers traveling to India in search of big fees in the Bhopal case.



CON

Interview with Peter Perlman, president, the Association of Trial Lawyers of America

Q Mr. Perlman, why do you oppose limiting the amount of fees that lawyers can earn in damage suits?

The contingency fee is the victim's key to the courthouse. It allows the person suffering from a tragedy to get a lawyer with the same abilities as the well-paid attorneys who represent the wrongdoer—often a rich and powerful corporation or special-interest group. Some cases require much expense and preparation. When you consider the chance of losing, in which case the lawyer gets nothing, the one-third contingency fee is most reasonable.

Q Why not go to a system, as in California, where the lawyer's percentage of the money awarded a victim decreases as the amount gets larger?

It denies severely injured people the right to the most effective counsel. It is not the victim who complains about contingency fees; it's the wrongdoer and insurance companies. Victims see the system as fair.

Q Haven't aggressive trial lawyers forced insurers to cancel coverage and raise rates tremendously?

That's absolutely incorrect. The so-called insurance crisis can be traced primarily to the drop in interest rates, which limits the investment income of insurance firms. There was no claim of a crisis in the late 1970s, when interest rates were high. Insurers were reducing their premiums to get a bigger market share. Rather than basing premiums on expected losses, they based them on expected investment return, and now that's come back to haunt them.



The open season on insurance companies in courtrooms all over the country has gone on so long that the insurers can no longer afford to play. Are you ready for . . .

A world without insurance?

By Jill Andresky with Mary Kuntz and Barbara Kallen

A 41-YEAR-OLD bodybuilder entered a footrace with a refrigerator strapped to his back to prove his prowess. During the race, he alleged, one of the straps came loose and the man was hurt. He sued everyone in sight, including the maker of the strap. Jury award: $1 million.

Two Maryland men decided to dry their hot-air balloon in a commercial laundry dryer. The dryer exploded, injuring them. They won $885,000 in damages from American Laundry Machinery, which manufactured the dryer.

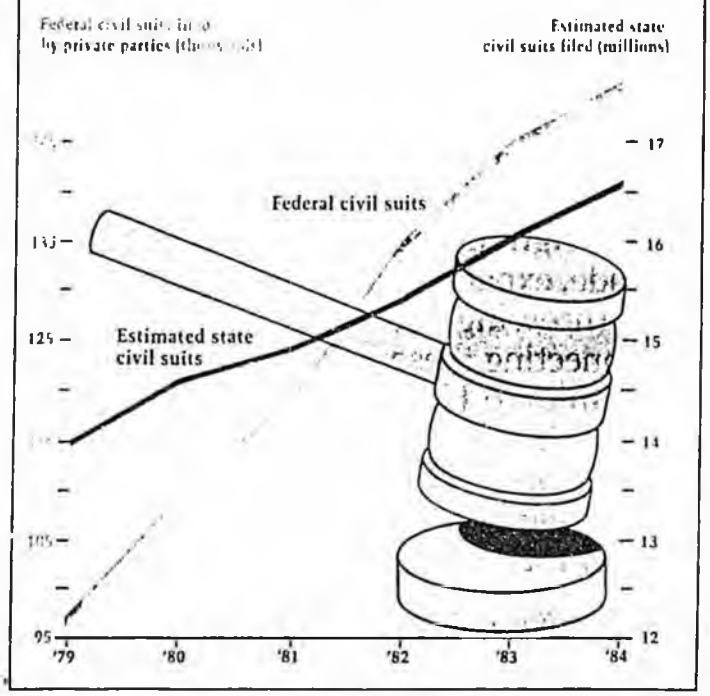
An overweight man with a history of coronary disease suffered a heart attack while trying to start a Sears lawnmower. He sued Sears, charging that too much force was required to yank the mower's pull rope. A jury in Pennsylvania awarded him $1.2 million, plus damages of $550,000 for delays in settling the claim. (Sears appealed but eventually settled out of court.)

Isolated cases of absurdly generous awards? Far from it. Last year the average product liability award in the U.S. was $1.07 million—up from $345,000 ten years earlier—and the average medical malpractice award was $950,000. In 1983 alone 360 personal-injury cases were settled with million-dollar awards or more, an incredible 13 times the number in 1975.

Americans now seem to look on a civil suit against a corporation or municipality as a kind of lottery—a lottery to be played whenever they can. Last year there was 1 private civil lawsuit filed for every 15 Americans. An estimated 16.6 million private civil suits were tried in state courts last year. Another 150,000 private civil suits were tried in federal courts, which is nearly twice the number ten years ago.

The litigation burden

There was 1 private civil lawsuit last year for every 15 Americans. And the beat goes on: Federal civil filings by private parties are up 50% since 1979, while state filings are up 20%.



Just handling the paperwork probably cost taxpayers over $360 million on all these actions last year. It cost insurance companies far more. In 1984 the property and casualty insurance industry as a whole paid out $116.10 for every $100 received in premiums—the worst numbers since the San Francisco earthquake and fire. Reinsurers, who take the brunt of the unpredictable risks, paid out nearly $141 for every $100 in premium income.

No industry can keep that up for long. "It's impossible for insurance companies to price liability products when they have no idea what the settlements and risks are going to be," says David O'Leary, a Hartford-based insurance analyst with the London brokerage firm of Fox-Pitt, Kelton. "Courts have expanded the definitions of liabilities for accountants and other industries to such an extent that insurers have started saying, we don't need the business."

For example, obstetricians can now be sued for "wrongful birth" if, for instance, a sterilized woman conceives. Accountants can be sued under "third party liability" by anyone who might reasonably have relied upon numbers they audited. The list goes on and on, and why not? Insurers have been picking up the tab and covering costs in part through their investment income for so long

that the system has taken on the look of natural law.

But insurers are not in the business of losing money. Their losses have become so appalling that at this point they are either raising their rates out of sight or getting out of the business. In April, Utica Mutual Insurance informed some 229 New York State municipalities that it would not renew their policies. Transit Casualty, a large carrier for restaurants in Connecticut, canceled most of that group's liability coverage. Mutual Fire, Marine & Inland Insurance announced it would not renew the malpractice policies of about 1,300 midwives as of July 3.

"I can't get any kind of coverage for sand-and-gravel and cement companies," says David Brennan, president of the Insurance Management Center, a Manchester, Conn. agency. "I've got one client who is a distributor of frozen chickens. Last year he paid $25,000 for coverage. This year I can't get anyone to even give me a quote. It's the same thing with an insulated-wire manufacturer, a fish distributor and even a group of nuns who own real estate as investment properties."

If they are willing to pound pavements, most business people can still find insurance. But they are paying vastly more for much lower coverage. One supermarket chain, for example, saw its average rates go from $8,000 per store a year and a half ago to $40,000 per store. Florida Power & Light's premiums for general liability coverage doubled in 1984 over 1983. The coverage provided was halved, $200 million instead of $400 million.

Pricey, but at least it got protection. For industries that have been especially hard hit by lawsuits, prospects have gotten much worse. Consider Acmat Corp., a $50 million (sales) asbestos-removal firm based in East Hartford. According to the firm, Cigna notified Acmat last December that all its coverage was being canceled because of its asbestos exposure. When Acmat protested, Cigna agreed to renew—so long as Acmat pulled out of the asbestos-removal business entirely. Acmat agreed, even though it meant "cutting our revenues in half overnight," says Henry Nozko Jr., executive vice president. But even that drastic measure failed to satisfy Cigna, which canceled the company's account on Apr. 1.

Nozko approached over 30 carriers, including Lloyd's of London. All turned him down. Finally, he convinced Great American Surplus Lines and three other firms to give him coverage. The price, assuming last year's volume of business: $6 million to buy $6 million of general liability coverage, including only $1 million of asbestos protection. That compares with $300,000 last year for $10 million of coverage. Why didn't he just bank that $6 million instead? "The policy gives us a worthless amount of protection, but we couldn't bid on public jobs without it," says Nozko.

A note on retributive justice: Now that legal-malpractice suits are becoming trendy, even lawyers are having a tough time finding coverage. Reuben & Proctor, an 80-member Chicago law firm, lost its coverage on July 1 from Crum & Forster's International Insurance.

The flight of insurers and reinsurers is most visible where the risks of winding up in a courtroom are great—both gradual and sudden-and-accidental pollution, directors' liability, municipal liability, medical malpractice and accountants' malpractice. "Our agent notified us a couple of months ago that everybody in our business was being canceled," says Irwin Singer, president of Atlas Oil Co., a fuel distributor. "They didn't care how good our safety record was. In fact, the very company that canceled our coverage complimented us on it."

In some cases, the retreat can be gradual. "Our normal general liability policy used to exclude all pollution, unless it was sudden and accidental," says Chuck Henry, a second vice president at Travelers. "Then the courts started saying in some cases that if the insured did not intend to cause damage, it was 'sudden and accidental'—even if it took years for the stuff to seep out." Now Travelers completely excludes pollution coverage on its general liability policy and will underwrite environmental hazard coverage only at restricted levels and only for customers who also buy Travelers' general liability policy.

Even such restrictions aren't enough for some insurers. Since the beginning of the year frightened insurers have been pulling out of property and casualty lines like the British army at Dunkirk.

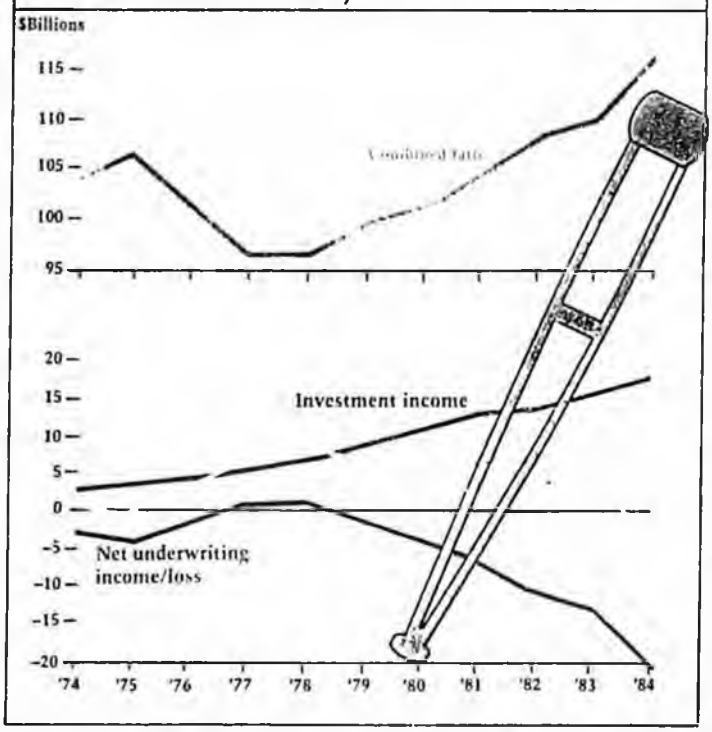
Property and casualty insurance has always been a boom and bust business, but the bust has never been this bad. Blame part of it on greed. After five years of cash-flow underwriting—that is, pricing products at a loss in underwriting terms in order to bring in extra dollars to invest at once-tempting interest rates—the industry has hit rock bottom. Last year it recorded a pretax loss of $3.8 billion.

Face it: There's no way that the insurance industry can fully recover from its current downswing until Congress—or state legislatures—step in and impose order on our self-destructive legal system. Pennsylvania has already made a start with legislation that curbs pain and suffering awards from municipalities. But it's only a start. Remedies in law will not become effective overnight.

In the meantime, property and casualty insurance is going to become much tougher to get, at any price. For example, insurance agent David Brennan expects that by September none of

A road to disaster?

For 8 of the last 11 years, property and casualty insurers have paid out more than they have gotten in premium income. Investment income had offset that worsening combined ratio until last year.



13 insurers he does business with will be willing to write new commercial policies for anyone.

Companies will have to scramble for any type of coverage they can find. By far the most common strategy is to accept limits on coverage—higher deductibles lower protection levels and, increasingly, exclusions for items such as legal defense costs and pollution liability. "We're paying more than double what we used to pay and we still haven't been able to replace all the coverage we lost," says Singer of Atlas Oil Co.

Insurers have also started pushing "claims-made" policies, which pay off only those claims filed during the policy term. Supporters of these insurance straitjackets argue that they will help insurers define their legal risks better and thus enable them to keep selling their products. But many are dubious. "Claims-made policies just postpone the problem," says Jon Harkavy, director of governmental affairs at the Risk and Insurance Management Society.

The last resort, of course, is self-insurance, either setting up a reserve fund to cover uninsured costs or, more commonly, paying them out of operating expenses. "Corporations of our size can afford to self-insure up to certain levels," says General Foods' risk manager Peter McDonough. "But that's not going to solve any of the major problems with the system."

Some companies are again setting up insurance captives, as they did in the mid-1970s. But captives are not very attractive from a tax standpoint (FORBES, *Nov. 19, 1984*), and they are risky to boot. Says O'Leary of Fox-Pitt, Kelton: "Many companies that set up captives ended up losing so much money that they have for the most part withdrawn."

But some see self-insurance as a curb on litigation. "I hope we're moving to the age of self-insurance," says Irving S. Shapiro, former chairman of E.I. Du Pont and now a partner at Skadden, Arps. "Once lawyers realize they're suing a defendant who doesn't have an insurance firm with deep pockets beyond them, they'll sue somebody else." Unless, perhaps, the company is as big as Du Pont.

For companies that aren't as big as Du Pont—and even for some that are—self-insurance today carries the risk of being pushed into Chapter 11 tomorrow. Shapiro's solution: a federal disaster-insurance fund for corporations, similar to the federal flood-insurance program. But wouldn't such a pot of gold be even juicier bait for plaintiffs' lawyers?

Marsh & McLennan is testing its own version of disaster relief—a stock insurance company for big firms known as ACE, for American Casualty Excess Insurance. ACE will provide the final $100 million in coverage—excess of at least $100 million in self-insurance or policies. Eleven firms have jumped at the opportunity to join up—but that's out of the reach of many companies.

Industry insurance pools are popular with utilities, lawyers, accountants, fuel distributors and others. Of course, the exposure for any insurer of a single high-risk industry is enormous, even when only claims-made policies are sold. So some companies, instead, try to spread their risk by setting up multi-industry insurance pools. Result: High-risk companies, again, are out of luck.

The fact is, the problem cannot be dealt with solely from the insurance side of the equation. It must be approached from the legal side. So long as judges keep expanding the definition of liability and juries keep handing out astronomically high awards, the chilling prospect of a world without insurance draws ever closer.

One simple but unpopular solution would be to prohibit—or at least severely limit—the contingency fee system that encourages lawyers to seek the highest possible damages. "You don't see any other country having the kind of insurance problems that we have, because none of them have the kind of jury awards or contingency system we've got," says James Corcoran, New York State's superintendent for insurance.

But there are problems with such a move. "We may be the only country that really has a contingency fee system," says F. Lee Bailey, a member of the three-lawyer consortium representing the Bhopal victims. "On the other hand, in most of the world, poor people go without any relief."

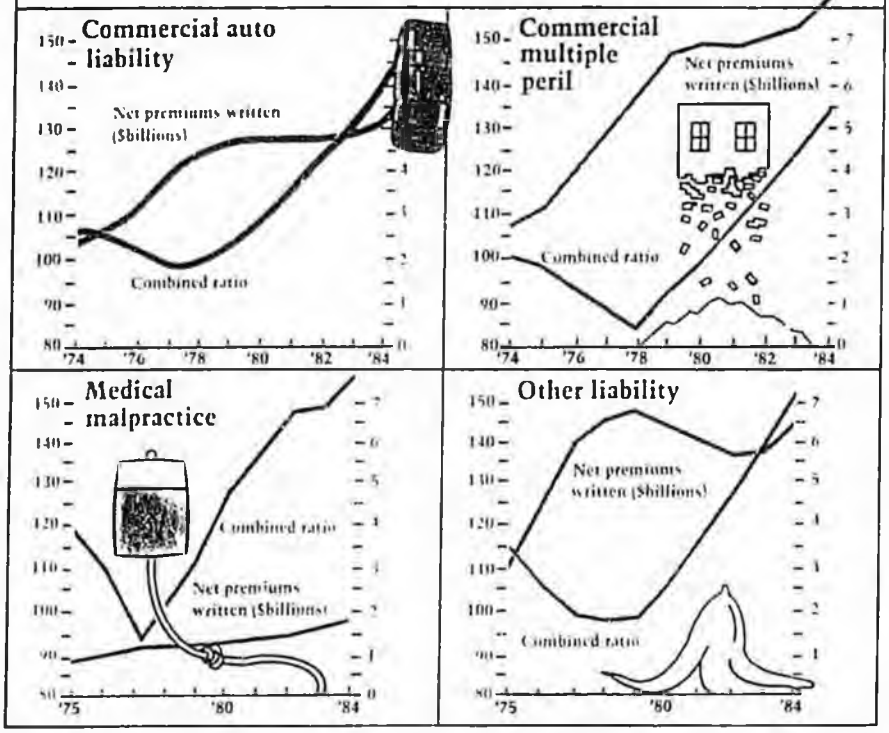
In the long run, maybe the only practical solution is legislative action to define liabilities and cap them at a fair and reasonable level. In New York, where obstetricians and neurosurgeons are turning away patients because of high malpractice insurance rates and where municipalities are scrambling for coverage, legislators have debated bills that attempt to cap liabilities for doctors and municipalities. Congress has contemplated a proposal by Senator Robert Kasten (R–Wis.) that would put a limit on corporate liabilities.

No longer do we have the luxury of pretending that the monster we have created will just go away.

It won't. ■

Losing propositions

In four big commercial liability lines, insurers paid out from $135 to $160 for every $100 of premium income taken in last year—a trend that has worsened steadily since 1978.



TRB

FROM WASHINGTON

THE TORT EXPLOSION

A court in Kansas has awarded ten million dollars, including eight million dollars in punitive damages, to a man who got polio after his daughter took the Sabin oral polio vaccine. A jury ruled that it is "outrageous" to sell the Sabin vaccine when the Salk vaccine is safer. The Salk vaccine *is* safer, in that the Sabin is a live virus that causes about four polio cases a year out of 24 million doses. On the other hand, the Sabin is more effective. Ten or 20 Americans a year get polio now, compared to several thousand a year during the Salk era. That, among other reasons, is why it is official U.S. policy to prefer the Sabin vaccine. But if this case becomes a precedent, no one will make the Sabin vaccine and that policy will be overruled.

When people fret about unelected judges making important social policy, they usually have in mind the Supreme Court's rulings about the Constitution. But another kind of judicial activism is coming to have an equal or greater effect on life in America. That is the explosion in tort law, set off primarily by state courts. Fear of lawsuits and inability to get insurance are affecting drug companies, municipalities, corporate directors, doctors, rock concert promoters, and others as surely as if the government had issued new laws or regulations. Many of these new judge-made regulations are ones no sane government would ever consider.

A Supreme Court ruling can take effect almost overnight. Tort law, by contrast, operates on a long fuse. A new development can take a couple of decades to percolate through the legal system, drive up insurance rates, and begin to affect everyday life. Little-remarked decisions of the past two decades are only now coming back to haunt us.

In one sense, the coming tort crisis is just another example of the paradigmatic problem of modern American government: our inability to take action for the general public good if it harms identifiable individuals. Trade protectionism, tax loopholes, and overgenerous entitlements are all part of the same dilemma. But courts add their own special madness. They blithely set policy on complex subjects about which they have no expertise. They are insititutionally inclined to focus on the costs of whatever behavior they have under scrutiny, without regard to the benefits.

Under our federal system, the same policy issue can be litigated again and again across the land, with similar or opposite results. However, since the plaintiffs tend to be local and the defendants from out-of-state, there is an inevitable tendency to follow the lead of whatever state has been most aggressive in finding liability.

The idea of tort law is that if my misbehavior causes you harm, I should pay you money to make up for it. Trial lawyers have worked wonders to overcome all these tiresome limitations—fault, causation, harm, damages—in recent years. Punitive damages—payments beyond all compensation for actual loss—used to be reserved for virtually criminal conduct. Now they are almost routine, and can be assessed again and again when a product or incident leads to multiple lawsuits. Courts have become far more imaginative in their definitions of actual harm as well, awarding large sums for emotional distress, fear of getting cancer (as opposed to actually getting cancer), and so on. Where it's impossible to know whether the defendant's activity actually caused the plaintiff's harm—did the victim get cancer from living downwind of a nuclear testing site, or just from living?—courts have held that the defendant must prove it *isn't* responsible, which is impossible.

But the biggest advances have been made in dispensing with the notion that you must have done something wrong in order to be held liable. No human endeavor is risk-free. If you can't plausibly be accused of failing to eliminate all risk, you can be accused of "failure to warn" of the risk that remains.

The first successful suit against the Sabin vaccine, in 1968, turned on the manufacturer's failure to warn recipients of the infinitesimal chance of catch-

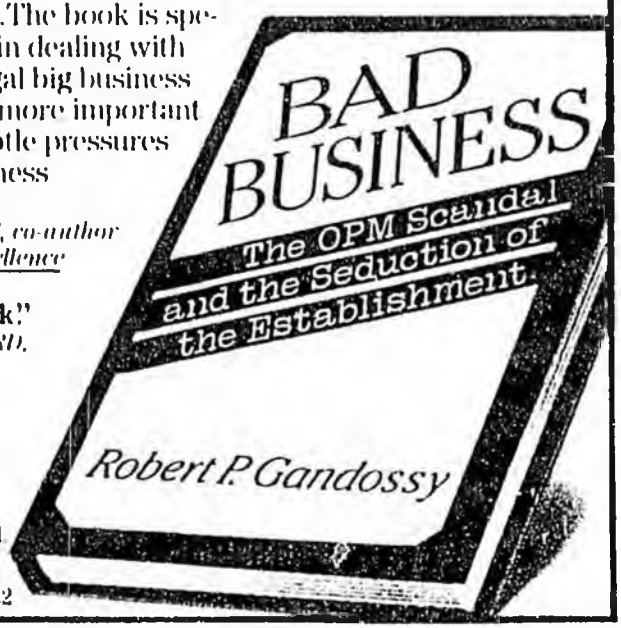
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TRB, *from page 4*

ing polio from it—as if this would lead any rational person to expose his children to the far greater risk of catching polio from *not* taking it.

More and more, though, any pretense of finding fault is abandoned and manufacturers of inevitably risky products are held "strictly liable" for any harm that comes from them. The theory is that they will absorb the cost and spread it around to all users. Whatever the theory, it is no defense that your product or activity is approved by the government agency that supervises such things. A chemical company recently was held liable for "mislabeling" a can of paraquat poison, even though the wording was not merely permitted but actually required by the Environmental Protection Agency.

In real life, any theory will do as long as it gets the case to the jury, whose natural sympathies will usually produce a large judgment without much concern for the legal technicalities. Fear of juries leads defendants to settle suits, whatever their merits. High settlements lead to skyrocketing insurance rates. And soon so much cost is being absorbed that the activity in question, be it practicing gynecology or manufacturing a vaccine or being on the city council, is no longer economically practicable.

Members of the Reagan administration who are alarmed about this trend regard it resentfully as backdoor government activism. In an era when new regulatory agencies and new social welfare programs don't have a prayer through normal democratic channels, they see liberal judges and greedy lawyers conjuring up vast schemes for income redistribution and controls on business through the courts. The "tax" that pays for these new programs is huge, but hidden ($12 for a dose of diphtheria vaccine that cost 15 cents a few years ago), so there is little political resistance. But they fear that the government often will end up footing the bill anyway, by interposing itself between some vital activity and a tort system gone wild. In 1976, for example, the government indemnified all manufacturers of swine flu vaccine. Otherwise, no one was willing to make it.

The irony is that the Reaganites are trapped here by their own dogmatism. The obvious solution to the problem of state courts competing against one another with ever-wackier theories of tort liability is national legislation setting sensible rules and exempting activities that meet federal standards from the risk of lawsuits. But overruling state law in this way would violate the axiomatic Reaganite belief in "federalism," while enhancing the power of national regulatory agencies would violate a related taboo. So the Reagan administration supports tort reform, so long as it *doesn't* mandate a uniform national standard.

Meanwhile, the fact that conservatives are alarmed by the tort explosion is no reason that liberals shouldn't be. As it now operates, tort law is more like a lottery than a rational and humane system of justice. Yes, some sufferers receive the balm of money. But people with the identical grievance collect radically different amounts, ranging from nothing if they don't sue (as many don't) to millions if they hit the jackpot with punitive damages. What you can collect depends on all sorts of arbitrary factors such as where you live, the size of the defendant, what judge you get, how much publicity there's been, and so on. It also depends a lot on factors like the amount of your lost earnings and the size of your medical bills. This means that affluent people—who are more likely to sue in the first place—collect more than poor people for the same grievance. Above all, collecting from the tort system depends on having someone to sue. If you just get cancer for no apparent reason, you're out of luck.

Anyway, most of the redistribution in tort law is from everyone else to the lawyers. In all the current litigation over asbestos, for example, the average cost per claim has been $101,000. Of that, $37,000 has gone to the defendant's lawyers, $25,000 to the plaintiff's lawyers, and $39,000 is left for the plaintiff. These numbers are typical. Studies of different aspects of the tort system always show that lawyers get over half the money.

Worst of all, from the liberal point of view, the tort system teaches a cramped lesson about justice and injustice. Most of the suffering in our society—dreadful diseases, loss of employment, simple poverty, whatever—is part of everyday life, not the result of specific actions that disrupt everyday life. Relief of suffering needn't depend on finding someone to blame. The instinct that says it's wrong for people to suffer unnecessarily should be directed into politics, not into lawsuits.

Lucrative contingent fees for attorneys and increasingly expansive court rulings on legal liability have combined to harm not only insurance companies, but all who purchase and depend on liability insurance.

A Lawyer Looks at Liability Law

BY JAMES G. FRIERSON

Consider the following. A restaurant's $25,000 liability insurance premium jumps to $80,000 in one year. A neurosurgeon in New York pays $101,000 in annual malpractice premiums. Twice as many liability lawsuits are filed in 1984 as were in 1978. Small child care centers go out of business due to their inability to obtain liability insurance. Huge underwriting deficits cause liability insurance companies to lose $3.8 billion dollars in 1984, their first operating loss in 78 years. American lawyers appear on TV from India within hours of the Union Carbide disaster. A U.S. Senate committee finds that product liability claims produce 77 cents in legal costs for every 66 cents that successful claimants receive.

The City of Sykesville, Md. receives a liability insurance premium increase of 700% in one year. More than 500 Ohio schools have their liability insurance canceled in 1985. The A.H. Robins Co., facing 3500 separate punitive damage claims, files for bankruptcy. Attorneys fly halfway across America to solicit the victims of a hotel collapse in Kansas City. Relatives of those killed in an airplane crash in Dallas endure the solicitation of attorneys as they attempt to identify the bodies of their loved ones.

These are but a few of the numerous examples that illustrate the legal liability disaster in America. Lucrative contingent fees for attorneys and increasingly expansive court rulings on legal liability have combined to harm not only insurance companies, but all who purchase and depend on liability insurance. Attempts to reform the system have been unsuccessful, primarily because of the political power of trial attorneys, the only group that consistently benefits from the present system.

Drastic problems call for drastic solutions. Three major changes in our legal system of liability lawsuits would go far in curing the present mess, while retaining fairness to deserving claimants. These changes would require substantial revision of the way we treat pain and suffering judgments, punitive damage awards and the payment of attorneys' fees.

Judgments for pain and suffering and for punitive damages are a major cause behind the huge increase in court judgments, as well as the extreme contradictions in the amount of money awarded in similar cases. The large amounts that may be paid under these categories cause some lawsuits to go to trial that otherwise might have been settled voluntarily. They are a major reason why attorneys' fees are so lucrative in personal injury cases.

VARIATIONS IN AWARDS

Pain and suffering awards and punitive damages often cause differences in lawsuits that make little or no sense. Recently Merrell Dow Pharmaceutical was sued in New York and California because of problems caused by an anti-cholesterol drug they distributed. The court in New York ordered punitive damages of $250,000 to be paid to the plaintiff, while the California court found that no punitive damages were justified. The facts were identical; only the courts were different.

A personal injury claim in Michigan might bring a $1 million pain and suffering award, while an identical case in Tennessee might result in a $50,000 pain and suffering award. Some plaintiffs win huge amounts based upon

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these nebulous categories, while similar plaintiffs receive absolutely nothing for pain and suffering or punitive damages. The result appears to depend upon which attorney was used, which court heard the case, which jury was selected—and pure luck.

While there have been heavily publicized cases of huge judgments, which sometimes make the plaintiff and his lawyer rich, many more unpublicized cases result in such small compensation that the plaintiff receives less than the financial losses incurred, after paying the attorney the typical one-third of the judgment, plus costs.

Most lawyers know the real reason for seeking pain and suffering and punitive damages in the typical cases: the award of these nonfinancial losses may be enough to pay the attorney's fee and costs, leaving the plaintiff full reimbursement for his real losses, including lost salary, medical expenses and property damage. However, this is a hit-or-miss method that rarely works perfectly. Plaintiffs normally win too much, or too little, for an exact reimbursement of their economic losses, after attorneys' fees and costs are paid. The examples shown in the accompanying chart are based upon actual lawsuits (attorneys' fees are assumed to be a one-third contingent fee and costs are estimated).

The last two cases shown in the chart involved almost identical fact situations, although one caused the plaintiff a net loss of $50,000, while the other produced a net gain of $182,000. It seems obvious that awarding the plaintiff all the economic losses caused by the defendant's actions, including attorney's fee and costs, would be a reasonable trade-off for no longer awarding pain and suffering and punitive damages.

AWARDS RECEIVED BY PLAINTIFFS

A Libel Case:

$6,700,000	Compensatory Damages (loss of business)
2,500,000	Punitive Damages
$9,200,000	Total
-3,066,666	Attorney's Fee
- 50,000	Costs
$6,083,334	Net Recovery; $616,666 less than the actual loss to the plaintiff

A Medical Malpractice Case:

$1,000,000	Compensatory Damages
1,000,000	Punitive Damages
$2,000,000	Total
-666,666	Attorney's Fee
- 10,000	Costs
$1,323,334	Net Recovery; $323,334 more than the actual loss to the plaintiff

A Products Liability Case:

$247,000	Lost Salary, Medical Expenses, Money Loss
50,000	Pain and Suffering Judgment
$297,000	Total
-99,000	Attorney's Fee
- 1,000	Costs
$197,000	Net Recovery; $50,000 less than the actual loss to the plaintiff

Another Products Liability Case:

$45,000	Actual Financial Loss
50,000	Pain & Suffering Judgment
250,000	Punitive Damages
$345,000	Total
-115,000	Attorney's Fee
- 3,000	Costs
$277,000	Net Recovery; $182,000 more than the actual loss to the plaintiff

ARBITRARY AWARDS

Awards for pain and suffering, by definition, are arbitrary and unreasonable. Since it is impossible to place a correct dollar figure on a specified amount of physical pain and mental suffering, it is unreasonable to do so. The law should provide for full restitution to a wronged plaintiff by full payment of all economic losses caused by the defendant, but it should not attempt the impossible, and it is impossible to decrease one's pain by the payment of money. The payment of pain and suffering damages will, at most, give the plaintiff (and his lawyer) some mental satisfaction, but this seems to be a minor benefit for such a major expenditure.

As citizens of a modern, technological society, we must all endure some pain and suffering at some time. It is simply a risk we all face. Money does not solve, or even affect, the problem. Many other countries recognize this fact, and as a result, they do not award money for pain and suffering. There is little valid reason to support America's policy of pain and suffering awards.

An even stronger argument can be made against punitive damage claims. A. with pain and suffering awards, punitive damage judgments are a major cause of the inconsistency of court judgments. They are a misguided attempt to impose society's penalty for wrongdoing in an inappropriate forum. The entire theory of assessing punitive damages in a personal, individual lawsuit is a contradiction in terms.

Punitive damages are assessed for a defendant's "outrageous conduct" or "reckless action" against society. The private plaintiff, under this concept, acts for society in claiming a penalty for the defendant's wrong. But why should a private person bring an action based upon a wrong to society? And why should this private person (and his attorney) benefit personally when a penalty is imposed?

If a person or company does an outrageous or reckless act that is a

wrong against society, the representative of society, the government, should be the one to prosecute the case, and the government should be the one to benefit financially when penalties are imposed. The penalties should not result in a windfall profit to a private plaintiff and the lawyer.

Private lawsuits allowing punitive damages also can cause the defendant to be punished many times over for the same wrongful act. After paying hundreds of claims, the A.H. Robins Co., as mentioned earlier, still faced 3500 different lawsuits claiming punitive damages. Is it really fair for a company to be punished thousands of times for the same act, such as in the Robins case where all the lawsuits involve the same defective birth control device?

European countries and four American states prohibit punitive damages. There is little or no evidence that companies and other potential defendants act any more recklessly in those jurisdictions than they do in the rest of the United States, where punitive damages are allowed.

TOWARD A JUST SOLUTION

Since pain and suffering awards and punitive damages have been used, indirectly, to pay attorneys, it would be unfair to eliminate such judgments without providing deserving plaintiffs with an alternative method to pay legal costs. The law should provide for the payment of all economic losses caused to a deserving plaintiff. The attorney's fee and legal costs are just as much economic losses caused by the defendant as are the losses of medical bills, lost salary and property damages. A successful plaintiff deserves to win and keep the amount of money necessary to pay all economic losses.

Radical changes, as long as they are fair, are the only method through which the problems can be solved.

Experience in other countries, almost all of which allow the collection of attorneys' fees, as well as experience in the United States where attorneys' fees are paid, such as in consumer law and antitrust law cases, proves that the payment of legal fees can be imposed fairly upon the defendant. If the parties cannot agree upon a fair attorney fee, the judge can serve as a referee and make the final decision. Alternatively, the law could provide that the lawyer for the winning plaintiff be entitled to a predetermined amount, such as $9 per hour. The exact amount can be based upon average time charges of attorneys, adjusted periodically for inflation.

At this point many lawyers will argue that they should be paid more than a standard fee per hour since they will collect only if they win the case as they do now with contingent fees. They will argue that contingent fees are necessary to allow people of limited financial means to afford to use an attorney in bringing a lawsuit. And they will argue that large fees, even one-third of a million-dollar judgment, are justified since the attorney takes a chance of receiving nothing if the case is lost.

These arguments have some validity. However, it is hard to justify fees as high as $333,334 or more in a single liability lawsuit. The payment of legal fees by the defendant can be arranged so that the lawyer is compensated for the risk of losing the case. We can provide that, upon successful completion of a liability lawsuit, the lawyer will be paid 150% of the normal hourly rate. A 50% premium over a lawyer's standard charges should compensate him fully for the risk of losing. After all, an

attorney usually will not accept a case unless he feels he has a reasonably good chance of winning.

Another method, often used in antitrust cases, is to allow the judge to add a multiplier based upon the difficulty of the case. For example, in a simple, obvious case the attorney might receive 120% of the standard hourly rate, while in a landmark case that created new law, the rate might be set at 200% of the hourly rate. Such a scale should provide sufficient incentive for lawyers.

Eliminating pain and suffering awards and punitive damage judgments, while adding a requirement for the payment of attorneys' fees, would have several definite advantages. First, plaintiffs would collect what they deserve in all cases. No longer would they have to hope to collect enough in pain and suffering awards or punitive damages to pay their attorneys. Second, attorneys would be compensated fairly.

Third, the opportunity to make a profit on a lawsuit by receiving huge pain and suffering or punitive damage awards would be eliminated. This would not only reduce many of the huge liability judgments, but it would also encourage plaintiffs to settle without a trial whenever insurance companies offer a fair settlement covering the plaintiff's economic losses. And finally, the reduction of huge judgments, while still treating fairly all concerned, would lead to the reduction of liability insurance premiums, thus benefiting all segments of society.

These changes, however, can be accomplished only by overcoming the opposition of trial lawyers, who have a vested interest in the present system of liability lawsuits. Changing these concepts state-by-state is an impractical goal. In addition to the problem of dealing with 50 different legislative bodies, lawyers often have great power in the state legislatures. The only practical course of action is a federal law.

Those who are familiar with the lack of success in reforming product liability law, which was to be accomplished by the so-called Kasten proposal, might doubt the ability of Congress to change the law in this area. However, the original Kasten proposal had several provisions that were validly opposed by consumer groups as well as trial lawyers. That bill would have changed the basic standard for finding liability from one of strict liability to one of negligence, resulting in many valid claims not being paid. Other provisions of that proposal would have seriously limited the period of time in which a lawsuit could be filed. Reported revisions of the Kasten bill will not attempt to change the method of handling attorneys' fees, punitive damages and pain and suffering awards.

However, the elimination of pain and suffering awards and punitive damages, while requiring payment of attorneys' fees, is necessary if we are to assure that successful plaintiffs win exactly what they deserve. These ideas are so reasonable, in fact, that only those with vested interests to protect should oppose them. A movement not only of insurance companies and trade associations, as is now under way, but also of city governments, day care center operators and all the millions of others faced with unreasonably high liability insurance premiums could be successful in creating one large lobbying effort to create a national law that would improve the system for everyone's benefit.

Those in favor of change in the manner in which we award damages in liability lawsuits should not be content with minor changes that might do little to solve the basic problems that have caused the liability mess we now face. Radical changes, as long as they are fair, are the only method through which the problems can be solved. In dealing with the reform of liability claims and lawsuits we should remember the advice of Henry George, who said, "There is danger in reckless change, but greater danger in blind conservatism." □

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THE OHIO GENERAL Insurance Company

CITIZENS COALITION FOR TORT REFORM, inc.

"Voices raised in unison..."

TO: ALL LEGISLATORS

FROM: CITIZENS COALITION FOR TORT REFORM

SUBJECT: ENCLOSED DATA FOR YOUR INFORMATION AND USE

ARE THESE THE FRIVILOUS INVESTMENTS INDICATED BY ROBERT HUNTER?

Sincerely,

Al Tamagni, Sr.
Chairman

738 H Street, Suite 100 • Anchorage, Alaska 99501 • (907) 276-1135

ALASKA INVESTMENTS OF INSURANCE COMPANIES IN ALASKA
AS OF DECEMBER 31, 1984

INSURANCE COMPANY INVESTMENTS	Total 1984 Investments (000)	Total 1984 Net Premiums (All Companies) (000)	Total 1983 Investments (000)	Total 1983 Net Premiums (All Companies) (000)
1 Domestic Life Company	1,931	663	2,459	594
4 Domestic and Foreign Title Insurance Companies	5,333	19,116	4,278	19,343
9 Domestic Property and Casualty Companies	18,179	119,463	36,049	83,050
201 Foreign Property and Casualty Companies	1,357,719	324,493	1,270,907	331,434
138 Foreign Life Insurance Companies	1,639,792	259,463	1,731,049	230,301
2 Hospital/Medical Service Corporations, F&D	634	51,854	628	46,700
3 Fraternal Benefit Societies	15,552	1,792	9,374	1,356
Total	3,039,140	776,844	3,054,744	712,778

TYPE OF INVESTMENT

	1983 (000)	1984 (000)	Percent Inc./Dec.
Alaska - State G. O. Bonds	218,483	210,107	(3.4)
Alaska - Political Subdivision Bonds	238,094	216,709	(8.9)
Alaska - Special Revenue Bonds	1,111,376	1,187,034	6.8
Alaska Industrial Bonds	1,047,565	874,285	(16.5)
Alaska Public Utilities	48,000	63,103	31.4
Alaska Real Estate	9,198	23,131	151.4
Alaska Mortgages	212,416	235,077	10.6
Common Stock and Bond Investments - % Allocated to Alaska Properties	143,005	204,660	43.1
U.S. Government Housing Authority Bonds	2,671	132	(95.0)
Alaska Policyholders Loan and Liens	12,002	10,807	(9.9)
Bank and Time Certificates	11,934	14,095	18.1
Total	3,054,744	3,039,140	(0.5)

CITY OF SOLDOTNA
RESOLUTION 86-9

A RESOLUTION SUPPORTING THE CITIZENS' COALITION FOR TORT REFORM REGARDING INSURANCE PREMIUMS

WHEREAS, the City of Soldotna has had its budget reserve seriously diminished by the unanticipated increase of $173,000 or 283% in its annual insurance premium; and

WHEREAS, other Alaska communities, businesses, school districts, and private citizens are similarly suffering because of the need for legislative redress of the problems peculiar to the Alaska insurance industry; and

WHEREAS, Alaska has a limited availability of liability insurance programs and has experienced a dramatic rise in liability premiums; and

WHEREAS, legislative remedies are needed to restore predictability and affordability to liability insurance programs; and

WHEREAS, the Citizens' Coalition for Tort Reform has identified those areas needing legislative remedy, and have proposed solutions;

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF SOLDOTNA:

That it supports the efforts of the Citizens' Coalition for Tort Reform to achieve legislative remedies, and urges the Alaska Legislature to make these reforms a priority of the second session of the 14th legislature.

ADOPTED this 19th day of February, 1986.

Mayor

ATTEST:

City Clerk

RESOLUTION 86-8

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF CORDOVA, ALASKA, SUPPORTING THE CITIZENS COALITION FOR TORT REFORM REGARDING INSURANCE PREMIUMS

WHEREAS, other Alaska communities, businesses, school districts, and private citizens are similarly suffering because of the need for legislative redress of the problems peculiar to the Alaska insurance industry; and

WHEREAS, Alaska has a limited availability of liability insurance programs and has experienced a dramatic rise in liability insurance programs; and

WHEREAS, the Citizens' Coalition for Tort Reform has identified many of those areas needing legislative remedy and have proposed solutions;

NOW THEREFORE BE IT RESOLVED that the Cordova City Council supports the efforts of the Citizens' Coalition for Tort Reform to achieve legislative remedies, and urges the Alaska Legislature to make these reforms a priority of the 2nd session of the 14th legislature.

PASSED AND APPROVED THIS 18 DAY OF February, 1986.

Mayor Erling T. Johansen

Acting City Clerk

LIABILITY SETTLEMENT CURRENT PROCESS

COMPARED TO

CITIZENS' COALITION FOR TORT REFORM PROPOSAL

The following example case is that of a case settled in Anchorage. The name being used is that of John Doe. The purpose is to demonstrate by actual figures, the mechanics of how a case is settled under current rule and statute and to compare how the same case would be settled under the proposals by the Citizens' Coalition for Tort Reform using the following portions of our tort reform bill.

1. Periodic payments
2. Sliding scale of attorney fees
3. A cap on non-economic awards
4. Elimination of Rule 82

NAME - JOHN DOE
AGE - 30
SEX - MALE
ADDITIONAL LIFE EXPECTANCY - 43.5 years
WORK LIFE EXPECTANCY - 31.5 years
ANNUAL BEFORE TAX INCOME - $40,000.00
ATTORNEY OVERHEAD - $30,000.
PLAINTIFF ATTORNEY COSTS - 40% of Gross Settlement

CURRENT METHOD OF CALCULATION

Loss of income $40,000 x 43.5 years	=$ 1,740,000
Pain, Suffering, Misc	750,000
Future cost of living etc.	500,000
TOTAL SETTLEMENT AMOUNT	=$ 2,990,000

COST ANAYLSIS

MONEY FOR ATTORNEY FEES	=$ 1,196,000
MONEY FOR ATTORNEY COSTS	=$ 30,000
NET MONEY TO INJURED PARTY TO CLIENT	=$ 1,764,000

PERCENT OF MONEY TO CLIENT = 58.9%
PERCENT OF MONEY TO ATTORNEY = 41.1%

DEFENDENDANT COSTS AT 30% = 987,000

TOTAL COSTS OF CASE TO INSURED = $3,887,000

PERCENT OF AWARD BASED ON TOTAL COSTS TO INJURED PARTY = 45.38%

THE AMOUNTS ABOVE ARE TAX FREE

C.

The remaining balance will be structured in the following manner.

1. Cash up front = $10,000.00
2. Deferred lumps of cash tax free
   - 10 years = $ 92,000
   - 15 years = $ 154,000
   - 30 years = $ 583,000

Total lump amount = $[illegible]9,000 TAX FREE

TOTAL GUARANTEED VALUE TO INJURED PARTY TAX FREE BASED ON:
1. GUARANTEED PERIOD = $3,250,101
2. NORMAL LIFE EXPECTANCY = $4,428,573

COST ANALYSIS

PRESENT VALUE COSTS	= $	658,332
ATTORNEY OVERHEAD COSTS	=	30,000
ATTORNEY FEES	=	107,498
NET PRESENT VALUE TO CLIENT	=	520,834
PERCENT OF AWARD TO INJURED PARTY	=	79%
PERCENT OF AWARD TO ATTORNEY	=	21%
DEFENDANT COSTS (denotes estimate of maximum fluctuation, up or down)	= $	75,000

TOTAL COST OF CASE TO INSURED = $733,332

PERCENT OF TOTAL AWARD TO INJURED PARTY = 71%

1. Please note the reduced costs to defendant
   $3,887,000 vs $733,332
   Reduction Amount = $3,153,668

2. Please note the continued and guaranteed income to the injured party on the basis of pay as claimed under periodic payments.

3. Note reduction in plaintiff attorney fees and costs -
   $1,226,000 vs $137,498
   Reduction Amount = $1,088,502

4. Please note increased percentage of money awarded going to injured party - 79% vs 58.9% - Amount of percentage increase = 20.1%

5. Please note the increased percentage of the overall costs going to the injured party - 71.0% vs 45.38% - Amount of percentage increase = 25.62%

QUESTIONS: WHO BENEFITS?
WHO LOSES?
WHO IS REALLY GETTING LESS MONEY?
WHO SAVES?

EXHIBIT A

STRUCTURED METHOD OF SETTLEMENT USING
COALITION REFORM PROPOSAL

A

To pay injured party $40,000 per year and compounding at 3% annually guaranteed 35 years and life. Tax free.

AGE	ANNUAL INCOME	AGE	ANNUAL INCOME
31	$41,200.	53	$ 76,625.
32	42,436.	54	81,290.
33	43,709.	55	83,728.
34	45,020.	56	86,239.
35	46,370.	57	88,826.
36	47,761.	58	91,490.
37	49,193.	59	94,234.
38	50,669.	60	97,153.
39	52,188.	61	100,067.
40	53,753.	62	103,069.
41	55,365.	63	106,161.
42	57,025.	64	109,345.
43	58,735.	65	112,625.
44	60,492.	66	116,003.
45	62,306.	67	119,483.
46	64,175.	68	123,067.
47	66,100.	69	126,759.
48	68,083.	70	130,561.
49	70,125.	71	134,477.
50	72,228.	72	138,511.
51	74,394.	73	142,666.
52	76,625.	74	146,945.

This will continue to compound as long as plaintiff shall live.

Total guaranteed income amount - 35 years = $2,421,101
Total income normal life expectancy = $3,599,573

NOTE: The above amounts are TAX FREE

B.

A lump amount of $250,000. is additional for non-economic award, after payment of attorney fees, in the amount of 107,498,00 and attorney overhead costs of $30,000.

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

SYNOPSIS OF THE ISSUE

Tort reform is an issue in many states, but Alaska's situation is unique and requires a solution this year by the Alaska legislature. The laws of Alaska are exceptionally liberal and allow virtually unlimited jury awards, often without regard to the actual economic value of the loss. This makes actual risk extremely difficult for insurers to predict. Some insurers and reinsurers have withdrawn from or refused to enter the Alaska marketplace. Those that have stayed are increasing their rates for liability insurance to astronomic levels. As a consequence many Alaska businesses and individual service providers, many of them critical to the public, are reducing their services, going out of business or operating without insurance. The danger is clear and present. The damage that will result from deferred action demands a legislative resolution of the issue this year. It has been the subject of two previous comprehensive studies.

The issue is non-partisan. The problems caused by the present tort reparation system cut across party lines. There are essentially three interest groups, each with a somewhat different stake in the issue:

1. The Business Community and Consumers
2. Insurance Companies
3. Trial Attorneys

The Citizens Coalition for Tort Reform represents the first group, the business community and consumers. The coalition, through HB532 and SB377 seek changes in the laws governing both tort reparations and insurance regulations to resolve the crisis. It affects everyone. At present our system is virtually wide open and we are all paying the bill for it. Allowing the issue to be referred to yet another study committee or allowing passage of a cosmetic reform bill will unnecessarily prolong a crisis which is costing consumers more every day.

738 H Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-1135

Doug This is an excellent piece to use for lobbying the-
practice reforms
Regards,
Brad

cma **LEGISLATIVE ALERT**

KEY CONTACT

CALIFORNIA MEDICAL ASSOCIATION • 925 L Street • Suite 1150 • Sacramento, CA 95814-3756 • (916) 444-5532

November 15, 1985

Brad Cohn, M.D.
450 Stanyan Street
San Francisco, CA 94117

Re: Defense of MICRA

Dear Dr. Cohn:

Ten years ago, in response to a malpractice insurance crisis, the California Legislature enacted sweeping reforms in statutes governing professional liability (AB 1xx - The Medical Injury Compensation Reform Act, MICRA).

On May 8, 1985 the California Supreme Court handed down a decision which favorably settled the legal challenges to MICRA, including the $250,000 cap on non-economic damages in medical malpractice cases.

Since the day the Governor signed the act in 1975, skeptics (including many physicians) predicted that the reforms would be ineffective. The only real test of such a measure is hard data. The statistics are as follows:

	Nationwide	California
Average size of malpractice awards	$974,000	$396,000
Premium increase in average policy since 1975	300%	150%
Premium increase in average policy in 1985	33%	15%

The above statistics eloquently explain why physicians must protect MICRA from alteration or repeal. Gutting MICRA is the number one priority of the California Trial Lawyers Association.

Please write to, call or meet with your State Senator before January and ask for a "NO" vote on any bill which would increase the cap, increase the threshold for periodic payments or otherwise weaken any provision of MICRA. A roster of members of the Senate is enclosed for your use.

After reading the attached analysis, if you have any questions please call me or Judge Gordon Cologne at (916) 444-5532. Thank you.

Sincerely,

Jay Dee Michael

Jay Dee Michael, Vice President
Government Relations

J&S:5a

cc: Component Society Medical Executives

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

Hon. Pat Rodey
Chairman
Senate Judiciary Committee
P.O. Box V
Juneau, AK 99811

Dear Mr. Chairman:

This documentation relating to the testimony of J. Robert Hunter before your Committee on February 26 has just come to our attention. Presumably this information has been turned up by your researchers, but in case it has not, we are offering it to you now.

Briefly, here is a summary of the contents:

A paper refuting the Nader-Hunter challenge on the 1985 profit/loss in the property casualty industry.

An article on the property casualty industry's pre-tax operating loss for 1984 from the March 20, 1985 "Wall Street Journal."

An Insurance Information Institute news release reporting year-end 1984 property/casualty industry operating results.

Sources of data on financial results for property/casualty insurance.

Concepts of profit/loss in the property/casualty insurance industry.

A refutation of the assertion by Mr. Hunter before your Committee that the Canadian Providence of Ontario has had and unsuccessful experience with "tort reform."

The Coalition does not represent the insurance industry nor is it a spokesman for the industry. However, we feel that a sound appreciation of how the industry operates is vital to an understanding of why substantial tort reform is in the public interest. This information from the Insurance Information Institute is presented in that spirit.

Thank you again for your efforts to make sense of this difficult issue.

Sincerely,

David A. McGuire

738 H Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-1135

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

DOCUMENTATION ON TESTIMONY OF
J. Robert Hunter
Before the House Labor and Commerce Committee, Judiciary Committee, Senate Labor and Commerce Committee and Senate Judiciary Commitee
February 24, 24 and 26, 1986

** A paper refuting the Nader-Hunter challenge on the 1985 profit/loss in the property casualty industry.

** An article on the property casualty industry's pre-tax operating loss for 1984 from the March 20, 1985 "Wall Street Journal."

** An Insurance Information Institute news release reporting year-end 1984 property/casualty industry operating results.

** Sources of data on financial results for property/casualty insurance.

** Concepts of profit/loss in the property/casualty insurance industry.

** A refutation of the assertion by Mr. Hunter before your Committee that the Canadian Providence of Ontario has had and unsuccessful experience with "tort reform."

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Insurance
Information
Institute

110 William Street
New York, N.Y. 10038
(212) 669-9200

Nader-Hunter Challenge on 1985 Profit/Loss in P/C Industry

At a press conference in Washington, D.C. on January 6, 1986, Ralph Nader and Robert Hunter, president of the National Insurance Consumer Organization (NICO), asserted that the property/casualty industry had a profit of $6.6 billion in 1985 rather than an operating loss of $5.5 billion, as reported by the Insurance Information Institute.

In interviews with the media on January 6, Dr. Sean Mooney, senior vice president and economist of the I.I.I., and other I.I.I. staff members refuted the Nader-Hunter assertions. By the end of the day, Hunter had lowered his $6.6 billion profit figure to $5.0 billion, as reported by The Wall Street Journal, Jan. 7, 1986, page 12.

At his press conference, Hunter claimed property/casualty insurers would earn $6.6 billion in this way:

	$ BILLIONS
Operating Loss	-$5.5
Capital Gains	+ 6.5
Federal Tax Credits	+ 3.5
Dividends to Policy-holders	+ 2.1
PROFIT	$6.6

In refuting the Nader-Hunter claims, Dr. Mooney noted:

1) Hunter accepts I.I.I's report of an operating loss of $5.5 billion based on underwriting and investment performance;

2) Nader's Capital Gains figure includes unrealized gains. This is unacceptable because it violates Generally Accepted Accounting Principles as required by auditors and the Securities and Exchange Commission as well as statutory insurance accounting principles. Unrealized capital gains represent increases in the market value of securities which have not been sold. Therefore, the companies have received no money from them. Hence, they are not included in profit and loss data.

3) Nader's Federal Tax Credits figure is one developed by NICO and grossly excessive. I.I.I. figures on page 3 are based on nine months of actual data reported by insurers.

4) Nader's Dividends to Policyholders entry is wrong. Under general accounting principles, a return to consumers is a price rebate and must be deducted from sales revenues.

The media asked why the industry reported operating figures and not after-tax income at the end of 1985. The I.I.I. year-end press release is based exclusively on data from A.M. Best Company, an independent analytical, rating

and information service organization. These data do not include after-tax income.

When the fourth-quarter data are in, the I.I.I. releases the figures, including after-tax income. (See March 20, 1985, Wall Street Journal story, based on March 19, 1985, I.I.I. release. Copies are attached.)

The I.I.I. reports on after-tax profit or loss on a quarterly basis.

The I.I.I.'s estimates for Profit & Loss in 1985 are as follows:

Profit (Loss) in P/C Industry

($ Billions)

	1985	
Underwriting Loss	$(25.2)	Underwriting loss here was supplemented by income from investments (interest and dividends) to produce an operating loss.
Investment Income	19.7	
Net Operating Loss	(5.5)	
Realized Capital Gains*	5.3	However, capital gains primarily from the sale of stocks offset this loss, plus
Tax Credits and Other* Income	1.9	tax credits and other minor income items so that
Net After-Tax Income*	1.7	net after-tax income was positive.

*Estimates by Insurance Information Institute.

Why are the I.I.I. figures right and the Nader-Hunter figures wrong? Because with nine months of data available, the net after-tax income was $1.49 billion. It is totally unrealistic to expect a gain in the last quarter more than three times the size of the gain in the prior nine months.

The Institute is hesitant to estimate the after-tax industry result, but based on nine-month data, the figure should be close to $1.7 billion -- far below the Nader-Hunter estimate.

Nader and Hunter question whether there has been a litigation "explosion" in the U.S.

There are many facts to demonstrate the increase in litigation in the U.S. over the last few years as well as the increase in the cost of the tort liability system.

-- Million-dollar verdicts awarded in the United States skyrocketed to 251 in 1982 from one in 1962 and to 360 in 1983, the latest year for which figures are available. The lure of jumbo awards in civil suits often contributes to increased litigation.

-- Civil suits filed in state courts rose 22 percent from 1977 to 1981 and appeals climbed 32 percent. Civil case filings in federal district courts soared to 206,000 in 1982 from a mere 35,000 in 1940. Last year there was one private civil lawsuit filed for every 15 Americans.

-- In the 15 years Chief Justice Burger has been heading the Supreme Court, federal court case filings have risen nearly two and a half times as fast as the population.

-- A 1984 Rand study of thousands of asbestos-related lawsuits showed: Cases closed took an average of two years and eight months, with 11 percent taking six years. How much did victims get? Only 37 cents of each dollar paid. The other 63 cents went for legal fees.

THE WALL STREET JOURNAL
March 20, 1985

Pre-Tax Operating Loss for '84 Is Posted By Property Insurers

By a Wall Street Journal Staff Reporter

NEW YORK – The nation's property-casualty insurance industry posted a pre-tax operating loss of $2.9 billion last year, the largest in its history. In 1983, the industry had pre-tax operating profit of $3.04 billion.

After tax credits and capital gains, however, the industry last year posted net income of $1.94 billion, down 68% from $6 billion in 1983.

Such results were expected. Last December, the Insurance Information Institute, a trade group, predicted that the property-casualty industry would post a net loss for 1984. But insurers' tax credits and capital gains both proved to be larger than anticipated, producing net income for the industry rather than a loss, Sean Mooney, the institute's economist, said.

The results released by the institute are based on data from companies representing 97% of the nation's property-casualty premium volume. They were compiled by two other trade groups, the Insurance Services Office and the National Association of Independent Insurers.

Based on the size of the 1984 operating loss, Mr. Mooney said, last year was the property-casualty industry's worst ever. He said the losses surpassed those sustained in 1906, the year of the San Francisco earthquake and fire, which resulted in $375 million damages.

In the fourth quarter, the industry had a pre-tax operating loss of $760 million, compared with pre-tax operating profit of $590 million a year earlier.

After tax credits and capital gains, fourth quarter net income was $846 million, down 40% from $1.4 billion in 1983.

For the full year, insurers had pre-tax losses from insurance underwriting of $20.52 billion, compared with $12.93 billion in 1983. Investment income, primarily interest on bonds and dividends on stocks, was $17.62 billion, up 10% from 1983. Capital gains were $3.17 billion, up 56%.

The industry's poor 1984 performance has been blamed on heavy weather-related claims and lingering effects of a six-year price war in commercial insurance that apparently ended last summer. Still, analysts don't expect earnings to improve until late this year or early 1986.



Insurance Information Institute

The Insurance Information Institute is a nonprofit educational, fact-finding and communications organization for the property and casualty insurance business. The Institute is supported by some 300 insurance companies and provides public relations and communications services to other insurance organizations in the fields of property, casualty, fidelity, surety and marine insurance. Headquartered in New York City, the Institute has offices in other major U.S. cities.

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Immediate

for INSURANCE SERVICES OFFICE, INC.
and the NATIONAL ASSOCIATION OF INDEPENDENT INSURERS

ISO, NAII REPORT YEAR-END 1984
PROPERTY/CASUALTY INDUSTRY OPERATING RESULTS

NEW YORK, March 19 -- The nation's property and casualty insurance industry reported net after-tax income of $1.94 billion in 1984, down 68 percent from the 1983 net income of $6.0 billion.

The industry recorded a pretax operating loss of $2.9 billion in 1984, compared with pretax operating income in 1983 of $3.04 billion. The 1984 operating loss consists of a pretax underwriting loss of $20.52 billion and pretax net investment income of $17.62 billion.

The industry's pretax underwriting loss of $20.52 billion for 1984 was $7.59 billion greater than the loss of $12.93 billion in 1983. The underwriting loss includes $2.10 billion of premiums returned to policyholders as dividends in 1984, compared with $2.16 billion a year ago.

(more)

The $17.62 billion of net investment income for 1984 (primarily dividends earned from stocks and interest earned on bonds), was up 10.3 percent from a year ago. Net investment income, combined with realized capital gains, which rose 56.1 percent to $3.17 billion, brings the industry's total pretax net investment gain for 1984 to $20.79 billion, up 15.4 percent from $18.01 billion a year ago.

The figures were released by Insurance Services Office, Inc. (ISO) and the National Association of Independent Insurers (NAII), reporting for insurers that account for 97 percent of the country's property/casualty insurance business.

The 1984 underwriting loss of $20.52 billion was 18.2 percent of the earned premiums of $112.49 billion. This compares with the 12.4 percent underwriting loss on earned premiums of $103.89 billion for the year 1983.

Written premiums for 1984 totaled $115.87 billion, up 9.4 percent from $105.87 billion in 1983. That growth compares with the 4.6 percent growth of 1983 over 1982 written premiums.

For the fourth quarter of 1984, the industry's net after-tax income was $848 million, compared with $1.40 billion for the fourth quarter of 1983, a decrease of 39 percent.

(more)

The industry recorded a fourth-quarter 1984 pretax underwriting loss of $5.85 billion, compared with the $4.03 billion loss a year ago. The fourth-quarter 1984 underwriting loss included $582 million of premiums returned to policyholders as dividends, compared with $793 million in the fourth quarter of 1983.

The industry's pretax net investment gain in the fourth quarter of 1984 was $6.20 billion, up 24.5 percent from $4.98 billion in the fourth quarter of 1983.

The fourth-quarter 1984 loss of $5.85 billion was 19.6 percent of the period's earned premiums of $29.91 billion. This compares with the 14.9 percent underwriting loss on earned premiums of $27.11 billion recorded for the fourth quarter of 1983.

Written premiums in the fourth quarter of 1984 totaled $29.45 billion, up 14.1 percent from $25.80 billion in the fourth quarter of 1983. That growth compares with the 6.7 percent growth of 1983 over fourth-quarter 1982 written premiums.

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3/19/5: 53TN
March 19, 1985

SOURCES OF DATA ON FINANCIAL RESULTS (Property/Casualty Insurance)

1. Most data published by the Insurance Information Institute are from A.M. Best Company, an independent analytical, rating and information service organization.

2. The A.M. Best Company data are collected from individual insurance companies throughout the United States. Each insurance company is required to report to each state in which it is licensed what is known as the convention statement. A.M. Best Company receives copies of these reports and adds the data up line by line, company by company, to produce a total. This total is then increased by a small factor (less than 3 percent) to produce an overall industry aggregate figure. The incremental factor is used mainly to reflect estimates for companies not required to report to the state insurance departments. In many states, small farm mutual companies are not required to report.

3. The Institute publishes data from a quarterly report issued jointly by Insurance Services Office, Inc. (ISO) and the National Association of Independent Insurers (NAII). These data are collected each quarter from

companies representing about 97 percent of premium volume in the U.S. The data are received by ISO and NAII in the form of answers to questions, e.g., what were your written premiums in the past quarter?

CONCEPTS OF PROFIT/LOSS IN THE PROPERTY/CASUALTY INSURANCE INDUSTRY

There are several ways of measuring profit and loss in the property/casualty insurance industry, as there are in any other industry. The different concepts used depend on the question being asked and the perspective of the inquirer. For example, a regulator frequently will have a different perspective on data than a shareholder of an insurance company. Some of the common measures of profitability are:

1. Net profit/loss after taxes.

This is the basic concept of bottom-line earnings. This number is the bottom line on the income statement of most U.S. companies. The figure includes losses or gains from underwriting, investment income (interest income and dividends), realized capital gains and federal income taxes. Shareholders are interested in this figure because it provides some indication of whether dividends will be paid and at what rate. However, this figure does include extraordinary items and other factors, which may be of a transitory nature. Of key importance for property/casualty insurance in recent years has been the impact on this figure of federal taxes and realized capital gains.

In the case of federal taxes, what was normally a subtraction from before-tax income has turned into an addition. This is because companies were losing money before taxes and received a credit for taxes paid in the prior three years -- a form of income-averaging for companies. Realized capital gains also increased in importance in the past few years, partly because of the strong stock market, but also because of the need by insurance companies to raise cash to pay losses. In calculating bottom-line profit or loss, the profit or loss from the sale of stock is included regardless of the purpose of the sale.

2. Operating profit/loss.

Because this figure includes the key operating concepts -- underwriting profit or loss and investment income, it is the most reliable indicator of how the property/casualty industry is doing. It excludes realized capital gains or losses and federal taxes.

3. Underwriting profit/loss.

The underwriting profit or loss is calculated by subtracting incurred losses (funds assigned to pay claims) and expenses (e.g., commission to insurance agents) from earned premiums. It does not include income from

investments. This figure tells a regulator how a company is doing in the basic functions of the business -- selling insurance and paying claims.

4. The combined ratio.

The combined ratio is similar to the underwriting profit or loss. The combined ratio is the sum of the ratio of incurred losses to premiums earned and the ratio of commissions and expenses to premiums written. A combined ratio above 100 means that the industry is incurring more in claims and expenses than it is taking in in premiums.

Insurance
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February 13, 1986

Nader's Charge on Ontario, Canada Termed Misleading

The Charge: Insurance Woes Unrelated To Tort Law. Leah R. Young. The Journal of Commerce. 86/02/11. Page 14A. Ralph Nader told Washington reporters that the experience in Ontario, Canada, which has many of the tort reform measures being proposed in the United States, "shows that the insurance emperor has no clothes," since, even with tort reform, Ontario is also experiencing high premiums and a shortage of insurance coverage. Jay Angoff, counsel to the Nader-supported National Insurance Consumer Organization, said Ontario already has a cap on compensation for pain and suffering, restrictions on punitive damages, prohibitions on injured parties specifying the amount they are seeking, restrictions on attorneys' contingency fees, few jury trials, and penalties for frivolous suits.

The charge is grossly inaccurate and misleading.

* On a per capita basis, commercial liability insurance premiums are much lower in Canada than in the U.S. In 1985, liability premiums (excluding auto) averaged $18 (C$25) per capita in Canada, compared with $60 per capita in the U.S. The different legal system in Canada is the most likely factor explaining this wide divergence in the cost of insurance.

* There are problems in commercial liability insurance in Canada, but they are not as severe as in the U.S.

* The problems in commercial liability insurance in Ontario, Canada reflect:

    1) the impact of recent statutes, which increase the incentives to litigate;

    2) an erosion of traditional common law disincentives to sue;

    3) the impact of the worldwide contraction in liability insurance capacity.

Richard J. Hassen — Chairman of the Board
Dan D. Hutson — Vice Chairman of the Board
Merchlin D. Moore — President
Charles [illegible] — Executive Vice President

Commercial liability premiums in Canada are expected to show an increase of 15% for 1985, contrasted with a 72% increase in the U.S.

There are, however, some problems of availability of commercial liability insurance in Ontario. This province is known to be litigious. Specific statutory provisions have increased the number and size of claims in Ontario Province:

a) The Family Law Reform Act of Ontario Province (1978). This law extended the number of persons who could sue. For example, under this law a person with only passing acquaintance with another relative (say a cousin or nephew) can sue for loss of companionship.

b) The province of Ontario passed a prejudgment interest act, which adds interest to awards from the date of filing.

Also, judicial procedures in Ontario have tended to increase awards beyond expectations. For example, courts in Ontario have tended to add to the award enough money to cover the taxes on interest earned from the award in future years.

In addition, Canada is affected by the worldwide shortage of liability insurance, caused mainly by severe losses by reinsurers in the U.S. market.

The Province of Ontario did not enact a series of tort reforms as might be inferred from the Nader charges. The reforms mentioned are features of the common law system and are not statutory law. Since they are part of common law, they are subject to change by judicial decision and, in fact, there has been erosion in these areas in recent years.

The following reviews the elements of the legal system in Ontario, Canada, that are highlighted in the Nader charge:

1) Cap on compensation for pain and suffering

In the early 1970s, Canadian courts established through case law a cap of C$100,000 on pain and suffering awards. The cap has since been eroded and the figure now is C$180,000. (Since the cap is set by case law, it can be changed by case law.)

2) Restrictions on punitive damages

These restrictions also are set by case law and have been in place for many years. The restrictions in Canada are in general tougher than those used by U.S. courts.

3) Prohibition on injured parties specifying the amount they are seeking.

This prohibition holds that a jury cannot be directly informed or led by evidence to know the amount of damages sought by a plaintiff. This rule is a common law rule and has been in place for decades.

4) Restriction on attorney's contingency fees.

In Ontario, attorneys fees are set by the Law Society. Contingency fees are prohibited.

5) Few jury trials.

Traditionally, Canada has used juries infrequently in civil cases.

6) Penalties for frivolous suits.

Defendants who win suits can collect legal fees and other costs from plaintiffs. This system has been in place for decades.

Insurance
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110 William Street
New York, NY 10038

February 11, 1986

Nader/Hunter Challenge

The Property/Casualty insurance industry shares the concern of state and federal public officials, business and the general public about developments leading to restricted insurance coverages and the rising cost of commercial insurance protection. The insurance industry is deeply disturbed about the actions it has felt compelled to take in certain lines of insurance and for selected types of coverage. The industry welcomes the commitment of the affected policyholders and public policymakers in restoring the legal and regulatory stability needed to provide a responsive insurance market. The industry already has responded with a number of programs in various states aimed at alleviating the distress in various industries.

The industry recognizes that competitive price cutting by the industry in the first half of the 1980's has been a major factor behind the current large increases in rates for commercial liability insurance. The industry beginning about 1979 entered a period of fierce price competition with two major results:

- commercial businesses throughout the U.S. got bargains in the purchase of liability insurance,

- the insurance industry ended up posting record operating losses in 1984 and 1985.

Richard J. Bagyen
Chairman of the Board

Don D. Hutson
Vice Chairman of the Board

Merlin D. Moore
President

However, the obvious cyclical factors in the industry tended to obscure a basic phenonomen which had been impacting on the liability insurance system for decades, namely the mushrooming growth in litigation in the U.S., and the associated problem of expanding concepts of liability.

Certain critics of the industry contend that the problems in the availability and affordability of commercial liability insurance are totally due to the competitive nature of the industry and are unrelated to developments in the tort system. The following pages provide brief responses to this and related challenges to the industry.

CHARGE: There is not a tort litigation explosion in this country.

There is a crisis in the civil justice system in America. It is not manufactured by the insurance industry.

* Awards are growing at an alarming rate.

In 1984, there were 401 awards of a million dollars or more in the U.S., up from 372 in 1983. In 1962, in a less litigious era, there was only one award over a million dollars.

The average size of verdicts for three common injuries -- cervical strain, knee injuries and vertebrae fractures -- and for wrongful death of adult males, increased at an average rate of 14.3% between 1974 and 1984, more than double the rate of inflation.

* Cases filed have grown at a spectacular rate.

In federal courts, product liability suits jumped 600% in ten years, from 1,579 in 1974 to 10,745 in 1984.

In state courts, the growth in filings has been at least four times as fast as the increase in population.

* We produce lawyers in this country at a faster rate than we produce babies. The annual rate of growth in the number of lawyers is six times the growth rate in population. Between 1970 and 1980, the number of lawyers in the U.S. increased 68%, while the overall population increased only 11%.

* In the insurance industry our loss data show what's happening. From 1965 to 1985, losses (dollars to be paid out in claims) in commercial liability insurance increased 2,046%, while inflation was up only 242%.

In 1984, losses in commercial liability insurance increased 25%, and in 1985 losses increased 43%.

* The civil justice system is grossly expensive. For example, in Los Angeles a typical trial costs the taxpayers $11,000.

* The system sometimes delivers meager justice. In asbestos cases, claimants receive only 37 cents of every dollar. The other 63 cents go to pay for litigation costs, according to a recent Rand study.

* The most eminent jurists in the United States believe there's a crisis.

In the words of Chief Justice Burger, the process of going to trial is "not only stressful and frustrating, but expensive and frequently unrewarding for litigants." Other critics of the system include Derek Bok, president of Harvard University and former dean of the Harvard Law School, as well as former Attorneys-General William Smith and Griffin Bell.

Last, but by no means least, is the opinion of the American public. Surveys conducted by the Gallup Organization and Cambridge Reports, Inc. show that the public is fed up with the system.

-- People complain about the excessive delays and outrageous costs of the system.

-- People favor reforms. They favor arbitration as an alternative to going to court.

-- People favor limitations on pain and suffering awards. They favor limits on contingency fees.

Why are people fed up with the sy ? Because they recognize that what's happening in our society is wrong.

-- In N.J. the Supreme Court ruled that you can't throw a party in your home and serve drinks without running the risk of being sued if someone is injured by an intoxicated guest.

-- Doctors, in addition to taking courses in healing people, are taking courses in how to avoid being sued. According to the AMA, $17.5 billion is spent in this country on defensive medicine - that's for unproductive tests designed to avoid lawsuits.

-- The threat of lawsuits is discouraging the manufacture of vaccines designed to prevent illnesses.

-- Directors of publicly-held companies are resigning because of the rise in lawsuits.

In sum, this is a basic issue of consumer and human rights. The trial lawyers naturally want the insurance industry to be around, because this is the deep pocket that funds them. But who pays for all this?

The answer is well known. Consumers - the general public - pay through higher insurance premiums. In sum, the insurance industry's current high rates are the symptom not the disease.

The pendulum has swung too far to one side -- we have too many lawyers, too many lawsuits and too many changes in legal doctrine.

Specific Nader-Hunter Challenges:

CHARGE:

The insurance industry is exempted from federal anti-trust law. (The implication being that insurance companies act as an OPEC-like monopoly to gouge consumers).

The insurance industry is not exempted from federal antitrust law. The McCarran-Ferguson Act of 1945 provides that regulation of the insurance industry should occur at the state level. However, federal anti-trust laws apply under McCarran-Ferguson if state regulation is deemed to be ineffective and the Sherman Act always applies in cases of boycott, coercion or intimidation. Federal agencies have exercised regulatory powers. The Department of Justice, for example, has successfully challenged acquisitions in the insurance industry which were viewed as discouraging competition. (U.S. vs. Chicago Title and Trust Co., et al., 242F. Supp.56, N.D.,Ill. 1965.)

CHARGE:

The insurance industry reports only underwriting losses. The industry states that in the ten years 1976 to 1985 insurance companies lost $81.3 billion. Insurers neglect to mention their investment income over the same period of $119.8 billion. So overall they made $38.5 billion.

-- The industry reports data including investment income. I.I.I. reports such data to the trade and general public every quarter. Key sources of data, I.I.I. Fact Book, and Best's Aggregates and Averages, prominently display data on investment income.

-- While $38.5 billion sounds like a lot of money, it amounts to an average of $3.85 billion per year. Premiums over this period averaged $96.8 billion so that profit margin on premiums was only about 4% -- 4 cents on the dollar, a profit margin below the rate achieved by most U.S. corporations. For the ten years 1975 through 1984, the rate of return on net worth in the industry averaged 10.9%, 2.3% points below the 13.2% rate of return for U.S. industry.

CHARGE:

The insurance industry pays little in taxes.

Adding up federal, state and local taxes, the industry pays about the same as the average for U.S. manufacturers.

The property/casualty industry pays relatively low federal taxes because much of its income is from tax-exempt state and local bonds.

CHARGE:

The increase in insurance rates is causing an inflationary jolt to the U.S. economy.

The property/casualty insurance industry makes up only 3.6% of the U.S. economy. A 21% increase (as occurred in 1985) in insurance premiums would not even change the inflation rate by a single percentage point.

Insurance rates have been a deflationary force over the past few years. Between 1978 and 1984, the consumer price index increased 59.2%. Premiums increased only 44.6% over the same period.

CHARGE:

The insurance industry won't tell us what we want to know. I have been asking for data, line by line, state by state showing data as follows:

Column 1	Premiums paid
Column 2	Losses paid
Column 3	Investment income

These data are available by line and by state.

Close to 2,000 insurance companies representing over 97% of insurance premiums report data on premiums, losses and expenses, by line, by state, every year.

They report this information in a document called the "Annual Statement", which is over 60 pages long, and contains details on premiums, losses, expenses, investments and taxes.

Insurance companies report on 28 separate lines of insurance. Data on small lines, such as day-care centers or professional liability for accountants, are included in aggregates and are not reported separately in the Annual Statement.

Investment income is not reported by line, as a company manages its investment portfolio as a whole. However, allocations can be made to lines of insurance and are reported on this basis in Best's Aggregates and Averages. (See, Best's Aggregates and Averages, 1985, pages 78 and 79).

CHARGE:

The insurance industry reports fictitious losses. They refer to incurred losses but don't tell us about paid losses.

Close to 90% of incurred losses are paid losses. Incurred losses represent losses paid, plus dollars set aside to cover losses to be

paid in future years. In many areas of insurance, such as medical malpractice, there is a time difference between when an accident occurs and when a claim is paid. The time difference can be quite long. In liability cases, the process of gathering evidence and court delays can result in a difference of many years between the time an accident occurs and the suit is finally resolved.

CHARGE:

Lloyd's holds the U.S. insurance industry in a vice-like grip. Lloyd's operates without any regulation and is dictating to the United States changes in our civil justice system.

It is estimated that Lloyd's writes only 1% of the reinsurance (insurance for insurance companies) in the U.S., so it can hardly be viewed as controlling the U.S. market. Lloyd's has lost a lot of money in liability insurance in the U.S. Its latest results show that while only 12% of its worldwide premiums were in liability insurance, this line was the source of 100% of its financial losses.

Like any responsible company, Lloyd's began withdrawing from areas where it was losing money, and stated the conditions under which it believes it can write business on a profitable basis.

Lloyd's is an accredited reinsurer throughout the U.S., an eligible excess or surplus line insurer in all jurisdictions as well as a licensed insurer in Illinois, Kentucky and the U.S. Virgin Islands. In addition, a number of federal agencies have also recognized Lloyd's insurance. Each year, Lloyd's files audited

financial statements with the U.S. Treasury Department, many State Insurance Departments and the National Association of Insurance Commissioners.

CHARGE:

Insurance companies say they are losing money, yet their stocks were up over 50% last year.

Every analyst of the industry forecast the property/casualty insurance industry would recover. The stock market practically always rises when it is generally believed that a depressed industry is on the road to recovery.

In general, the stock market is a poor indicator of the financial health of an industry. In 1977, the property/casualty stock index fell 4%. The following year, the industry recorded one of its most profitable years in history, with an 18.1% return on net worth.

CHARGE:

What is needed is a federal insurance office to review the industry and to set standards for state regulators.

What is being proposed is some kind of dual regulatory system. These systems don't work very well, as we know from the banking industry.

The banking industry has a dual system of federal and state regulation. Yet, the failure rate of banks is far higher than that of

the insurance companies. In addition, despite federal regulation and a federal insurance system, bank failures in recent years have cost taxpayers billions of dollars. One bank, Continental Illinois, received a commitment of $4.5 billion from the federal government to stave off bankruptcy. Failures in the insurance industry do not cost taxpayers, as they are covered by state guaranty funds which are collected from the insurance industry itself.

CHARGE:

What is needed is a federal reinsurance program. Reinsurance is largely concentrated among foreign firms. This would free U.S. business from foreign tyranny just as the goal of energy independence was designed to free U.S. citizens of pressures exerted by oil-producing nations.

A federal reinsurance program could cost the taxpayers of this country billions of dollars. Under a general federal reinsurance program, insurance companies could lay off all their bad risks on the federal government while maintaining only the profitable risks. This also would mean that the losses now being suffered by reinsurers in U.S. markets would be borne by the Federal government, rather than by the private sector.

The foreign tyranny assertion is baseless. About 75% of the reinsurance market is in the U.S. The main advantage of keeping U.S. reinsurance markets open to foreign companies is that the supply is expanded. This means that more insurance capacity is available to

U.S. firms and at a cheaper rate than if reinsurance were restricted to the U.S. companies alone.

Also, pursuing a protectionist policy in insurance markets would have the same negative repercussions of protectionism as in any other industry. Other nations would retaliate, not only against U.S. insurance companies operating abroad, but also against other U.S. exporting industries, such as aircraft manufacturing and agriculture.

In general, the reinsurance industry represents less than 10% of primary premiums. (I.I.I. Reinsurance Monograph, page 60). About 75% of this market is with U.S. companies, and 25% with foreign re-insurers. (I.I.I. Reinsurance Monograph, page 42).

CHARGE:

Thirty-eight states have laws that protect insurance agents by denying groups the right to form their own cooperative insurance coverage.

There are very few restrictions on the formation of groups to purchase insurance or to self-insure. In fact, it is estimated that 25% of commercial lines insurance is in the self-insurance area. Group insurance policies, such as those purchased by employers for their workers or unions for their membership, are allowed in all states. The laws in question deal only with the formation of "fictitious" groups, that is a group of people, who have no formal

relationship with one another. The prohibition on "fictitious" groups is designed to protect consumers who cannot join such "fictitious" groups from paying more for an insurance policy.

CHARGE:

State regulation of insurance is so weak as to be almost non-existent. Only half the states have actuaries on their staff.

The major states have full staffs of qualified actuaries. Small states without actuaries regularly hire actuaries on a contractual basis and consult with experts in other state insurance departments when they have an actuarial problem. In addition, the NAIC publishes actuarial guidelines in its field examiner's handbook and has set up an actuarial task force to deal with problems common to all states. Moreover, insurance companies often are examined by regulators from several states who pool information on companies.

February 18, 1986

NADER'S CHARGE ABOUT ONTARIO TERMED INACCURATE AND MISLEADING

At a press conference in Washington, D.C., on Feb. 10, Ralph Nader reporters that Ontario, Canada, is experiencing high premiums and a shortage of insurance coverage despite having laws which have many of the tort reform measures being proposed in the United States. Representatives for the National Insurance Consumer Organization said that Ontario already has a cap on compensation for pain and suffering, restrictions on punitive damages, prohibitions on injured parties specifying the amount of the award they are seeking, restrictions on attorneys' contingency fees, few jury trials, and penalties for frivolous suits.

This represents another misleading charge from Nader/Hunter. Here are the facts:

* On a per capita basis, commercial liability insurance premiums are much lower in Canada than in the U.S. In 1985, liability premiums (excluding auto) averaged $18 (C$25) per capita in Canada, compared with $60 per capita in the U.S. The different legal system in Canada is the most likely factor explaining this wide divergence in the cost of insurance.

* There are problems in commercial liability insurance in Canada, but they are not as severe as in the U.S.

* The problems in commercial liability insurance in Ontario, Canada reflect:

1. The impact of recent statutes, which increase the incentives to litigate.

2. An erosion of traditional common law disincentives to sue.

3. The impact of the worldwide contraction in liability insurance capacity.

Commercial liability premiums in Canada are expected to show an increase of 15% for 1985, contrasted with a 72% increase in the U.S.

There are, however, some problems of availability of commercial liability insurance in Ontario. This province is known to be litigious. Specific statutory provisions have increased the number and size of claims in Ontario Province:

a. The Family Law Reform Act of Ontario Province (1978). This law extended the number of persons who could sue. For example, under this law a person with only passing acquaintance with another relative (say a cousin or nephew) can sue for loss of companionship.

b. The province of Ontario passed a prejudgment interest act, which adds interest to awards from the date of filing.

Also, judicial procedures in Ontario have tended to increase awards beyond expectations. For example, courts in Ontario have tended to add to the award enough money to cover the taxes on interest earned from the award in future years.

In addition, Canada is affected by the worldwide shortage of liability insurance, caused mainly by severe losses by reinsurers in the U.S. market.

The Province of Ontario did not enact a series of tort reforms as might be inferred from the Nader charges. The reforms mentioned are features of the common law system and are not statutory law. Since they are part of common law, they are subject to change by judicial decision and, in fact, there has been erosion in these areas in recent years.

The following reviews the elements of the legal system in Ontario, Canada, that are highlighted in the Nader charge:

1. Cap on compensation for pain and suffering. In the early 1970s, Canadian courts established through case law a cap of C$100,000 on pain and suffering awards. The cap has since been eroded and the figure now is C$180,000. (Since the cap is set by case law, it can be changed by case law.)

2. Restrictions on punitive damages. These restrictions also are set by case law and have been in place for many years. The restrictions in Canada are in general tougher than those used by U.S. courts.

3. Prohibition on injured parties specifying the amount they are seeking. This prohibition holds that a jury cannot be directly informed or led by evidence to know the amount of damages sought by a plaintiff. This rule is a common law rule and has been in place for decades.

4. Restriction on attorneys' contingency fees. In Ontario, attorneys' fees are set by the Law Society. Contingency fees are prohibited. This system has been in place for decades.

5. Few jury trials. Traditionally, Canada uses juries infrequently in civil cases.

6. Penalties for frivolous suits. Defendants who win suits can collect legal fees and other costs from plaintiffs. This system has been in place for decades.

Sean Mooney, Ph.D., CPCU
I.I.I. Senior Vice President and Economist

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

TO: ALL LEGISLATORS

FROM: CITIZENS' COALITION FOR TORT REFORM

SUBJECT: ENCLOSED DATA FOR YOUR USE AND REVIEW

Thanks,

Al Tamagni, Sr.
Chairman

738 H Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-1135

On Saturday February 1, 1986, the Fort Richardson Flying Club's flight operations were suspended due to the inability of the Department of the Army to negotiate the renewal of the excess liability policy with the previous carrier. The suspension also affects the Fort Wainwright Flying Club. The remaining Army Flying Clubs are not affected.

The Alaska Flying Clubs do approximately 25% of the total flying of all Army flying clubs. There are currently 289 members of which 74 are Active Duty Military, 50 Reserves, and 57 Retired Military. Dues are assessed at $15.00/month.

The Army is requesting a maximum liability of $250,000 per seat and $5,000,000 per occurrence, with a $100,000 deductible. The deductible is self-insured by the Army's established rate for hull and liability to $100,000.

The majority of Anchorage area flight schools are currently carrying $100,000 per seat liability and $500,000 per occurrence. The Armys established limits may not be affordable for the flying club to continue operations.

The impact on the Fort Richardson Flying Club is wide ranging as outlined below:

1) Financial - The club's annual operating budget exceeds $500,000 per year. The eleven (11) member staff has an annual payroll of approximately $136,000. The maintenance on the airplanes is accomplished by a contracted mechanic at a cost of $25-30,000 per year.

2) Contracted personnel:

a. Thirteen (13) Flight Instructors - per hour basis.
b. Eighteen (18) lease back airplane owners - per hour basis.

3) Alaska State Student Loan (ASSL) Program - Currently approximately 35 students are utilizing the ASSL Program with approximately $85,000 on account at the flying club. ASSL funds are required to be placed on account at the flying club. The state requires 25 hours of instruction per three month period or 8.3 hours per month. An extended down time can put many students in non-compliance with state requirements for maintaining full-time status.

4) Veterans - The Flying Club is approved for the training of Veterans for flight training. There are currently twelve (12) members using veterans assistance for flight training.

5) Current students - there are approximately 107 current students enrolled in the flying club - includes ASSL students. In CY1985 there were 91 students who obtained pilot ratings.

As a Veteran utilizing the flying club for flight training, I have been unable to train since 1 February 1986. In the event of a permanent closure, I would be forced to transfer schools and run the risk of losing my benefits for flight training as the maximum allowed break in training is six months.

I feel the Army should do the following:

1) That the Department Army (ACIF) Army Central Insurance Fund set obtainable and affordable liability limits.

2) That the Army Central Insurance Fund self-insure the flying clubs until an acceptable commercial policy is obtainable, and if that is not possible, then the ACIF establish a reasonable rate for the liability deemed necessary to maintain the airplanes.

SIGNED_____ DATE _____

CLUB MEMBER (FT. RICHARDSON FLYING CLUB)

ADDRESS:

_____

_____

PHONE # (H)_____ (W)_____

Is It Us?

The following is a condensed transcript of an interview conducted by the AIA with Victor O. Schinnerer & Company management, including J. Sprigg Duvall, president; Paul Genecki, senior vice president, and Thomas H. Porterfield, vice president.

AIA: Both DPIC and Victor O. Schinnerer (VOSCO) had agreed to meet with us today but we were advised yesterday that DPIC had decided that they could not make the meeting. And so we are with VOSCO people only. But in this current market, they provide coverage for at least half the insured architects.

Is there any good news for architects about insurance?

DUVALL: We did a study some time ago that indicated that the losses we paid in dollars represented only six one hundredths of 1 percent of the construction values put in place by the architects and engineers against whom those claims were made. That's an incredibly high performance: a very low error rate. The problem is, in those rare instances—and six one-hundredths of 1 percent means a rare instance—it's very costly.

AIA: Looking at that small percentage, what can architects learn from those claims?

DUVALL: If you look at the period '80 to '84, the frequency of claims against architects did not increase all that much. It went from 43 per 100 insureds in 1980 to 44.4 in 1984. So it's not the frequency of claims; it's the severity of them that is the problem.

AIA: Of the claims that go to trial, do architects win more or lose more?

GENECKI: They win two-thirds of all the claims that go to court.

DUVALL: But I'm afraid in most of the cases we settled out of court, there really was a basis for a finding of fault against the [illegible]ed, in the minds of our defense lawyers and probably the [illegible]itects themselves, because they had to give their permission to settle the cases.

AIA: What kinds of people were the claimants?

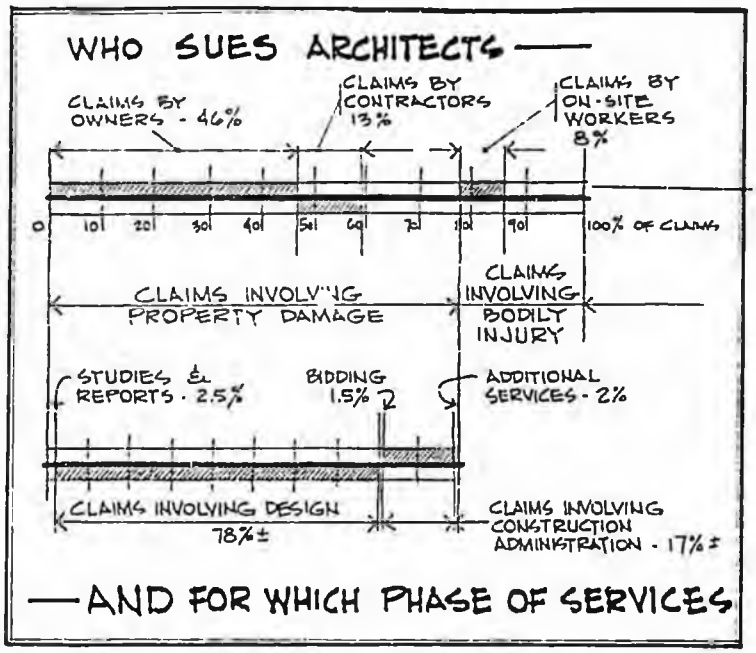
DUVALL: The most recent study we did involved 802 claims on architectural projects, and in 372 of those, the claimant was the owner.

AIA: So these were claims that might have been prevented contractually?

DUVALL: Not in every case, because I suspect some number of these claims by owners were actually third-party actions when the owners had been sued by the contractors. The second largest category is bodily injury claims by the public.

AIA: Is there any way architects can use these data to protect themselves?

DUVALL: As a starting point, architects should use the standard AIA documents. Also, if I were an architect, I would be very careful about the financial integrity of my client. I'd be very careful about the degree to which he had been involved in previous construction and how that had turned out.



AIA: What else do the claims data say?

DUVALL: I think the claims data would disabuse a lot of architects about what they think the problems are. I know in the past, there was a feeling that bodily injury and death was a major element. The fact of the matter is, although 22 percent of the claims involve bodily injury and death, only 15 percent of the loss dollars are spent on those claims. If we could eliminate that 15 percent, we would avoid probably one year's rate increase.

AIA: Then pain and suffering would not be architects' issues?

DUVALL: Not major issues, no.

AIA: Is it true that half of the 22 percent of the bodily injury claims involve on-site workers?

GENECKI: Yes. They're the biggest single group we can identify.

AIA: So if we could convince state legislatures to include us under the workers' compensation umbrella, we could put an end to 50 percent of the bodily injury claims.

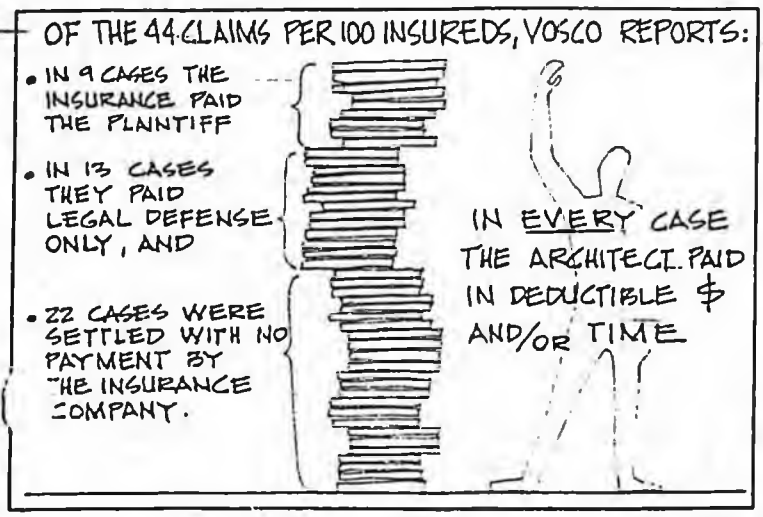
At the same time, architects feel that the judicial system is a lottery and that there's no predictable fairness to it all. Do the claims data bear out that sentiment?

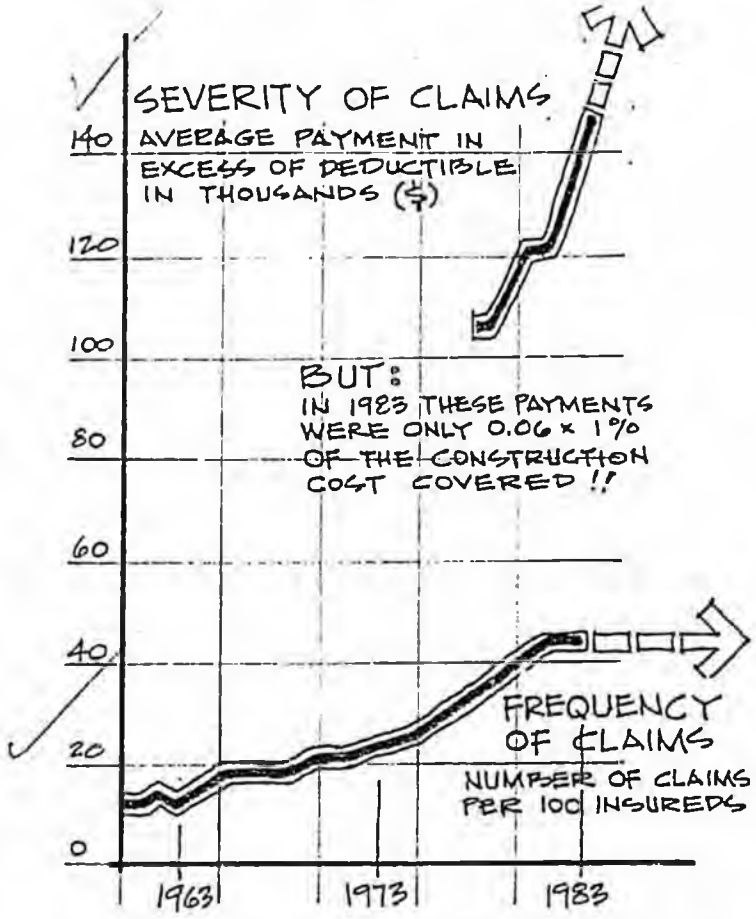
DUVALL: Well, we've paid when we thought we would win; we've won when we thought we would lose. But I think, overall, we've probably paid when we should have and won when we should have.

PORTERFIELD: We don't believe the legal system is out to get design professionals.

DUVALL: I think it's more a case that buildings are very complicated. To me, a modern building is very much like a ship, and there are virtually no ships that are perfectly designed, and there are virtually no buildings that are perfectly designed. Buildings, like ships, need shakedown cruises. There's going to be a list of things that need correction. The problem is that where years ago owners looked to architects to pay only for the major corrections, now they're looking to them to pay for more and more.

AIA: What's an architect to do, then, given that mentality?





DUVALL: In the short term, if I were an architect, I would be collecting my insurance premium as a direct reimbursement. As a reimbursable expense, it would be provided in the contract that the owner is going to pay to the architect a percentage of each billing, which will be a line item for insurance. And if my insurance costs are $2.20 per $100 of billings and I've billed the client for $10,000, I'm going to charge him $220 and show it as an item.

Now, the argument is that'll encourage claims, but when you've reached the point where claims are running at 44-plus per hundred insureds, there's not much more claims encouragement you can give. That is a frightening frequency of claims.

AIA: What else could an architect do?

GENECKI: He could build into his contract that, after some period of operation of the structure, the owner will, on a fee basis, have the architect come back and make a detailed analysis, a walk-through of the structure, to see if maybe there are some maintenance items that the owner is not particularly aware of. Or the architect finds out that the building is being used a little differently from the way he was told originally and adjustments need to be made.

AIA: By the same token, could you say, given the fact that roofs are the primary cause of claims, that the architect should go back and watch the supervision of the placement of the roof on [illegible] building? On the one hand, architects could increase their [illegible]ntial liability because they would be physically on the roof observing the entire installation; on the other hand, they might decrease liability because finally roofs would be put on correctly. Do you have any feelings about that at all—which argument is the stronger of the two?

GENECKI: We'd rather see them out there

DUVALL: The presence of a knowledgeable person has got to create some deterrent to the roofing subcontractor from cutting corners, if nothing else.

GENECKI: Surely if the roof does fail, then the courts, the owner and everybody else are going to expect the professional would have been more involved.

AIA: But they expect it anyway.

DUVALL: Yes, I'm not sympathetic to these theories of "let's not do that because by doing it there is more liability."

AIA: You'd probably say charge more and be present.

DUVALL: Charge more and do it. Be there—with knowledgeable people. Just a body there isn't going to do it.

Here we're touching on another subject that is near and dear to me, and that is, I don't think architects charge enough [illegible] and I don't think architects pay their consultants enough, and I think a lot of these things happen because there isn't sufficient talent, sufficient staff available, competent staff to get done what needs to be done to avoid having these problems. I think the fees are remarkably low.

GENECKI: Sticking with roofing, we don't have the empirical evidence yet, but it's my guess that 50 percent of all of the claims involving roofing also involved the substitution of material or a system different from that in the original drawings and specs.

AIA: That gets us back to the 78 percent of the cases that are property damage. You say 46 percent of those are initiated by the owner. Is it possible that those claims could be defeated, so to speak, by having better owner-architect relations or having better owner-architect contracts?

GENECKI: Yes, especially if you include relations.

DUVALL: It used to be that nobody wanted to talk to the owner about the possibility that disputes could arise. At 44 claims per 100 insured we're well past it. If at the outset of a project, an architect has frankly discussed with the owner the problem and the need for some form of contingency fund, I think it can be controlled much better than it is being now.

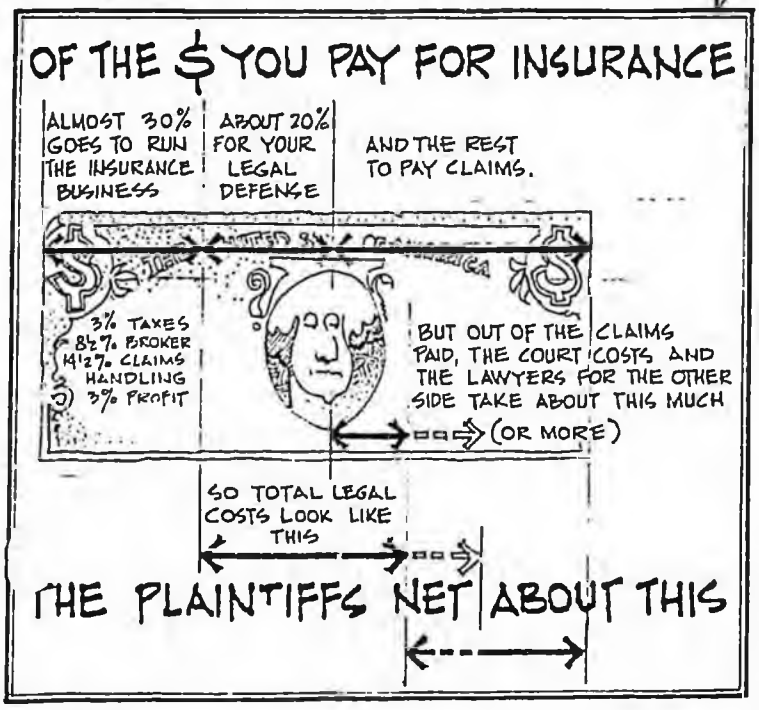
AIA: Are there any kinds of owners who need special handling, special education?

DUVALL: Well, you have the committee owners. And that generally involves churches, hospitals and schools.

GENECKI: And local government.

DUVALL: Churches have always bothered me because they represent a disproportionate amount of loss and they have all the elements that have got to lead to problems. They have a limited budget; they always want far more than they can afford, it's a committee of amateurs. Probably most serious of all, they have a

Continued on page six



Resolution 86-4

A RESOLUTION SUPPORTING THE CITIZEN'S COALITION FOR TORT REFORM REGARDING INSURANCE PREMIUMS.

WHEREAS, the City of Houston has had its budget reserve seriously dimished by the unanticipated increase of 16% in its annual insurance premium; and,

WHEREAS, other Alaska communities, businesses, school districts, and private citizens are similarly suffering because of the need for legislative redress of the problems peculiar to the Alaska insurance industry; and

WHEREAS, Alaska has a limited availability of liability insurance programs and has experienced a dramatic rise in liability premiums; and

WHEREAS, legislative remedies are needed to restore predictability and affordability to liability insurance programs; and

WHEREAS, the Citizens' Coalition for Tort Reform has identified those areas needing legislative remedy, and have proposed solutions;

NOW, THEREFORE, BE IT RESOLVED by the COUNCIL OF THE CITY OF HOUSTON, ALASKA, that it supports the efforts of the Citizens' Coalition for Tort Reform to achieve legislative remedies, and urges the Alaska Legislature to make these reforms a priority of the 2nd session of the 14th legislature.

PASSED AND APPROVED THIS 13th DAY OF FEBRUARY, 1986.

ROBERT O. LEMOINE, MAYOR

ATTEST:

ELSIE M. O'BRYAN, CITY CLERK

D.J.'s ALASKA RENTALS INC.
Formerly Andrews Alaska Rentals & Sales
405 BONIFACE PARKWAY • ANCHORAGE, ALASKA 99504-1099
(907) 337-2552
DON REDMOND, President

December 18, 1985

Citizens Coalition for Tort Reform
738 H Street
Anchorage AK 99501

To Whom It May Concern:

D.J.'s Alaska Rentals, Inc., a tool and equipment rental agency, submits the following information that reflects typical positions of many professionals and businesses in Alaska and nationwide concerning increases in liability insurance costs:

From December 31, 1984 through December 31, 1985 our General Liability costs for $1,500,00.00 in coverage was $23,763.00. Annual cost per $1000.00 was $15.84.

From December 31, 1985 through December 31, 1986 General Liability quoted cost for ONLY $300,000.00 in coverage is $30,737.20. Annual cost per $1000.00 is $102.44, which is 6.47 times the 1985 cost!

THERE HAVE BEEN NO CLAIMS FILED!

Sincerely

Don Redmond

Don Redmond, President

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison..."

MEMORANDUM

TO: ALL LEGISLATORS

FROM: CITIZENS COALITION FOR TORT REFORM

SUBJECT: ENCLOSURE

Enclosed please find a copy of the testimony submitted by Dennis DeWitt of the Health Association of Alaska, dated February 17, 1986 to the Labor and Commerce Committee. Attached to this testimony, you will find the McMilliman and Robertson, Inc. report from the state of New York and you will also find the information from the state of California which indicates that tort reform does, can and will work.

Also enclosed you will find a letter to Mr. Richard E. Wagner from an attorney in Fairbanks regarding Rule 82.

As you have probably already been informed by the House Labor and Commerce Committee (this information was forwarded to Sid Billingsly the committee aide); that virtually all homeowners and automobile policy holders in the State of Alaska are being assessed an additional surcharge ranging in the amount of $3.00 to $45.00 per year to pay attorney fees under Rule 82. There are an estimated 300,000 to 400,000 homeowners in Alaska and approximately 300,000 to 400,000 automobile insurance policy holders.

As you can well calculate, there is anywhere from approximately 2 to 6 million dollars that are being collected and paid out in attorneys fees simply because of Rule 82, which is obsolete due to the fact there is no need for the rule and Alaska is the only State with such a rule remaining.

Additionally, as you will see, the new Federal Insurance Administrator has a position as to how really effective the riot insurnace was that was established by Mr. Hunter.

Also enclosed are the remarks made to the joint House and Senate Labor and Commerce committee by David J. Frazier, Chairman of the Board of MICA.

This is for your information and hopefully will be useful in determining the facts of tort reform.

Sincerely,

738 H Street, Suite 300 • Anchorage, Alaska 99501 • (907) 276-1135

health
association
of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Tom Boling
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Marine Robertson
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Ketchikan

Alternate Delegate to the
National Congress of
Hospital Governing
Boards
Sharon Jean
Central Peninsula
General Hospital
Soldotna

Physician Member of
the Board
Morris Horning, M.D.
Anchorage

President
Dennis DeWitt
Juneau

FORMERLY

alaska
state
hospital
association

Testimony Before the
LABOR AN COMMERCE COMMITTEE
February 17, 1986

Mr. Chairman and members of the Labor and Commerce Committee. I am Dennis L. DeWitt, President of the Health Association of Alaska. The Health Association of Alaska represents 31 hospitals and nursing homes in Alaska. I appreciate the opportunity to testify before you on the issue of liability insurance and tort reform.

You are no strangers to the crisis facing Alaskans today. Our membership shares the problems of accessibility and affordibility just the same as every other segment of society today. We are concerned with both parts of the problem and urge you to adopt a bill such as HB 552, as we believe that it will help us address both parts of the crisis.

We believe that the study by Milliman & Robertson, Inc., Consulting Actuaries demonstrates that tort reform will have a beneficial impact on the liability crisis. The study, which is attached, shows that there is a potential savings of 28% by passing legislation requiring periodic payments, collateral source offset, limitations on non-economic damages, and contingency fee limitations.

In California tort reform was passed in 1975. A summary is attached. It took 10 years and five court suits to get it validated by the California State Supreme Court. Anticipating court challenges following the enactment of the reform, and pending definitive appellate court determinations (the first issued in July of 1984), many many trial court judges were not willing to apply the reforms, and defense attorneys did not seek authorized protections. Nonetheless, observers detected an impact at the settlement stage of court action, as well as significant psychological impact in prompting physicians to form their own insurance carriers.

We hear a great deal about protecting the consumer. I suggest that it is the consumer that will benefit from tort reform. The cost of malpractice insurance is reflected in prices to the public. The more significant issue is the level of coverage.

South Peninsula is limited to $500,000 of insurance. Thus if you or I were injured and permanently disabled as a result of an accident that occurred while we were there for treatment our recovery would be limited to $500,000 and the keys to the hospital. That translates to about $15,000 for the next 38 years for salary replacement for Mr. Navarre pls the right to effectively manage his new enterprise, the South Peninsula Hospital. We simply do not believe that this situation is in the best interest of the consumer.

We believe that the Rand study, the actuarial studies, and the history of California tort reform indicate that tort reform does solve the availability and affordibility issues in terms of liability insurance. We also believe that the reforms found in HB 532 are reasonable and will, if adopted, contribute significantly to the solution.

I would be pleased to respond to any questions.

Moreover, data now available indicate a slower rate of increase in the average plaintive verdict award and the cost of physicians' malpractice insurance premiums. Recent information shows that in 1984 the average jury award for a medical malpractice case in California was $396,662, compared to the national average of $974,858. (To place this in context, it should be noted that the average plaintiff award in California for all personal injury suits combined is slightly higher than the national average.) Although the national experience is rising malpractice awards, 333% since 1975, the upward trend in Calfornia for the same period is markedly slower, showing an increase of only 150%.

Similarly, physicians' malpractice premiums in California in 1974 had an average increase of only 16% compared to the national average increase of 32% for all physicians.

Hospitals and nursing homes in Alaska are facing increasing premiums and decreasing limits of coverage. MICA informed its insured that the 1986 premium would double and the coverage would be limited to $500,000 per exposure and $1 million in the aggregate per year. For facilities that is a decrease from $10 million in 1985.

I would like to share three specific examples with you. At South Peninsula Hospital in Homer which is insured by MICA, the 1985 premium was $35,232 with $10 million exposure, the 1986 premium was $69,236 with a per occurrence limit of $500,000 and aggregate of $1 million. Kodiak Island Hospital is insured with a captive group through the Lutheran Hospital and Home Society of Fargo North Dakota(LHHS). They have the advantage of a large homogeneous group with a broad base. They are self insured as a group for the first $20 million. Their 1984 rates were $9,174, 1985 rates were $23,254, and 1986 rates of $47,000. The coverage has changed in that in 1984 the Society self insured the first $ 2.25 million but now must self insure the first $25 million. Central Peninsula Hospital in Soldotna also with the LHHS has had premium increases from $14,894 in 1984 to $135,000 in 1986.

MILLIMAN & ROBERTSON, INC.
CONSULTING ACTUARIES

TWO PENNSYLVANIA PLAZA NEW YORK, N.Y. 10001
212/279-7166

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MARTIN FELDMAN, F.S.A.
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STEVEN G. SORRENTINO, A.S.A.

WENDELL MILLIMAN, F.S.A.
STUART A. ROBERTSON,
CHAIRMAN EMERITUS

September 11, 1985

Mr. Kirk Johnson
General Counsel
American Medical Association
535 North Dearborn
Chicago, Illinois

Dear Mr. Johnson:

We have completed our review of the potential medical professional liability cost savings related to the American Medical Association (AMA) proposed National Professional Liability Reform Act of 1985 (the Bill). This report describes our approach, our conclusions and a number of important limitations related to this type of analysis.

APPROACH

The objectives of this project were as follows:

1. To identify the potential one-time savings in medical professional liability cost attributable to the four tort reforms in the Bill. (We did not attempt to assign a value to the peer review, discipline and risk management aspects of the Bill.)

2. To identify the potential reductions in medical professional liability claim severity trend rates attributable to the Bill.

Our approach to achieving this objective included the following steps:

1. Estimate the medical professional liability premium (including self-insured costs) in the United States in 1984.

2. Estimate a range of potential savings for each of the four tort reforms in the Bill separately and combined. The bill language we evaluated is included in Appendix A.

We hear a great deal about protecting the consumer. I suggest that it is the consumer that will benefit from tort reform. The cost of malpractice insurance is reflected in prices to the public. The more significant issue is the level of coverage.

South Peninsula is limited to $500,000 of insurance. Thus if you or I were injured and permanently disabled as a result of an accident that occurred while we were there for treatment our recovery would be limited to $500,000 and the keys to the hospital. That translates to about $13,000 for the next 38 years for salary replacement for Mr. Navarre pls the right to effectively manage his new enterprise, the South Peninsula Hospital. We simply do not believe that this situation is in the best interest of the consumer.

We believe that the Rand study, the actuarial studies, and the history of California tort reform indicate that tort reform does solve the availability and affordibility issues in terms of liability insurance. We also believe that the reforms found in HB 532 are reasonable and will, if adopted, contribute significantly to the solution.

I would be pleased to respond to any questions.

3. Estimate the potential impact on claim severity trend rates of the reforms in the Bill.

SUMMARY OF CONCLUSIONS

The next three sections describe the results from each of the thre areas.

Estimated Premium

Table 1 below summarizes the result of our review of medical professional liability costs in the United States in 1984. Appendix B describes the sources of these estimates.

Table 1

Estimated Medical Professional Liability Premium Costs in the United States

	Item	Amount in Millions
1.	U.S. Direct Written Premium 1984	$2,258
2.	Joint Underwriting Associations (JUA) not included in 1	120
3.	Patient compensation funds (PCF), Catastrophe funds (Cat Fund) and other "pay-as-you-go" financial mechanisms	166
4.	Hospital self-insurance programs and hospital programs insured outside the United States	200
5.	Total	$2,744

The $2.7 billion total somewhat underestimates the 1984 cost since we could not identify a source which would permit us to estimate the cost of all governmental self-insurance programs nor the amount of premiums paid directly to non-United States insurers.

Our experience with medical professional liability insurers, JUA's and PCF's indicates that costs have been increasing at more than 15% per year since 1984. By 1986, medical professional liability costs are therefore likely to exceed $3.6 billion.

Potential Initial Savings

Table 2 below summarizes our estimates of the potential savings for each of the four tort reform components for a typical state.

Table 2

Potential Initial Savings from Reform Bill

Item	Potential Savings ("Typical" State)
Periodic Payments	6%
Collateral Source Offset	8%
Limitation on Non-Economic Damages	12%
Contingency Fee Limitation	9%
Total	28%

Applied to the 1984 medical professional liability costs of $2.7 billion, the potential initial savings is approximately $800 million. Applied to the estimated 1986 medical professional liability costs of $3.6 billion, the potential initial savings is approximately $1.0 billion.

Appendix C describes the models used to develop these estimates. In addition to the cautions in the LIMITATION section below, the following should be considered:

1. To realize the potential savings it is necessary that law impact claim settlements to the same extent as court awarded claims, even though the statutory language only applies specifically to court awards. In the extreme case, if the law had no effect on settlements the value of the savings when applied only to court awards would be approximately 5%.

2. The savings will vary from state to state based on considerations which are discussed in Appendix C. Application of models to a range of state situations implies that the range of savings within which the experience of most states is likely to fall would be 23% to 33%.

3. The potential initial savings might not be fully reflected in cost reductions immediately after passage of a state law. Insurers and JUA's might be reluctant to decrease rates by the full amount of potential savings until the effectiveness of the law could be tested. PCF's generally charge premiums based on expected claim payments. For several years after passage of state law claim payments will reflect the prior law, and PCF charges will not be immediately affected. Self-insurance costs may be subject to considerations like those of insurers if the self-insurance program is fully funded or like those of PCF if the self-insurance program is not fully funded.

If the laws were applicable to claims reported on or after the effective date then it could take three to five years to realize the full initial cost savings. If laws were applicable to claim occurrences on or after the effective date then it would take two to three years longer (five to eight years) to realize the full initial cost savings.

Impact on Trends

The element of the Bill which we anticipate will have a significant effect on claim severity trends is the limitation on non-economic damages. Appendix C describes the manner in which the impact of the law on cost trends has been estimated.

We believe the reduction in trend over the 1986-1989 period for a typical state will approximate 4% per year, with most states realizing a trend savings ranging from 3% to 6%. The trend reduction in the typical state is equivalent to $80 million per year at 1984 cost levels and $100 million at 1986 cost levels. The annual savings will continue to increase since rising cost levels will increase the $2.7 billion base ($2.0 billion after the law change) and inflation will increase the potential for non-economic loss in excess of $250,000 per claimant.

LIMITATIONS ON RESULTS

The following limitations should be considered in utilizing these results:

1. The projected potential savings rely on models which depend critically on the judgments which are applied. We believe the judgments are reasonable. Other reasonable judgments could result in significantly different results.

2. The actual savings which might result from passage of these tort reforms will depend on factors such as plaintiff behavior, attorney behavior and court interpretations which cannot be predicted in advance. Actual results may therefore differ significantly on these projections.

3. There are a number of studies underway (the GAO study for example) which are gathering statistical and non-statistical information. If such information were currently available it could significantly affect our judgments and conclusions. As part of this project we are not responsible for updating this report to reflect information which becomes available after the report is issued.

4. The Bill is currently in outline form. Actual bill language could produce results which differ from the intended results. We have relied on interpretations from AMA Counsel regarding the intentions of the bill language.

   We assume that the agency responsible for administering the Bill would prepare minimum criteria which any state law would need to meet in order to become eligible for the benefits under the Bill. Appendix A comments on some elements which must be included in the actual operation of a state law in order to realize the potential savings.

We appreciate this opportunity to assist the American Medical Association on this important and challenging project.

Sincerely,

Allan Kaufman

Allan Kaufman, F.C.A.S.

AK/dmk

STATE ISSUES FORUM
444 North Capitol Street, N.W.
Suite 500
Washington, D.C. 20001
202/638-1100

CALIFORNIA

Contact: Gene Marsh
916/442-5532

Development of Legislation: Medical Injury Compensation Reform Act of 1975

- California Assembly's Select Committee on Medical Malpractice formed in 1973; Preliminary Report issued in 1974 after public hearings and review of recommendations of both the State Attorney General and HEW's Report of the Secretary's Commission on Medical Malpractice;
- January 1975: two major medical malpractice insurance carriers in Southern California stop writing coverage for physicians; a third carrier in Northern California threatens to cease unless a premium rate hike of 384% is allowed;
- Northern California physicians request Insurance Commissioner's permission to form a physician-owned insurance company;
- On approval of the 384% insurance premium rate increase in Northern California, many Northern California physicians withdraw from practice: virtually all surgery was discontinued at various hospitals in the San Francisco Bay Area;
- Governor calls special legislative session to consider malpractice reform; Northern California physicians return to work.

Legislative Purpose of the Medical Injury Compensation Reform Act of 1975 (MICRA):

(1) to reduce the incidence and severity of medical malpractice injuries by strengthening governmental oversight of the education, licensing and discipline of physicans and health care providers;

(2) to curtail unwarranted insurance premium increases by authorizing alternative insurance coverage programs and by establishing new procedures to review substantial rate increases; and

(3) to reduce the costs and increase the efficiency of medical malpractice litigation by revising a number of legal rules applicable to such litigation (American Bank & Trust Co. v. Community Hospital of Los Gatos-Saratoga, 36 Cal.3d 359, 363-64, 1984).

Enacted Legislation

The California Hospital Association supported MICRA provisions that:

- o permitted the defendant to introduce evidence of collateral source recovery by the plaintiff and the plaintiff to introduce evidence of the amount paid to secure such benefits;
- o established a $250,000 limit on noneconomic damages, e.g., awards for pain and suffering;
- o limited attorney contingency fees: 40% of the first $50,000; 33 1/3% of the next $50,000; 25% of the next $100,000; and 10% of any amount exceeding $200,000;
- o mandated periodic payments for awards in excess of $50,000;
- o changed the statute of limitations for minors from one year after reaching majority to three years from the date of the alleged wrongful act;
- o required 90-day notice to defendant of intent to sue;
- o permitted arbitration agreements beween physicans and patients;
- o restructured the Board of Medical Quality Assurance (formerly the Board of Medical Examiners) and strengthened its disciplinary abilities; and
- o required health facilities to report certain disciplinary sanctions taken against staff members.

** Legislation enacted in 1978 requires any malpractice complaint filed to be accompanied by a certificate of merit verifying that a physician of the appropriate specialty has examined the situation and found cause for a medical malpractice action. Originally a temporary measure due to expire in January 1984, the law was extended to January 1987 in the 1983 legislative session.

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CHARLES J. CLASBY
OF COUNSEL

February 11, 1986

(HAND DELIVERED)

Mr. Richard E. Wagner
Alaska 100 Insurance, Inc.
Pouch 1872
Fairbanks, AK 99707

RECEIVED FEB 11 1986

Dear Rick:

This will confirm my discussion with you a few days past, wherein I expressed to you my opinion that the automatic assessment of attorney's fees in favor of the "successful party" in litigation, as required by Alaska Civil Rule 82, should be abolished.

As you know, I represent a great number of plaintiffs in personal injury actions, and I also represent a number of insurance companies in defending such actions. I have a varied trial practice and am involved in numerous cases requiring litigation which do not involve personal injury, e.g., real property, contracts, mining, property damage, etc.

It is my opinion that the "attraction" or "spectre" (depending on your point of view) of Alaska Civil Rule 82 many times diverts the attention of the parties from the merits of the dispute. Further, it is my opinion that it is the "little guy" who is more detrimentally affected by Alaska Civil Rule 82 than any other party to litigation. For instance, many times plaintiffs will settle their claims (and again I am talking about all kinds of claims, not only personal injury) for much less than the claims merit, because they cannot economically undergo the risk of losing the case, and at the same time, having a judgment entered against them for significant sums of money in favor of the successful party pursuant to Alaska Civil Rule 82. By the same token, I am aware of cases where plaintiffs' claims are kept alive and are pursued when they would ordinarily be settled, except that a plaintiff is looking for an additional award of attorney's fees pursuant to Alaska Civil Rule 82. The concomitant of this position involves an insurance company who has written a policy for comparatively low limits ($25,000.00 for

auto liability) and the claimant is offered settlement of the policy limits, plus Rule 82 based on the amount of the policy limits, but the plaintiff elects to pursue the case to judgment, even though the defendant himself may be personally without significant assets with which to satisfy a judgment. The reason for pursuing the case to judgment is that an award of attorney's fees pursuant to Alaska Civil Rule 82 will be based upon the total amount of the judgment, not the amount of the policy limits that are available. Therefore, in many cases, if the matter is taken to judgment it is possible for a claimant to wind up with more money pursuant to an award of attorney's fees than he or she would otherwise get from the policy limits themselves.

The abolishment of Alaska Civil Rule 82 would not abolish the court's power to grant an award of attorney's fees in appropriate cases. Before the enactment of Alaska Civil Rule 82, the court always had the inherent power to grant a successful party an award of attorney's fees in an appropriate case, such as where the court was to find that the claim being brought, or the defense being raised, was frivolous. Abolishing Alaska Civil Rule 82 would not abolish the inherent power of the court to award attorney's fees in such a case.

Therefore, at least from the viewpoint of this trial lawyer, I believe that it would be in the best interests of the people of the State of Alaska to have Alaska Civil Rule 82 abolished.

Very truly yours,

RICE, HOPPNER, BROWN & BRUNNER

Lloyd I. Hoppner

LIH/mcb

Insurance Information Institute

The Executive Letter
Special Report

January 27, 1985

INTERVIEW: FEDERAL INSURANCE ADMINISTRATOR JEFFREY S. BRAGG

Q: The reinsurance market for commercial liability is tight and getting tighter. There are some who propose that the federal government should serve some role in expanding the capacity of the reinsurance market. How do you feel about that?

A: That proposal is extremely premature. It would be totally inappropriate for the federal government to take any role in commercial liability -- or any other line of insurance for that matter -- when there is a short-term availability problem. If we have learned only one thing over the years, it is that the insurance industry is cyclical and, from time to time, we are faced with availability problems. We have seen these availability problems are short-lived, and premature involvement by the federal government is just not productive. I would caution the Congress and others who call for a government solution to these kinds of problems not to get involved at this time, not to take the bait. Allow free enterprise a chance to self-correct. Only if that correction doesn't take place would you want to see the government become involved in an availability issue.

For example, the riot reinsurance program was created over the objections of many people in the industry, including many of the reinsurers. There was a market for federal riot reinsurance for a period of time, but that market all but dried up during the last four years, and we were able to terminate the program. To create programs which later prove to be unnecessary is a tremendous burden on the industry and on government. That is why I think it is premature to consider a government role in these areas. Had the government waited in the area of the riot reinsurance program and in the crime insurance program, Congress would have discovered there was no need to get involved.

Flood insurance obviously is a different situation. We knew for years that there was not a market available in the private sector. One never developed in the first place. So there is a case for a National Flood Insurance Program (NFIP).

Q: What, in your view, is the federal government's role in the insurance marketplace?

A: The federal government does not have a role in regulating insurance. I think the federal government does have a role in administering the NFIP, and perhaps some other lines of business which, like the NFIP, simply can't be handled by the private sector. I tend to view what the government should be doing in the insurance marketplace very, very narrowly.

I think a case could be made, for example, for some federal role in the area of earthquake insurance. But beyond floods and earthquakes, I am not persuaded that the government needs to be involved in any other area.

Q: Are you suggesting that, other than natural disasters, there is little place for the federal government in insurance?

A: That is basically right. The reason is because the federal government would probably have to pay disaster assistance claims in the event of a major earthquake, and does make disaster assistance payments after major flooding in this country. And so insurance provides a benefit to the government as an alternative to disaster assistance and at the same time provides a higher level of compensation to victims of a major catastrophe like a flood or an earthquake.

Q: Your agency currently administers the Federal Crime Insurance Program (FCIP) and yet you leave that off of the list of insurance programs that the government ought to be in.

A: We have tried to eliminate the FCIP for the past four years now. The majority of the policies and claims are in one state, and the program just does not address problems of federal proportions. It was a mistake, I think, to ever create the FCIP Getting it off the books has been a major personal goal as well as a goal of the Administration.

Q: What is the current status of the crime insurance program?

A: The program has now been extended another three months (until March 1986), basically because Congress can't agree whether it wants to continue the program for a longer period. More and more pressure is being placed on reducing deficits, and over the long period, I am convinced the program is going to die. The Congress, everybody wants the flood insurance program to be continued, and the reason the flood program is only extended for brief periods of time is because it is being held hostage by those who want to see the crime insurance program continued. Eventually, we will see that the flood insurance program will have a long-term extension and the crime insurance program will be phased out.

Q: It must be difficult to administer a program when you have a month-to-month lease.

A: Yes, it is. And we have incurred almost $100,000 in costs simply sending notice to our insureds that the crime insurance program is going to be terminated, allowing them to cancel and rewrite, which we don't want to encourage them to do. The false starts we keep getting from the Congress are expensive.

Q. At the same time that Congress passed the Gramm-Rudman legislation to eliminate deficits, it limited increases in flood

insurance premiums to no more than 5%. How does one reconcile the goal of a balanced budget with limitations on needed premium growth?

A: There is a conflict between those goals. There is some question about whether claims payments under the flood insurance program, or the crime insurance program for that matter, would fall under the Gramm-Rudman Act. But notwithstanding that, we are facing the situation in which many members of Congress support rate increases and other members of Congress oppose any rate increases. We have to settle for compromises. We are going to implement a 5% increase during this fiscal year because Congress said that was all we could implement. And we will be going ahead next fiscal year with a rate increase. Our goal is still to make the NFIP self-supporting.

Q: Implicit in the way the National Flood Insurance Program was constructed is a set of incentives to discourage building or rebuilding in certain flood-prone areas. Has there been a noticeable impact? Can we look back now and see actual movement away from construction in the floodplain?

A: We can clearly see that aspect of the program has had a positive impact in terms of reducing losses. I don't think anybody could quantify that, but you can go into any community in the country that participated in the flood insurance program and you can see where the regulations implemented to enforce those restrictions have had a positive impact.

One area where the floodplain management aspect of the program was not as successful was caused by the fact that until 1981 we didn't support floodplain management adequately by having the insurance rates reflect what happened when somebody did build at a lower elevation or built in an area of higher risk. Until we brought the rates more in line with the risk, we were not supporting the floodplain management aspects of the program as well as we could and should have been doing.

Q: Is the flood insurance program reaching everybody that it should?

A: No. We estimated we are only reaching about 25% of our at-risk population. The program evened out in the late '70s at just short of 2 million policies, which is where we are today.

One of the major purposes of the Write Your Own program was to harness the marketing and distribution elements of the private sector so we could reach a much higher percentage of the at-risk, uninsured property owners. Happily, I can report 27-30% of the business sold now by the Write Your Own companies is brand new business, so our early results indicate the Write Your Own program is doing precisely what we intended it to do; to reach many of those people who heretofore had not purchased our product and to make it available to them.

Q: But even with many insurers involved in the Write Your Own program, three-quarters of the potential market still is not participating.

A: That is exactly right. I don't think we should anticipate reaching all 8 million of the potential insureds, because obviously as the program increases its penetration we are going to get less and less high-risk population. But one of the other significant things in this Write Your Own program is that now as we expand our policy base, we are by and large getting a better quality risk. We have now the very worst of the risk, so as we improve our penetration we gain a better spread of risk and that, we are certain, is going to have a positive impact on our goal of self-sufficiency.

Q: You spoke of two major natural disasters, floods and earthquakes. We have a flood insurance program. Is there a federal earthquake program in the offing?

A: In an article in I.I.I.'s Insurance Review (November/December 1984), I encouraged the industry to bring proposals to the table which could deal effectively with the earthquake insurance problem. Many segments of the insurance industry have brought together specific proposals to deal with that problem. Yet, I am a little concerned that there does not seem to be a consensus developed in the industry regarding which of the proposals should move forward. I have to compliment the industry for at least working to generate proposals and treating the issue seriously, but unless we present Congress with an industry consensus, there will be little chance of enacting any insurance solution to the problem.

Q: Is there a willingness on the part of Congress and the Administration to entertain these proposals?

A: I haven't presented a specific earthquake insurance program to the Administration. I believe the right proposal could be sold to the Administration, particularly when it is contrasted with what might be the result if we had to make massive disaster assistance payments in lieu of an insurance program. Administratively at least, an earthquake insurance program would have to pay for itself or I don't think the Administration would entertain it.

You could make a case that if a catastrophe should happen, in the short run, there could be federal dollars available to supplement insurance payments. But I think we should strive for a program which calls on the government only as a last resort, after insurance payments have been exhausted and after the industry has made as significant a financial and administrative contribution as it is capable of making. Then I think the government could be persuaded to take up the remaining burden.

Marc Rosenberg, I.I.I. Vice President-Federal Affairs

MICA Medical Indemnity Corporation of Alaska

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M E M O R A N D U M

DATE: FEBRUARY 24, 1986

SUBJECT: TORT REFORM - HOUSE BILL #532 &
SENATE BILL #377

Remarks made by David J. Frazier before a joint House and Senate Committee Chaired by Mike Navarre in Anchorage

My name is David J. Frazier and I am presently serving as the Chairman of the Board of Governors of the Medical Indemnity Corporation of Alaska. I was appointed to the Board by two Governors during the last ten years. Most recently I was reappointed to the Board by Governor Sheffield in 1985.

The reason we are here today is to discuss tort reform in the State of Alaska. MICA is back after operating under legislative mandate for ten years. Our enabling legislation was enacted by Legislature in 1976. We find ourselves caught in a struggle between time and a legal system that does not promote the best interests of Alaskans.

You will recall that the Medical Indemnity Corporation of Alaska is a non-profit insurance company that provides hospital and physician medical malpractice liability. We feel that MICA has done its best to full-fill its role as a public organization.

We have an excellent Board made up of nine (9) Alaskans appointed by the Governor. Currently our board consists of;

1. The Hospital Administrator from Nome

2. Physician representatives from throughout the State:

   a. An Internist from Fairbanks
   b. A Surgeon from Anchorage
   c. A General Practioner from Anchorage
   d. A Radiologist from Juneau

3. Our public members include:

   a. A banker from Juenau
   b. A risk manager from Anchorage

4. The board also has two insurance industry representatives including:

   a. A workers' compensation expert

   b. Myself who specializes in employer-medical community relations.

The Medical Indemnity Corporation has hired the best claims personnel available in Alaska. Our office manager and director has twenty-five years experience in claims containment procedures. His claims manager is an RN with 15 years experience working with the medical community and is highly regarded amoung the physicians and hospitals. Our staff is sought after to meet with our insureds to provided educational training and information regarding insurance programs provided by the Medical Indemnity Gorporation of Alaska.

MICA has a comprehensive risk management program that is now over six years old. We have held risk management meetings in every hospital throughout the State of Alaska. We have held risk management seminars inviting every physician in every community in Alaska. These seminars emphasize medical records keeping, advanced training, patient consent, risk avoidence, and what happens if the insured is sued. In addition we have a video tape library system that is available to physicians and hospital employees who are not able to attend our seminars.

We have retained one of the most renowned physician, risk consultants in the United States. He is in such high demand by other physician liability companies throughout the lower 48, that we are very fortunate to have Dr. Brittian visit and discuss liability concerns with our insureds on a regular basis.

The Medical Indemnity Corporation retains as its actuary an irdividual who works exclusive with physician-hospital liability companies throughout the United States. Our actuary continually monitors MICA's claims experience. He compares it with U. S. standards and calculates rates that are in conformance with enabling legislation mandated in 1976. These rates are fair, adequate and not excessive. They realistically reflect the claims situation in the State of Alaska.

Every step of our ten year experience has been followed closely by the Division of Insurance. Often the Director has personnally monitored our committee and board sessions. The Director has reviewed and approved every rate and policy filling since inception. The operation of the Medical Indemnity Corporation is closely followed by the Division of Insurance on behalf of the legislature and the administration.

I believe that the Medical Indemnity Corporation of Alaska has done all the right things and has full-filled its mandate to the public to the best of its ability.

Why then are we back again telling you this story? I believe that it is because the legislature did only part of its job in 1976 and still has a portion to complete or the liability claims crisis will continue here.

I believe we are back to tell you that even though we did everything right, MICA's claims experience is no different than the rest of the hospital-physician companies in the United States. To offset expenses this year our average rate increase to provide $500,000 policies was 90%. To increase a physician's policy to $1,000,000 an additional premium charge of 40% is required.

We continue to spend most of our revenue on legal expenses. It is not uncommon for us to spend the first $100,000 before the aggreved patient gets one (1) cent.

The system is just not efficient. It doesn't work like your Aetna or Blue Cross coverage. Nor does it operate like our excellent workers' compensation system. Whereas these programs return 90 cents on the dollar, we are lucky to get 40 cents on the dollar to the aggreved. There is something wrong with a system like that. We are doing more dancing with the legal system than we do good for Alaskans, whom we are supposed to serve.

Back in 1975 and 1976 the Governors Commission on Insurance Reform made a number of recommdations to the legislation and senate regarding revision in tort law. This legislature has before it two bills that embody most of those recommendations. You have an opportunity to complete that job by now enacting the provision Senate Bill #377 and House Bill #532. These are good bills, they protect the interest of the majority of the people and they are politically positive in nature.

Non-enactment protects the status quo, special interest groups, economic windfalls for plaintiff trial attorneys and the eventual restriction of medical services to the general public. If the Senate and House do not act on these bills I predict the following will happen:

1. Within 24 months MICA will be the only insurance company underwriting physician and hospital medical liability policies.

2. The Medical Indemnity Exchange Company of California and other companies who are now operating in Alaska will have completely pulled out.

3. MICA'S premiums will again double, policy limits will not exceed $500,000 and our reinsurors will discontinue support.

   Reinsuror support is contingent on predictability. Insurance companies and their reinsurors cannot tolerate total unpredictability. The number and especially the amount of claims will continue to be unpredictable if tort legislation is not enacted. Adequate premiums cannot be projected if this situation continues.

4. MICA will be preassured to underwrite all medical practitioners and hospital is who apply. If that happens our inability to accept or reject applications will have an adverse effect on claims experience.

5. MICA will have no alternative but to solicite the State for more funds. If you fail to enact, MICA will be back to the State within 36 months for a sum of up to $10 million dollars.

It is my belief that if you do enact the proposed legislation there is a good chance that you will have acted in time. Enactment insures uninterrupted and continuous health services to all Alaskans. I hope you feel as I do that good health care is more important than enriching a few who take advantage of our preferential legal procedures.

Thank you for taking into consideration the concerns of the Medical Indemnity Corporation of Alaska.

F.Y.I
from
SENATOR
STURGNLEWSKI

MARCH 24, 1986 $1.95

TIME

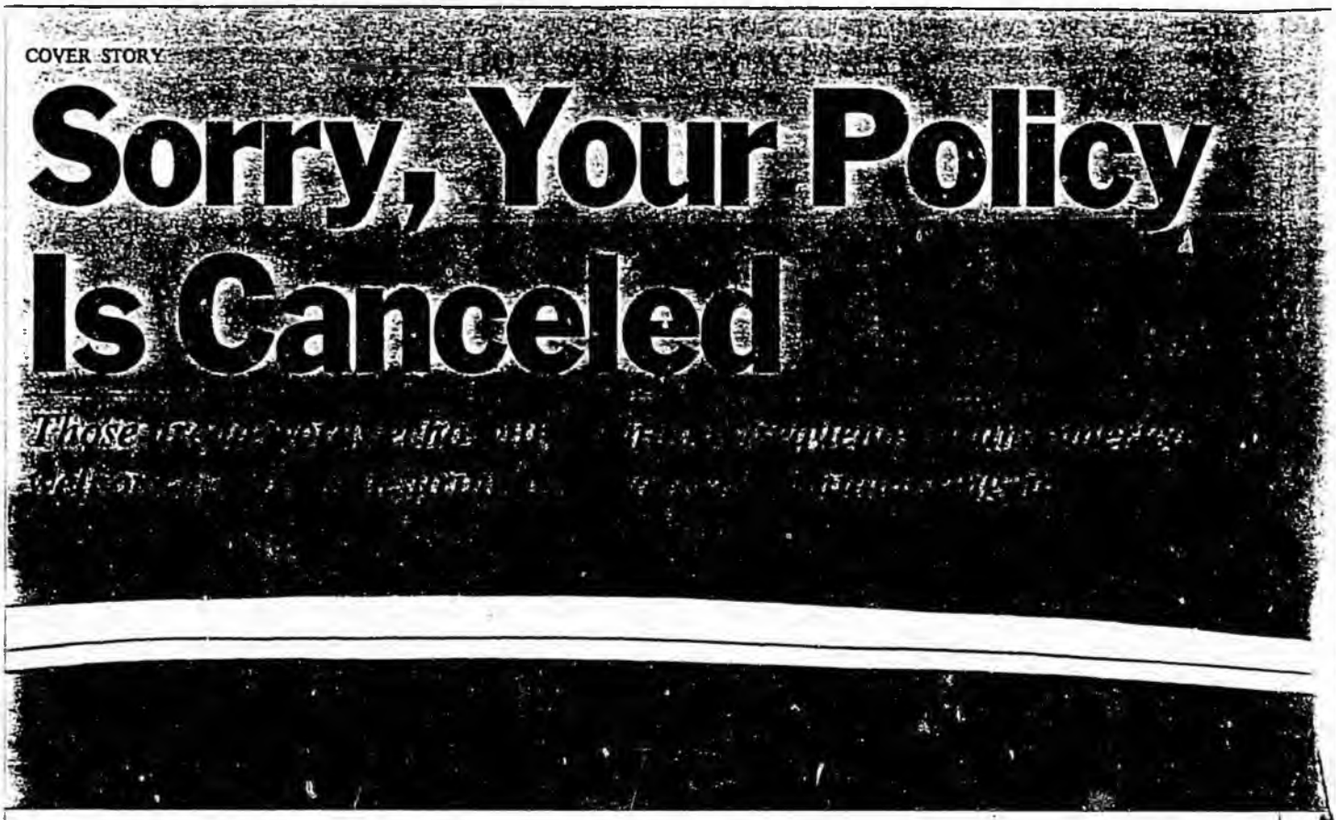
Sorry, America, Your Insurance Has Been Canceled



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COVER STORY

Sorry, Your Policy Is Canceled



Nation

TIME/MARCH 24, 1986

On the Hawaiian island of Molokai, pregnant women who want a doctor in attendance when they give birth fly to neighboring Oahu or Maui. The five Molokai doctors who once delivered babies have stopped doing so because malpractice insurance would cost them more than the total of any obstetrical fees they could hope to collect.

Will County, Ill., last week closed its forest preserves until it can get a new liability policy on them—if that can be done at all—and Blue Lake, Calif. (pop. 1,200), has shut its skating rink, parks and tennis court. Hundreds of other towns in California and in New York State are "going bare." That is, they simply cannot get liability insurance.

The Texas sesquicentennial cattle drive, part of the state's celebration of 150 years of independence from Mexico, bogged down this month after one day on the road because liability insurance covering the 49 longhorn steers that were involved was doubled and the organizers could not afford it. The drive resumed last Friday with only 28 steers, whose owners agreed to pay for the insurance themselves.

Century Cartage Co., a small truck line out of Atlanta, is still in business only because the Georgia Public Service Commission approved an "emergency" 5% rate increase for its customers. But that boost came nowhere near meeting the cost of liability-insurance premiums that doubled to $48,000 last year and then leaped to $114,000 at the start of 1986.

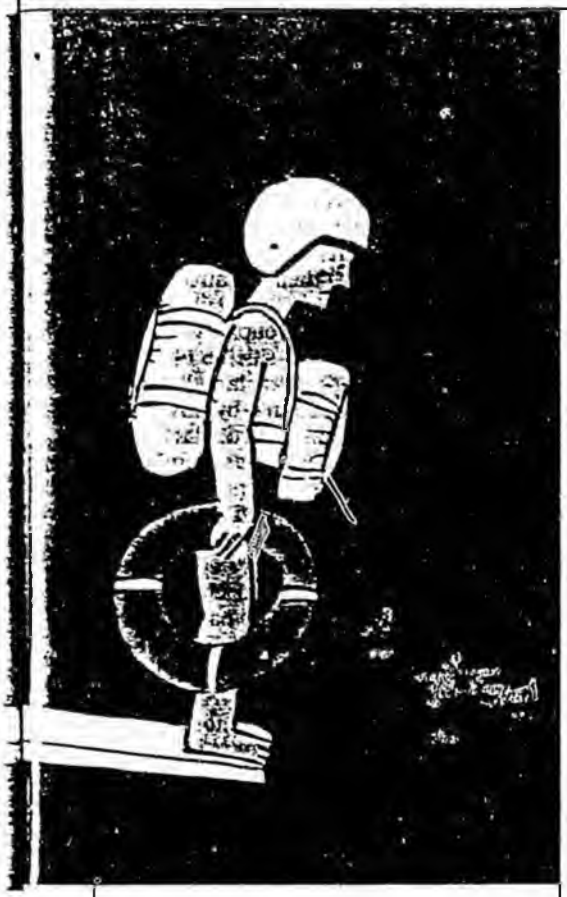
Outrageous? Yes. Ridiculous? In many cases. Unreasonable? Certainly. And yet the examples represent just a small sampling from a rising flood of problems growing out of what has become a new national crisis. Given the litigious nature of American society these days, just about any kind of business, profession or government agency is likely to become the target of a suit alleging malpractice or negligence resulting in personal injury. That makes liability insurance, the kind that pays off on such claims, just about as vital as oil in keeping the economy functioning. But in the past two years, liability insurance has become the kind of resource that oil was in the 1970s: prohibitively expensive, when it can be bought at all. The result is a pinch from which few can escape—not even liability specialists like J.B. Spence or Robert Rearden.

Spence, a Miami lawyer, is the kind of attorney insurers often blame for their troubles. He has won and earned a healthy slice of several multimillion-dollar awards for clients who suffered personal injuries. But if Spence should be sued for malpractice or negligence, as is happening to lawyers more and more, he would have to pay any court-ordered damages out of his own pocket. "There is no market that will sell me liability insurance," says Spence. "I am going bare, and it is a frightening prospect."

Rearden, president of Duncan Peek Inc., an Atlanta insurance brokerage, earns commissions selling policies at soaring premium rates. But when the time came to renew his own professional liability policy, his carrier wanted to jack up his $13,000 premium by 861%, to $125,000; Rearden had to scramble to find another company that would only triple his premium cost. "And that's me, and I'm in the insurance business!" wails Rearden. "That's what I mean when I say this crisis is affecting everybody."

And how. After years of eye-popping damage awards and shortsighted insurance-company practices, the U.S. is in danger of having its insurance canceled. The cost of this crisis, once generally hidden, is now hitting home. The $9.1 billion Americans paid last year in liability-insurance premiums was almost 60% higher than the figure as recently as 1983 and roughly equal to the combined 1985 budgets of the National Aeronautics

Illustrations for TIME by Guy Billout



and Space Administration and the Central Intelligence Agency. This year's total is sure to show another giant leap.

Every American pays: doctors and their patients, ski-slope operators and their patrons, municipal governments and their taxpayers, those who process cheese and those who eat pizza, those who take the bus and those who lease private jets, those who drill for oil and those who heat their homes.

Even more insidiously, the problem threatens the very character of American life, from the Great Peace March across the U.S. (which came apart last week in the Mojave Desert, partly because of a lack of liability coverage) to police patrols in New York's suburban Rockland County (suspended last week in the towns of Piermont and Sloatsburg; 13 officers have been told to sit at headquarters' desks while the towns look for a liability insurer to replace one that has gone into receivership). Factory owners seeking to expand, entrepreneurs seeking to launch new enterprises, young businessmen seeking to set up shop: all are running into an obstacle far harder to surmount than high taxes and interest rates in their pursuit of the American dream. Liability insurance has become their most crippling cost.

As a result, doctors have been marching on state capitols, some threatening to shut down their practices. Industry groups and insurance companies have launched loud lobbying and advertising campaigns. Bills have been introduced or passed in all 50 state legislatures to limit liability awards or regulate insurance practices or both. Congress has held public hearings. But federal and state lawmakers, who have been faced with cutting through a jungle of conflicting statistics, arcane accounting practices and tangled legal theory, have mostly come out baffled. Says South Dakota Republican Senator Larry Pressler: "We have not been able to get past the finger-pointing stage."

Consumer groups point to the insurance companies. When interest rates were high, they say, insurers wrote policies with little concern about how they would make good if claims went up and returns on their investments went down. Insurers point to the legal system. Juries, they say, have been handing out punitive damage awards that resemble lottery jackpots. Lawyers point to the negligence of Big Business. It can be redressed, they say, only if individuals have a right to present their cases to a jury. Businessmen point to changing attitudes. The individualistic notion of taking risks and accepting responsibility, they say, has been replaced by a sue-everyone-in-sight reaction to any accident. What makes the problem such a nightmare is that, to some extent, all of the finger pointers have a point.

What it finally boils down to is a matter of statistical logic and insurer psychology. If a few giant jury awards, actual or merely possible, can offset the premiums on an entire line of insurance, the companies feel they must raise premiums for everybody until there is some hope of making a profit. This means that premiums may bear no relationship to an individual policyholder's record, and buyers of many kinds of insurance are suddenly paying three or four times as much as they did a year or so earlier. Of all places, Hartford, Conn., known as the insurance capital of the world because so many carriers have their headquarters there, saw its own municipal liability coverage slashed to only $4 million, vs. $31 million in the 1984-85 fiscal year, despite a 20% rise in total premiums, to $1.8 million.

Some insurers are shying away from covering certain types of risks at any price. If there is no way of figuring what kind of damages a jury might award to the parents of a child molested at a day-care center, for example, then the companies will find it best to stop writing that kind of insurance at all. Says James Wood, a member of a firm of actuaries whose headquarters are in Atlanta: "If you are an insurer and have $100,000 in assets, do you want to risk those assets to keep day-

Risky business, life.
Always has been.
But is it
more so these days?
Must be. The horror
stories go on and
on and on . . .

Lacrossed Up



As one of only two U.S. makers of lacrosse equipment, William H. Brine of Milford, Mass., lets customers know how to place reorders by printing his company's phone number on the back of each helmet. Now the helmets carry another message: a warning that lacrosse is a dangerous game. In 1984, Brine *(photo)* paid $8,000 annually for $25 million worth of product-liability insurance. In December, he received notice that his premium was going up to $200,000 for just $1 million of protection. Brine is taking his chances uninsured. "If we have a large judgment against us," he says, "it could be the end of lacrosse."

Other sporting-goods manufacturers face similar dilemmas: many U.S. firms have decided to abandon the manufacture of amateur hockey gear.

care centers open? The answer is probably no, because you do not know what you have to charge when you do not know what the ultimate costs of providing coverage might be." Most insurers flatly refuse to write policies to protect companies against suits arising from injuries caused by environmental pollution. They say they have no way of gauging the risk. That complicates further the question of who will pay for cleaning up toxic-waste dumps.

The dubious distinction of paying the highest increase on record may belong to Specialty Systems Inc., a Richmond, Ind., company that specializes in removing asbestos from buildings. Insurers are so terrified of anything having to do with asbestos that they canceled Specialty's policies three times between November 1984 and last April, though the nine-year-old company has never been sued. Because customers demand proof of insurance before they will give Specialty any business, the company wound up buying a $500,000 policy from the Great American Insurance Co. of Cincinnati, on which it will pay at least $460,000 in premiums, an increase of more than 4,900% over the $9,361 premium on its last full-year policy. Says Specialty President Frederick Treadway: "About half a million dollars paid to the insurance company for virtually nothing."

The situation is studded with an endless variety of similar horror stories *(see boxes)*. Among the most prominent are those that involve municipal services. The city council of Blue Island, Ill. (pop. 22,000), last October voted down a 30% increase in property taxes thought necessary to pay rocketing liability-insurance premiums, and the town expects to self-insure for the 1986-87 fiscal year, taking a chance that a large judgment might force taxes up anyway. Five counties in Missouri closed their jails for several weeks last fall, sending some prisoners elsewhere for incarceration and releasing minor offenders outright. The jails reopened after the counties' sheriffs set up a self-insurance pool, which was financed by tax money.

Among professionals, malpractice insurance problems have plagued lawyers, engineers, members of corporate boards and even clergymen. A growing number of clerics are buying, or having their churches buy, policies to protect them against suits like the one brought by a California couple who attributed the suicide of their 24-year-old son largely to inept counseling by his pastors. (That particular suit, filed in 1980, was dismissed for a second time last year; the case is still being appealed.) Suits against doctors, particularly specialists such as obstetricians and neurosurgeons, have been more successful and have led to some of the highest insurance premiums. A typical annual premium for an obstetrician in Los Angeles is about $45,000, and for a neurosurgeon in Long Island, N.Y., about $83,000.



CYNTHIA JOHNSON

Manufacturers massing to urge product-liability reform on Capitol Hill

"There are going to be people who are dumb and stupid."

Product-liability insurance presents a major problem for the makers of everything from toys to antitoxins. Pertussis vaccine for children ran short a year ago because Connaught Laboratories suspended production for a nine-month period during which it could not find insurance at an acceptable price. Now Lederle Laboratories, the only other maker of the vaccine, is talking of halting output in July if a threatened cutoff of its liability insurance materializes. Beech Aircraft figures the cost of liability premiums at a stunning $80,000 on each plane it sells. Says William Mellon, director of corpo-

Strung Out


STERLING—IMAGE BANK

When New York City's Roosevelt Island was opened for residential development nearly eleven years ago, part of its allure was a tramway that would soon connect the community to midtown Manhattan in six scenic minutes. That lifeline was cut last month when the tram's liability premium soared from $800,000 to nearly $9 million a year. Operators shut down the system, forcing some 5,250 islanders to spend up to an hour commuting on buses and subways.

After two weeks, New York State assumed responsibility for the tramway under a "self-insurance" plan that is increasingly becoming the solution of last resort for municipal services. Many legislators, however, are dubious about forcing governments to enter the insurance business. Meanwhile, the little tram that couldn't, now can—at least until somebody sues.

Bad Trip


BARR—COLUMBIA/LIAISON

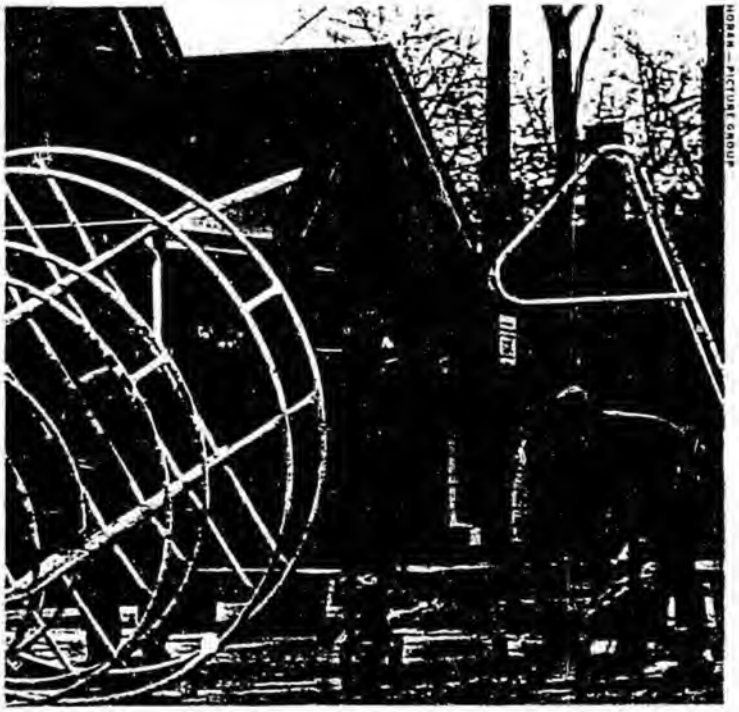
For sponsor PROpeace, the anti-nuclear Great Peace March between Los Angeles and Washington turned out to be a movable flop, beset by celebrity no-shows, cold weather and a lack of funds that last week caused the project's collapse. One major headache was the inability to obtain a $5 million liability policy required by some municipalities along the marchers' route. Because they lacked such coverage, 900 or so PROpeaceniks were denied the use of a schoolyard in Claremont, Calif., where they had planned to camp their third night on the road.

Sponsors of public events ranging from San Francisco's Chinese New Year festival to Maine's Fryeburg country fair have also run into trouble securing liability coverage. The main reason: the unpredictable nature of claims made by audience members, onlookers and participants.

rate communications: "The owner-pilot market has all but dried up, and one cause is the cost of product liability. It has driven the price of a new airplane out of the reach of the average person who wants to buy one." Some commercial fishing boats that once sailed out of Pacific Northwestern ports have been put into dry dock because owners could not afford liability-insurance premiums that commonly have doubled in the past year or so.

Rising premiums are forcing up prices on a variety of services too. Ski-lift tickets are jumping by $2 or $3 at many resorts. Through last year Kennestone Hospital in Marietta, Ga., insured itself for the first $1 million of any claims that might be made and paid a premium of $70,000 for additional coverage up to a maximum of $10 million. Now the premium has quintupled to $350,000, and on top of that the hospital has had to come up with another $1 million for its self-insurance trust fund, because the deductible was raised to $2 million. Says Executive Director Bernard Brown: "If you come to our hospital, you pay the price. It is being passed through."

Day-care centers, which have become an essential part of American life in an era of two-career families, are a striking example of how the insurance crunch may soon affect the lives of many unwary citizens. Operators fume that allegations of child abuse at a handful of centers have spooked insurers into indiscriminately canceling liability policies or demanding giant premiums. Mission Insurance Group, the chief provider of coverage for day-care centers, abruptly pulled out of the business last year. The handful of insurers that will still write day-care policies insist either on specifically excluding claims for damages arising from sexual abuse or setting up rules for strict supervision, such as unannounced visits by special investigators. Says Suzanne Grace, associate director of the Georgia Day Care Association: "The insurers are telling us, 'We don't care what your record is.' This business has the perceived risk of killing an insurance company."



Workers dismantling playground equipment on Chicago's Northwest Side

Says the insurer: "Park districts are a terrible risk for any carrier."

There is one area of general agreement about what has caused the insurance crisis: plain old-fashioned greed. Ah, but *whose* greed?

Insurers and some of their customers blame aggressive lawyers, inventive judges and soft-hearted juries for twisting legal concepts of negligence into novel shapes to justify excessive damage awards to people who claim personal injury (a tort in legal parlance). Avaricious lawyers, they argue, seek outrageously high damages for clients who have flimsy cases, so that the lawyers can reap huge contingency fees (if the case fails the plaintiff's attorney earns nothing, but if it succeeds he commonly takes one-third and, on occasion, as much as 50% of the award). Says Edward Levy, general manager of the Association of California Insurance Companies: "Lawyers are out to make a buck, and they seem to have little concern for the overall societal effects of what they are doing."

Plaintiffs' attorneys are every bit as willing to point the finger. Insurance companies, they charge, are using deceptive tales of excessive damage awards to justify the exorbitant premiums that they charge the public. Says Browne Greene, president-elect of the California Trial Lawyers Association: "Their greed takes us back to the robber barons of the 19th century." Many consumer organizations add that insurers are seeking unjustified premium hikes to cover up their own bad management and poor judgment of risks.

City Halt



Insurance woes have made for a sorry spectacle in the Northern California seaside village of Point Arena (pop. 450). When its $2 million liability policy expired in July, village officials decided to take the chance of going without coverage. A new policy was eventually offered, but at 50% more than the old rate of $6,700. Point Arena declined. Says Tracy Du Pont *(photo)*: "We would be broke."

Fearing personal vulnerability in litigation against the town, Du Pont's predecessor Kay Spack resigned in August. The town council voted to install wry signs at town limits warning visitors to "enter at your own risk," but abandoned the plan when a motel owner threatened to sue. Less wry is the prediction of some experts that two-thirds of California's 440 towns and cities will be forced to operate without liability insurance by next July.

Overboard

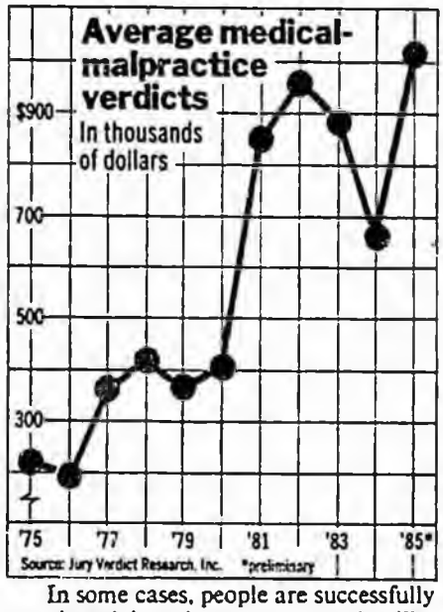


When the board of Detroit's Armada Corp. meets these days, the directors could easily fit into a subcompact car—never mind a limo. The company, which produces automotive exhaust systems, had carried $10 million in liability coverage for its ten-member board and 28 corporate officers. Last November it was notified that the rate would increase from $45,000 a year to $720,000. Armada refused to pay. Fearing exposure to litigation, eight board members, including Chairman Jerry D. Luptak *(photo)*, resigned last month. (Luptak remained as president.)

Vice President Lowell Robinson could not recruit more than two new directors. Says he: "It's getting very difficult to find qualified people." The number of lawsuits filed against directors of U.S. corporations, by some estimates, has climbed by more than 150% since 1974.

Americans have always been a litigious people. But there does seem to be a rise in the number and size of liability suits facing every type of company, from soccer-ball makers to cigarette manufacturers. From 1977 to 1981, the number of civil lawsuits in state courts grew four times as fast as the population of the U.S. And in the decade between 1974 and 1984, the number of product-liability suits in federal courts expanded 680%. The first million-dollar verdict did not occur until 1962, but there were 401 in 1984, according to Jury Verdict Research Inc., a private group. The average verdict in product-liability cases now tops $1 million; preliminary figures for 1985 indicate that the average verdict in medical malpractice cases also exceeded $1 million for the first time. These giant awards, insurers say, exert an influence out of proportion to their numbers. They set a target for plaintiffs and their attorneys to shoot for, and move defendants to offer high out-of-court settlements rather than take a chance on what a jury might do.

The Association of Trial Lawyers of America counters by arguing that the Jury Verdict Research figures on averages are distorted by a relatively small number of huge verdicts. In addition, they say, the figures count only the initial outcomes of trials that the plaintiffs won. If defendant victories, out-of-court settlements and verdicts reduced on appeal were factored in, say the lawyers, even the average level of awards would be much lower. ATLA asserts that more than two-thirds of the million-dollar awards compensate victims or relatives for genuinely serious injuries, such as death or permanent paralysis, reflecting a laudable determination by juries to see that companies pay the price for misdeeds that once went unpunished.



In some cases, people are successfully pressing claims that seem patently silly. One example: a man who attempted suicide by jumping in front of a subway train sued the New York City Transit Authority, contending that the motorman of the subway that hit him had been negligently slow in bringing the train to a halt. He won $650,000 in an out-of-court settlement.

Yet much of the lore surrounding the subject has been exaggerated. ATLA analyzed several cases that insurers regularly trot out to prove that the system has got out of hand and found that the facts did not quite support the versions that have passed into insurance folklore and public print, although one or two, even after correction, still sound odd. Some examples:

▸ According to one frequently cited tale, a body builder competing in a footrace with a refrigerator strapped to his back was injured when one of the straps came loose; he sued several defendants, including the strapmaker, and won $1 million. The facts, according to the lawyers' group: ten athletes competed in a televised stunt race, each with a 400-lb. refrigerator strapped to his back; each received a written contract guaranteeing that the equipment had been tested for safety. Franco Columbo, a world-champion body builder, did fall and suffered total knee displacement that required extensive surgery. At the trial, testimony showed that the equipment had never been tested on anyone of Columbo's size while running (he is 5 ft. 7 in., much smaller than anyone else in the race). In fact, the engineer for the fitness center that developed the contest said that he had warned the organizer, Trans World International, that the whole race was unsafe. Columbo did win slightly less than $1 million from Trans World, but the strapmaker was not sued because the strap never broke.

▸ Another tale allegedly involves a fat man with a history of coronary disease who suffered a heart attack while trying to start a Sears lawn mower, sued Sears and the manufacturer, contending that too much force was required to pull the rope, and won $1,750,000. The real story, the trial lawyers point out, is that a 32-year-old doctor, who had no history of heart trouble, fell victim to a heart attack after futilely yanking the lawn mower's starter cord 15 times. A Philadelphia jury found that the mower's exhaust valve failed to meet the manufacturer's own specifications, hindering start-up to the extent that the rope indeed had to be pulled with excessive force. The jury did award $1,750,000, but the case was subsequently settled for an undisclosed amount.

Birth Pangs


STEVE LISS

Six out of every ten babies born in Rhode Island draw their first breath in the Women & Infants' Hospital of Providence, a 102-year-old institution that handles only obstetrical and gynecological cases. The facility also takes high-risk cases from nearby hospitals, a practice not calculated to attract insurance salesmen. Women & Infants' has managed to hold on to a $3 million primary malpractice policy, but it has been trying vainly since last October to renew its $10 million supplemental coverage.

No field in medicine has been harder hit by the insurance crisis than obstetrics. According to the American College of Obstetricians and Gynecologists, 73% of its 24,500 members have been sued for malpractice at least once. To escape the soaring cost of malpractice protection, some 3,000 ob-gyns have abandoned the specialty.

Crying Shame

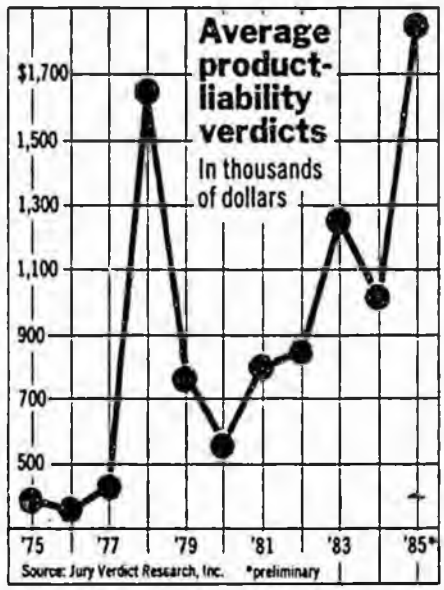

BILL PIERCE

The Edith B. Jackson child-care program operates seven day-care homes, a nursery school and toddler center for some 45 children in New Haven, Conn. Affiliated with Yale University, the widely recognized project has not incurred a single insurance claim in 13 years in business. Yet last year the program's liability coverage was canceled, and the only substitute policy available, for $2,400, is six times the 1984 premium and specifically excludes coverage for child abuse.

Co-Director Judy Silverman *(left in photo)* charges that underwriters are unduly skittish about day care because of a few widely publicized child-abuse cases. But even she is worried: "We try to be very careful," she says, "but I am uneasy. If a case of abuse came up and we were sued, my co-director and I could be held responsible."

▸ Another oft-used example is of two Maryland men who supposedly put a hot-air balloon into a commercial laundry dryer. The machine exploded, injuring both men, who won $885,000 from the maker of the dryer. What actually happened is that the men took the balloon to a hospital that had laundry equipment designed for industrial purposes. The dryer vibrated violently and then exploded. Both men were injured; one required microsurgery to reattach his hand, which was almost severed. The dryer's maker had a patent on a device that would have stopped the dryer automatically if it began to vibrate excessively, but had declined to install the device on the dryer because of the cost. Oddly, in this case the actual award, $1,260,000, exceeded the figure usually quoted, but the lawyers point out that the common account of the case ignores the dryer manufacturer's failure to install the protective device.

▸ In yet another celebrated case, a burglar supposedly fell through the skylight of a school, sued and was awarded $260,000, plus $1,500 a month. The full story, it seems, is that a 19-year-old man and three friends tried to take a floodlight off the roof of a California high school as a lark; he fell through the skylight and suffered loss of the use of all four limbs, plus severe brain damage. The skylight had been painted the same color as the roof and was indistinguishable at night; the school district knew that it was dangerous because someone else had been killed falling through a similar skylight at another school six months earlier, and had scheduled the skylight for repainting. It settled out of court for $260,000, plus $1,200 a month initially, to be increased by 3% each year. Still, it seems debatable whether someone should be so generously compensated for injuries, even that severe, sustained while committing a theft.



Yet whatever the merits of these and other specific cases, the insurance companies are correct in their basic contention: an evolution in liability law has led to higher jury awards and is at least partly responsible for the rise in insurance rates. One important change: the amounts assessed by juries to compensate for lost wages, medical payments and the like now make up a small part of many liability awards. Juries are increasingly likely to add on far larger amounts for noneconomic damages, that is, for such unquantifiable things as pain and suffering.

Equally significant is the growing size of punitive damages, which supposedly serve the same purpose as a don't-ever-do-anything-like-that-again fine of the defendant. Juries sometimes find that a person's actual damages amounted to only a few thousand dollars, yet decide that the corporation at fault should also pay punitive damages in the millions. In one startling case, now awaiting decision by the U.S. Supreme Court, an Alabama couple sued Aetna Life & Casualty Co., claiming that it had wrongfully refused to pay $1,650 of the wife's hospital bill. A jury awarded them punitive damages of $3.5 million, or 2,121 times the size of the disputed bill.

Courts and legislatures have steadily expanded definitions of who can be sued, and on what grounds. These days you usually can sue city hall, despite the doctrine of sovereign immunity, which holds that governments cannot be sued without their consent. State laws, and court interpretations of them, have granted that consent more and more.

Another legal concept being used ever more widely is that of strict liability, which makes possible an award of damages without any proof of negligence. Initially it was applied, for example, to businesses conducting abnormally dangerous activities. Now it has been expanded to product-liability cases: a plaintiff need not prove that the manufacturer of a product was negligent, only that the plaintiff was injured while using the product in the manner intended.

More states have also adopted looser standards of comparative negligence. Even if an accident was partly due to the plaintiff's own negligence, he can successfully sue someone else who also bears some of the blame. In California, for example, a woman who stumbled in a church parking lot on the way to a meeting sued the church, the group holding the meeting and the city, contending that the lot was not lit well enough. Although the defendants felt she was largely responsi-

Truck Stop


TAYLOR—BLACK STAR

Tom Leonard's Miami-based trucking firm, founded by his grandfather in 1919, was besieged in recent years by a fleet of problems, including sharp tax increases and price competition. The company (1984 sales: $21 million) managed to work around all of them but one: finding the $5 million in liability insurance it was required to carry. Because many Leonard trucks hauled parts of the space shuttle, rockets and other explosives, underwriters kept hiking rates, limiting coverage and finally refusing to provide sufficient insurance at any price. When his coverage expired last July, Leonard simply shut down.

Insurance is scarce for carriers of any hazardous materials, especially if flammable or toxic. "Companies used to write us up with no problem," says Leonard. "But when rates changed, we may as well have been child molesters."

Sawed Off


JEROME MACIO

The saws, lathes and other woodworking equipment manufactured by the Oliver Machinery Co. of Grand Rapids are designed to last for years. That sign of good workmanship is anathema to insurers, who shun hazardous products that can lead to lawsuits over long periods. "A machine may be 50 or 60 years old, been through a number of owners," says Company President Dana Baldwin. "But if someone gets hurt on it, we will get sued." Largely because of that exposure, Oliver's product-liability premium quadrupled this year, from $72,000 to $282,000.

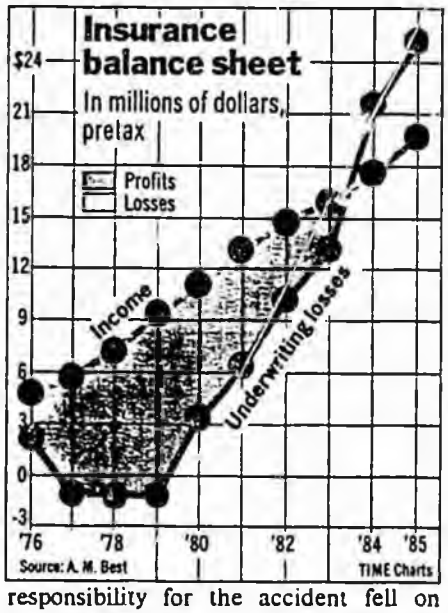
Oliver swallowed its rate hike, but others cannot; 34 of the 113 members of the Wood Machinery Manufacturers of America have left the business. In their place are small, single-product companies that do not have the same long insurance "tail" that often gets caught in lawsuits.

ble, all three agreed to a settlement paying her $80,000.

Perhaps the thorniest concept, one that has become a growing factor in many cases, is called "joint and several liability." It allows a plaintiff to sue everyone who might share in the responsibility for an accident, and if any one of the defendants is found to be partially at fault, that defendant may be forced to pay the entire judgment. Originally, it was applied to wrongdoers who had acted in concert, but now is more often invoked against defendants who acted independently. In practice, it increasingly means that awards fall most heavily on the defendant with "deep pockets," often the one carrying the most insurance. The doctrine is now in force in nearly all states.

One way to show how these concepts work—and the effects they can have on insurance coverage—is through a classic case settled last year that began with a child's fall and ended with most of Chicago's parks being stripped of certain kinds of playground equipment. It began in 1978 when two-year-old Frank Nelson fell through a wide space at the top of a slide in a city playground and struck his head on the pavement 11 ft. below. He suffered severe brain damage: the left side of his body is still paralyzed, and his speech and vision are impaired. Nelson's family sued the manufacturer of the slide, the contractor who installed it and the Chicago Park District. Lawyers contended that the district had been negligent in failing to warn against use of the slide by small children, in not providing proper supervision of the playground and not putting a softer surface under the slide.

Officials of the park district and its insurer, U.S. Fidelity and Guaranty Co. of Baltimore, still contend that the primary



responsibility for the accident fell on Frank's mother; she allowed the boy to go on a slide he was too young to use, and should have been watching him more closely. But they never formally accused the mother of negligence in pretrial proceedings; such an argument would not have succeeded unless they also could have convinced a jury that the park district bore no blame whatever. In this case the park district was the defendant with the deep pockets—$50 million in liability insurance—and Fidelity was afraid that it would be hit with the largest share of any judgment. Paul Jacob, the insurer's Chicago branch manager, notes that in Illinois a defendant who is found to bear any part of the responsibility for an accident can be liable for all of a damage award. Says he: "Showing that any defendant is not 1% negligent is virtually impossible."

Unwilling to risk paying the damages a jury might award to a child who had been so severely injured, Fidelity offered a settlement. It proposed to put up $1.5 million to buy an annuity that will make payments each year to Frank Nelson for the rest of his life. The family accepted, and the case was closed without trial.

But that is not quite the end of the story. Fidelity at first canceled the park district's insurance, but eventually renewed for much less coverage at a greatly increased premium. "Park districts are a terrible risk for any carrier to have to assume," explains Jacob. Finally, the park district, gun-shy because several suits are still pending against it, began tearing down all jungle gyms and slides over 6½ ft. high and carting them out of the city's 513 playgrounds. "Accidents happen no matter what you do," says Park District Treasurer Jack Matthews. "In the past, when Johnny fell off the swings, the park superintendent took him to the hospital, and that was the end of it. Now the parks are inundated with suits."

Such cases show how complex and changing legal doctrines can increase the risks faced by insurance companies and make those risks more unpredictable. But, as consumer advocates point out, they do not explain the full story. The legal doctrines in question have been evolving for many years. The rise in the number of personal-injury lawsuits and the size of jury awards has also been gradual. But apart from medical malpractice insurance, which has been a headache for both doctors and insurers for at least a decade, it is only in the past two years that liability premiums have exploded and policies have been canceled wholesale.

What happened? Lawyers and consumer activists charge that insurers are paying the price—or, rather, trying to

Stiff Drinks


STEVE LISS

From 5 to 6 p.m., the price of a Heineken beer at the Red Blazer restaurant in Concord, N.H., was $14.75 instead of the usual $2.25, and a Beefeater's martini cost $40. Inflation? Sort of. The Red Blazer and some 400 other New Hampshire bars sponsored an Unhappy Hour last month to dramatize the rising cost of liability insurance for liquor retailers. The restaurant's premium had been hiked from $1,000 to $12,000 annually, and its owner hoisted bar tabs in protest. As courts have held tavern owners at least partly responsible for damage caused by intoxicated customers, retail liquor outlets have felt the squeeze from insurance companies. But Unhappy Hour prices are not likely to become permanent: New Hampshire Insurance Commissioner Louis Bergeron argues that higher premiums have actually raised bar costs no more than 18¢ a drink.

Hung Up


BROOME—PICTURE GROUP

When a late-winter storm dumped nearly 100 in. of snow on California's Sierra Nevada range near Lake Tahoe in March 1982, operators of the Alpine Meadows ski area closed down their 13 lifts and warned guests not to venture onto the slopes. When an avalanche struck, however, it did not bury the ski trails but the parking lot and a ski-patrol building, killing seven people. The families of three victims sued Alpine Meadows for $10 million in damages.

Last December a jury decided that the resort was not responsible for the tragedy. Nevertheless, Alpine Meadows did not emerge unscathed: legal fees for the trial totaled some $700,000, and the resort's 1986 liability premium doubled, to nearly $800,000. Like other businesses hit with major cost increases, Alpine Meadows passed on the added expense. It raised the price of a one-day lift ticket from $24 to $26.

make the public pay the price—for their own mismanagement and bad judgment. Liability insurance has always been a notoriously cyclical industry. Says Robert Hunter, head of the National Insurance Consumer Organization: "At the top of the cycle you write [policies for] everybody, no matter how bad, and at the bottom you cancel everybody, no matter how good. It's a manic-depressive cycle."

Harsh words, but again containing some truth. In the best of times, property and casualty insurers, the kind that issue liability policies, rarely make much money on underwriting: the premiums collected have exceeded claims paid in only two of the past ten years. Most of their profits come from investing the premiums they collect. Five years ago, when the prime rate, keystone of the U.S. interest-rate structure, hit an incredible high of 21½%, such investments paid off very, very well.

Insurers grudgingly concede that they went all out to attract premium income that could be invested at those towering interest rates. They wrote liability policies that posed a high risk at premiums low enough to almost guarantee an underwriting loss; competitive rate-cutting slashed some premiums by 20% or more. But the insurers never got the bonanza they expected. Underwriting losses rose faster than investment income grew even when interest rates were at their peak.

Then the bottom fell out. Interest rates began tumbling in 1981; the prime is now at an eight-year low of 9%. Underwriting losses ballooned. Foreign reinsurers—Lloyd's of London is the biggest—that indemnify most American casualty companies against extraordinary losses, cut back sharply or ran away from the business entirely, leaving the American firms to shoulder the losses alone. Finally, in 1984 underwriting losses swallowed up investment income entirely and, according to industry statistics, property-casualty insurers suffered an overall pretax loss of $3.8 billion. It was the first red-ink figure in nine years. In 1985 the pretax loss increased to $5.5 billion. Some 40 liability insurers have become insolvent in the past two years.

Like the figures on jury verdicts, the insurers' profit-and-loss statistics are in sharp dispute. Consumer advocates insist that if adjustments are made for some quirks in insurance accounting (primarily involving the treatment of taxes, dividends and the rising paper value of investments), the industry made a net profit every year. The Insurance Information Institute, indeed, has acknowledged an industry profit after taxes of $1.7 billion last year, which it contends still amounts to a poor return.

The National Insurance Consumer Organization maintains that the true figure was $5 billion. Given that, the industry's critics argue, the premium increases now being posted go far beyond what is justified. Sneers Gerry Spence, a famed Wyoming trial lawyer (no relation to Miami's J.B. Spence): "What the insurance companies have done is to reverse the business so that the public at large insures the insurance companies." Consumerists often point to the judgment of Wall Street, hardly a Naderite stronghold. Stock traders bid up the price of property-casualty insurance shares an average of about 50% last year, in the apparent belief that the industry at minimum is on its way back to solid profitability.

Well, maybe. But that road to recovery threatens, at least for the moment, to cripple large segments of the U.S. economy and be extremely costly for every policyholder, taxpayer and consumer. Every day brings word of new repercussions: doctors raising their fees, playgrounds closing, swimming meets being called off, transit systems facing financial jolts, fraternities having their coverage canceled, oil-field service companies closing down. Amid all of the attendant finger pointing, a serious search is under way for some solutions.



In the Pool

Many Americans have experienced the insurance crisis only at second hand, in the form of rising prices for goods and services ranging from ski-lift tickets to medical care. When insuring their homes and cars, most consumers for once have largely escaped the cost crunch. Liability coverage for drivers and homeowners has risen an average of only 1½% annually since 1980, about the same as inflation. Says Sean Mooney, chief economist for the industry-supported Insurance Information Institute: "Personal-liability premiums haven't taken a quantum leap, and I don't expect them to." Behind this stability is a basic principle of underwriting: the larger the pool of premium payers, the less the shared risk. Out of 131 million U.S. car owners, 90% carry at least some liability protection, creating a kitty of $49 billion in 1985, against $40 billion in claims. Similarly, 55 million U.S. homeowners paid $15 billion in premiums last year to offset $11.6 billion in claims. This huge pool of consumers also makes risk much more predictable—and therefore rates lower—than for narrower lines of insurance. Automobile-accident law is relatively well established, leaving juries with few opportunities to award damages wildly out of line from similar cases.

Personal-liability insurers can still be jarred by novel rulings. In 1984 the New Jersey Supreme Court held that homeowners, like saloon keepers, are responsible for accidents caused by intoxicated guests. So far the ruling has had no effect on insurance rates, though companies warn that further widening of homeowner liability could eventually increase premiums.

Nor do all consumers feel that personal liability rates are being shared equitably. Eight California plaintiffs have filed suit seeking to overturn the state's 1984 mandatory automobile insurance law. Plaintiffs charge that policy writers charge excessive rates to residents of high-risk neighborhoods, usually in inner cities, even if applicants have spotless driving histories. While the case is pending, California authorities have stopped enforcing the [illegible] policy-coverage [illegible] forced the rates [illegible] billion [illegible] policies [illegible]

Self-insurance is a strategy that many businesses, professional people and governments are exploring (or, more often, being forced into). But the experience of doctors indicates it is not much of a solution. In the mid-1970s, doctors organized a number of companies, promptly dubbed "bedpan mutuals," to write malpractice insurance at lower premiums. But several of the bedpan mutuals are said to be in financial trouble, and as a group they too are raising premiums rapidly. Going bare is an act of desperation: business executives and professionals who are operating without insurance almost unanimously voice deep worry that a single big lawsuit could wipe them out.

As might be expected, many are seeking new legislation as a solution. But what line should it take? One approach is called tort reform, which involves putting limits on damage awards in malpractice, negligence and personal-injury cases. Advocates insist that this will allow insurers to get enough of a handle on their potential risks to make writing liability policies a predictable exercise rather than a crapshoot. The leading ideas:

- Put limits on pain-and-suffering awards and punitive damages. Republican Senator Mitch McConnell of Kentucky has introduced a congressional bill encouraging states to cap pain-and-suffering awards at $100,000 and to require that punitive damages be paid to a court, as outright fines are, rather than to a plaintiff and his or her attorney.
- Establish stricter standards for proving who really bears how much of the blame for an accident or injury. Senator John Danforth, a Missouri Republican, is sponsoring a bill that would set uniform federal standards in product-liability cases to replace the present morass of 50 often conflicting state laws; it would require a plaintiff to prove negligence or fault by the manufacturer.
- Either abolish the doctrine of joint and

several liability or revise it along the lines of a proposition that Californians will put to a vote on June 3. The proposition would make a defendant's share of any pain-and-suffering award proportionate to the defendant's degree of blame; a defendant found to bear 25%, say, of the responsibility for an accident or injury could be forced to pay no more than 25% of the damages. That would be more equitable, but requiring juries to assess proportionate shares of fault among several defendants would add to the complexity of lawsuits and the time needed to settle them.

▸ Limit contingency fees, so that lawyers would have less incentive to seek outsize damages for their clients. Several states are pondering variations on a California law that sets up a sliding scale in medical malpractice cases: an attorney can take up to 40% of the first $50,000 of a judgment, but that share dwindles by stages to only 10% of any amount over $200,000.

▸ Institute some sort of punishment, perhaps a fine, for attorneys who file frivolous suits. At minimum, reformers often urge adoption of the European system, under which the loser of a lawsuit usually pays the winner's court costs.

This last idea has yet to gain much ground, but different combinations of the others are being advanced in several states. The National Conference of State Legislatures estimates that around 1,200 bills have been introduced since last December dealing with the insurance crisis in one way or another, and most contain some sort of tort reform. On the federal level, besides the McConnell and Danforth proposals, a Reagan Administration study group headed by Assistant Attorney General Richard Willard is expected to recommend a bill limiting pain-and-suffering awards and punitive damages; it would also establish tighter standards for gauging fault to govern suits in federal courts. (Uncle Sam has more than a bystander's interest: the U.S. was a defendant in more than 10,000 damage suits in fiscal 1985, and wound up paying $200 million to plaintiffs.)

Some 600 members of the National Association of Manufacturers descended on Washington last week to lobby for the Danforth bill, which besides setting national standards for product-liability suits would establish a new procedure for speedy out-of-court settlement of claims for economic damages. They first gathered at the Marriott Hotel to swap horror stories and pep talks. Under present legal rules, "you're afraid to try anything, put any new product on the market," cried Gust Headbloom, president of Michigan's Apex Broach & Machinery Co. Peter J. Nord, president of Schauer Manufacturing Corp. in Cincinnati, which makes battery-charging machines, drew loud applause by declaring, "There are going to be people who are dumb and stupid and screw up no matter what we do." Ohio Democratic Congressman Thomas Luken showed up to cheer on the manufacturers. Said he: "Probably no recent issue has snowballed so quickly."

After eating paper-bag lunches, the manufacturers boarded buses to Capitol Hill to buttonhole legislators from their home states. So many Michiganders packed into the office of Democratic Senator Carl Levin that several of the businessmen had to perch on upended attaché cases. Levin warned them that "the whole spirit of Congress is to get away from regulation," but promised to take a careful look at the Danforth bill. Plaintiffs' attorneys, needless to say, oppose all tort-reform plans. They commonly accuse insurers of creating a sense of crisis to enact laws that would deny just compensation to victims of malpractice or injury. More troubling, they insist that all the tort-reform ideas would undermine a fundamental principle of democracy: the idea that any citizen should have unrestricted access to the courts for redress of any grievances he might suffer. Robert Habush, president of the Association of Trial Lawyers, says of the tort-reform movement, "In my 25 years in law, this is as serious a threat to the civil justice system as I have ever seen. People have decided there is going to be a hanging, and it is just a question of what tree and what rope."

In all probability, that seriously overstates the case. Present and former trial lawyers populate state legislatures and Congress in numbers large enough to wield formidable blocking power. There is a question, too, of whether the courts would uphold any serious tort reforms that might be enacted. One omen: the Cook County, Ill., circuit court last year ruled that major parts of a newly enacted law stretching out damage awards in medical malpractice cases violated the Illinois constitution.

The alternative legislative approach to the insurance crisis is tighter regulation of insurance companies. At the federal level, trial lawyers and consumer advocates are pressing for repeal of the insurance industry's exemption from antitrust laws. That exemption allows insurers to share information and, according to their opponents, engage in collusive premium-setting policies that would be illegal in any other industry. In state legislatures, many proposed bills would enlarge the authority of insurance commissioners to block arbitrary policy cancellations and gargantuan premium increases. The Florida department of insurance has written a proposed bill that would require insurers to disclose what discounts and surcharges they apply to premium rates. Without that information, says Insurance Commissioner Bill Gunter, "the rate itself is meaningless." He adds, "We think insurers need someone to look over their shoulder and keep them honest."



One mildly encouraging sign is that a growing number of legislators seem to recognize that, just as the crisis has no single cause, it cannot have any single solution. They are proposing various combinations of tighter insurance regulation and tort reform. A bill on the verge of enactment by the Minnesota legislature would set up "joint underwriting associations" to issue liability policies, written by the state, to customers who could not get commercial insurance; any losses would be picked up jointly by the state's insurers. But to limit those losses, the bill also would restrict punitive damages, among other tort reforms.

Some combination of measures seems needed, and fast. Anything that affects matters ranging from the pace of oil exploration to the availability of slides in Chicago playgrounds must be taken very seriously. The nation, once proud of its frontier individualism, has gradually adopted a no-risk mentality based on the belief that if anything bad happens, someone should be made to pay. But as damage awards lose any connection to actual damages and insurance companies flail around anxiously, that someone is turning out to be everyone. *—By George J. Church. Reported by Anne Constable/Washington, B. Russell Leavitt/Atlanta and Michael Riley/Los Angeles*

SOME OBSERVATIONS ON THE NEED FOR TORT REFORM

Gustave H. Shubert

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PREFACE

This paper is an edited transcript of a speech made by Gustave H. Shubert, Director of The Institute for Civil Justice, to the National Conference of State Legislatures in Denver, Colorado, in January, 1986. An earlier version of the talk was presented to the Public Policy Institute in Albany, New York, November, 1985.

The work described in this paper is part of the research program of The Institute for Civil Justice. The paper draws on studies of civil court congestion and delay, alternative dispute resolution, the public costs of civil litigation, asbestos-related litigation, punitive damages, and medical malpractice. It explores the relevance of policy research to a subject of much current public debate: tort reform.

SOME OBSERVATIONS ON THE NEED FOR TORT REFORM

Gustave H. Shubert

BACKGROUND

I am here to talk about the need for reform in the civil justice system. There has been a lot of discussion this morning about legislative action, about the need for change in the insurance industry, and about the need for changes in business practices. My task is to set the background and describe the need for reform; I leave it to others to deal with potential courses of action.

In considering the problems of the civil justice system, problems with which all of us here today are concerned, I am reminded of my experience with the Air Force in Korea: One night, the lights went out and North Korean and Chinese troops started pouring over the fence of the base. I happened to be on the command net and heard the Base Commander, who had been rousted out from the Officers' Club, saying, "Colonel Jones, Colonel Jones, where are you? Where is that base defense plan I asked you to design last month?" That plan, of course, had never been prepared.

I think we are finding ourselves in a similar situation with regard to civil justice today. Plans aside, even the basic, fundamental information necessary to understand the need for reform has not yet been developed.

When we started The Institute for Civil Justice within The Rand Corporation in 1979 (I think most of you will agree that the problems we are talking about were with us in 1979 and before), there was virtually no systematic knowledge of the civil justice system or its operations. There was a feeling of general unease in certain sectors, particularly in the insurance industry, about the absence of information necessary to understand the operations of the system. On the one hand, there were the academics who were outlining rather elegant--but largely data-free--theories of legal behavior. At the other end of the spectrum, there was some information available on the operations of courtrooms--how many

jurors to impanel if one wanted to have three juries per week for so many weeks and so forth--but the entire area between these extremes was devoid of systematic research.

THE WORK OF THE INSTITUTE FOR CIVIL JUSTICE

Our job at Rand and at The Institute for Civil Justice is to try to fill that gap as much as we can to develop an understanding of the relationships between the various factors and the various players that comprise the civil justice system. The ICJ has focused on trying to understand the fairness of the system, the efficiency of the system, and its overall effectiveness. Translating that into researchers' terms:

- We are concerned with the outcomes the system has been producing: Are they consistent with the law? How do they vary as the law evolves? Have they been changing over time? What are some of their potential policy implications?
- We are concerned with the benefits and costs of the system: Who's paying what to whom--both in terms of compensation and in terms of transactions costs? What is the distribution of costs and benefits among various segments of our society?
- We are concerned with the overall effectiveness of the process by which outcomes are reached, costs incurred, and benefits distributed.

Then, knowing as much as we can and trying to accrue knowledge about these key issues as we go along, we disseminate information to those, like yourselves, who are concerned with the need for reform to help you decide what changes are needed and to perceive the ways in which they can be achieved.

I would like to convey to you this morning a few pieces of information about what we have learned in each of these areas--outcomes, costs, and timeliness--and to draw out some of the implications that I see for the important matters you are here to consider.

Research on Outcomes

First, let me deal with the question of outcomes. When we began our work, we found that there had been no data gathered in any systematic way pertaining to the outcomes the system is producing over time. We were confronted with anecdotal information, on the one hand, from people who would argue that the American jury was out of control, awarding more and more money to less and less deserving people all the time. Conversely, we encountered arguments that the American jury is the backbone of the civil justice system; that the jury is responsible and predictable; and, therefore, that the jury should be retained and enhanced as the fundamental basis of our civil justice system. These arguments had one common characteristic: Neither one had a shred of empirical evidence to support it.

So we began to examine what the American jury has been doing for the past 20 years. We found that, in terms of aggregate performance over time in Cook County and in San Francisco (the two areas that we chose for intensive study, developing the first longitudinal data bases regarding civil suits for money damages ever assembled in this country) the *median* jury award has remained essentially constant (in constant dollars) for 20 years. Considering only those cases in which the plaintiff prevailed, the fiftieth percentile award has been flat. In fact, in Cook County the median has actually decreased somewhat, hovering around the level of $7,900 in 1979 dollars. That doesn't look like much to get excited about. However, when we looked at *average* awards, we found that toward the middle of the period the average award began to take off at an ever-increasing pace. This divergence between the average and median awards was accounted for almost exclusively by the top ten percent of cases. I will come back to the implication I draw from that in just a minute.

In these studies we found a number of other things. For example, in both Cook County and San Francisco, juries systematically inflate awards from between the time of filing and the time an award is made. So we have, in effect, juries awarding implicit prejudgment interest at the prevailing rate of inflation during the interval between filing and award.

Furthermore, we found that the circumstances of an injury affect the compensation awarded--something that I believe is not the intent of the law. The loss of two legs in an automobile accident, for example, is "worth" an average of $250,000 in compensation. In contrast, the same loss to the same kind of plaintiff, but resulting from a workplace accident, brings an average compensation of $750,000. Now we are not talking about punitive damages here: We are talking just about compensatory awards.

In another analysis, we examined the relationship between the nature of the litigants and the kinds of compensation that are awarded. We found in Cook County, for example, that blacks win less often, and, when they win, they obtain lower awards.

We also found a relationship (in both Cook and San Francisco Counties) between the apparent wealth of the defendant and the amount of compensation awarded by the jury for serious injuries. (Nothing in this field, it seems, is simple: We found no such "deep pocket" effect for relatively minor injuries.) Some of you probably know this intuitively or anecdotally. But to my knowledge, this is the first time that any attempt has been made to test the so-called "deep pocket" theory systematically and to see whether there is, in fact, any direct association between the size of awards and the characteristics of the plaintiff and defendant.

We are now examining carefully the phenomenon of punitive damages. We are assessing the characteristics of cases in which punitive damages occur and attempting to understand the implications of trends in punitives for the future. We are also attempting to estimate the effects of punitive damages on corporate decisionmaking, corporate behavior and the propensity to settle, as well as the amounts that are agreed upon.

The bottom line that I draw from our studies of the outcomes produced by the civil justice system is that one ought to focus on where the difficulty is. That difficulty seems to us to be primarily in the area of large, complex cases--the cases that are, in effect, new types of litigation for our system--cases involving product liability, professional malpractice of various kinds, suits against government, and

litigation in the area of business and contracts. The vast bulk of civil cases--the small suits (the fender-bender types, if you will)--seem to be proceeding relatively normally as far as verdicts are concerned. And recall that it is true that at the median, awards have remained (in constant dollars) relatively constant over time. It is in the area of the new types of litigation that the problems we have been talking about so far today are occurring, and it is in this area, I believe, they are likely to continue.

Research on Costs

What about costs? The first question we asked was: How do we, as citizens, value the services performed for us by the civil justice system--as expressed by our expenditures of tax dollars? What share of our public resources do we allocate toward supporting this system in the United States? This is, after all, the system dedicated to resolving all of our noncriminal disputes--disputes between individuals, between organizations, and between organizations and individuals.

The ICJ developed a method for assessing the costs of the civil justice system to the public--to you and me as taxpayers. We found that on an annual operating basis, we in the United States at the federal, state, and local levels are devoting about $2.2 billion per year to operating that system. Now you might say, "That sounds like an awful lot of money to me," or you might say, "When I compare that amount of money with what we put into other public systems in this country, it doesn't look like much--in fact it looks rather small." The point I want to make is that at least we now know where our priorities are, expressed in dollar terms. We are finally in a position to ask and answer meaningfully questions about the significance of changes in public funding and whether increases in funding to improve the quality of that system would strain our overall resources.

With regard to private costs, we began by analyzing private costs of asbestos litigation. This is an important area in and of itself, but also because we believe it is a precursor of future massive toxic torts litigation. I think our results are reasonably well known by now. If you visualize a pipeline into which we put money at one end and see compensation coming out the other, that pipeline starts with a total

expenditure of about $95,000--the full private-dollar input into the civil justice system for the average case. There is an immediate draw-down of $35,000, about 37 percent of that initial amount, for defense costs--legal fees and related costs of corporations engaged in litigation. The remaining $60,000 is paid to the plaintiff. The plaintiff, in turn, spends about $25,000--about 40 percent--of what he recovers (26 percent of the total) on his legal fees and costs. The plaintiff himself, then, ends up with about $35,000--37 percent of all the funds expended. So of all the monies spent, the injured parties net just a little more than a third of the total. These results raise two bottom-line questions in the cost area: Is it appropriate to spend nearly twice as much money determining how much should go to whom as is eventually provided in compensation to injuried parties; and, would an increase in public resources, including some spent on thought about the problem, help reduce the extraordinary expenses that we are encountering in the private sector in the process of awarding compensation?

Research on Process

That brings me to the area of the overall effectiveness of the process. Here I will focus on the problems of congestion and delay and of the quest for alternatives that will lead to more efficient ways of resolving our disputes. Effectiveness, of course, must be measured in many dimensions, not just in terms of timeliness.

Court congestion and delay are problems that are widely known and discussed. When we began our work on them, we reached for the book entitled *Congestion and Delay: What We Are Doing About It*, and found that it had yet to be written. There was no data base in this country concerning the problem, either at the state or national level, that explained what the problem was, what its dimensions were, and what was being done about it. The ICJ, in effect, began putting that book together, and by providing our findings to officials of the judiciary in all the states and throughout the federal court system, we helped them to better understand their problems and all the different remedies that were being tried, or had been tried, or were being considered, to deal with congestion and delay.

We analyzed the history of corgestion and delay in the Los Angeles Superior Court, the largest single trial court in the United States--one in which the mean time to trial is now about 48 months. Although attempts have been made again and again to deal with congestion and delay in the Los Angeles Superior Court, none of these efforts have had lasting effect. (I do not mean to point a finger at this particular court; jurisdictions across the country have attempted to reduce backlogs with little permanent effect on time-to-trial or on caseload.)

We believe the explanation lies in the changing composition of the caseload in the Los Angeles Superior Court--a change which my earlier remarks about the "new litigation" foreshadowed. Since World War II, the Los Angeles Superior Court has evolved from essentially a debt-collection mechanism to an institution primarily concerned with personal injury litigation: handling product liability and medical malpractice suits of increasing scientific and technological complexity; and grappling with the problem of asbestos litigation, of which Los Angeles is a major center. In short, the case mix has gone from one which required considerably less than one judge-day per trial to one which currently calls for more than three judge-days per trial, without consciously recognizing the causes and without adjusting its management mechanisms to accommodate them. The ICJ is now working with the Los Angeles Superior Court to see if together we can discover some answers to that problem--answers that will provide for handling routine cases in a prompt, efficient, and low-cost way; and, at the same time, permit targeting of complex litigation for special channeling and treatment to process those cases expeditiously, fairly, and at less cost to the parties and the public.

We have concluded that there are indeed better ways. If one understands the system, if one develops th_ facts about the system, it is possible to make it work better.

One further illustration: As we began the Institute in 1979, California initiated a mandatory judicial arbitration program in an effort to avoid the conventional and congested litigation track by shunting cases through an alternative dispute resolution mechanism. We evaluated the first year's experience with that program, and I think

there is a very important lesson that flows from that analysis. We found that in the large districts in California, a system designed as an alternative intended to save time and money was costing *more* and taking *longer*--yet no one was aware of these effects. We were able to identify the factors responsible for this counter-intuitive and perverse effect. Our work led to legislation which sought to correct these effects. Now the system is operating more efficiently and at less cost.

The bottom-line message I want to leave with you here is that there are dangers in whatever reforms you seek--dangers of unintended effects that may, indeed, be perverse. I emphasize the need to not only watch what you are doing, but also the equally important need to monitor the results and the impacts of what you have done.

THE NEED FOR REFORM

Is there a need for reform? What do I draw out of our work? It seems to me that:

- When you have radical changes in the types of litigation that you are attempting to handle;
- When the outcomes reflect the consequences of those changes;
- When you see that the *public* costs of settling even routine disputes through jury trials exceed the stakes (the average jury trial in this country costs taxpayers around $8,000--not including the costs to the parties--and the median verdict in Cook County is around $7,900. As Chief Justice Burger has been saying for the last couple of years, when you have a system where the process costs more than the stakes, you have a system that is not operating as efficiently as it might.);
- When you find that you have a mean time to trial of five years or more;
- When you find your alternatives are costing more and taking longer;

we must conclude that change may indeed be necessary.

Furthermore, we have a system that appears to prevent actions that everyone in this room would agree are socially desirable. Here I am talking about a system that withholds compensation where compensation is deserved, or provides compensation on an irrational, random, or unfair basis. I am talking about a system which, for example, delays (and even

prevents) through its rules--and some of the derivatives of those rules--the cleanup of toxic waste sites and causes all kinds of perverse behavior.

Let me give you two cross-cutting examples to conclude this discussion about what research has to say about the problem--something about asbestos in the courts and something about medical malpractice.

Example--Asbestos in the Courts

The ICJ has just published a document dealing with asbestos litigation, and I would like to sum up what I think that report says about our civil justice system. At the beginning of the period of asbestos litigation the system had strong, positive aspects. It provided incentives for lawyers to seek compensation for injured parties when the outcomes were very uncertain and the financial rewards of seeking that compensation were far from clear. The system demonstrated its flexibility, its capacity to absorb new knowledge, at least within some limits, and its ability to incorporate this knowledge into the legal process; and it demonstrated that it held at least the promise of deterring behavior which was known to be potentially hazardous and injurious. But as the asbestos litigation system entered its current phase--the "mega-plaintiff/mega-defendant" phase--we are processing thousands of cases, taking thousands or hundreds of thousands of man-years, with expenditures in the billions of dollars, and the weaknesses of the system, I think, have begun to overshadow its strengths.

We have a system in which plaintiffs, who may or may not be injured, have cases filed over which they have essentially no control. We have a system which idealizes individualized justice, but in fact delivers justice by the carload, where the individual is submerged in the batch processing of hundreds, sometimes even thousands, of cases. We have a system in which the incentives to lawyers provided by the rules and by the outgrowths of those rules are often conflicting and transcend the interests of the people they represent. We find that the rules themselves are frequently inappropriate, or at least, inconsistent. States like New York, with a two-year statute of limitations, make it virtually impossible to seek compensation for any long-term disease, such as those associated with asbestos--whereas other

states with much longer statutes do permit recovery. We find that the litigation is virtually endless: Since there are 20 defense firms per case on average, representing 20 defendants, the same issues are litigated 20 times in each case. These cases go on day after day, week after week, month after month on a repetitive basis.

The procedures used in these cases are tailored to trials, trials which almost never take place, as opposed to settlements which eventually do. Dispositions are slow, outcomes are inconsistent. Judges themselves are responding to their own incentive systems, which tell them to avoid handling these dirty, protracted, difficult, and acrimonious cases that are often appealed. No judge has a strong incentive to subject himself to the appeal process. The dispositions, as I mentioned, are not just slow, they are glacial. So to put some flesh on the bones for the need for reform, I think it is fair to say that in this area, outcomes are affected by considerations outside as well as inside the law. One is left with only one question about the need for reform: Will it work?

Example--Medical Malpractice

That brings me to the medical malpractice policy research conducted by The Institute for Civil Justice. Here we sought to determine whether the reforms introduced in response to the medical malpractice situation of the mid-1970s had any effect; and if they did, whether or not they were the intended effects. We can give a qualified "yes" to these questions. On the whole, in those states that took action through their legislatures to dampen medical malpractice activity in contrast to states which did not, suits were less likely to be filed; when they were filed, they were more likely to be dropped; if they were pursued, they were more likely to be settled rather than tried--and settled for a lesser amount.

As we went through the various measures that were legislated, however, we found substantial variation in the effects observed. For example, simply relaxing the collateral source rule, which many had thought would have a profound effect on this litigation, seemed to have no statistically significant effect at all. Here was a reform measure which, like California's initial approach to arbitration, did not have

its intended effects. Mandatory inclusion of payments from collateral sources, on the other hand, did have a significant effect. The lesson from all of this certainly is not, "Don't try for improvement." Rather, the lesson that I draw from this is: Try to estimate in advance as best you can the impact of legislation on costs, outcomes, and process, and build into every reform measure--or every measure for change--the capacity to evaluate the impact of that change; to provide, if you will, for some mid-course correction that will be available if these reforms are not having their intended effect.

CONCLUSION

People with more authority than I--people who are on the firing line--told you earlier this morning that we are in tough times. This is not just a consequence of an "insurance problem," although I believe the current insurance situation is, in part, a high-profile symptom of the maladies of our civil justice system. That symptom may turn out in the long run to be a benefit: (1) if it forces attention to the problem from those who are responsible for policy changes, be they chief executive officers, legislators, the bar, or the judiciary; (2) if it forces us to understand the system and how it operates; and (3) if it enables us to produce constructive changes toward fairer, more efficient, and more effective resolution of our civil disputes and forces us to make rational choices among the options we are confronted with today.

I think underlying all our problems with the civil justice system is the inability of this country to decide whether it wants to have a pure compensatory system or whether it wants to have a fault-based liability system. We can't decide whether everybody should be compensated for every injury no matter what its cause, or whether we want compensation to be limited in a strict way, in a comparative way, or in a contributory way to those who have caused the injury. My personal assessment is that we are experiencing the disadvantages of trying to operate both systems in tandem, the worst of both worlds. We are attempting to compensate everyone within a fault-based system and we are incurring huge social overhead costs by attempting to do so. I believe it is time to focus on that overall choice and to be rational in doing so.

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Court Expenditures for Various Types of Civil Cases
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J. W. Adler, D. R. Hensler, C. E. Nelson, and G. Rest
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An Economic Analysis
G. L. Priest
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J. S. Kakalik, P. A. Ebener, W.L.F. Felstiner, G. W. Haggstrom, M. G. Shanley
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A History of Civil Delay in the Los Angeles Superior Court
M. Selvin and P. A. Ebener
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A Policymaker's Guide
E. Rolph
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Deep Pockets, Empty Pockets
Who Wins in Cook County Jury Trials
A. Chin, M. A. Peterson
1985

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Asbestos in the Courts
The Challenge of Mass Toxic Torts
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D. R. Hensler and J. Adler, with the assistance of G. Rest
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M. A. Peterson
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G. Eads and P. Reuter
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P-7180-ICJ
The Impact Of Fee Arrangement on Lawyer Effort
H. Kritzer, W.L.F. Felstiner, A. Sarat, D. Trubek
1986

ENGROSSED SUBSTITUTE SENATE BILL NO. 4630
AS AMENDED BY THE HOUSE

State of Washington 49th Legislature 1986 Regular Session
by Committee on Judiciary (originally sponsored by Senator Talmadge)

Read first time 2/5/86.

AN ACT Relating to civil actions; amending RCW 5.60.060, 4.22.030, 51.24.060, 4.16.350, 4.24.115, 4.16.160, 4.16.310, and 4.16.300; adding a new section to chapter 4.22 RCW; adding new sections to chapter 4.24 RCW; adding new sections to chapter 4.56 RCW; adding new sections to chapter 5.40 RCW; adding a new section to chapter 7.70 RCW; adding a new section to chapter 48.19 RCW; adding a new section to chapter 48.22 RCW; creating new sections; repealing RCW 4.56.240; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. Sec. 100. PREAMBLE. Tort law in this state has generally been developed by the courts on a case-by-case basis. While this process has resulted in some significant changes in the law, including amelioration of the harshness of many common law doctrines, the legislature has periodically intervened in order to bring about needed reforms. The purpose of this chapter is to enact further reforms in order to create a more equitable distribution of the cost and risk of injury and increase the availability and affordability of insurance.

The legislature finds that counties, cities, and other governmental entities are faced with increased exposure to lawsuits and awards and dramatic increases in the cost of insurance coverage. These escalating costs ultimately affect the public through higher taxes, loss of essential services, and loss of the protection provided by adequate insurance. In order to improve the availability and affordability of quality governmental services, comprehensive reform is necessary.

The legislature also finds comparable cost increases in professional liability insurance. Escalating malpractice insurance premiums discourage physicians and other health care providers from

initiating or continuing their practice or offering needed services to the public and contribute to the rising costs of consumer health care. Other professionals, such as architects and engineers, face similar difficult choices, financial instability, and unlimited risk in providing services to the public.

The legislature also finds that general liability insurance is becoming unavailable or unaffordable to many businesses, individuals, and nonprofit organizations in amounts sufficient to cover potential losses. High premiums have discouraged socially and economically desirable activities and encourage many to go without adequate insurance coverage.

Therefore, it is the intent of the legislature to reduce costs associated with the tort system, while assuring that adequate and appropriate compensation for persons injured through the fault of others is available.

PART I

ACCELERATED PHYSICIAN-PATIENT PRIVILEGE

Sec. 101. Section 294, page 187, Laws of 1854 as last amended by section 1, chapter 56, Laws of 1982 and RCW 5.60.060 are each amended to read as follows:

(1) A husband shall not be examined for or against his wife, without the consent of the wife, nor a wife for or against her husband without the consent of the husband; nor can either during marriage or afterward, be without the consent of the other, examined as to any communication made by one to the other during marriage. But this exception shall not apply to a civil action or proceeding by one against the other, nor to a criminal action or proceeding for a crime committed by one against the other, nor to a criminal action or proceeding against a spouse if the marriage occurred subsequent to the filing of formal charges against the defendant, nor to a criminal action or proceeding for a crime committed by said husband or wife against any child of whom said husband or wife is the parent or guardian, nor to a proceeding under chapter 71.05 RCW: PROVIDED, That the spouse of a person sought to be detained under chapter 71.05 RCW may not be compelled to testify and shall be so informed by the

court prior to being called as a witness.

(2) An attorney or counselor shall not, without the consent of his client, be examined as to any communication made by the client to him, or his advice given thereon in the course of professional employment.

(3) A clergyman or priest shall not, without the consent of a person making the confession, be examined as to any confession made to him in his professional character, in the course of discipline enjoined by the church to which he belongs.

(4) A ((regular)) physician or surgeon or osteopathic physician or surgeon shall not, without the consent of his patient, be examined in a civil action as to any information acquired in attending such patient, which was necessary to enable him to prescribe or act for the patient, ((but--this--exception-shall-not-apply-in-any-judicial proceeding-regarding-a-child's-injuries,-neglect-or-sexual-abuse,--or the-cause-thereof)) except as follows:

(a) In any judicial proceedings regarding a child's injury, neglect, or sexual abuse or the cause thereof; and

(b) Within ninety days of filing an action for personal injuries or wrongful death, the claimant shall elect whether or not to waive the physician-patient privilege. If the claimant does not waive the physician-patient privilege, the claimant may not put his or her mental or physical condition or that of his or her decedent or beneficiaries in issue and may not waive the privilege later in the proceedings. Waiver of the physician-patient privilege for any one physician or condition constitutes a waiver of the privilege as to all physicians or conditions, subject to such limitations as a court may impose pursuant to court rules.

(5) A public officer shall not be examined as a witness as to communications made to him in official confidence, when the public interest would suffer by the disclosure.

PART II

ATTORNEYS' FEES

NEW SECTION. Sec. 201. A new section is added to chapter 4.24 RCW to read as follows:

The court shall, upon petition by a named party in any tort action, except those provided for in RCW 7.70.070, determine the reasonableness of that party's attorneys' fees. The court shall take into consideration the following:

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) The fee customarily charged in the locality for similar legal services;

(4) The amount involved and the results obtained;

(5) The time limitations imposed by the client or by the circumstances;

(6) The nature and length of the professional relationship with the client;

(7) The experience, reputation, and ability of the lawyer or lawyers performing the services;

(8) Whether the fee is fixed or contingent;

(9) Whether the fixed or contingent fee agreement was in writing and whether the client was aware of his or her right to petition the court under this section.

NEW SECTION. Sec. 202. Section 201 of this act applies to agreements for attorney's fees entered into after the effective date of this section.

PART III

LIMITATION ON NONECONOMIC DAMAGES

NEW SECTION. Sec. 301. A new section is added to chapter 4.56 RCW to read as follows:

(1) As used in this section, the following terms have the meanings indicated unless the context clearly requires otherwise.

(a) "Economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of

obtaining substitute domestic services, loss of employment, and loss of business or employment opportunities.

(b) "Noneconomic damages" means subjective, nonmonetary losses, including, but not limited to pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, injury to reputation and humiliation, and destruction of the parent-child relationship.

(c) "Bodily injury" means physical injury, sickness, or disease, including death.

(d) "Average annual wage" means the average annual wage in the state of Washington as determined under RCW 50.04.355.

(2) In no action seeking damages for personal injury or death may a claimant recover a judgment for noneconomic damages exceeding an amount determined by multiplying 0.43 by the average annual wage and by the life expectancy of the person incurring noneconomic damages, as the life expectancy is determined by the life expectancy tables adopted by the insurance commissioner. For purposes of determining the maximum amount allowable for noneconomic damages, a claimant's life expectancy shall not be less than fifteen years. The limitation contained in this subsection applies to all claims for noneconomic damages made by a claimant who incurred bodily injury. Claims for loss of consortium, loss of society and companionship, destruction of the parent-child relationship, and all other derivative claims asserted by persons who did not sustain bodily injury are to be included within the limitation on claims for noneconomic damages arising from the same bodily injury.

(3) If a case is tried to a jury, the jury shall not be informed of the limitation contained in subsection (2) of this section.

PART IV

APPORTIONMENT OF DAMAGES

NEW SECTION. Sec. 401. A new section is added to chapter 4.22 RCW to read as follows:

(1) In all actions involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault which

is attributable to every entity which caused the claimant's damages, including the claimant or person suffering personal injury or incurring property damage, defendants, third-party defendants, entities released by the claimant, entities immune from liability to the claimant and entities with any other individual defense against the claimant. Judgment shall be entered against each defendant except those who have been released by the claimant or are immune from liability to the claimant or have prevailed on any other individual defense against the claimant in an amount which represents that party's proportionate share of the claimant's total damages. The liability of each defendant shall be several only and shall not be joint except:

(a) A party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as an agent or servant of the party.

(b) If the trier of fact determines that the claimant or party suffering bodily injury or incurring property damages was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the claimants total damages.

(2) If a defendant is jointly and severally liable under one of the exceptions listed in subsections (1)(a) or (1)(b) of this section, such defendant's rights to contribution against another jointly and severally liable defendant, and the effect of settlement by either such defendant, shall be determined under RCW 4.22.040, 4.22.050, and 4.22.060.

(3)(a) Nothing in this section affects any cause of action relating to hazardous wastes or substances or solid waste disposal sites.

(b) Nothing in this section shall affect a cause of action arising from the tortious interference with contracts or business relations.

(c) Nothing in this section shall affect any cause of action arising from the manufacture or marketing of a fungible product in a generic form which contains no clearly identifiable shape, color, or

marking.

Sec. 402. Section 11, chapter 27, Laws of 1981 and RCW 4.22.030 are each amended to read as follows:

Except as otherwise provided in section 401 of this 1986 act, if more than one person is liable to a claimant on an indivisible claim for the same injury, death or harm, the liability of such persons shall be joint and several.

Sec. 403. Section 4, chapter 85, Laws of 1977 ex. sess. as last amended by section 5, chapter 218, Laws of 1984 and RCW 51.24.060 are each amended to read as follows:

(1) If the injured worker or beneficiary elects to seek damages from the third person, any recovery made shall be distributed as follows:

(a) The costs and reasonable attorneys' fees shall be paid proportionately by the injured worker or beneficiary and the department and/or self-insurer;

(b) The injured worker or beneficiary shall be paid twenty-five percent of the balance of the award: PROVIDED, That in the event of a compromise and settlement by the parties, the injured worker or beneficiary may agree to a sum less than twenty-five percent;

(c) The department and/or self-insurer shall be paid the balance of the recovery made, but only to the extent necessary to reimburse the department and/or self-insurer for compensation and benefits paid;

(i) The department and/or self-insurer shall bear its proportionate share of the costs and reasonable attorneys' fees incurred by the worker or beneficiary to the extent of the benefits paid or payable under this title: PROVIDED, That the department or self-insurer may request court approval of costs and attorneys' fees or may petition a court for determination of the reasonableness of costs and attorneys' fees.

(ii) The sum representing the department's and/or self-insurer's proportionate share shall not be subject to subsection (1) (d) and (e) of this section.

(d) Any remaining balance shall be paid to the injured worker or

beneficiary;

(e) Thereafter no payment shall be made to or on behalf of a worker or beneficiary by the department and/or self-insurer for such injury until the amount of any further compensation and benefits shall equal any such remaining balance. Thereafter, such benefits shall be paid by the department and/or self-insurer to or on behalf of the worker or beneficiary as though no recovery had been made from a third person;

(f) If the employer or a co-employee are determined under section 401 of this 1986 act to be at fault, (c) and (e) of this subsection do not apply and benefits shall be paid by the department and/or self-insurer to or on behalf of the worker or beneficiary as though no recovery had been made from a third person.

(2) The recovery made shall be subject to a lien by the department and/or self-insurer for its share under this section.

(3) The department or self-insurer has sole discretion to compromise the amount of its lien. In deciding whether or to what extent to compromise its lien, the department or self-insurer shall consider at least the following:

(a) The likelihood of collection of the award or settlement as may be affected by insurance coverage, solvency, or other factors relating to the third person;

(b) Factual and legal issues of liability as between the injured worker or beneficiary and the third person. Such issues include but are not limited to possible contributory negligence and novel theories of liability; and

(c) Problems of proof faced in obtaining the award or settlement.

(4) In the case of an employer not qualifying as a self-insurer, the department shall make a retroactive adjustment to such employer's experience rating in which the third party claim has been included to reflect that portion of the award or settlement which is reimbursed for compensation and benefits paid and, if the claim is open at the time of recovery, applied against further compensation and benefits to which the injured worker or beneficiary may be entitled.

(5) In an action under this section, the self-insurer may act on behalf and for the benefit of the department to the extent of any

compensation and benefits paid or payable from state funds.

(6) It shall be the duty of the person to whom any recovery is paid before distribution under this section to advise the department or self-insurer of the fact and amount of such recovery, the costs and reasonable attorneys' fees associated with the recovery, and to distribute the recovery in compliance with this section.

(7) The distribution of any recovery made by award or settlement of the third party action shall be confirmed by department order, served by registered or certified mail, and shall be subject to chapter 51.52 RCW. In the event the order of distribution becomes final under chapter 51.52 RCW, the director or the director's designee may file with the clerk of any county within the state a warrant in the amount of the sum representing the unpaid lien plus interest accruing from the date the order became final. The clerk of the county in which the warrant is filed shall immediately designate a superior court cause number for such warrant and the clerk shall cause to be entered in the judgment docket under the superior court cause number assigned to the warrant, the name of such worker or beneficiary mentioned in the warrant, the amount of the unpaid lien plus interest accrued and the date when the warrant was filed. The amount of such warrant as docketed shall become a lien upon the title to and interest in all real and personal property of the injured worker or beneficiary against whom the warrant is issued, the same as a judgment in a civil case docketed in the office of such clerk. The sheriff shall then proceed in the same manner and with like effect as prescribed by law with respect to execution or other process issued against rights or property upon judgment in the superior court. Such warrant so docketed shall be sufficient to support the issuance of writs of garnishment in favor of the department in the manner provided by law in the case of judgment, wholly or partially unsatisfied. The clerk of the court shall be entitled to a filing fee of five dollars, which shall be added to the amount of the warrant. A copy of such warrant shall be mailed to the injured worker or beneficiary within three days of filing with the clerk.

(8) The director, or the director's designee, may issue to any person, firm, corporation, municipal corporation, political

subdivision of the state, public corporation, or agency of the state, a notice and order to withhold and deliver property of any kind if he or she has reason to believe that there is in the possession of such person, firm, corporation, municipal corporation, political subdivision of the state, public corporation, or agency of the state, property which is due, owing, or belonging to any worker or beneficiary upon whom a warrant has been served by the department for payments due to the state fund. The notice and order to withhold and deliver shall be served by the sheriff of the county or by the sheriff's deputy, or by any authorized representatives of the director. Any person, firm, corporation, municipal corporation, political subdivision of the state, public corporation, or agency of the state upon whom service has been made shall answer the notice within twenty days exclusive of the day of service, under oath and in writing, and shall make true answers to the matters inquired of in the notice and order to withhold and deliver. In the event there is in the possession of the party named and served with such notice and order, any property which may be subject to the claim of the department, such property shall be delivered forthwith to the director or the director's authorized representative upon demand. If the party served and named in the notice and order fails to answer the notice and order within the time prescribed in this section, the court may, after the time to answer such order has expired, render judgment by default against the party named in the notice for the full amount claimed by the director in the notice together with costs. In the event that a notice to withhold and deliver is served upon an employer and the property found to be subject thereto is wages, the employer may assert in the answer to all exemptions provided for by chapter 7.33 RCW to which the wage earner may be entitled.

PART V

LIMITATION OF ACTIONS

NEW SECTION. Sec. 501. A new section is added to chapter 4.24 RCW to read as follows:

It is a complete defense to any action for damages for personal

injury or wrongful death that the person injured or killed was engaged in the commission of a felony, if the felony was causally related to the injury or death in time, place, or activity. However, nothing in this section shall affect a right of action under 42 U.S.C. Sec. 1983.

Sec. 502. Section 1, chapter 80, Laws of 1971 as amended by section 1, chapter 56, Laws of 1975-'76 2nd ex. sess. and RCW 4.16.350 are each amended to read as follows:

Any civil action for damages for injury occurring as a result of health care which is provided after June 25, 1976 against:

(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatrist, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;

(2) An employee or agent of a person described in subsection (1) of this section, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in subsection (1) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;

based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury or condition or one year of the time the patient or his representative discovered or reasonably should have discovered that the injury or condition was caused by said act or omission, whichever period expires later, except that in no event shall an action be

commenced more than eight years after said act or omission: PROVIDED, That the time for commencement of an action is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic diagnostic purpose or effect.

For purposes of this section, notwithstanding RCW 4.16.190, the knowledge of a custodial parent or guardian shall be imputed to a person under the age or eighteen years. Any action not commenced in accordance with this section shall be barred((; PROVIDED, That the limitations in this section shall not apply to persons under a legal disability as defined in RCW 4.16.190)).

PART VI

INDEMNIFICATION AGREEMENTS

Sec. 601. Section 2, chapter 46, Laws of 1967 ex. sess. and RCW 4.24.115 are each amended to read as follows:

A covenant, promise, agreement or understanding in, or in connection with or collateral to, a contract or agreement relative to the construction, alteration, repair, addition to, subtraction from, improvement to, or maintenance of, any building, highway, road, railroad, excavation, or other structure, project, development, or improvement attached to real estate, including moving and demolition in connection therewith, purporting to indemnify against liability for damages arising out of bodily injury to persons or damage to property:

(1) Caused by or resulting from the sole negligence of the indemnitee, his agents or employees is against public policy and is void and unenforceable;

(2) Caused by or resulting from the concurrent negligence of (a) the indemnitee or the indemnitee's agents or employees, and (b) the indemnitor or the indemnitor's agents or employees, is valid and enforceable only to the extent of the indemnitor's negligence and only if the agreement specifically and expressly provides therefor, and may waive the indemnitor's immunity under industrial insurance, Title 51 RCW, only if the agreement specifically and expressly provides therefor and the waiver was mutually negotiated by the parties. This subsection applies to agreements entered into after

the effective date of this 1986 section.

PART VII

BUILDER LIMITATION

Sec. 701. Section 2, chapter 4 , Laws of 1955 and RCW 4.16.160 are each amended to read as follows:

The limitations prescribed in this chapter shall apply to actions brought in the name or for the benefit of any county or other municipality or quasimunicipality of the state, in the same manner as to actions brought by private parties: PROVIDED, That, except as provided in RCW 4.16.310, there shall be no limitation to actions brought in the name or for the benefit of the state, and no claim of right predicated upon the lapse of time shall ever be asserted against the state: AND FURTHER PROVIDED, That no previously existing statute of limitations shall be interposed as a defense to any action brought in the name or for the benefit of the state, although such statute may have run and become fully operative as a defense prior to February 27, 1903, nor shall any cause of action against the state be predicated upon such a statute.

Sec. 702. Section 2, chapter 75, Laws of 1967 and RCW 4.16.310 are each amended to read as follows:

All claims or causes of action as set forth in RCW 4.16.300 shall accrue, and the applicable statute of limitation shall begin to run only during the period within six years after substantial completion of construction, or during the period within six years after the termination of the services enumerated in RCW 4.16.300, whichever is later. The phrase "substantial completion of construction" shall mean the state of completion reached when an improvement upon real property may be used or occupied for its intended use. Any cause of action which has not accrued within six years after such substantial completion of construction, or within six years after such termination of services, whichever is later, shall be barred: PROVIDED, That this limitation shall not be asserted as a defense by any owner, tenant or other person in possession and control of the improvement at the time such cause of action accrues. The limitations prescribed in this section apply to all claims or causes

of action as set forth in RCW 4.16.300 brought in the name or for the benefit of the state which are made or commenced after the effective date of this 1986 section.

Sec. 703. Section 1, chapter 75, Laws of 1967 and RCW 4.16.300 are each amended to read as follows:

RCW 4.16.300 through 4.16.320 shall apply to all claims or causes of action of any kind against any person, arising from such person having constructed, altered or repaired any improvement upon real property, or having performed or furnished any design, planning, surveying, architectural or construction or engineering services, or supervision or observation of construction, or administration of construction contracts for any construction, alteration or repair of any improvement upon real property. This section is intended to benefit only those persons referenced herein and shall not apply to claims or causes of action against manufacturers.

PART VIII

PERIODIC PAYMENTS

NEW SECTION. Sec. 801. A new section is added to chapter 4.56 RCW to read as follows:

(1) In an action based on fault seeking damages for personal injury or property damage in which a verdict or award for future economic damages of at least one hundred thousand dollars is made, the court or arbitrator shall, at the request of a party, enter a judgment which provides for the periodic payment in whole or in part of the future economic damages. With respect to the judgment, the court or arbitrator shall make a specific finding as to the dollar amount of periodic payments intended to compensate the judgment creditor for the future economic damages.

(2) Prior to entry of judgment, the court shall request each party to submit a proposal for periodic payment of future economic damages to compensate the claimant. Proposals shall include provisions for: The name of the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, the number of payments or the period of time over which the payments shall be made, modification for hardship or unforeseen

circumstances, posting of adequate security, and any other factor the court deems relevant under the circumstances. After each party has submitted a proposal, the court shall select the proposal, with any changes the court deems proper, which in the discretion of the court and the interests of justice best provides for the future needs of the claimant and enter judgment accordingly.

(3) If the court enters a judgment for periodic payments and any security required by the judgment is not posted within thirty days, the court shall enter a judgment for the payment of future damages in a lump sum.

(4) If at any time following entry of judgment for periodic payments, a judgment debtor fails for any reason to make a payment in a timely fashion according to the terms of the judgment, the judgment creditor may petition the court for an order requiring payment by the judgment debtor of the outstanding payments in a lump sum. In calculating the amount of the lump sum judgment, the court shall total the remaining periodic payments due and owing to the judgment creditor converted to present value. The court may also require payment of interest on the outstanding judgment.

(5) Upon the death of the judgment creditor, the court which rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages. Money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor.

(6) Upon satisfaction of a periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security posted pursuant to this section shall revert to the judgment debtor.

NEW SECTION. Sec. 802. Section 5, chapter 56, Laws of 1975-'76 2nd ex. sess. and RCW 4.56.240 are each repealed.

PART IX

MISCELLANEOUS

NEW SECTION. Sec. 901. A new section is added to chapter 5.40 RCW to read as follows:

A breach of a duty imposed by statute, ordinance, or administrative rule shall not be considered negligence per se, but may be considered by the trier of fact as evidence of negligence; however, any breach of duty as provided by statute, ordinance or administrative rule relating to electrical fire safety, [illegible] smoke alarms, or driving while under the influence of intoxicating liquor or any drug, shall be considered negligence per se.

NEW SECTION. Sec. 902. A new section is added to chapter 5.40 RCW to read as follows:

It is a complete defense to an action for damages for personal injury or wrongful death that the person injured or killed was under the influence of intoxicating liquor or any drug and that such condition contributed more than fifty percent to his or her injuries or death. If the amount of alcohol in a person's blood is shown by chemical analysis of his or her blood, breath, or other bodily substance to have been 0.10 percent or more by weight of alcohol in the blood, it is conclusive proof that the person was under the influence of intoxicating liquor.

NEW SECTION. Sec. 903. A new section is added to chapter 4.24 RCW to read as follows:

(1) Except as provided in subsection (2) of this section, a member of the board of directors or an officer of any nonprofit corporation is not civilly liable for any act or omission in the course and scope of his or her official capacity unless the act or omission constitutes gross negligence.

(2) Nothing in this section shall limit or modify in any manner the duties or liabilities of a director or officer of a corporation to the corporation or the corporation's shareholders.

NEW SECTION. Sec. 904. A new section is added to chapter 4.24 RCW to read as follows:

A member of the board of directors or a superintendent of any school district is not civilly liable for any act or omission in the course and scope of his or her official capacity unless the act or omission constitutes gross negligence.

NEW SECTION. Sec. 905. A new section is added to chapter 7.70 RCW to read as follows:

Members of the board of directors or other governing body of a public or private hospital are not individually liable for injuries resulting from health care administered by a health care provider granted privileges to provide health care at the hospital unless the decision to grant the privilege to provide health care at the hospital constitutes gross negligence.

NEW SECTION. Sec. 906. A new section is added to chapter 48.22 RCW to read as follows:

The commissioner shall by regulation require insurers authorized to write casualty insurance in this state to form a market assistance plan to assist persons and other entities unable to purchase casualty insurance in an adequate amount from either the admitted market or nonadmitted market.

For the purpose of this section, a market assistance plan means a voluntary mechanism by insurers writing casualty insurance in this state in either the admitted or nonadmitted market to provide casualty insurance for a class of insurance designated in writing to the plan by the commissioner.

The bylaws and method of operation of any market assistance plan shall be approved by the commissioner prior to its operation.

A market assistance plan shall have a minimum of twenty-five insurers willing to insure risks within the class designated by the commissioner. If twenty-five insurers do not voluntarily agree to participate, the commissioner may require casualty insurers to participate in a market assistance plan as a condition of continuing to do business in this state. The commissioner shall make such a requirement to fulfill the quota of at least twenty-five insurers. The commissioner shall make his or her designation on the basis of the insurer's premium volume of casualty insurance in this state.

NEW SECTION. Sec. 907. A new section is added to chapter 48.19 RCW to read as follows:

The commissioner shall, in reviewing a casualty rate filing, determine in accordance with sound and reliable actuarial principles

whether this act requires an insurer to grant its policyholders a credit in such casualty rate filing. Upon determining that data in support of such a credit is actuarially credible, the commissioner shall approve or disapprove such casualty rate filing in accordance therewith. The commissioner shall not approve any casualty rate that is inadequate, excessive, or unfairly discriminatory.

NEW SECTION. Sec. 908. The commissioner shall, as chairman of the tort reform study commission, require the task force to study the effectiveness of joint underwriting authorities throughout the United States to specifically determine:

(1) The price as it relates to a filed Insurance Services Organization rate;

(2) The solvency of such mechanisms;

(3) The effect it has on the admitted market;

(4) The effect it has on the nonadmitted market;

(5) The effect or availability on the voluntary market; and

(6) What effect it has on lines or classes of insurance not designated.

NEW SECTION. Sec. 909. The insurance commissioner shall submit a report to the legislature by January 1, 1991, on the effects of this act on insurance rates and the availability of insurance coverage and the impact on the civil justice system.

NEW SECTION. Sec. 910. Except as provided in sections 202 and 601 of this act and except for section 904 of this act, this act applies to all actions filed on or after August 1, 1986.

NEW SECTION. Sec. 911. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. Sec. 912. Section 904 of this act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect immediately.

Version #2
Lauterbach
3/10/86

Original sponsor: Josephson

IN THE SENATE

BY THE LABOR AND COMMERCE COMMITTEE

CS FOR SENATE BILL NO. 404 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to insurance; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 21.36.190(d) is amended to read:

(d) This section does not apply to workers' compensation insurance when issued to an association of employers formed for purposes other than the purchase of insurance and that

(1) has a constitution and bylaws; the requirement of this paragraph does not apply to municipalities, school districts, and regional educational attendance areas;

(2) incorporates a safety program;

(3) as a group has preferred characteristics over similar risks written on an individual basis; and

(4) has filed and received approval from the director for the rating program to be applied to the group.

* Sec. 2. AS 21.36.190 is amended by adding a new subsection to read:

(e) The provisions of (a) and (b) of this section do not apply to coverage purchased through a joint insurance arrangement formed under AS 21.76.

* Sec. 3. AS 21.36.210(a) is amended to read:

(a) An insurer may not exercise its right to cancel a policy of personal [AN] automobile insurance [POLICY] except for the following reasons:

(2) the driver's license or motor vehicle registration of either the named insured or of an operator who resides in the same household as the named insured or who customarily operates a motor vehicle insured under the policy has been under suspension or revocation during the policy period or, if the policy is a renewal, during its policy period or the 180 days immediately preceding its effective date.

* Sec. 4. AS 21.36.210(d) is amended to read:

(d) This section does not apply to

(1) the failure to renew a policy, except as to coverage in force for less than 12 months;

(2) a policy that has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer, unless it is a renewal policy;

(3) a policy issued under an automobile assigned risk plan or automobile insurance plan;

(4) a policy insuring more than four motor vehicles;

(5) a policy covering the operation of a garage; automobile sales agency, repair shop, or service station; or public parking place;

(6) a policy providing insurance only on an excess basis;

(7) any other contract providing insurance to the named insured, even though the contract may incidentally provide insurance with respect to motor vehicles.

* Sec. 5. AS 21.36.210(f) is amended to read:

(f) An [NOTWITHSTANDING (e) OF THIS SECTION, AN] insurer may not exercise its right to cancel a policy of personal insurance other than personal automobile insurance, except for the following reasons [THE TYPE DESCRIBED IN (e) OF THIS SECTION

CONDITIONS OR CIRCUMSTANCES ARISES]:

(1) nonpayment of premiums, including nonpayment of additional premiums, calculated in accordance with the current rating manual of the insurer, justified by a physical change in the insured property or a change in its occupancy or use;

(2) conviction of the insured of a crime having as one of its necessary elements an act increasing a hazard insured against;

(3) discovery of fraud or material misrepresentation made by the insured or a representative of the insured in obtaining the insurance or by the insured in pursuing a claim under the policy;

(4) discovery of a grossly negligent act or omission by the insured that substantially increases the hazards insured against; or

(5) physical changes in the insured property that result in the property becoming uninsurable.

* Sec. 6. AS 21.36.220 is amended to read:

Sec. 21.36.220. NOTICE OF CANCELLATION. An insurer may not exercise its right to cancel a personal insurance policy unless a written notice of cancellation is mailed or delivered to the named insured, at the address shown in the policy, at least 20 days before the effective date of cancellation. However, if [, EXCEPT THAT WHEN] cancellation is for nonpayment of premium, the notice shall be mailed or delivered to the named insured at the address shown in the policy at least 10 days before the effective date of cancellation, and must [SHALL] include or be accompanied by a statement of the reason for the cancellation. [THIS SECTION DOES NOT APPLY TO THE FAILURE TO RENEW A POLICY, EXCEPT AS TO COVERAGE IN FORCE FOR LESS THAN 12 MONTHS.]

* Sec. 7. AS 21.36.220 is amended by adding a new subsection to read:

(b) An insurer may not exercise its right to cancel a policy of business or commercial insurance unless a written

cancellation is mailed or delivered to the named insured, at the address shown in the policy and to the agent or broker of record, at least 60 days before the effective date of cancellation. However, if cancellation is for nonpayment of premium, the notice shall be mailed or delivered to the named insured at the address shown in the policy and to the agent or broker of record at least 10 days before the effective date of cancellation, and must include or be accompanied by a statement of the reason for the cancellation.

* Sec. 8. AS 21.36 is amended by adding a new section to read:

Sec. 21.36.235. RETURN OF PREMIUM UPON CANCELLATION. If an insurer cancels a policy under AS 21.36.220(b), it shall return any unearned premium to the agent or broker of record or directly to the insured or premium finance company, if applicable, by the effective date of cancellation, except that if cancellation is for nonpayment of premium, any unearned premium shall be returned within 30 days after the notice of cancellation is given. If the unearned premium is returned by the insurer to a person other than the insured, that person shall promptly return the unearned premium to the insured unless otherwise provided by agreement between the person and the insured.

* Sec. 9. AS 21.36.240 is amended to read:

Sec. 21.36.240. FAILURE TO RENEW. An insurer may not fail to renew a <u>personal insurance</u> policy in force for less than 12 months. An insurer may not fail to renew a policy [IN FORCE FOR 12 MONTHS OR MORE] unless a written notice of nonrenewal is mailed or delivered to the named insured, at the address shown in the policy, at least 20 days <u>for a personal insurance policy, and at least 60 days for a business or commercial insurance policy,</u> before the expiration date of the policy [,] or of the anniversary date of a policy

term longer than one year or with no fixed expiration date. This section does not apply

(1) if the insurer has in good faith manifested in any way its willingness to renew;

(2) in case of nonpayment of premium for the expiring policy; or

(3) if the insured fails to pay the premium as required by the insurer for renewal.

* Sec. 10. AS 21.36.250 is amended to read:

Sec. 21.36.250. NOTICE OF ELIGIBILITY. When a policy of automobile liability insurance is cancelled, other than for nonpayment of premium, or is not renewed in accordance with [FOR FAILURE TO RENEW A POLICY OF AUTOMOBILE LIABILITY INSURANCE TO WHICH] AS 21.36.240 [APPLIES], the insurer shall notify the named insured of possible eligibility for automobile insurance through the automobile assigned risk plan, or automobile insurance plan. The notification must [SHALL] accompany or be included in the notice of cancellation or nonrenewal required by AS 21.36.220 [AS 21.36.230] and 21.36.240.

* Sec. 11. AS 21.36.310 is amended to read:

Sec. 21.36.310. DEFINITIONS. In AS 21.36.210 - 21.36.310

(1) "business or commercial insurance" means insurance other than personal insurance, life insurance, disability insurance, title insurance, or an annuity contract;

(2) "nonpayment of premium" means failure of the named insured to discharge when due any obligations of the named insured in connection with the payment of premium on a policy, or any installment of the premium, whether the premium is payable directly to the insurer or its agent or indirectly under any premium finance plan or extension of credit;

(3) "personal automobile insurance" means insurance not related to business or commercial activities, covering [(2) "POLICY" MEANS AN INSURANCE POLICY COVERING THE RISKS AND EXPOSURES LISTED IN AS 21.36.210(e) OR AN AUTOMOBILE POLICY THAT INCLUDES] automobile liability [COVERAGE], uninsured or underinsured motorists [MOTORIST COVERAGE], automobile medical payments [COVERAGE], or automobile physical damage [COVERAGE], that is delivered or issued for delivery in this state, [INSURING AS THE NAMED INSURED, ONE INDIVIDUAL OR HUSBAND AND WIFE RESIDENT OF THE SAME HOUSEHOLD,] and under which the insured vehicles are of the following types only:

(A) a motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance, nor rented to others, or

(B) any other four-wheel motor vehicle with a load capacity of 1,500 pounds or less that is not used in the occupation, profession, or business of the insured, nor used as a public or livery conveyance, nor rented to others;

(4) "personal insurance" does not include an annuity contract or a policy of life insurance, disability insurance, or title insurance; the term means personal automobile insurance, or insurance covering

(A) loss of or damage to real property that is used predominantly for residential purposes and that does not consist of more than four dwelling units;

(B) loss of or damage to personal property, including personal effects, household furniture, fixtures and equipment located in not more than four dwelling units; or

(C) legal liability of natural persons for loss of, damage to, or injury to, persons or property if the insurance

does not cover liability arising from or in connection with business or commercial activities;

(5) [(3)] "renewal" or "renew" means

(A) the issuance and delivery by an insurer of a policy replacing at the end of the policy period a policy previously issued and delivered by the same insurer,

(B) the issuance and delivery of a certificate or notice extending the term of a policy beyond its policy period or term, or

(C) the extension of the term of a policy beyond its policy period or term under a provision for extending the policy by payment of a continuation premium.

* Sec. 12. AS 21 is amended by adding a new chapter to read:

CHAPTER 76. JOINT INSURANCE ARRANGEMENTS.

Sec. 21.76.010. AUTHORITY TO ESTABLISH JOINT INSURANCE ARRANGEMENTS. (a) Municipalities, school districts, and regional educational attendance areas may enter into cooperative agreements with each other for the purpose of establishing, operating, or participating in joint insurance arrangements through which the participating members agree to pool contributions and

(1) assume risks from losses on a group basis; or

(2) purchase coverage on a group basis.

(b) A joint insurance arrangement under (a)(1) of this section may be only for property insurance.

(c) A joint insurance arrangement under (a)(2) of this section may be for any kind of insurance defined by this title except for

(1) life, annuity, disability, and title insurance; and

(2) surety.

(d) A joint insurance arrangement shall be considered an

alternative or supplement to any other policy or contract of insurance authorized or required by law, including insurance under AS 21.75.

Sec. 21.76.020. REGULATION BY DIVISION OF INSURANCE. A joint insurance arrangement may not be considered insurance for the purpose of any other law of the state and is not subject to regulations of the director except as expressly provided in this chapter.

Sec. 21.76.030. GENERAL PROVISIONS OF COOPERATIVE AGREEMENTS. A cooperative agreement shall provide for the proper operation of the joint insurance arrangement, and include provisions for

(1) administration of the arrangement by a board of directors, specifying the number of members of the board and other requirements necessary for the proper functioning of the board;

(2) appointment of an administrator and other persons as necessary for the proper functioning of the arrangement;

(3) organization of the arrangement, including a roster of participating members and the names of the members of the board of directors;

(4) procedures to establish and promote an aggressive risk management and program among the members of the arrangement, including procedures for identifying and reducing the risks that can be reduced through implementing better safety technologies and improved work techniques and procedures;

(5) enforcing the collection of contributions or payments in default from members of the arrangement;

(6) the addition of new members to the arrangement or the withdrawal of members from the arrangement;

(7) the method of apportioning costs and disposition of excess contributions;

(8) transmission of financial statements and audit reports

of the arrangement to participating members;

(9) terminating the arrangement and disposing of its assets; and

(10) establishing and administering a joint insurance fund.

Sec. 21.76.040. FINANCIAL PROVISIONS OF AGREEMENTS. (a) A cooperative agreement must include a provision requiring an annual determination by a casualty actuary who is a member of the American Academy of Actuaries that procedures for establishing reserves for losses of the joint insurance arrangement are actuarially sound.

(b) A joint insurance arrangement shall be subject to an annual independent audit. The audit shall be conducted in accordance with generally accepted auditing standards and must include a review of the actuarial assumptions used for establishing the reserves under (a) of this section. The audit report must include certification from a casualty actuary who is a member of the American Academy of Actuaries that the actuarial assumptions continue to be sound and the level of the reserves are adequate.

(c) A joint insurance arrangement shall use a method of accounting that conforms with generally accepted government accounting principles.

Sec. 21.76.050. CONTRACTING WITH PRIVATE ADMINISTRATORS. A cooperative agreement may authorize the board of directors to enter into contracts for services necessary to perform the functions of a joint insurance arrangement. The person contracting to perform the functions must be appropriately licensed under this title if this title so requires.

Sec. 21.76.060. DELEGATION OF POWER TO SETTLE CLAIMS. A cooperative agreement may delegate to the board of directors, or authorize delegation by the board to another person or group, the power to

compromise, arbitrate, or otherwise settle claims on behalf of the arrangement.

Sec. 21.76.070. EXCESS INSURANCE. A cooperative agreement may authorize the board of directors to purchase excess or catastrophic insurance on behalf of the joint insurance arrangement. The cost of the insurance shall be apportioned in the manner specified in the joint insurance agreement. The board may purchase insurance under this section only from an insurer authorized to do business in the state or from an unauthorized insurer if the insurance is placed through a licensed surplus lines broker.

Sec. 21.76.080. JOINT INSURANCE FUND. (a) A joint insurance arrangement shall establish a joint insurance fund. The fund consists of money

(1) contributed by members of the joint insurance arrangement through budgetary appropriations or transfers from a self-insurance reserve; and

(2) collected by the joint insurance arrangement through subrogation of a claim paid from the fund to a member of the arrangement.

(b) An expenditure may be made from a joint insurance fund only to pay claims, losses, or benefits, including interest on them, and the administrative and adjustment expenses incurred in connection with them, involving the types of protection for which the fund provides coverage as specified in the joint insurance agreement.

(c) The administrator shall keep the fund separate from other funds of a member of a joint insurance arrangement.

(d) For each type of protection offered by the joint insurance arrangement, the method of accounting must show the order, source, date, and amount of each payment from the fund.

(e) Within 60 days of the end of the fiscal year, the administrator shall furnish a detailed report of the operation and condition of the fund to the board of directors and the director of insurance. The report furnished to the director of insurance shall be available for public inspection.

(f) Money held by a fund as reserves and money not needed for daily operations may be invested by the board of directors.

(g) A fund may not be terminated unless the administrator certifies that an amount of money sufficient to pay accrued and contingent expenditures has been placed in a fully collateralized escrow account.

Sec. 21.76.090. FILING OF AGREEMENT. The board of directors shall file a copy of the cooperative agreement with the director of insurance at least 60 days before the effective date of the agreement. The agreement shall be available for public inspection.

Sec. 21.76.100. REGULATIONS. A cooperative agreement may authorize the board of directors to adopt regulations not inconsistent with law for the fair and equitable administration of the joint insurance arrangement and the joint insurance fund.

Sec. 21.76.110. SUBROGATION. A joint insurance arrangement has a cause of action for reimbursement of money paid to a participating member for a loss or injury if the participating member recovers money for the loss or injury from a third party. The joint insurance arrangement also has a direct cause of action for reimbursement against a third party responsible for loss or injuries sustained by a participating member if the joint arrangement has paid money to the participating member for the loss or injuries.

Sec. 21.76.900. DEFINITIONS. In this chapter

(1) "adjustment expenses" means expenses for investigative, processing, legal, actuarial, arbitration, and settlement services

incurred in the adjustment of losses, claims, or benefits;

(2) "administrator" means a person or group appointed by the board of directors to administer a joint insurance arrangement or a joint insurance fund;

(3) "board" or "board of directors" means the board of directors provided for in a cooperative agreement;

(4) "cooperative agreement" means a written agreement entered into by two or more entities described in AS 21.76.010 for the purpose of establishing, operating, or participating in a joint insurance arrangement;

(5) "fund" or "joint insurance fund" means a fund established under AS 21.76.080;

(6) "joint insurance arrangement" means a joint insurance arrangement authorized under AS 21.76.010.

* Sec. 13. AS 21.39.155(a) is amended to read:

(a) The director may require carriers, except a reciprocal insurer formed by and insuring only a group of municipalities or nonprofit public utilities under AS 21.75 or a joint insurance arrangement formed under AS 21.76, as a condition of writing a line of insurance dealing with workers' compensation, to participate in an assigned risk pool if the director finds that mandatory carrier participation is in the public interest.

* Sec. 14. AS 21.80.180(5) is amended to read:

(5) "insolvent insurer" means an insurer

(A) authorized to transact insurance in this state, except an assessable reciprocal insurer formed by and insuring only municipalities or nonprofit public utilities, a joint insurance arrangement formed under AS 21.76, the Medical Indemnity Corporation of Alaska, and the Health Care Providers Joint

Underwriting Association established under AS 21.88, either at the time the policy was issued or when the insured event occurred, and

(B) determined to be insolvent by a court of competent jurisdiction;

* Sec. 15. AS 21.80.180(6) is amended to read:

(6) "member insurer" means a person, except an assessable reciprocal insurer formed by and insuring only municipalities or nonprofit public utilities, a joint insurance arrangement formed under AS 21.76, the Medical Indemnity Corporation of Alaska, and the Health Care Providers Joint Underwriting Association established under AS 21.88, who

(A) writes any kind of insurance to which this chapter applies under AS 21.80.020 including the exchange of reciprocal or interinsurance contracts, and

(B) is licensed to transact insurance in this state;

* Sec. 16. AS 21.36.210(e), 21.36.230, and 21.36.300 are repealed.

* Sec. 17. This Act takes effect immediately in accordance with AS 01.-10.070(c).

Lauterbach

Original sponsors: Sund, M.M.Miller, Hurley, et al

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 589 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to disability insurance."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 21 is amended by adding a new chapter to read:

CHAPTER 55. STATE DISABILITY INSURANCE.

ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit incorporated legal entity to be known as the Comprehensive Disability Insurance Association. Membership consists of all insurers licensed to transact disability insurance in the state and all licensed hospital or medical service corporations in the state. All members shall maintain membership in the association as a condition of doing disability insurance business in the state.

Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the director of the division of insurance. In determining voting rights at members' meetings, a member is entitled to vote in person or proxy. The vote shall be a weighted vote based upon the member's cost of disability insurance derived from or on behalf of state residents in the previous calendar year, as determined by the director. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented. Members of the board may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated

by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Sec. 21.55.030. GENERAL POWERS. The association may

(1) exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative functions;

(4) establish administrative and accounting procedures for the operation of the association.

Sec. 21.55.040. OVERSIGHT BY DIRECTOR. The association shall submit its articles, bylaws, and operating rules to the director for approval.

Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association is exempt from the Administrative Procedure Act (AS 44.62).

Sec. 21.55.060. TAX EXEMPTION. The association is exempt from the payment of fees and taxes levied by the state or any of its political subdivisions except taxes levied on real or personal property.

ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make available to residents the following types of disability insurance plans:

(1) a group state plan for groups of from 3 - 25 residents, subject to the prohibition against fictitious groups in AS 21.36.190;

(2) an individual state plan for residents who are standard risks according to criteria established in regulations adopted by the director; and

(3) an individual state plan for residents who are high risks according to criteria established in regulations adopted by the director.

(b) For each type of plan listed in (a) of this section, the association shall offer three alternatives related to deductibles as described in AS 21.55.120.

(c) The association shall make available to residents who are 65 years of age and older a medicare supplement plan. The plan shall provide coverage of 50 percent of the deductible and copayment required under medicare and 80 percent of the charges covered in AS 21.55.110 to the extent that the charges are not paid by medicare. The coverage shall include a limitation of $1,000 per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than $100,000.

(d) The association may not deny coverage under a state plan to a resident who satisfies the requirements of AS 21.55.300 - 21.55.310. The association may determine whether a person is a standard risk or a high risk in accordance with the director's regulations.

Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE PLANS. Except as provided in AS 21.55.120 - 21.55.160, the minimum standard benefits of a disability insurance plan offered under AS 21.55.100 shall be benefits, including coverage for catastrophic illness, with a lifetime maximum of $1,000,000 per individual, for reasonable charges or, when applicable, the allowance agreed upon between a provider and a carrier for charges actually incurred, for the following health care services, rendered to an individual covered by the plan for the diagnosis or treatment of nonoccupational disease or injury:

(1) hospital services;

(2) professional services that are rendered by a physician or by a registered nurse at the physician's direction, other than services for mental or dental conditions;

(3) the diagnosis or treatment of mental conditions, as defined in regulation of the director, rendered during the year by one or more physicians on other than an inpatient basis or, at their direction, by their staffs of registered nurses, up to a yearly maximum benefit of $1,000;

(4) legend drugs requiring a physician's prescription;

(5) services of a skilled nursing facility for not more than 120 days in a calendar year if the services commence within 14 days following a confinement of at least three consecutive days in a hospital for the same condition;

(6) home health agency services, as defined in regulations of the director, up to a maximum of 180 visits in a calendar year if the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except that in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the home health agency services may commence irrespective of whether the covered person was previously confined or, if the covered person was confined, irrespective of the seven-day period, and the yearly benefit for medical social services may not exceed $200; in this paragraph, "medical social services" means services rendered under the direction of a physician by a qualified social worker holding a master's degree from an accredited school of social work, including assessment of the social, psychological and family problems related to or arising out of the covered person's

illness and treatment, appropriate action and utilization of community resources to assist in resolving the problems, and participation in the development of treatment for the covered person;

(7) use of radium or other radioactive materials;

(8) outpatient chemotherapy for the removal of tumors and treatment of leukemia, including outpatient chemotherapy;

(9) oxygen;

(10) anesthetics;

(11) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis;

(12) rental of durable medical equipment that has no personal use in the absence of the condition for which it was prescribed;

(13) diagnostic x-rays and laboratory tests as defined in regulations of the director;

(14) oral surgery for excision of partially or completely unerupted impacted teeth or excision of a tooth root without the extraction of the entire tooth;

(15) services of a licensed physical therapist rendered under the direction of a physician;

(16) transportation by a local professional ambulance to the nearest health care institution qualified to treat the illness or injury;

(17) confinement in a facility established primarily for the treatment of alcoholism and licensed by the state, or in a part of a hospital used primarily for this treatment, for a period of at least 45 days within any calendar year;

(18) other services that are medically necessary in the

treatment or diagnosis of an illness or injury as may be designated or approved by the director.

Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan may require deductibles of $200 a person, $500 a person, or $750 a person. The amount of the deductible may not be greater when a service is rendered on an outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall also be applied to that individual's deductible in the following calendar year. The $200 maximum, the $500 maximum, and the $750 maximum may be adjusted yearly to correspond with the change in the medical care component of the consumer price index, as adjusted by the director. The base year for the computation shall be the first full calendar year of operation of the association.

(b) A state plan shall require a maximum copayment of 20 percent for charges for all types of health care in excess of the deductible and 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

(c) The sum of the deductible and copayments required in any calendar year under a plan may not exceed a maximum limit of $1,000 per covered individual or $2,000 per covered family. Covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of 100 percent, except that expenses incurred for treatment of mental and nervous conditions shall be paid at the rate of 50 percent. The $1,000 and $2,000 maximums shall be adjusted yearly to correspond with the change in the medical care component of the consumer price index as adjusted by the director.

(d) In this section, "consumer price index" means the consumer

price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor.

Sec. 21.55.130. BENEFIT LIMITATIONS. (a) A state plan shall limit benefits with respect to each pregnancy, other than a pregnancy involving complications of pregnancy, to a maximum of $250. In this subsection, "complications of pregnancy" means

(1) conditions requiring hospital stays, when the pregnancy is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but does not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and

(2) nonelective caesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy, that occurs during a period of gestation in which a viable birth is not possible.

(b) A state plan may limit lifetime benefits to a maximum of not less than $1,000,000 per covered individual.

Sec. 21.55.140. PREEXISTING CONDITIONS. (a) A preexisting condition exclusion in a state plan may not exclude coverage of a preexisting condition unless

(1) the condition first manifested itself within the period of six months immediately before the effective date of coverage in a manner that would cause a reasonably prudent person to seek diagnosis, care, or treatment;

(2) medical advice or treatment was recommended or received within the period of six months immediately before the effective date of coverage; or

(3) the condition is pregnancy existing on the effective date of coverage.

(b) A policy may not exclude coverage for a loss due to preexisting conditions for a period greater than 12 months following the effective date of coverage. An individual state plan issued as a result of conversion from a group state plan shall credit the time covered under the group state plan toward the exclusion for preexisting conditions. An individual high risk plan issued as a result of conversion from an individual standard risk plan shall credit the time covered under the standard risk plan toward the exclusion for preexisting conditions.

Sec. 21.55.150. CARE AND SERVICES NOT COVERED. A state plan may not provide benefits for charges for the following:

(1) care for an injury or disease either

(A) arising out of and in the course of an employment subject to a workers' compensation or similar law or where the benefit is required to be provided under a workers' compensation policy to a sole proprietor, business partner, or corporation officer; or

(B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in a motor vehicle or other liability insurance policy or equivalent self-insurance;

(2) treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered or for replacement of an anatomic structure removed during treatment of

tumors;

(3) travel, other than transportation by local professional ambulance to the nearest health care institution qualified to treat the illness or injury;

(4) private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room;

(5) services or articles to the extent that the charge exceeds the reasonable charge in the locality for the service;

(6) services or articles that are determined not to be medically necessary, except for the fabrication or placement of the prosthesis as specified in AS 21.55.110(11) and (2) of this section;

(7) services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services or articles;

(8) services or articles furnished, paid for or reimbursed directly by or under any law of a government, except as otherwise provided in this chapter;

(9) services or articles for custodial care or designed primarily to assist an individual in the activities of daily living;

(10) service charges that would not have been made if no insurance existed or for which the covered individual is not legally obligated to pay;

(11) eyeglasses, contact lenses, or hearing aids or the fitting of them;

(12) dental care not specifically covered by this chapter; and

(13) services of a registered nurse who ordinarily resides in the covered individual's home, or who is a member of the covered individual's family or the family of the covered individual's spouse.

Sec. 21.55.160. COORDINATED COVERAGE. The minimum standard benefits of a state plan may be satisfied by catastrophic coverage offered in conjunction with basic hospital or medical-surgical plans on an expense incurred or service basis as approved by the director as providing at least equivalent benefits.

Sec. 21.55.170. STATE PLAN PREMIUMS. (a) The association may not charge a rate for coverage issued by or through the association that is excessive, inadequate, or unfairly discriminatory.

(b) The association shall use separate scales of premium rates based on age for individual risks and group risks. The association may charge a higher premium for a high risk plan than for a standard risk plan.

(c) Notwithstanding (a) of this section, the schedule of premiums for coverage under each type of state plan listed in AS 21.55.100 shall be designed so that each type of plan is self-supporting. The premiums shall be based on generally accepted actuarial principles.

ARTICLE 3. ADMINISTRATION OF PLANS.

Sec. 21.55.200. SUBMISSION OF PLANS. A member of the association may submit to the director for approval a policy of disability insurance or medicare supplement that is being proposed to serve as a state plan. The time and manner of the submission and approval shall be prescribed by regulations of the director.

Sec. 21.55.210. SELECTION OF WRITING CARRIERS. The association may select policies and contracts, or parts of them, submitted by a member of the association, or by the association or others, to develop specifications for bids from a member that wishes to be selected as a writing carrier to administer a state plan. The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle large group disability insurance cases,

efficient claim paying capacity, and the estimate of total charges for administering the plan.

Sec. 21.55.220. DUTIES OF WRITING CARRIERS. (a) The writing carrier shall perform the administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the director. The director shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be considered an approval. Six months before the expiration of each three-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of AS 21.55.210 in selecting a writing carrier for the subsequent three-year period.

(b) The writing carrier shall provide to all eligible persons enrolled in a state plan an individual policy or certificate, setting out a statement of the insurance protection to which the person is entitled, with whom claims are to be filed, and to whom benefits are payable. The policy or certificate must indicate that coverage was obtained through the association.

(c) The writing carrier shall submit to the association and the director on a monthly basis a report on the operation of the state plans. Specific information to be contained in the report shall be determined by the association.

(d) Claims shall be paid by the writing carrier and shall indicate that the claim was paid under a state plan. A claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

(e) The writing carrier shall be reimbursed from the state plan

premiums received for its direct and indirect expenses. Direct and indirect expenses shall include a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses that are assignable to the maintenance and administration of the state plans. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms before selection as the writing carrier.

(f) The writing carrier shall at all times when carrying out its duties under this chapter be considered an agent of the association and the director.

Sec. 21.55.230. OPERATION OF THE PLAN. (a) Upon notification as an eligible person or group under AS 21.55.320, a person or group may enroll in a state plan by payment of the appropriate state plan premium to the writing carrier.

(b) An employer that has in its employ one or more eligible persons enrolled in a state plan may make all or a portion of a state plan premium payment directly to the writing carrier.

(c) At least 85 percent of the state plan premiums paid to the writing carrier shall be used to pay claims; not more than 15 percent may be used for the payment of agent referral fees under this chapter and for payment of the writing carrier's direct and indirect expenses under this chapter.

(d) Each contributing member of the association shall share the losses due to claims expenses of the state plans for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be

incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments allocated to the payment of benefits shall be the liability of the contributing members. Contributing members shall share in the claims expense of the state plans and operating and administrative expenses of the association in an amount equal to the ratio of the contributing member's total disability insurance premium, received from or on behalf of state residents, as divided by the total disability insurance premium received by all contributing members from or on behalf of state residents, as determined by the director.

(e) The association shall make an annual determination of each contributing member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the director, provide for interim assessments against the contributing members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plans and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment is due within 30 days of receipt by a contributing member of a written notice of a fiscal year end or interim assessment. Failure by a contributing member to tender to the association the assessment within 30 days shall be grounds for termination of the contributing member's membership. A contributing member that ceases to do disability insurance business in the state remains liable for assessments through the calendar year during which the disability insurance business ceased. The association may decline to levy an assessment against a contributing member if the assessment would not exceed $10.

(f) Net gains, if any, from the operation of the state plans

shall be held at interest and used by the association to offset future losses due to claims expenses of a state plan or allocated to reduce state plan premiums.

ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.

Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a) Subject to AS 21.36.190, a state resident or a group of from 3 to 25 state residents is eligible to enroll in a state plan described in AS 21.55.100.

(b) Additional eligibility requirements may not be imposed by the director, the association, or a writing carrier.

Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON OR GROUP. (a) A person or group may enroll in a state plan by submission of a certificate of eligibility to the writing carrier. The certificate must include the following:

(1) name, address, age, and length of time at residence of the applicant;

(2) name, address, and age of spouse and children if any, if they are to be insured; and

(3) a designation of the plan desired, including deductible option chosen.

(b) A person may not be covered by more than one policy under this chapter at any one time. Upon ceasing to be a resident of the state a person is not eligible to purchase or renew coverage under a state plan.

Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days of receiving the certificate described in AS 21.55.310, the writing carrier shall either reject the application for failing to comply with the requirements of AS 21.55.300 and 21.55.310 or forward the eligible person a notice of acceptance and billing information. Insurance is

effective immediately upon receipt of the first month's premium, and is retroactive to the date of the application, if the applicant otherwise complies with the requirements of this chapter.

Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The association, under a plan approved by the director, shall disseminate appropriate information to the residents of the state regarding the existence of the state plans and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(b) The association shall devise and implement means of maintaining public awareness of the provisions of this chapter and shall administer this chapter in a manner that facilitates public participation in the state plans.

(c) The writing carrier shall pay an agent's referral fee of $50 to each insurance agent who refers an applicant to a state plan, if the application is accepted. Selling or marketing of qualified state plans is not limited to the writing carrier or its agents. The referral fees shall be paid by the writing carrier from money received as premiums for a state plan.

(d) An insurer that rejects or applies underwriting restrictions to an applicant for disability insurance in the state shall notify the applicant of the existence of the state plans, the requirements for being accepted, and the procedure for applying.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

(1) formulate general policies to advance the purposes of this chapter;

(2) supervise the creation of the State Comprehensive Disability Insurance Association;

(3) approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the coverages and premiums to be charged;

(4) appoint advisory committees;

(5) conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(6) contract with the federal government or another unit of government to ensure coordination of the state plans with other governmental assistance programs;

(7) undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of this chapter;

(8) contract with insurers and others for administrative services; and

(9) adopt regulations necessary to administer this chapter.

Sec. 21.55.500. DEFINITIONS. In this chapter

(1) "association" means the Comprehensive Disability Insurance Association created in AS 21.55.010;

(2) "state plan" means a policy of insurance offered by the association through a writing carrier;

(3) "writing carrier" means the insurer or insurers selected by the association and approved by the director to administer a state plan.

SB 377

Testimony to the Hawaii House of Representatives Committee on Health and Committee on Consumer Protection and Commerce, Octoer 22, 1985.

My name is William K. Scheuber. I am President of Medical Underwriters of California, a management company owned by the Alameda-Contra Costa Medical Association. Medical Underwriters operates Medical Insurance Exchange of California which provides professional liability insurance to about 740 medical doctors in Hawaii, and to more than 3400 doctors in Alaska, Idaho, Nevada and California.

I understand that you would like to hear from us our views of the professional liability situation as it now confronts insurers and the doctors they insure. I presume that you would also like some suggestions as to what you might consider doing about it here in Hawaii.

In the past 15 months MIEC has increased the number of doctors it insures in Hawaii by 400, a growth of 135%. Such growth is unusual in the insurance industry, but we take no credit for salesmanship because MIEC has no salesmen. The growth occurred because almost nobody else has been offering Professional Liability insurance in Hawaii for more than a year. Nobody else is offering it because it is the judgement of insurance professionals that it is impossible to make a profit on medical malpractice insurance, and worse that it is a virtual certainty that such insurance will result in losses of massive size. Hawaii is not alone with this reputation. Private companies along with special funds set-up by state legislatures have abandoned Professional Liability, or gone broke, in almost every state in the Union in the past ten years. Two of the 42 companies newly formed by doctors in 1975 and since have gone broke after less than ten years of existence; at least three are in my opinion presently insolvent, and at least a dozen more are in a condition I would not want our company to be in.

(Exhibit I) (Exhibit II)

Until the 1975 "malpractice crisis," insurance companies had never separated professional liability from other kinds of losses. After the first five years of keeping separate statistics, Best's, the insurance rating service, (not known for colorful writing), reported in January of 1980: "Medical Malpractice, now in its sixth year as an individual line, has demonstrated its ability to stun the underwriter... Since five years ago, experience has deteriorated drastically... it shows an underwriting loss of $960 million and a combined loss ratio of 116%."

In another five years - this year - it was even worse. This January, (Exhibit III), Best's reported underwriting losses for med cal malpractice alone, of $3.4 billion for the previous five years, an average combined loss rati of 147%. (Combined Loss Ratio is all losses and loss cos incurred divided by premiums earned.) It estimated loss for the 1984 year alone at $1.1 billion. Best's six month report from January 1, 1985 to June, 1985 increased the combined loss ratio to 169%. The numbers tell the story, and they are mournful numbers.

this is why reserves for future losses are as high as they are

This is what is happening now, this year. But the past gives us no comfort, either, because it tells us that the present will only get worse. The company which for twenty-five years covered the New York State sponsored doctors' program withdrew from the program in 1974, eleven years ago. It never received more than 40 million in annual premiums, and in the 25 years of its coverage, its total premium was $225 million. Its losses when it quit, eleven years ago, were under $100 million. In the next ten years, to the present, the carrier has paid more than 355 million in claims and claims expenses. In 1984 alone, its tenth year after it stopped insuring, it paid out $30 million. It still has 1300 known claims to dispose of. It still receives new claims at the rate of 200 each year.

This time it is the reinsurers who are suddenly alarmed. The past ten years have identified Professional Liability as the worst loser in the whole property-casualty insurance industry which, in America, is itself a big loser. The uniquely American Liability Industry is now receiving frantic attention from the reinsurance industry, world wide. They are raising American rates by shocking percentages or, when coverage expires, refusing to renew it on any terms. They are behaving in 1985 just as the primary insurers did in 1975.

Some grand old names in the dignified world of reinsurance are seeking mid-term to pull out of contracts they are already committed to. This is unprecedented behavior.

Mr. Peter Miller, Chairman of Lloyds of London, spent a large part of this summer traveling among the insurance centers of the United States, stating (Exhibit IV) (Exhibit IVa), on behalf of Lloyds of London, the thesis that casualty risks in the United States -- he didn't mention any other countries -- have become uninsurable. Only the most optimistic he says, will continue to insure them and only with huge rate increases. He's not the only one talking like this.

The following are representative quotes from "Business Insurance" (Exhibit V), a trade publication, which covered last month's meeting of worldwide reinsurers, among them the largest American Reinsurers. The meeting was held, appropriately, in Monte Carlo.

"No one wants North American casualty business. Even the reinsurers with the capacity to write U.S. risks are refusing, because of large losses and their assessment that it is impossible to properly price U.S. casualty insurance."

"They are saying that the tort system - and the courts - in the United States make casualty business uninsurable. They say they have no ability to ascertain what losses will be."

"The reaction is the same in the Far East."

'Reinsurance rates could jump as much as 500% to 1000% for the most risky long-tail casualty business." Risky long-tail casualty buiness is exactly what Medical Malpractice Insurance is. (Exhibit VI).

You may reasonably ask: Well, if it's so bad, what's MIEC doing here? We came to Hawaii for the same reason we came into existence in 1975: because no company would insure our doctors. A little less acutely, the same thing happened in Hawaii. The doctors needed us because most sensible doctors didn't want to practice medicine without insurance coverage, so they had to create their own insurance company. We will continue to be an insurance company owned by its policyholders as long as the policyholders are willing to pay whatever premiums are necessary for us to survive and prosper and to serve them. The doctors in turn of course will include those premiums in their costs as long as patients and the legislators who fund government programs are willing to pay them. Either the premium rates will go up to pay the losses or losses will diminish to the point where our owners can lower the premiums. Doctors will certainly lower the premiums if it becomes possible to do so. They don't want to make money from each other as owners of an insurance company. They do want an insurance company that can and will continuously provide reliable and equitable protection.

We have some suggestions on how to begin to lower those premium rates, rather than just letting the crisis ride. As a doctor-owned company, we've done something the commercial insurance industry never did. Out of the tremendous motivation which is prevalent among doctors to avoid damage and lawsuits, we've taken vigorous action in loss prevention, claims administration, and underwriting, in an organized program

designed to reduce injuries and losses. With the help of doctors and legislators, we've explained and defended the reforms which were enacted in 1975 by the California Legislature at the urgent request of the public and the medical profession.

Ten years after their enactment the four most important of the California reforms have been found constitutional. The reforms are the best that any State in the nation has enacted, and their effect is just beginning. They place a limit on awards for pain and suffering, place limits on the percentage of the award which the plaintiff's lawyer can charge as a fee, permit the jury to know what other resources were available to the patient for the payment of losses, so he is not paid twice for the same loss, and permit the use of periodic payments to assure that the money will be used for the patient's needs and for the purpose intended. We believe that these reforms (Exhibit VII) are the best hope of diminishing losses in California in the next five to ten years, and we respectfully suggest that the Hawaii Legislature as the Legislatures of other states are doing, consider the California reforms as a start toward a long term solution.

As it always has, the Plaintiff's bar everywhere is exercising its creativity in developing new grounds for litigation. Plaintiffs lawyers are now diligently expanding in the courts their pleas for punitive damages, their allegations of "Bad Faith" on the part of the insurance carrier against the insured in the administration of claims, and worst of all, expanding the extremely profitable abuse of the "Deep Pocket" doctrine, which says that a defendant who is only 1% responsible for an injury must pay the entire loss if the other defendants are not able to pay. It will be obvious from our Exhibits (XXI through XXVII) that the motivation for these maneuvers has nothing to do with justice, but has a lot to do with the winning of huge legal fees, based on a percentage of the award. This has proved outrageously

responsibility for difficult and dangerous medical situations with potential for massive and long-term damage, experience the biggest lawsuits and the biggest losses. In New York State and everywhere else, it is the Professors of neurosurgery in the medical schools who have multiple law suits against them, with multimillion dollars at risk. They are certainly not incompetent, but their services are difficult and complex. Any bad result highly-skilled doctors are involved in is viewed as a potential jack-pot by the plaintiff's bar.

3. 80% of all losses incurred in the forty years between 1935 and 1975 were incurred in the five years between 1970 and 1975. The frequency continues to increase at the same rate. Without much doubt, this is because modern medicine is becoming more difficult and complex, and because public expectations are high.

4. It isn't our "legal system" which is bad. It's the exploiters of the legal system who are bad. A lack of public vigilance and protest over many years has permitted them to arrange everything to suit themselves. The defense attorneys take some of the blame, and say of their plaintiff colleagues: "For too long the Association of Trial Lawyers has monopolized the attention of Appellate Court Judges." They need to be limited, and watched. What most needs to be watched and limited is the profitable contingency fee, which is the great motivator for chicanery and injustice. It motivates some plaintiff attorneys to exploit damage by creating liability where it does not exist. Combined with the twin threats of punitive damages against the

defendant and bad faith against the carrier, contingency percentages can and do make the plaintiffs attorney aspire to become an instant millionaire. This motivates a depressing number to engage in the equivalent of legal extortion and blackmail.

One organization of defense counsel (California Defense Council) is embarrassed and frightened by the activities of their plaintiff colleagues, and is trying to prevent the Golden Goose from being killed: "As we have travelled around the country drumming up support for California Defense Council, we are impressed by... an almost universally shared preception that unless something radical is done, the system as we know it is not long for this world."

5. Plaintiffs attorneys are too often overpaid for their work, since lawyers are usually the only ones perm ced to judge its value. We know of a case in which the plaintiffs attorney was paid, with a judge's approval, a fee of $640,000 for arranging a settlement in the case of a child who was paralyzed at birth and was 18 months old at the time of settlement. Without going to court or arguing a case, the plaintiff's lawyers fee amounted to $35,500 a month for the 18 months which elapsed between the injury and the settlement, more than $1,000 a day including Saturdays, Sundays and Holidays. Because the premium out of which this fee was paid ultimately comes from sick people who pay doctors fees, one medical society asked the judge on what basis he approved $640,000. The judge made no analysis of the time spent or services rendered, and replied only that this fee was not unusual.

In another settlement, an agreement was reached to pay the injured patient $16,000 per month for life. The patient's age gave him a life-expectancy of 20 years. His attorney also will receive, as his fee, $16,000 per month, for the rest of his life. The attorney, however, has a life-expectancy of 30 years.

We think the system can be a good and fair one, but it needs examination, modification, and public vigilance over the activities of the insurance industry, the lawyers, and the courts, as well as over the medical profession.

The officers and executives of MIEC will consider it a privilege to provide this committee and the Hawaii Legislature with any further information, research experience or counsel we may possess in our specialized field which may assist in improving the situation in Hawaii, as we have done in other parts of the country.

BS/lmm/COR7

Exhibit I Alameda Contra Costa Medical Association Bulletin

Best's Comparison of Professional Liability Carriers

MIEC Receives "A" Rating

The *1984 Best's Key Rating Guide* has been published and distributed. For the first time, many of the physician-owned carriers formed in the mid-to-late '70's have been assigned a rating by Best's. The guide compares significant premium, surplus and loss reserve figures and ratios of 23 physician-owned carriers and three commercial carriers showing 1983 year-end results. Some are compared to 1982 figures.

The following are highlights of this comparision:

- Eighteen doctor owned companies were eligible for a Best's rating this year. Only seven, including MIEC, received a rating of "A" (Excellent). Three received "B+" or "B" (Very Good) and the other eight received "Deferred" or "Omitted" ratings. This is hardly a resounding vote of confidence in the financial or managerial strengths of doctor-owned insurance companies by the insurance industry's premier financial rating service.
- Premium to surplus ratios, an important indicator of an insurance company's financial strength and margin of safety, deteriorated at 14 (61%) of the 23 companies. Given the long-term, cumulative and unpredictable, although generally negative trend of medical malpractice loss development, this is a disturbing fact. Premium to surplus ratios greater than 2:1 were reported by eight (35%) of the 23 companies in 1983, compared to five (22%) in 1982. The average premium to surplus ratio of all 23 companies was 1.53:1. MIEC's premium to surplus ratio was a conservative 0.45:1.
- Total net written premiums of the 23 companies were $600 million, up less than 1% from 1982.
- Loss reserves continue to grow rapidly as might be expected in this line of business. The ratio of loss reserves to surplus provides another indication of the safety margin available to policyholders. The *average* ratio of loss reserves to policyholder surplus of the 23 companies was 6.86:1 and ranged as high as 25:1 at one of the carriers. At a 25:1 loss reserves to surplus ratio, a 4% underestimation of loss costs on pending claims would wipe out the surplus of the company, threatening its continued existence. MIEC's loss reserve to surplus ratio was 1.91:1.
- Seven of the companies (30%) reported loss reserve to surplus ratios of more than 5:1, up from six (26%) in 1982. Only six of the companies reported improvements in the loss reserve to surplus ratios compared to 1982. MIEC was one of those six.
- The number of policyholders insured by the 23 surveyed companies declined from almost 110,000 in 1982 to just over 101,000 in 1983. This reflects the increasing competition from commercial carriers which has been a growing concern for several years. It also reflects the disappearance of the Florida company, currently in rehabilitation by the insurance department of the State of Florida, and California's PSIE which was absorbed by a commercial carrier earlier this year.
- Average surplus per policyholder for the 23 companies increased to $3,856 from $3,358 in 1982, but some companies have less than $1,000 surplus per policyholder. MIEC's surplus per policyholder was $8,969.
- Nine of the companies suffered overall reductions in policyholders' surplus between 1982 and 1983. MIEC recorded a 26% gain in surplus between 1982 and 1983.

MIEC received an "A" rating which was accompanied by the following comment from Best's:

> "Based on our current analysis of the exchange's financial position and operating performance, we assign a Best's rating of 'A' (Excellent). After careful review of your financial statement, we are pleased to be able to assign a Best's rating of 'A.' This reflects successful operating results over the past five years and conservative liquidity and leverage positions."

Copies of this comparison of professional liability carriers is available at ACCMA headquarters.

(II)

Dr. Schreiber

NORCAL
Mutual Insurance Company

Justin N. Tierney
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June 14, 1985

Mr. Donald J. Fager
President
Board of Trustees
Physician Insurers Association of America
Two Princess Road
Lawrenceville, NJ 08648

Dear Don:

Thank you and the other members of the Board, including Jim Todd, for your understanding of my concerns and your willingness to let me attend the meeting of the Board of Trustees on Monday, June 24, at the O'Hare Hilton.

As background for the meeting, I thought it best to amplify my few comments at the Annual Meeting in Atlanta.

All of the members of the Board should have received a copy of a letter addressed to me by Al Yamashiro, NORCAL's Vice President and CFO, dated May 9 which contained the financial results and underwriting experience for thirty of the PIAA member companies. The data for the other companies was not available at the time of the compilation.

My concerns can be grouped in four areas:

A. The Financial Stability and Security of Doctor Owned Companies Is Critically Impaired.

1. Twenty-eight of thirty companies have reported 1984 underwriting losses.

2. Twelve of the twenty-eight companies with 1984 underwriting losses had insufficient investment income to overcome the underwriting loss.

3. Seven companies have discounted their loss reserve, further diminishing the ability of each of these companies to have sufficient funds to pay their ultimate losses.

4. Twenty-eight of the thirty companies have accumulated $1.3 billion in underwriting losses which in turn will be further impacted by adverse development of the reported $3.2 billion of losses outstanding and not paid.

Exhibit III

California being a notable exception—have a far poorer loss record. That is to say, the full story of this business, the extent of its distress, is seen only partially in the 122.6% combined ratio of commercial insurers. And in this story of losses past and losses to come lurks a dividend payout still in excess of 10% which over the past five years has aggregated $6.6 billion, making a mockery of the five-year pre-dividend underwriting gain of $390 million. If it were not for the payout of $1.5 billion in dividends to policyholders in 1984, investment income in the workers' compensation line would have exceeded the underwriting loss.

MISCELLANEOUS LIABILITY

We come to that category of insurance, long-tail liability, with its giant loss reserves and their potential of throwing off such a stream of investment income that underwriting considerations (supposedly) can be ignored. It is with the liability lines that some companies exchanged underwriting prudence for a seat at the financial poker table and started a chain reaction of price cutting that pulled the whole commercial side of the property/casualty insurance business into its worst underwriting decline. Admittedly other factors entered into this deplorable scenario, but the overriding rationale (in what turned out to be a decision to substitute finance for insurance) was simply that investment income, at interest rates at one time running up to 20%, offered a quicker route to a profitable bottom line.

And now the day of reckoning is here. The combined loss and expense ratio in liability business passed the 150% mark in 1984 as the pure loss ratio jumped by nearly 10 points and the underwriting loss topped $4.1 billion. Approximately 25% of the total underwriting loss for the industry last year came from coverages producing 7.1% of the premium volume.

If any section of the business actually went out of control during the competitive frenzy of 1979-1984, it was liability insurance—and like the dilemma of workers' compensation, the turnaround can't be accomplished with anything resembling speed. It takes years for long-tail losses to surface and years more for them to be settled.

The use of loss reserves as an investment income producer is supposed to be the formula for making money in this business, but the record of the past five years is devastating in insurance terms and the investment solution no longer exceeds the underwriting loss. There was in 1984 the single redeeming feature of a 15% increase in miscellaneous liability premiums, little enough and long overdue when lined up against a 35-point rise in the pure loss ratio in the same 12 months.

Medical malpractice as a separate line of insurance was born of a crisis in 1975 and after only a few years of confusing rearrangement has returned to the point of desperation. No part of the industry handling this business is doing so with success. The stock companies, with 59% of the volume, have a combined ratio of 161%, up 20 points from 1983; the mutuals, including some of the so-called bed pan companies, have 20% of the business and a 172% combined ratio, up six points; and the reciprocals, 21% of the total and mostly professionally sponsored companies, are sporting a 166% combined ratio.

Where does this business go from here? Doctors still insured with commercial companies are, in at least two states, restive and planning to start their own companies. In another state an effort was made to put a proposition on the ballot last November that would have put a cap on malpractice tort awards. Medical malpractice premium volume rose an estimated 16% in 1984, but pure losses were up by 26% and the pure loss ratio for the line is estimated at 110%. The dollar underwriting loss came to 65% of earned premiums. Can that be remedied in a single year? The answer to the medical malpractice dilemma would seem to lie in large part outside the realm of insurance, but it is to be hoped that the insurance concept will not be lost in the process of restoring equity to a situation that is obviously out of hand.

Medical Malpractice

Year	Net Premiums Written $000	Loss & LAE Ratio %	Und. Expense Ratio %	Combined Ratio Before Divs. %	Combined Ratio After Divs. %	Statutory Und. Gain or Loss After Divs. $000
Stock Companies						
1980	721.963	106 84	17 78	126 62	127 04	-191.863
1981	723.032	119 23	20 15	139 39	139 66	-284.781
1982	814.368	122 79	20 58	143 37	143 52	-346.589
1983	893.529	121 03	20 63	141 66	141 73	-364.141
1984*	1.080.000	141 00	20 10	161 10	161 17	-627.800
5 Yrs	4.232 892	123 93	19 92	143 85	144 03	-1.815.174
Mutual Companies						
1980	276.382	143 42	7.89	151.30	153 22	-136.199
1981	319.164	128 70	7 14	135 84	138.78	-118.123
1982	350.279	155 52	7 74	163 26	167.07	-224.351
1983	352 866	153 34	8 55	161.89	165 15	-232.388
1984*	355 000	160 90	8 50	169 40	171.90	-242.560
5 Yrs	1.653.691	149 11	7.98	157.10	160 04	-953.621
Reciprocals						
1980	276 612	99 72	10 63	110.35	111.89	-32.690
1981	294 085	114 84	10 25	125 10	130 42	-80.512
1982	323.702	139 57	11.21	150 78	154 13	-140.814
1983	317.849	139 62	12.21	151.83	155.68	-167.224
1984*	375.000	150 20	12.20	162.40	166 20	-232.050
5 Yrs	1.587.248	130 33	11.37	141 70	145 28	-653.290
Total Industry						
1980	1.274.957	114 14	14 08	128 22	129.20	360.752
1981	1.336.281	120 62	14 87	135 49	137.39	-483.416
1982	1.448.349	133 82	15 52	149 35	150 97	-711.754
1983	1.564.244	132 35	16 19	148 55	150.11	-763.753
1984*	1.810.000	146 86	16 19	163 05	164 37	-1.102 410
5 Yrs	7.473.831	130 88	15.46	146 34	147 82	-3.422.085

*Estimated

Exhibit IV

LOS ANGELES TIMES
June 10, 1985

Losses, Fraud Hit Lloyd's of London

By BRUCE KEPPEL,
Times Staff Writer

For nearly three centuries, Britain's venerable insurance market, Lloyd's of London, has withstood and richly profited from the periodic turbulence characteristic of the property-casualty insurance business. But the 1980s have been exceptionally unkind to the industry worldwide—and now Lloyd's is proving not to be immune.

Lloyd's, whose entrepreneurial zeal in insuring almost anything from a communications satellite to a starlet's bust is matched by shrewd assessments of the actual risks involved, paid out more in claims than it received in premiums in 1981, the most recent year for which figures have been audited.

Investment Income

The $55.7-million underwriting loss (based on current exchange rates) was more than offset, however, by investment income earned from the premiums, resulting in a net profit of about $195 million.

Still, that was the market's slimmest profit since 1977. And 1982, now being audited, could produce the exchange's first net loss since 1965 and 1966, though not as great as the 8% loss in those years, Lloyd's Chairman Peter North Miller said in an interview last week in Los Angeles.

Miller laid much of the blame for Lloyd's change of fortune not to the cutthroat competition for premium income that has damaged or destroyed many a U.S. insurer but to liability litigation and extravagant court awards in this country. Lloyd's does 35% of its business in the United States, he said. "The courts in America tend to throw liability around a bit," Miller said.

He added this warning: "Without reform of tort law in the U.S., there will not be a market to cover the liabilities that Americans want to see covered." He cited pollution-cleanup insurance, which is now both required and difficult to find as a result of regulatory uncertainty in this country and multibillion-dollar litigation such as what followed New York's Love Canal disaster.

Miller has been voicing his warning across the United States, speaking to the National Assn. of Insurance Brokers at Sea Island, Ga., and then on the West Coast last week. Today, he heads for Kansas City to address state regulators attending a meeting of the National Assn. of Insurance Commissioners.



"Without reform of tort law in the United States, there will not be a market to cover the liabilities Americans want to see covered."

—Peter North Miller, chairman of Lloyd's of London



ROB SCHUMACHER / Los Angeles Times

As if underlining the urgency of the industry's concern, a San Francisco Superior Court jury decided May 31 that Manville Corp., which is struggling with massive damage claims for asbestos poisoning from exposures dating back decades, had liability insurance during key periods over more than half a century ago—even though the actual policies could not be found and the originating companies have since merged into others.

That was good news for Denver-based Manville, but it sent another shudder through the already reeling property-casualty insurance industry.

Interpretation of Liability

Court interpretations have in the past led to huge liability awards and created uncertainty for insurers, Miller said. Insurers must be able to calculate the true nature of the risks they are underwriting, he explained, and that is complicated by shifting interpretations of what constitutes liability.

"Lloyd's will insure almost anything," he said, "*provided* we can know what is required of us."

After the tanker Torrey Canyon foundered in the English Channel in 1967, spilling massive amounts of oil on British and French beaches and oyster beds, he said, it became impossible to get insurance against such a disaster. Lloyd's finally offered to provide coverage but only on specified terms.

"We said, 'Let's sit down and talk about what it is we can provide,'" Miller said, "and it's a helluva lot."

No one questions Lloyd's ability to withstand present adversities within the insurance market. Lloyd's record is superb compared to that of the industry in general. And its security is rock solid, with an estimated $12 billion of reserves on top of $5 billion of premium income.

Far more uncharacteristic is the persistent whiff of financial scandal that has tainted a handful of its 384 insurance syndicates in recent years—scandals regarding misuse of member funds. These events, whose very rarity provoked con-

Exhibit 2a

Business Insurance
June 10, 1985

Changing market creates new role for brokers: Miller

By LINDA J. COLLINS

SEA ISLAND, Ga.—The tightening property/casualty insurance market is creating new responsibilities for insurance brokers, says Lloyd's of London Chairman Peter North Miller.

"There is more to placing insurance than just driving the hardest bargain possible for one's client. The broker has a responsibility to his client to see that the insurance industry continues to exist," Mr. Miller told the National Assn. of Insurance Brokers' annual meeting.

Brokers in recent years have too frequently tried to place business at any rate due to fear of competition and loss of business, said Mr. Miller, former chairman of Lloyd's broker Thomas R. Miller & Son (Insurance) Ltd. He said that brokers should realize and stress to others that brokers, underwriters and clients all need to take a long-term view of the industry, rather than focusing on short-term gains.


Mr. Miller

"We, the brokers, have a job to do as intermediaries when one of the parties with which we must negotiate is in one of three positions: either no longer there, because he has gone out of business or been sacked because of losses; or enfeebled and unable to give us the insurance answers which our clients require; or demanding prices and policy forms which make our clients shudder."

Turning to capacity problems created by the tightening market, Mr. Miller noted that Lloyd's capacity, expressed in terms of the British pound, has increased by 29% in 1985 over 1984.

"However, over 60% of Lloyd's income is receivable in United States dollars, which have been steadily strengthening against the pound sterling. . .The effective rate for 1984 for premium income limit purposes was $1.45 equaled 1 pound, and that for 1985 is $1.16 equals 1 pound—being the exchange rate in each case at the first of January."

Taking this into consideration, Mr. Miller said: "One is left with a figure of true increase (in capacity at Lloyd's) in 1985 of perhaps 15%.

"The crisis of capacity, so much talked about, is not at Lloyd's," he stated.

However, Mr. Miller said that the projected shortfall in U.S. property/casualty insurance capacity, which the Insurance Services Office has estimated may reach more than $62 billion by 1987, will continue to plague insurance buyers. "There is little or nothing that Lloyd's can, or indeed should, do to try to create all the new capacity apparently needed" in the U.S. marketplace.

"Our underwriters must—and I am sure will—remember they are actually in business to make a profit, and at last they have a chance of making an underwriting profit as well as a profit on investment income," Mr. Miller said.

The current U.S. legal climate and current liability policies written on occurrence forms are the major factors deterring Lloyd's underwriters from accepting certain types of U.S. liability risks, Mr. Miller explained.

"We begin to feel in England that it is not possible to insure liabilities in the United States, because the legal system is so heavily weighted against insurers," he said.

"We insurers have little faith that we shall receive justice at the hands of the American legal system," he added. ■

 EXHIBIT V

Reinsurance crunch real, experts agree

By LINDA J. COLLINS

HONOLULU—The reinsurance crisis is real and will continue to plague the insurance industry at least through 1986, a panel of insurance executives predicts.

As part of a discussion of "The Marketplace of Tomorrow" at the Independent Insurance Agents of America's annual convention earlier this month, a panel composed of an insurer, a reinsurance intermediary, an agent and a broker also predicted that:

- Facultative reinsurance capacity will decrease very rapidly during 1986.
- Underwriters at Lloyd's of London will insist on the use of the new claims-made policy by U.S. insurers seeking reinsurance.
- The insurance industry will remain cyclical in nature, although the swings of the cycle may moderate due to better data collection methods and the continued exodus of insurance companies and independent agents from the marketplace.

In addressing the current reinsurance crisis in the United States, James J. Meenaghan, president and chief executive officer of the reinsurance broker John F. Sullivan Co. in Seattle, said that reinsurers' underwriting losses have been more severe than those experienced by direct insurers over the past five or six years.



Mr. Meenaghan

"They've suffered worse underwriting ratios and they've suffered much bigger drops in surplus, or financial capacity, than have the domestic companies in the U.S.," Mr. Meenaghan explained. He added that the loss experience of reinsurers of U.S. casualty business in



Mr. Budd

of London, lead underwriters' unanimous message was that members of Lloyd's syndicates have no interest in writing U.S. business because of the reinterpretation of insurance contracts and large awards made by U.S. courts, Mr. Budd said.

Facultative reinsurance, in particular, is disappearing very rapidly, he added.

"The feeling, particularly in the foreign markets that don't live day-to-day with our legal system, is that the American legal system is totally out of control as respects the way in which insurance contracts are interpreted," Mr. Budd explained.

"They feel they have absorbed the worst of that economically, and I think they have the facts and figures to prove it."

These factors are spurring foreign reinsurers to issue a cry for widespread use by U.S. insurers of the Insurance Services Office's controversial new commercial general liability claims-made policy, which is scheduled for introduction in January.

Mr. Meenaghan said that reinsurers, particularly at Lloyd's of London, are insisting on—rather than simply encouraging—the use of the claims-made form.

"I think that some of the major financial entities in the world... are shell-shocked by the proliferation of claims they have received for asbestosis, and on and on," Mr. Meenaghan said.

"They're absolutely insisting on a change" to the claims-made form if they are to continue to provide reinsurance coverage to the U.S. marketplace."

The claims-made policy is needed in the industry, Mr. Budd said, because insurance companies have to somehow contain the overall limit on what they are insuring. He added that there also is a defi-

Continued on next page

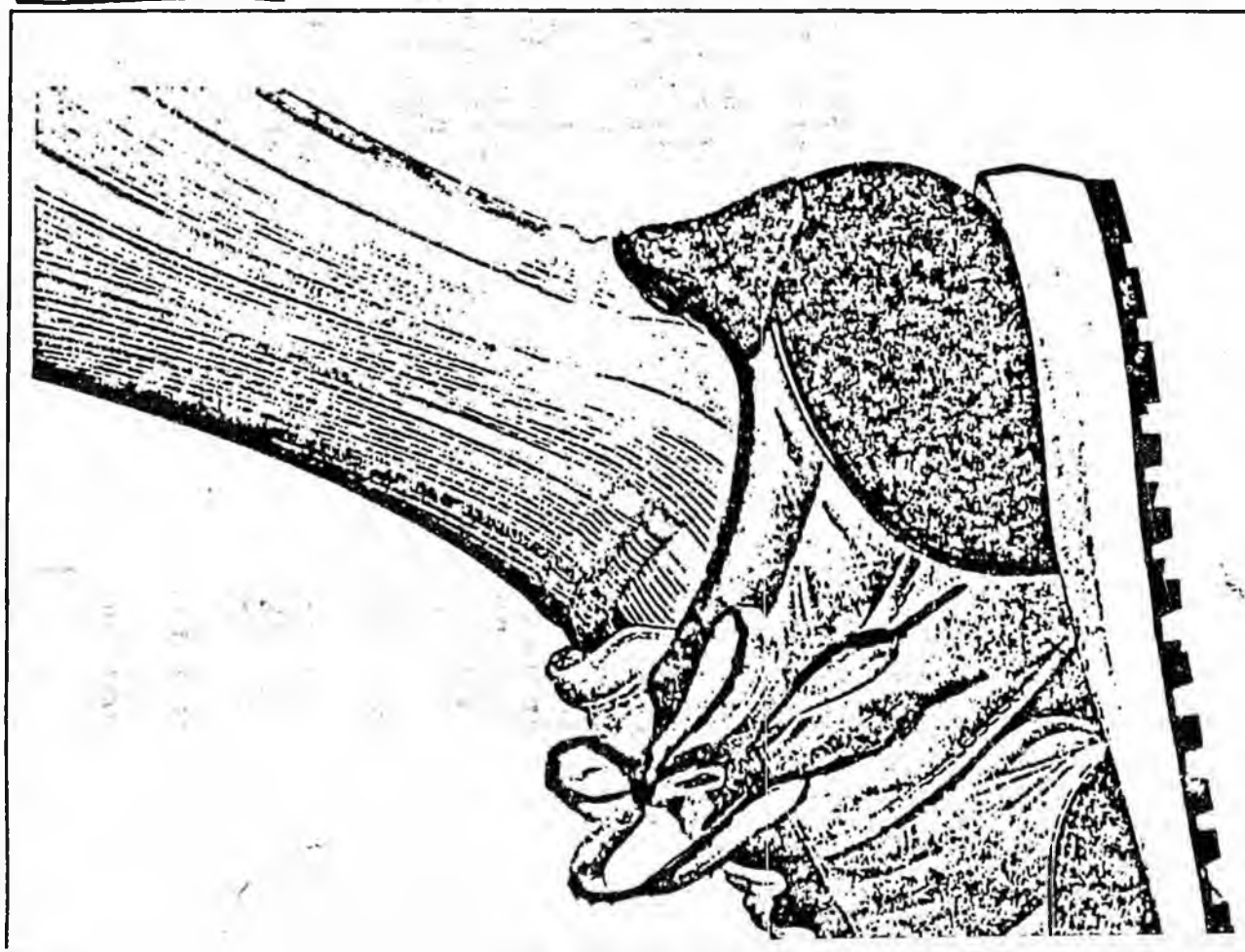


Exhibit VI

Merrett Syndicates Limited

UNDERWRITING AGENTS AT LLOYD'S

ARTHUR CASTLE HOUSE
33 CREECHURCH LANE LONDON EC3A 5AJ
REGISTERED OFFICE REG NO 1035551

TELEPHONE 01-283 3434
TELEX 885986 MERRET G

11th Jan 1985

Jackie

Dear David

As we are all only too well aware, we have just come off a most interesting renewal season for Treaty Reinsurance.

It is apparent that we have an opportunity at this time and essential that we reappraise our premium position on Treaty business. In any event, as you know, we have not been particularly interested in writing new business recently. I thought it would be a good idea, therefore, to put our own position in writing so that you can appreciate the fact that, for the foreseeable future, we will not be interested in writing any new Treaty Reinsurance either property or casualty. As you are aware from this most current renewal season, our prime responsibility is to existing clients. We will not be likely to change this attitude for some time.

I am letting you have this information in writing so you may make other arrangements for any new business you may be bringing into the market in the immediate future.

With kind regards,

Yours sincerely,

Robin

ROBIN A.G. JACKSON

Exhibit VII

CALIFORNIA "TORT REFORM" STATUTES
UPHELD BY SUPREME COURT IN 1984-85

I. Periodic payment of future damages exceeding $50,000

II. Changes to the collateral source rule

III. Limitation on contingent fees

IV. Limitation on recovery for non-economic damages

LIMITATION OF NON-ECONOM DAMAGES

§3333.2. Recovery of Noneconomic Losses—Definitions.

(a) In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.

(b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars ($250,000).

(c) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital. Leg.H. 1975 Second Extra. Sess. chs. 1, 2, operative December 12, 1975.

Ref.: Cal Frms Pl & Pr, "Dentists," "Hospitals," "Physicans and Other Medical Personnel."

1976 Note: See Note at Code of Civil Procedure §364.

Exhibit XX

The Herald, Monday, September 2, 1985 Page 41

Business insurance rates skyrocket

Customers may ultimately foot bill

By Kim Fevors
Staff writer

It costs $32.50 for an office appointment with Dr. Conrad Anderson in Fremont.

And unless his malpractice insurance holds steady at $10,000, the general practitioner next year may raise his fees.

A few miles away in downtown Hayward, residents of the Green Shutter Hotel on Main Street pay $90 a week for a room with a bath, $75 without. Their rates may go up.

"Somewhere along the line you have to pass on the costs," says hotel co-owner Dave Duveau, who two weeks ago learned his premium — if he doesn't change insurers — will cost $42,000 this year. In 1984 his property-casualty-liability insurance was $30,000.



Conrad Anderson

Anderson's $10,000 malpractice premium insures him up to $1 million per lawsuit and a maximum of $3 million each year.

The news was even worse for Bob Oddone. He has to find new, and probably more expensive, insurance for Le Club Moderne, one of Hayward's oldest drinking establishments.

Insurance agent Ed Boese began calling insurers the day Oddone learned the policy on his Main Street bar would not be renewed.

"There's absolutely nothing wrong with his (Oddone's) business," says Boese, a partner with Farrell, Boese and Whited insurance brokers in San Francisco.

"It's a problem with the insurance industry as a whole ... and the little businesses like Bob's are merely the victims, not the cause."

Across the nation all kinds of businesses are facing insurance premium increases ranging from 25 percent to more than 1,000 percent. Others, such as Oddone's, are being dropped by insurers as unprofitable clients.

Hardest hit seem to be bars, liquor stores, restaurants, rental agencies and day care centers — businesses that have experienced increased insurance claims during recent years. But municipalities and professionals, including doctors, accountants and lawyers, face skyrocketing insurance bills because of generous court awards.

Industry analysts attribute the increases to insurance companies' big underwriting losses in 1983 and 1984.

During the "premium price wars" of the late 1970s insurance companies raised rates in a fierce competition for business, hoping to invest incoming monies at 18 and 20 percent interest rates.

"Insurers were willing to write almost any risk at any price," says George A. Porter, president of the Independent Insurance Agents and Brokers of California.

But interest rates — and the insurance industry's profit margins — began dropping at about the same time the nation's courts began approving huge casualty and liability awards.

Last year the industry reported $3.8 billion in losses. Seventeen insurance companies went broke.

"I've been in the business 45 years and I haven't seen anything like this" says Boese, who specializes in hotel and apartment building insurance.

Helping make up the insurance industry's losses through increased premiums are many East Bay businesses:

- Insurance costs at Di Julio Pontiac GMC in Fremont "went up 97 percent this year" says general sales manager Ron Freitas, who declined to provide figures. A common premium increase for auto dealerships is from $5,000 to $10,000, says a spokesman for the Northern California Motor Car Dealers Association.
- Alameda County's medical malpractice insurance premiums increased this year from $1.6 million to $2.3 million. Highland Hospital had to increase its total coverage from $30 million to $100 million.
- Owners of Arnie's Time Out, a neighborhood bar on Mission Boulevard in Hayward, reluctantly paid a new premium of $2,000, up from $1,400. "You have to have insurance," says co-owner Doris Bishop.

Child-care providers statewide are being forced out of business by the huge increase in rates. In Southern Alameda County, insurance problems have shut down five homes.

The state's major home-care insurer is BMF Market Services of Sherman Oaks. Last year a home-care operator licensed for 12 children would have paid BMF $270 for $1 million in liability coverage and $75,000 in accident, car accident and personal property coverage.

This year BMF is charging $1,165 for only $300,000 liability and the remaining $75,000 coverage.

Other insurers are refusing to handle child-care policies following highly publicized allegations and convictions involving child abuse at day-care homes in Northern and Southern California.

The state Senate Monday approved an emergency measure requiring insurance companies to join a state-operated insurance pool for day-care centers. SB 1476 goes next to the Assembly.

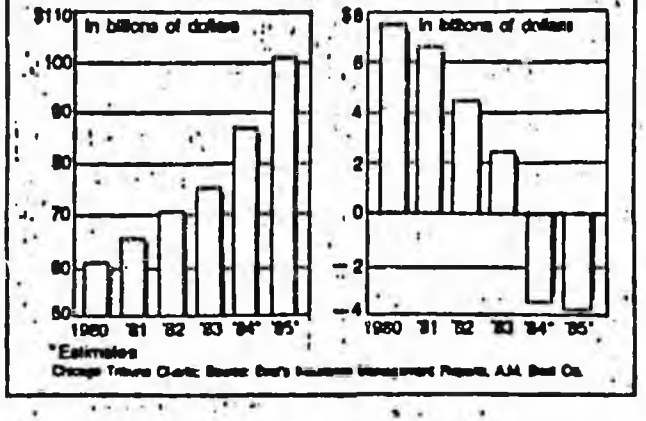
Insurance costs for California physicians have eased somewhat since the state Legislature in 1975 imposed restrictions on medical malpractice suits.

Anderson's $10,000 malpractice premium insures him up to $1 million per lawsuit and a maximum of $3 million each year.



Bob Oddone

Oddone has to find new, and probably more expensive, insurance for Le Club Moderne, one of Hayward's oldest bars.



"High risk" specialists such as obstetricians, neurosurgeons and orthopedic surgeons are paying $35,000 to $38,000 for the same coverage. In New York that coverage would cost $100,000, says Anderson, a director with the Medical Insurance Exchange, which sells malpractice policies in Northern California, Nevada, Idaho, Alaska and Hawaii.

Also contributing to the rise in insurance premiums are increasingly generous court awards in personal-injury suits.

"The court system's broad interpretation ... encourages lawsuits where fiscally responsible, adequately insured individuals and businesses end up paying for the mistakes of uninsured or underinsured entities," Porter says.

In 1983 more than 600 personal-injury cases nationwide were settled with awards of $1 million or more, reports show.

California particularly "has had a lot of serious problems with the number of lawsuits in the liability area," says Dennis Jay, spokesman for the National Association of Professional Insurance Agents.

In 1982 there were 13 awards or settlements over $1 million statewide. A year later the number had risen to 19.

"We monitor insurance markets around the country ... these days when people fall on the sidewalk they no longer think 'I need better footing next time.' They think instead, 'I'll call my lawyer.'"

David Blakesley, an agent with Cooper McKenzie Murphy in Pleasanton, believes insurance companies are playing catch-up from the lowered premium rates they offered in the mid-'70s.

"What they are really doing is within 1 or 1½ years bringing in enough dollars to pay for their losses — they're making an increase quickly to make their financial statements look better."

The insurers are overreacting, Blakesley contends.

"If the insurance companies had stretched (the premium increases) over two or three years, it would have been a lot easier (for businesses), but they want to be profitable now."

And insurance rates are not expected to drop anytime soon, Porter maintains.

"We've been in a buyers market for five years. Insurance rates are going up, and won't be coming down in the foreseeable future.

"Each company is taking a much closer look at individual risks and pricing the product accordingly," Porter says.

"Premiums are going up ... to insure companies have the reserves and surplus to meet future claims expenses."

Exhibit XIV

Editorial

Damage awards harm economy

U.S. Attorney General Edwin Meese's warning should be heeded. In a speech at the State Bar's annual meeting in San Diego last weekend, he said enormous damage awards in injury lawsuits, often without proof of fault, threaten serious harm to the nation's economy.

Meese said the insurance industry is in a "position of precariousness" because of expanding liability. Small businesses are being forced to to go without insurance and face possible bankruptcy from lawsuits. He said he favored "re-establishment of fault as the critical standard by which liability is determined."

The nation's top law enforcement officer focused on California Supreme Court decisions establishing a doctrine of liability in product cases that lets victims of defective products collect damages without having to prove fault. But he could also have taken on the "joint and several" liability rule established by California courts.

Under this rule, also known as the "deep pocket" doctrine, local governments and businesses can be forced to pay all of a damage award in a personal injury lawsuit, even if they're minimally at fault for an accident, if other defendants are unable to pay. It has encouraged lawyers to name cities, counties and businesses as defendants based on their ability to pay multimillion-dollar awards.

Meese put it mildly when he said that in our litigous society, "the desire for compensation has overcome a sense of balance." The situation has been worsed by broadened court interpretations of liability, jury verdicts based on sympathy rather than reason and ambulance-chasing lawyers waving the banner of victims' right to sue.

Last year, the average product liability award in the United States was $1.07 million, up from $345,00 just 10 years earlier. The average medical malpractice award was $950,000. In 1983, 360 personal injury cases were settled with million dollar awards or more, 13 times the number in 1975.

One-fourth of the obstetricians and general practitioners responding to a California Medical Association survey said they had stopped or were considering stopping their delivery of babies in response to rising malpractice insurance premiums. Similar tales of liability insurance woes stemming from large damage awards are coming from almost every profession and industry.

Some Californians are taking matters into their own hands. Spurred by the Legislature's failure to act, the California Chamber of Commerce is urging business and public support for an initiative that would limit the amount paid for pain and suffering (non-economic losses) in deep pocket cases to the degree the defendant was at fault.

Other potential remedies include tighter definitions of liability, ceilings on damage awards, limits on trial lawyer fees that encourage pursuit of multimillion-dollar awards, greater use of arbitration, more restrictive statutes of limitation and periodic rather than lump sum payment of large awards.

Meese accurately described the bottom line. If the trend of increased damage awards continues, he warned, "the impact on our nation's economy could be almost devastating ... The size and unpredictability of these awards threatens to suppress the commercial vitality on which our nation's economy depends."

Exhibit XIII

Continued from previous page

M&M's Mr. Sinnott.

A&A's Mr. Polstein says that last July A&A clients that wanted $200 million to $250 million in D&O coverage had to settle for about $100 million. "Now it's a question of getting them $50 million or $75 million," he explains.

To find some of these more difficult coverages, brokers are turning more often to the surplus lines market.

"We've had to use surplus lines more, but we find it's more complicated," said Gene McCrory, president of North American Insurance Agency Inc. in Oklahoma City.

Robinson-Conner also is continuing to use the surplus lines market more, said Mr. Conner.

In one instance, an admitted insurer found out how much a policyholder was going to pay for coverage in the surplus market and said: "Well, if you're going to pay that much, we'll write it," Mr. Conner said.

Bartlett's Mr. Miles also reports using the surplus lines market more, but doesn't believe it is doing a good job.

"I don't think they have enough staff to answer all the demand for quotes," Mr. Miles said.

"Sometimes we had to go to the excess/surplus market and use creative marketing: different pieces at different layers with different insurers," said Donald R. Weber, chairman and chief executive officer of Financial Guardian Group Inc. in Kansas City, Mo.

In some cases to secure hard-to-place coverage, brokers are putting together policies with higher deductibles or large self-insured retentions.

"Some clients have volunteered to take deductibles, clients that heretofore wouldn't even discuss it," said Robinson-Conner's Mr. Conner.

But self-insurance is not a good alternative, especially for smaller clients that have paid only $50,000 to $250,000 in premiums previously.

Capacity also tight in London market

By STACY SHAPIRO

LONDON—To say that placing U.S. property and casualty risks in the London market is difficult is the "classic English understatement," says John Woodson, managing director of the international division of Lloyd's of London broker Willis Faber P.L.C.

Rates are rising and capacity is shrinking in London for all lines of business, observers agree.

"It is fairly common knowledge that London has extremely restricted capacity in the liability field," said Simon Harrap, managing director of broker Stewart Wrightson North America Group Ltd.

"Property is tight but not impossible, and wrongful acts—errors and omissions—is somewhere in between," Mr. Harrap said.

Americans are flocking to the London market, looking for much-needed capacity they cannot find in the U.S. market, sources in the market say.

Some are indeed finding new capacity. Willis Faber, for example, has 40% more American business on its books this year than it had last year, Mr. Woodson said.

But, many U.S. insurance buyers are coming away from London disappointed because the capacity they seek simply isn't there, brokers and underwriters say.

'A lot of Americans fly over to spend time looking for capacity, and they are shocked when they arrive. There are more U.S. buyers coming over here on a wing and a prayer and many are disappointed by what they see,' Mr. Harrap says.

"A lot of Americans fly over to spend time looking for capacity, and they are shocked when they arrive," Mr. Harrap said.

"There are more U.S. buyers coming over here on a wing and a prayer and many are disappointed by what they see," he added.

Mr. Harrap says buyers last year could buy excess liability limits of $300 million.

"Now they're lucky to find $50 million," he says.

"If everything is right and all markets pull together, $150 million to $200 million is the maximum amount a client can find in capacity" for liability risks, said Brian Hibbert, chairman of C.T. Bowring Insurance Ltd.

"In reality, though, it is more like $100 million to $125 million," Mr. Hibber comments.

Rate increases can range anywhere from 25% to 400%, Mr. Hibbert added.

"Everything's up this year," he said. "And many policyholders do not have full programs. You heard of the saying "Swiss cheese"? Well, if a program is layered to $100 million, then it may be that none of the layers is complete or there are exclusions."

"Prices are increasing. Errors and omissions are up 100%, particularly for architects and engineers, where there is beginning to be a lack of market capacity," commented Colin Bird, who recently left Minet Holdings P.L.C. to join Lloyd's of London broker J. Besso & Co.

"The problem is new business. There is not a class of business that isn't distressed. Even property people are having their problems. And yet, business is coming from everywhere," Mr. Bird said.

"I've never known this before," he continued. "The whole world market is trouble. . . .The only bargain is that Lloyd's is still offering the most secure policy in the world, despite its troubles."

Adding to Lloyd's troubles is that some underwriters are saying that, because they are taking in so much business at higher rates, they soon may reach the premium limits set by Lloyd's. However, brokers agree that underwriters seem to have saved enough capacity to write renewal business and some new, good risks.

Adding to the upheaval in London is the Insurance Services Office's proposed commercial general liability claims-made form, which is to take effect Jan. 1, and the claims-made umbrella form that is currently being drafted in London (see story, page 1).

The reinsurance market is particularly interested in the claims-made forms, said Nigel Huntington Whiteley, director of the North American division of E.W. Payne Ltd)., a subsidiary of Sedgwick Holdings P.L.C.

Mr. Huntington said that, by the beginning of the year, reinsurers "will probably not provide casualty reinsurance cover unless the ceding companies write on a claims-made form."

And, he adds that in the last six months, "there has been further reduction in capacity, particularly because of Lloyd's premium income limitations," Mr. Huntington said.

"The large industrial companies can't buy anything like they could since last year." ■

Spicer & White members sue

LONDON—Lloyd's of London underwriting agency Spicer & White (Underwriting Agencies) Ltd. plans to transfer the management of Syndicate 895 to another agency after 172 members of the syndicate filed suit against Spicer & White.

The members sued Spicer & White in London High Court after agency withdrew its offer of a five-year interest-free loan to help members pay anticipated losses of 19 million pounds ($26.4 million). The offer was backed by Chase Manhattan Bank and Spicer & White's parent company, Lloyd's broker Willis Faber P.L.C. (*BI*, June 3)

High rates idle shrimp boats

ARANSAS PASS, Texas—Shrimp boats that would be fishing in the Gulf of Mexico are sitting in port even though the shrimping season began last week because some owners cannot afford the price of hull and liability coverage.

The cost of hull and protection and indemnity coverage combined have increased 100% to 300% for the shrimpers, according to Ralph Rayburn, executive director of the Texas Shrimp

Exhibit XI

■ INSURANCE

Rising Premium Charges Swamp Some Businesses

BY JEFF PELLINE

Commercial fishermen, home day-care operators, engineers, rental car dealers and truckers all have the same complaint: Soaring insurance costs are eroding profits and threatening to put many of them out of business.

Insurance companies generally agree, but they say the rate increases are justified. Insurers say that their losses are greater than ever, blaming the rash of huge liability awards from the courts, along with a drop in income from investments.

Seventeen insurance companies went broke last year, a near record, and the industry wants to reverse the trend as quickly as possible, according to the Insurance Information Institute.

"They're grabbing for straws, and we're at the bottom and getting the worst of it," said Peter Kondrashoff, 44, a commercial fisherman who pays $23,737 a year to insure his boat and three-man crew against property and casualty losses, up from $18,544 last year.

"I'm terrified to see the bill for next year's rates, which I'll get next month," said Kondrashoff, who has been catching fish off the Northern California coast for 25 years and is paying more than ever for insurance.

Examples abound of businesses' hardships because of rising insurance rates:

■ Thrifty Rent-A-Car, a 15-year-old car rental company based in San Francisco, filed for Chapter 11 bankruptcy protection on June 20, about a week after being told it needed to make a $75,000 cash deposit to cover rising insurance premiums.

"It's probably going to put us out of business," said Bill Wristen, Thrifty's operations manager. Under Chapter 11, Thrifty continues to operate while it devises a debt repayment plan and is protected from creditor lawsuits. (The car rental agency is an independently owned franchise of the national car rental chain that has the same name.)

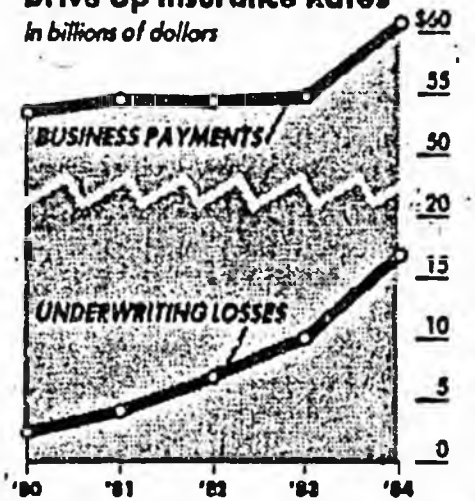
The Thrifty franchise, which posts yearly revenues of $5 million, has seen its insurance rates more than double to $500,000 from $215,000 in the past year, Wristen said. Other local independent car rental

Page 27 Col. 1

BUSINESS INSURANCE COSTLIER AND SCARCER

Underwriting Losses Drive Up Insurance Rates

In billions of dollars



Source: A.M. Best Co.

Hard-to-Buy Insurance

The following types of insurance are the most difficult to get because of risk and the potential for large claims:

1. Municipal liability
2. Pollution liability
3. Liquor liability
4. Long-haul trucker coverage
5. Medical malpractice
6. Commercial fishing boat coverage
7. Asbestos removal from buildings
8. Consumer product liability
9. Day-care center coverage
10. Company director and officer liability

Source: Insurance Information Institute

Exhibit XII



Times photo/Alan Glyth

...transit information booklets.

...on downtown Concord.

"Through this ordinance, we can attack and solve traffic problems together," said Taggart.

But Bob Kinert of PG&E suggested the ordinance should apply to more residential areas to spread the traffic burden fairly.

Unlike Pleasanton, a pioneer in transportation systems management, Concord isn't setting a goal of 20 or 30 percent and making all businesses conform to it. Instead, new developments must set a goal that the Planning Commission considers reasonable.

Public housing faces 1,300% insurance hike

By Sharon Bernstein
UCI News Service

MARTINEZ — The insurance policy on the county's public housing projects will be canceled in early November and a new policy will cost the Housing Authority 13 times as much.

Under what housing officials say is the best offer they've received, property insurance will go from $28,947 under Fremont Indemnity, which canceled the Housing Authority's policy, to $366,000 under Alexander and Alexander of San Francisco.

As an alternative to what he called the "outrageous" premiums, the Housing Authority's director, Perfecto Villarreal, has started setting up a $500,000 self-insurance fund.

But officials of the federal Department of Housing and Urban Development said even if the county sets up its own fund, it will need emergency insurance for very large claims, and will probably still end up spending hundreds of thousands of dollars for insurance.

County Administrator Phil Batchelor said the Housing Authority is the fourth public agency to be hit with an insurance surprise this summer — the others are the county child care program for foster children, the mosquito abatement district and the health department, where doctors are faced with skyrocketing malpractice insurance costs.

Villarreal said he sent out 56 letters to insurance companies, soliciting bids for county coverage, and did not get one positive response.

The Board of Supervisors, whose members also serve as the board of the Housing Authority, has ordered Villarreal to write a letter to the state demanding a full scale investigation into insurance company practices with regards to public agencies.

Richard Payne, Senior Vice President of Alexander and Alexander, refused to comment on the tremendous increase in premiums to the Housing Authority.

But in a letter to Villarreal dated Sept. 3, Payne wrote: "I personally recognize that the premiums are extraordinarily high compared to what you paid last year, however, as far as I can determine that is all the market has to offer."

Bruce Vincent, a housing management officer with HUD in Washington, said Contra Costa's increase, which works out to 1,300 percent, is high, but it could be worse. "The average rate of increase for all lines (of insurance) is 400 percent," he said. "We've even seen one come in at 3,000 percent."

Vincent said one reason for the sudden increase in premiums is a change in investment markets for insurance companies.

Please see INSURANCE, Page 28

State threatens insurance firms

Wants to stop rising premiums

By Bill Snyder
Times staff writer

SAN FRANCISCO — Hoping to slow a wave of stunning increases in commercial insurance premiums, a state agency is threatening to take legal action against some of California's 650 casualty companies.

Businesses ranging from banks to brake shops have found the cost of liability insurance increasing from 100 percent to 500 percent this year, while others have found it impossible to get insurance at any price.

Bruce Bunner, head of the state Department of Insurance, said the increases threaten the survival of some businesses and may be in violation of state law.

In a letter to chief executive officers of the state's property and casualty companies, Bunner warned that his department may bring charges of unfair trade practices against insurance companies that cancel or make drastic changes in commercial policies before they have expired.

Policy cancellations are estimated to be occurring three or four times more often this year...

...ship, said E. Harlan Miller, president of the brokers' association.

One East Bay contractor lost his insurance and almost went out of business. "The good news was he found another carrier. But the bad news was his premium increased from $3,000 to $10,000 a year," said Jorge Sandoval, a spokesman for the Department of Insurance.

In Richmond, liability insurance for the Alvarado Bank increased by about 100 percent this year, while the deductible portion of the policy jumped by 1,000 percent, said Alvarado's president Timothy Thomason.

"Other banks haven't been able to get insurance at any price," he said, noting that the financial industry may start its own insurance pool.

Liability insurance for the banks has nothing to do with stability of deposits, but covers everything from bonding employees to the taking of hostages during a robbery.

Particularly galling to Thompson is the fact that the 2-year-old bank had insurance problems even though it has never filed a ...

SLIDING SCALE CONTINGENT FEE

ARTICLE 8.5. CONTINGENCY FEE AGREEMENTS

Section
6146. Limitations; periodic payments.
6147. Contract; duplicate copies; contents; effect of noncompliance; application to contracts for recovery of workers' compensation benefits.

Article 8.5 was added by Stats.1975, 2d Ex.Sess., c. 1, p. 3967, § 24.2.

Heading of Article 8.5, "Contingent Fee Agreements: Medical Injury Claims", was amended by Stats.1982, c. 415, p. 1760, § 1, to read as it now appears.

§ 6146. Limitations; periodic payments

(a) An attorney shall not contract for or collect a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon such person's alleged professional negligence in excess of the following limits:

(1) Forty percent of the first fifty thousand dollars ($50,000) recovered.

(2) Thirty-three and one-third percent of the next fifty thousand dollars ($50,000) recovered.

(3) Twenty-five percent of the next one hundred thousand dollars ($100,000) recovered.

(4) Ten percent of any amount on which the recovery exceeds two hundred thousand dollars ($200,000).

* * * The limitations shall apply regardless of whether the recovery is by settlement, arbitration, or judgment, or whether the person for whom the recovery is made is a responsible adult, an infant, or a person of unsound mind.

(b) If periodic payments are awarded to the plaintiff pursuant to Section 667.7 of the Code of Civil Procedure, the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and include this amount in computing the total award from which * * * attorney's fees are calculated under this section.

(c) * * * For purposes of this section:

(1) "Recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office-overhead costs or charges * * * are not deductible disbursements or costs for such purpose.

(2) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500), * * * or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

(3) "Professional negligence" is a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that the services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

(Added by Stats.1975, 2nd Ex.Sess., c. 1, p. 3967, § 24.2. Amended by Stats.1975, 2nd Ex.Sess., c. 2, p. 3989, § 1.185, urgency, eff. Sept. 24, 1975, operative Dec. 12, 1975; Stats.1981, c. 714, p. 2580, § 23.)

1975 Legislation.

Medical malpractice insurance, action for declaration of rights and duties, see note under Code of Civil Procedure § 364.

Operative effect of Stats.1975, 2d Ex.Sess., c. 2, see note under § 160.

Law Review Commentaries

Medical malpractice: Alleged "crisis" in perspective. Wylie A. Aitken (1975) 3 West.St.U.L.Rev. 27.

Patient's compensation board: Answer to medical malpractice crisis. Dennis E. Carpenter. (1975) 3 West.St.U. L.Rev. 15.

Price of health care availability: Economics of medical malpractice. (1979) 11 Southwestern L.R. 1371.

Proposed legislation: Amend MICRA to include mandatory mediation of medical malpractice claims. (1980) 14 U.S.F.L.Rev. 439.

Library References

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C.J.S. Attorney and Client § 313 to 317.

Notes of Decisions

1. In general

Limitations on attorney contingent fee contracts are to be applied prospectively to contracts entered into after the effective date of c. 1, 2nd Ex.Sess., 1975, to avoid impairment of obligations. Op.Leg. Counsel, 75 A.J., 2nd Ex. Sess., 378.

COLLATERAL SOURCE

§3333.1. Introduction of Evidence of Amount Payable as Benefit in Action for Personal Injury—Health Care Provider Defined—Professional Negligence Defined.

(a) In the event the defendant so elects, in an action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.

(b) No source of collateral benefits introduced pursuant to subdivision (a) shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

(c) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital. Leg.H. 1975 Second Extra. Sess. chs. 1, 2, operative December 12, 1975, 1976 ch. 1079.

Ref.: Cal Fms Pl & Pr, "Dentists," "Hospitals," "Physicians and Other Medical Personnel."

1976 Note: See note following Code of Civil Procedure §364.

PERIODIC PAYMENTS

667.7. Action Against Health Care Provider With Judgment Ordering Payment of Future Damages in Whole or Periodically—Definitions—Legislative Intent.

(a) In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars ($50,000) in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

(b) (1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

(c) However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In such cases the court which rendered the original judgment, may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

(d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security given, pursuant to subdivision (a) shall revert to the judgment debtor.

(e) As used in this section:

(1) "Future damages" includes damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(2) "Periodic payments" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(3) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

(4) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

(f) It is the intent of the Legislature in enacting this section to authorize the entry of judgments in malpractice actions against health care providers which provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the Legislature that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also the intent of the Legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time which might alter the specifications of the original judgment. Leg.H. 1975 Second Extra. Sess. chs. 1, 2, operative December 12, 1975.

Ref.: Cal Fms Pl & Pr, "Dentists," "Hospitals," "Physicians and Other Medical Personnel"; W. Cal. Pro., "Attorneys" §6A.

Exhibit VIII

Association For California Tort Reform

Tort Report

September 1985

TORT REPORT

INSIDE:

- MICRA Amendments Defeated
- MICRA Limits Upheld
- Montana Limits Punitives
- The Insurance Crisis
- Tobacco Litigation

The Association for California Tort Reform is a statewide coalition of businesses and organizations dedicated to the reform of California's tort liability laws. Inquiries should be directed to ACTR, 1130 K Street, Suite 250, Sacramento, CA 95814, (916) 442-1111.

Assembly Refuses to Button Deep Pocket

Coalition Moves Ahead on Initiative

Both SB 75 (Foran) and an alternate deep pocket bill, AB 1332 (W. Brown) were voted two-year bills by the Assembly Judiciary Committee last week. ACTR-sponsored SB 75 would have limited a defendant's liability for noneconomic damages to that defendant's proportion of fault as determined by the factfinder. This would be a change from the present law of joint liability which holds each defendant liable for the entire amount of the plaintiff's damages regardless of degree of fault. SB 75 stalled in Assembly Judiciary after approval by the Senate, repeating the pattern set by similar bills introduced in past legislative sessions.

AB 1332 was a spot bill by Elihu Harris, which was amended to give relief to cities and counties when the claim relates to traffic accidents. In a multiple defendant action, a public entity defendant would be held liable for noneconomic damages only to the proportion of fault as determined by the factfinder. Private sector defendants in the same action would still be held jointly liable for the entire judgment. This measure merely reflects existing law regarding public entities in a somewhat narrowed interpretation. By protecting public entities only, the bill would shift additional costs to the private sector. Private sector defendants, already beseiged with skyrocketing liability insurance premiums and increasing unavailability of coverage at any price for certain risks, would find themselves in a worse situation than the status quo.

Assembly Inaction Spurs Initiative Effort

The same day the Assembly Judiciary Committee refused to give relief to all deep pocket defendants, a coalition of interests including business and government voted to move ahead on getting an initiative before the voters. The proposed initiative, which has been named the Fair Responsibility Act of 1986, would tie actual fault to liability for noneconomic damages similar to the provisions of SB 75. Work is now in progress to place the

(continued on page 4)

Labor and Management Negotiating Termination Proposals

Lieutenant Governor Leo T. McCarthy recently served as a mediator in an attempt to bring labor and management together on a solution to wrongful termination litigation. ACTR, together with allied groups the California Employment Law Counsel, California Chamber of Commerce and other employer representatives, sponsored AB 1400 (McAlister) in the California Legislature this year. This bill provides incentives for employers and employees to arbitrate disputes over firings. The measure prohibits punitive damages in termination proceedings but retains compensatory relief for wrongful terminations.

Labor sponsored SB 1348 (Greene). That bill would require an employer to discharge an employee only for "just cause." Termination could be accomplished only after a Notice of Intent to Discharge was provided to the employee and the employer had an opportunity to exercise mediation and arbitration rights. The bill sets forth requirements for a fund for disbursement to the Department of Industrial Relations which would administer the program. Contributions would be mandatory from employers and employees.

McCarthy wrote to the sponsors of both bills and invited them to a meeting in his office to discuss whether a compromise could be reached. The realistic political assessment is that no bill will be approved by the legislature unless labor and management can agree on a bill.

The initial meeting was productive and promising. The participants identified the following issues for further exploration and discussion: (1) the length of time a person must be employed to be covered by the provisions of the act; (2) additional incentives to ensure that arbitration is a preferred method of resolution rather

(continued on page 4)

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DEEP POCKET INITIATIVE

(continued from page 1)

initiative on the June '86 ballot. Contributions have been received from numerous supporters including ACTR, California Medical Association, California Chamber of Commerce, Association for California Insurers, California Manufacturers Association and Cal-Tax. A volunteer grass roots effort will be launched to gather signatures, and Dick Woodward of Woodward & McDowell, campaign managers for the initiative, believe a sufficient number of signatures can be gathered to put this troublesome issue before the voters in June.

THE INSURANCE CRISIS *(continued from page 3)*

risks for the future are simply eliminating coverage of high risk areas and pricing available policies out of reach for many businesses. Bailing out of the markets on the part of insurers and reinsurers is most evident where risks of litigation are high, such as in pollution, directors' liability, municipal liability and professional malpractice. Good safety records are not determinative of whether a policy will be continued or at what price.

The insurance industry is likely to withdraw more coverage areas and raise premiums for available policies still higher so long as no action is taken to impose balance on our legal system. That balance is not forthcoming from the courts, so either Congress or state legislatures must act. Even then, legislative remedies take time, and changes are likely to be slow and incremental. Proposals in California that would cap noneconomic damages or hold defendants liable only for their proportionate share of such damages, in accordance with their degree of fault as determined by the factfinder (SB 75), have hit repeated roadblocks in the Assembly. Meanwhile, it is clear that so long as courts continue to expand theories of liability and juries continue to award unrealistic amounts in damages, the prospect of an uninsured society draws ever closer to reality.

MONTANA LIMITS PUNITIVES *(continued from page 2)*

outside the presence of the jury, that the plaintiff has presented a prima facie claim for punitive damages.

The most significant change effected by the new law is that in cases when punitive damages are awarded, they may not exceed $25,000 or one percent of the defendant's net worth, whichever is greater. Previously, the only guideline was that the amount was to constitute punishment since it would be absorbed directly by the defendant and could not be covered by insurance. Although remittitur remains available in most jurisdictions to reduce an award that is excessive, Montana has now statutorily mandated a cap on the amount that can be recovered on punitive damages. The significance of this new law can be appreciated best in light of the fact that punitives must be based on breach of a noncontractual obligation where the defendant has been found guilty of oppression, fraud, or malice, either actual or presumed. Evidently, the Montana Legislature determined that even conduct falling within these categories is insufficient to warrant imposition of punitives that could bankrupt a business.

TERMINATION PROPOSALS

(continued from page 1)

than litigation; (3) constructing a two-tiered standard with just cause for line employees and good cause for legitimate business reason for managerial employees; (4) employer providing early notice explaining the reasons for the discharge to the employee so the employee would be able to prepare his case; (5) standards for when front pay would be a remedy in lieu of reinstatement. Another meeting was scheduled for October 8, at 10:00 a.m. in Lieutenant Governor McCarthy's office.

Exhibit K



THE OWNER OF PARIS' O'KITCH CAFES SUED McDONALD'S AFTER LOSING HIS FRANCHISE

THE BACKLASH GROWS AGAINST FRIVOLOUS SUITS

A PLAINTIFF IS ORDERED TO REIMBURSE $1.8 MILLION IN LEGAL FEES AFTER PRESENTING 'OBVIOUSLY FALSE' EVIDENCE

There was never any love lost between Raymond Dayan and McDonald's Corp. In the early 1970s Dayan, a Chicago entrepreneur, waged a court fight to win a valuable franchise for McDonald's restaurants in France. So it was no surprise when Dayan marched back to court after McDonald's terminated his franchise in 1978. After a nine-month trial, Dayan lost his case in 1983. An Illinois court held that he violated McDonald's standards for quality, service, and cleanliness. But the case is important because of what happened next: The judge slapped Dayan with a bill for $1.8 million for McDonald's legal fees and expenses.

In U.S. courts, unlike those in Europe, each side normally pays its own attorneys' fees. That "American rule," say critics, fosters litigation—especially against large companies. Plaintiffs, who often pay their lawyers only out of winnings, can force "deep pocket" companies to spend enormous sums, making almost any claim worth settling. Says J. Nicholas Filler, who teaches law at the University of Massachusetts at Amherst: "A plaintiff has almost nothing to lose except a little time."

That is beginning to change. Growing intolerance for frivolous suits is leading to changes in the American rule. In the McDonald's case, Judge Richard L. Curry said that without Dayan's "untrue allegations" there would have been no dispute. In April, Illinois' intermediate appellate court agreed. The judges declared that Dayan, who now calls his Paris restaurants "O'Kitch," submitted "obviously false" evidence. McDonald's, said the judges, proved that there had been "indescribable unsanitary conditions," including evidence that "dog urine and excrement were found next to stored food. Rat poison was found spilled beside an 'oozing' carton of McDonald's sauce."

REVIVING A 1933 LAW. The McDonald's award is the most dramatic of several similar recent decisions from courts all over the U.S. The Illinois courts relied on an infrequently used 1933 state law that permits courts to assess fees against anyone who brings a suit based on claims that are "made without reasonable cause and found to be untrue." Many states have similar laws, but until recently judges have been reluctant to use them. The movement to punish those who bring frivolous suits may have been spurred last June when the U.S. Supreme Court, for the first time, assessed a charge against someone who had brought a series of meritless appeals. And last summer federal rules went into effect that impose new duties on lawyers to be certain their cases are "well grounded in fact." Now, says attorney Daniel R. Solin, judges "are starting to say that just because you're an individual or a small corporation suing a large corporation does not mean that you have the right to bring a frivolous lawsuit."

Solin's New York firm, Solin & Breindel, has had two recent victories over fees on behalf of corporate clients. In one case, now being appealed, U.S. District Judge Gerard L. Goettel called a suit by two former employees of New York's St. Regis/Sheraton hotel "clearly one of the most frivolous employment discrimination actions ever brought." He ordered not only the plaintiffs but also their lawyer to pay $10,000 each.

COMPOUNDING A BIAS? This is not the only way the American rule has been altered. Through scores of laws, Congress has said that in certain types of suits the winner can collect fees from the loser. Because those provisions were meant to foster certain kinds of cases, such as civil-rights suits, losing plaintiffs have rarely been made to pay their opponents' fees. That fact, say critics, together with a view of the courts as places to test novel theories, has encouraged baseless suits. Says John Cibinic Jr., a law professor at George Washington University: "We've gotten to the point where there are just plain silly suits."

But if the new interest in punishing those who bring frivolous suits is good for business, some worry that it may be bad for the legal system. The recent changes, says Oscar Chase, a New York University Law School professor, "make me nervous because they further an imbalance that I see as already existing in American litigation against less well-heeled parties." Says Gabe Kaimowitz, a civil-rights lawyer: "What judges are doing is trying to keep people like me out of the courts." Kaimowitz was recently ordered to pay more than $19,000 in an employment-discrimination case that a federal judge declared was baseless.

Dayan says the ruling against him in the McDonald's case was unfair: "To me a frivolous lawsuit is if I sue you for no reason whatsoever. But I had a contract, and there was merit to it." He is appealing to Illinois' highest court. As part of the original decision, Judge Curry declared that since any appeal would be "a needless extension of a baseless lawsuit," Dayan could end up paying McDonald's fees for the appeals as well as the $1.8 million. So far, McDonald's reports, it has spent $500,000 on the appeals. Dayan is getting his day in court, but it may be an expensive one. ■

■ INSURANCE

Some Firms Swamped By Rising Premiums

From Page 19

agencies say they're faced with similar troubles. They already are struggling to stay profitable, because ferocious price wars are keeping profit margins at razor-thin levels.

■ Last month, day-care center operators in Contra Costa County threatened to strike over rising premiums.

The 310-member Diablo Valley Day-Care Providers Association was fuming at rates that have jumped tenfold for some operators in the past year.

Some, such as Maria Martinez, who offers child care from her Pleasant Hill home, have been forced to pass the cost along to their customers. Martinez plans to raise her weekly rate by about $8 to $73.

Insurers defend the increases, saying they have been hit with huge underwriting losses. Well-publicized cases of child abuse in day-care centers have made day care a high-risk industry, said John McCann, a vice president of the Insurance Information Institute in San Francisco.

Mission Insurance of Los Angeles, one of the leading day-care center insurers, quit the business two months ago, reportedly because it was unable to get other companies to share the risk in writing its policies. The procedure, known as reinsurance, protects one company from being hit with a large claim that could force it out of business.

■ Sarginson Distributing, a Modesto-based petroleum distributor, is paying about $8000 for liability insurance that cost just $1500 last year.

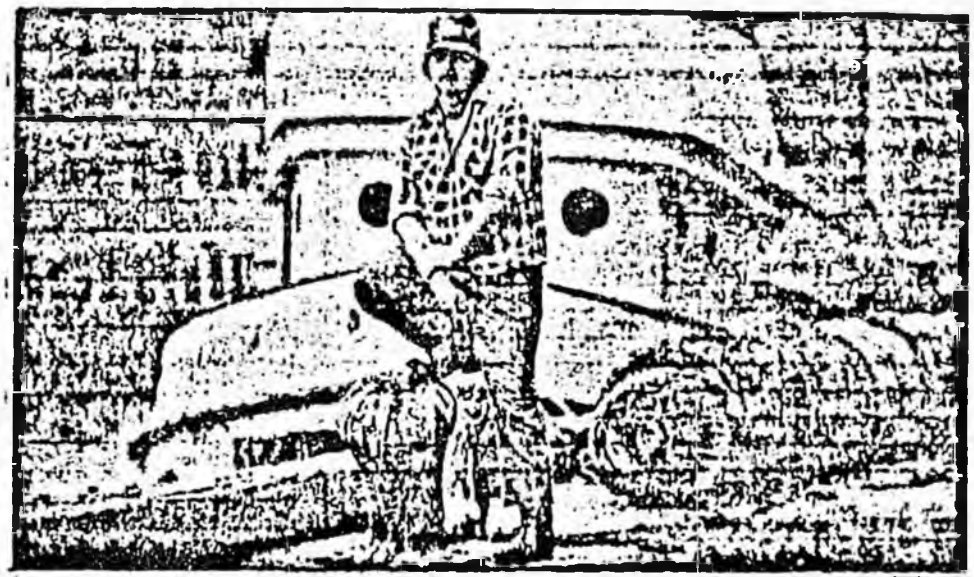
"We've had a very good insurance record, too," said owner John Sarginson. "I'm going to meet with my banker to talk about financing the new rates."

Initially, he was told the rates would rise to $15,000 but he negotiated a lower price, arguing that a tenfold increase was unjustified.

"We can't afford this much longer," Sarginson said.

■ Commercial fishermen such as Kondrashoff are upset over higher rates caused by underwriting losses, primarily a result of crab fishing accidents in Alaska. Losses from Alaskan crab fishing accidents have totaled more than $50 million in the past five years, far exceeding insurance premiums paid, according to Tom Caspell, an insurance broker with Durham & Bates in Portland.

"We've already been plagued by a lot of problems like poor fishing, and this puts an added strain on us," responded Kondrashoff.



BY TOM MEY

Fisherman Peter Kondrashoff has been hard-hit by rising insurance rates for commercial fishing

Last week, members of Congress met with fishermen in Seattle to discuss their troubles. Next month, congressional hearings are scheduled in more cities on the West Coast and Gulf Coast. In October, Congress is expected to introduce legislation to help put a cap on the soaring rates, said Marc Rosenberg, vice president of the Insurance Information Institute in Washington.

Commercial fishing boat coverage, municipal liability, pollution liability, long-haul trucker coverage, medical malpractice, company director and officer liability, and day-care center coverage are among the most costly and hard-to-get types of coverage.

Last week, professionals ranging from midwives to engineers gathered in Washington with consumer advocate Ralph Nader to decry insurance rates that have climbed as much as 1000 percent in recent years for some businesses. The rate increases "reflect a major economic crisis," Nader told a press conference.

While disputing Nader's charges that the crisis was "manufactured by a very wealthy insurance industry," insurers concede that a wide range of businesses are feeling the pinch.

"The real pressure is on the small businessman who basically has no choice but to pay the premiums," said Robert Nevins, executive vice president of Fred S. James & Co., an affiliate of San Francisco-based Transamerica Corp. and the nation's fifth-largest insurance brokerage firm.

But insurers don't expect relief for at least two years. Nevins predicts that business insurance will rise an average of 30 percent this year and 20 percent or more in 1986.

Jury awards continue to escalate, resulting in underwriting losses that have outpaced interest income and surpassed previous records set from the 1906 San Francisco earthquake, according to the insurers. "It's a tried expression, but there's no such thing as a free lunch," Nevins said. "Somebody has to pay for the increased risk."

Last year, the nation's insurance companies posted a record operating loss of $4 billion, their first loss in nine years, according to David Ostwald, vice president of the Insurance Services Office in New York. Although the loss is expected to be trimmed to $2.9 billion this year, the industry won't return to profitability until at least 1986, Ostwald said.

Traditionally, insurance companies have relied on income from investments to boost earnings, said Richard Griebel, a spokesman for Novato-based Fireman Fund's Insurance Co. But recent falling interest rates have sharply cut the companies' ability to make money from their investments.

In addition, price-cutting for the past six years because of ferocious competition has kept rates lower than insurers wanted, Ostwald said. Normally, the industry experiences a cycle where rates hit bottom every three years.

"Insurance companies have been slitting their wrists and selling policies for far less than they should have," Ostwald said.

The rate-cutting cycle extended past three years because insurance companies were afraid they'd lose business to competitors, Nevins said.

"We hope that the insurance business will do a better job of controlling the ups and downs in the future — for everybody's sake," he said.

Exhibit A

EDITORIALS

The Deep Pocket

A SWIMMER RAN into the surf at Newport Beach and dived in. His head struck a andbar, and he suffered serious head injuries nd is now a quadriplegic.

He brought suit against the city, contend- ng that the city was negligent because it did ıot post signs to warn him that waves caused ındulations of the ocean bottom that could be angerous. A jury agreed, and the city has been rdered to pay $6 million in damages.

Newport Beach's 65,000 residents are ealthy enough, we suppose, to cover their ability. Other cities are not as affluent but are eing put to the same risk. This is because a 978 state Supreme Court decision put city trea- ıries up for grabs through an extraordinary idening of liability of public agencies. In a ase called American Motorcycle vs. Superior ourt, the court said that any defendant who ontributed one percent or more to the damage ffered by a plaintiff could be held responsi- le for the entire damage settlement if other efendants were unable to pay. This has be- ome known as the Deep Pocket Theory.

There can be no question that the high ourt's decision has encouraged a floodtide of ligation, blaming cities for injuries because reets were inadequately lit, intersections ere poorly designed, or stop signs were ob- ured.

The League of California Cities recently nducted a survey of the impact of Deep Pock- litigation upon local governments; 162 of the ate's cities responded. They reported that er the last three fiscal years, they have paid it a total of $42.4 million in judgments or ttlements and that their potential liabilities

San Francisco Chronicle

THE VOICE OF THE WEST

Richard T. Thieriot, Editor and Publisher

Charles de Young Thieriot, Publisher 1955-77
George T. Cameron, Publisher 1925-55
Founded 1865 by Charles and M.H. de Young

in current claims and suits amount to more than $210 million. They have spent, in just three years, $15.8 million in legal costs.

The city treasuries have been raided in other ways. If they assess potential litigation and find that a bush or a street light probably did contribute one or two percent to an accident, they often make the judgment that settling the case, buying out the plaintiff, even if everyone involved in an accident was unquestionably drunk, is the most prudent course of action. Proposition 13 in 1978 made it difficult to raise new taxes. Liability insurance costs have soared as a result of the new rash of suits: Hayward's insurance went from $58,000 to $225,000 — 388 percent of the original premium; Lodi's policy jumped from $48,900 to $248,000, rising to 505 percent of the original figure. And the deductible amounts on insurance policies have been increased, often to as much as $500,000. If the trend continues, there is no question that Deep Pocket will mean future cutbacks of city services.

★ ★ ★

THE EFFECTIVE opposition of some powerful lawyers in the state stopped an effort to legislate reform in the last session of the state Legislature. They have both greed and compassion on their side, but neither justice nor reason.

When reform failed last year, it was before cities throughout the state encountered their huge increases in insurance premiums. The insurance emergency may give reform a better chance this year.

One measure before the Legislature, sponsored by Senator John Foran, D-San Francisco, would go part way toward solution. It would leave the cities liable for medical costs — even if they had minimal responsibility for an accident — but would require them to pay only their share of pain and suffering damage costs. Under that plan, a city found to be three percent responsible for an accident might still end up paying thousands of dollars in medical bills, but only three percent of the cost of pain and suffering.

That reform might curb the enthusiasm of some civil damage suit lawyers but would still leave the taxpayers vulnerable — which they should not be. True reform will come only with termination of the entire Deep Pocket doctrine the Supreme Court has inflicted upon local governments.

Exhibit XI

■ INSURANCE

Rising Premium Charges Swamp Some Businesses

BY JEFF PELLINE

Commercial fishermen, home day-care operators, engineers, rental car dealers and truckers all have the same complaint: Soaring insurance costs are eroding profits and threatening to put many of them out of business.

Insurance companies generally agree, but they say the rate increases are justified. Insurers say that their losses are greater than ever, blaming the rash of huge liability awards from the courts, along with a drop in income from investments.

Seventeen insurance companies went broke last year, a near record, and the industry wants to reverse the trend as quickly as possible, according to the Insurance Information Institute.

"They're grabbing for straws, and we're at the bottom and getting the worst of it," said Peter Kondrashoff, 44, a commercial fisherman who pays $3,737 a year to insure his boat and three-man crew against property and casualty losses, up from $18,544 last year.

"I'm terrified to see the bill for next year's rates, which I'll get next month," said Kondrashoff, who has been catching fish off the Northern California coast for 25 years and is paying more than ever for insurance.

Examples abound of businesses' hardships because of rising insurance rates:

■ Thrifty Rent-A-Car, a 15-year-old car rental company based in San Francisco, filed for Chapter 11 bankruptcy protection on June 20, about a week after being told it needed to make a $75,000 cash deposit to cover rising insurance premiums.

"It's probably going to put us out of business," said Bill Wristen, Thrifty's operations manager. Under Chapter 11, Thrifty continues to operate while it devises a debt repayment plan and is protected from creditor lawsuits. (The car rental agency is an independently owned franchise of the national car rental chain that has the same name.)

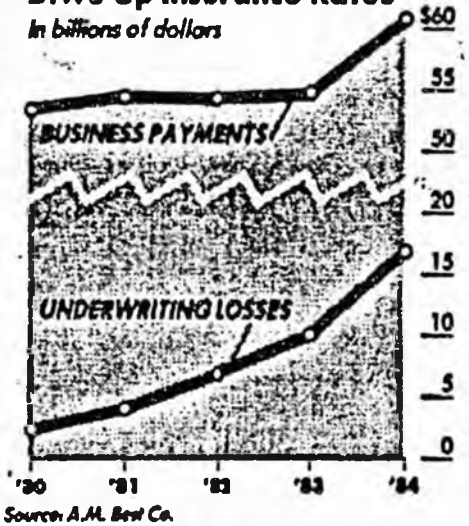
The Thrifty franchise, which posts yearly revenues of $5 million, has seen its insurance rates more than double to $500,000 from $215,000 in the past year, Wristen said. Other local independent car rental

Page 27 Col. 1

BUSINESS INSURANCE COSTLIER AND SCARCER

Underwriting Losses Drive Up Insurance Rates

In billions of dollars



Source: A.M. Best Co.

Hard-to-Buy Insurance

The following types of insurance are the most difficult to get because of risk and the potential for large claims:

1. Municipal liability
2. Pollution liability
3. Liquor liability
4. Long-haul trucker coverage
5. Medical malpractice
6. Commercial fishing boat coverage
7. Asbestos removal from buildings
8. Consumer product liability
9. Day-care center coverage
10. Company director and officer liability

Source: Insurance Information Institute

Exhibit XII



Times photo/Alan Greth

...transit information booklets.

on downtown Concord.

"Through this ordinance, we can attack and solve traffic problems together," said Taggart.

But Bob Kinert of PG&E suggested the ordinance should apply to more residential areas to spread the traffic burden fairly.

Unlike Pleasanton, a pioneer in transportation systems management, Concord isn't setting a goal of 20 or 30 percent and making all businesses conform to it. Instead, new developments must set a goal that the Planning Commission considers reasonable.

Public housing faces 1,300% insurance hike

By Sharon Bernstein
UCI News Service

MARTINEZ — The insurance policy on the county's public housing projects will be canceled in early November and a new policy will cost the Housing Authority 13 times as much.

Under what housing officials say is the best offer they've received, property insurance will go from $28,947 under Fremont Indemnity, which canceled the Housing Authority's policy, to $366,000 under Alexander and Alexander of San Francisco.

As an alternative to what he called the "outrageous" premiums, the Housing Authority's director, Perfecto Villarreal, has started setting up a $500,000 self-insurance fund.

But officials at the federal Department of Housing and Urban Development said even if the county sets up its own fund, it will need emergency insurance for very large claims, and will probably still end up spending hundreds of thousands of dollars for insurance.

County Administrator Phil Batchelor said the Housing Authority is the fourth public agency to be hit with an insurance surprise this summer — the others are the county child care program for foster children, the mosquito abatement district and the health department, where doctors are faced with skyrocketing malpractice insurance costs.

Villarreal said he sent out 56 letters to insurance companies, soliciting bids for county coverage, and did not get one positive response.

The Board of Supervisors, whose members also serve as the board of the Housing Authority, has ordered Villarreal to write a letter to the state demanding a full scale investigation into insurance company practices with regards to public agencies.

Richard Payne, Senior Vice President of Alexander and Alexander, refused to comment on the tremendous increase in premiums to the Housing Authority.

But in a letter to Villarreal dated Sept. 3, Payne wrote: "I personally recognize that the premiums are extraordinarily high compared to what you paid last year, however, as far as I can determine that is all the market has to offer."

Bruce Vincent, a housing management officer with HUD in Washington, said Contra Costa's increase, which works out to 1,300 percent, is high, but it could be worse. "The average rate of increase for all lines (of insurance) is 400 percent," he said. "We've even seen one come in at 3,000 percent."

Vincent said one reason for the sudden increase in premiums is a change in investment markets for insurance companies.

Please see INSURANCE, Page 28

State threatens insurance firms

Wants to stop rising premiums

By Bill Snyder
Times staff writer

SAN FRANCISCO — Hoping to slow a wave of stunning increases in commercial insurance premiums, a state agency is threatening to take legal action against some of California's 650 casualty companies.

Businesses ranging from banks to brake shops have found the cost of liability insurance increasing from 100 percent to 500 percent this year, while others have found it impossible to get insurance at any price.

Bruce Bunner, head of the state Department of Insurance, said the increases threaten the survival of some businesses and may be in violation of state law.

In a letter to chief executive officers of the state's property and casualty companies, Bunner warned that his department may bring charges of unfair trade practices against insurance companies that cancel or make drastic changes in commercial policies before they have expired.

Policy cancellations are estimated to be occurring three or four times more often this year ship, said E. Harlan Miller, president of the brokers' association.

One East Bay contractor lost his insurance and almost went out of business. "The good news was he found another carrier. But the bad news was his premium increased from $3,000 to $10,000 a year," said Jorge Sandoval, a spokesman for the Department of Insurance.

In Richmond, liability insurance for the Alvarado Bank increased by about 100 percent this year, while the deductible portion of the policy jumped by 1,000 percent, said Alvarado's president Timothy Thomason.

"Other banks haven't been able to get insurance at any price," he said, noting that the financial industry may start its own insurance pool.

Liability insurance for the banks has nothing to do with stability of deposits, but covers everything from bonding employees to the taking of hostages during a robbery.

Particularly galling to Thompson is the fact that the 2-year-old bank had insurance problems even though it has never filed a claim, a complaint shared by

Exhibit XIII

Continued from previous page

M&M's Mr. Sinnott.

A&A's Mr. Polstein says that last July A&A clients that wanted $200 million to $250 million in D&O coverage had to settle for about $100 million. "Now it's a question of getting them $50 million or $75 million," he explains.

To find some of these more difficult coverages, brokers are turning more often to the surplus lines market.

"We've had to use surplus lines more, but we find it's more complicated," said Gene McCrory, president of North American Insurance Agency Inc. in Oklahoma City.

Robinson-Conner also is continuing to use the surplus lines market more, said Mr. Conner.

In one instance, an admitted insurer found out how much a policyholder was going to pay for coverage in the surplus market and said: "Well, if you're going to pay that much, we'll write it," Mr. Conner said.

Bartlett's Mr. Miles also reports using the surplus lines market more, but doesn't believe it is doing a good job.

"I don't think they have enough staff to answer all the demand for quotes," Mr. Miles said.

"Sometimes we had to go to the excess/surplus market and use creative marketing: different pieces at different layers with different insurers," said Donald R. Weber, chairman and chief executive officer of Financial Guardian Group Inc. in Kansas City, Mo.

In some cases to secure hard-to-place coverage, brokers are putting together policies with higher deductibles or large self-insured retentions.

"Some clients have volunteered to take deductibles, clients that heretofore wouldn't even discuss it," said Robinson-Conner's Mr. Conner.

But self-insurance is not a good alternative, especially for smaller clients that have paid only $50,000 to $250,000 in premiums previously.

Capacity also tight in London market

By STACY SHAPIRO

LONDON—To say that placing U.S. property and casualty risks in the London market is difficult is the "classic English understatement," says John Woodson, managing director of the international division of Lloyd's of London broker Willis Faber P.L.C.

Rates are rising and capacity is shrinking in London for all lines of business, observers agree.

"It is fairly common knowledge that London has extremely restricted capacity in the liability field," said Simon Harrap, managing director of broker Stewart Wrightson North America Group Ltd.

"Property is tight but not impossible, and wrongful acts—errors and omissions—is somewhere in between," Mr. Harrap said.

Americans are flocking to the London market, looking for much-needed capacity they cannot find in the U.S. market, sources in the market say.

Some are indeed finding new capacity. Willis Faber, for example, has 40% more American business on its books this year than it had last year, Mr. Woodson said.

But, many U.S. insurance buyers are coming away from London disappointed because the capacity they seek simply isn't there, brokers and underwriters say.

'A lot of Americans fly over to spend time looking for capacity, and they are shocked when they arrive. There are more U.S. buyers coming over here on a wing and a prayer and many are disappointed by what they see,' Mr. Harrap says.

"A lot of Americans fly over to spend time looking for capacity, and they are shocked when they arrive," Mr. Harrap said.

"There are more U.S. buyers coming over here on a wing and a prayer and many are disappointed by what they see," he added.

Mr. Harrap says buyers last year could buy excess liability limits of $300 million.

"Now they're lucky to find $50 million," he says.

"If everything is right and all markets pull together, $150 million to $200 million is the maximum amount a client can find in capacity" for liability risks, said Brian Hibbert, chairman of C.T. Bowring Insurance Ltd.

"In reality, though, it is more like $100 million to $125 million," Mr. Hibber comments.

Rate increases can range anywhere from 25% to 400%, Mr. Hibbert added.

"Everything's up this year," he said. "And many policyholders do not have full programs. You heard of the saying "Swiss cheese"? Well, if a program is layered to $100 million, then it may be that none of the layers is complete or there are exclusions."

"Prices are increasing. Errors and omissions are up 100%, particularly for architects and engineers, where there is beginning to be a lack of market capacity," commented Colin Bird, who recently left Minet Holdings P.L.C. to join Lloyd's of London broker J. Besso & Co.

"The problem is new business. There is not a class of business that isn't distressed. Even property people are having their problems. And yet, business is coming from everywhere," Mr. Bird said.

"I've never known this before," he continued. "The whole world market is trouble. . . .The only bargain is that Lloyd's is still offering the most secure policy in the world, despite its troubles."

Adding to Lloyd's troubles is that some underwriters are saying that, because they are taking in so much business at higher rates, they soon may reach the premium limits set by Lloyd's. However, brokers agree that underwriters seem to have saved enough capacity to write renewal business and some new, good risks.

Adding to the upheaval in London is the Insurance Services Office's proposed commercial general liability claims-made form, which is to take effect Jan. 1, and the claims-made umbrella form that is currently being drafted in London (see story, page 1).

The reinsurance market is particularly interested in the claims-made forms, said Nigel Huntington Whiteley, director of the North American division of E.W. Payne Ltd)., a subsidiary of Sedgwick Holdings P.L.C.

Mr. Huntington said that, by the beginning of the year, reinsurers "will probably not provide casualty reinsurance cover unless the ceding companies write on a claims-made form."

And, he adds that in the last six months, "there has been further reduction in capacity, particularly because of Lloyd's premium income limitations." Mr. Huntington said.

"The large industrial companies can't buy anything like they could since last year."

Spicer & White members sue

LONDON—Lloyd's of London underwriting agency Spicer & White (Underwriting Agencies) Ltd. plans to transfer the management of Syndicate 895 to another agency after 172 members of the syndicate filed suit against Spicer & White.

The members sued Spicer & White in London High Court after agency withdrew its offer of a five-year interest-free loan to help members pay anticipated losses of 19 million pounds ($26.4 million). The offer was backed by Chase Manhattan Bank and Spicer & White's parent company, Lloyd's broker Willis Faber P.L.C. (*BI*, June 3).

High rates idle shrimp boats

ARANSAS PASS, Texas—Shrimp boats that would be fishing in the Gulf of Mexico are sitting in port even though the shrimping season began last week because some owners cannot afford the price of hull and liability coverage.

The cost of hull and protection and indemnity coverage combined have increased 100% to 300% for the shrimpers, according to Ralph Rayburn, executive director of the Texas Shrimp

Exhibit XIV

Editorial

Damage awards harm economy

U.S. Attorney General Edwin Meese's warning should be heeded. In a speech at the State Bar's annual meeting in San Diego last weekend, he said enormous damage awards in injury lawsuits, often without proof of fault, threaten serious harm to the nation's economy.

Meese said the insurance industry is in a "position of precariousness" because of expanding liability. Small businesses are being forced to to go without insurance and face possible bankruptcy from lawsuits. He said he favored "re-establishment of fault as the critical standard by which liability is determined."

The nation's top law enforcement officer focused on California Supreme Court decisions establishing a doctrine of liability in product cases that lets victims of defective products collect damages without having to prove fault. But he could also have taken on the "joint and several" liability rule established by California courts.

Under this rule, also known as the "deep pocket" doctrine, local governments and businesses can be forced to pay all of a damage award in a personal injury lawsuit, even if they're minimally at fault for an accident, if other defendants are unable to pay. It has encouraged lawyers to name cities, counties and businesses as defendants based on their ability to pay multimillion-dollar awards.

Meese put it mildly when he said that in our litigous society, "the desire for compensation has overcome a sense of balance." The situation has been worsed by broadened court interpretations of liability, jury verdicts based on sympathy rather than reason and ambulance-chasing lawyers waving the banner of victims' right to sue.

Last year, the average product liability award in the United States was $1.07 million, up from $345,00 just 10 years earlier. The average medical malpractice award was $950,000. In 1983, 360 personal injury cases were settled with million dollar awards or more, 13 times the number in 1975.

One-fourth of the obstetricians and general practitioners responding to a California Medical Association survey said they had stopped or were considering stopping their delivery of babies in response to rising malpractice insurance premiums. Similar tales of liability insurance woes stemming from large damage awards are coming from almost every profession and industry.

Some Californians are taking matters into their own hands. Spurred by the Legislature's failure to act, the California Chamber of Commerce is urging business and public support for an initiative that would limit the amount paid for pain and suffering (non-economic losses) in deep pocket cases to the degree the defendant was at fault.

Other potential remedies include tighter definitions of liability, ceilings on damage awards, limits on trial lawyer fees that encourage pursuit of multimillion-dollar awards, greater use of arbitration, more restrictive statutes of limitation and periodic rather than lump sum payment of large awards.

Meese accurately described the bottom line. If the trend of increased damage awards continues, he warned, "the impact on our nation's economy could be almost devastating ... The size and unpredictability of these awards threatens to suppress the commercial vitality on which our nation's economy depends."

Exhibit XV

The Herald, Monday, September 2, 1985 Page 41

Business insurance rates skyrocket

Customers may ultimately foot bill

By Kim Favors
Staff writer

It costs $32.50 for an office appointment with Dr. Conrad Anderson in Fremont.

And unless his malpractice insurance holds steady at $10,000, the general practitioner next year may raise his fees.

A few miles away in downtown Hayward, residents of the Green Shutter Hotel on Main Street pay $80 a week for a room with a bath, $75 without. Their rates may go up.

"Somewhere along the line you have to pass on the costs," says hotel co-owner Dave Duveau, who two weeks ago learned his premium — if he doesn't change insurers — will cost $42,000 this year. In 1984 his property-casualty-liability insurance was $28,000.



Conrad Anderson

Anderson's $10,000 malpractice premium insures him up to $1 million per lawsuit and a maximum of $3 million each year.

The news was even worse for Bob Oddone. He has to find new, and probably more expensive, insurance for Le Club Moderne, one of Hayward's oldest drinking establishments.

Insurance agent Ed Boese began calling insurers the day Oddone learned the policy on his Main Street bar would not be renewed.

"There's absolutely nothing wrong with his (Oddone's) business," says Boese, a partner with Farrell, Boese and Whited insurance brokers in San Francisco.

"It's a problem with the insurance industry as a whole ... and the little businesses like Bob's are merely the victims, not the cause."

Across the nation all kinds of businesses are facing insurance premium increases ranging from 25 percent to more than 1,000 percent. Others, such as Oddone's, are being dropped by insurers as unprofitable clients.

Hardest hit seem to be bars, liquor stores, restaurants, rental agencies and day care centers — businesses that have experienced increased insurance claims during recent years. But municipalities and professionals, including doctors, accountants and lawyers, face skyrocketing insurance bills because of generous court awards.

Industry analysts attribute the increases to insurance companies' big underwriting losses in 1983 and 1984.

During the "premium price wars" of the late 1970s insurance companies raised rates in a fierce competition for business, hoping to invest incoming monies at 18 and 20 percent interest rates.

"Insurers were willing to write almost any risk at any price," says George A. Porter, president of the Independent Insurance Agents and Brokers of California.

But interest rates — and the insurance industry's profit margins — began dropping at about the same time the nation's courts began approving huge casualty and liability awards.

Last year the industry reported $3.8 billion in losses. Seventeen insurance companies went broke.

"I've been in the business 45 years and I haven't seen anything like this" says Boese, who specializes in hotel and apartment building insurance.

Helping make up the insurance industry's losses through increased premiums are many East Bay businesses:

- Insurance costs at Di Giulio Pontiac GMC in Fremont "went up 97 percent this year" says general sales manager Ron Freitas, who declined to provide figures. A common premium increase for auto dealerships is from $5,000 to $10,000, says a spokesman for the Northern California Motor Car Dealers Association.
- Alameda County's medical malpractice insurance premiums increased this year from $1.6 million to $2.2 million. Highland Hospital had to increase its total coverage from $30 million to $100 million.
- Owners of Arnie's Time Out, a neighborhood bar on Mission Boulevard in Hayward, reluctantly paid a new premium of $3,000, up from $1,400. "You have to have insurance," says co-owner Doris Bishop.

Child-care providers statewide are being forced out of business by the huge increase in rates. In Southern Alameda County, insurance problems have shut down five homes.

The state's major home-care insurer is BMF Market Services of Sherman Oaks. Last year a home-care operator licensed for 12 children would have paid BMF $279 for $1 million in liability coverage and $75,000 in accident, car accident and personal property coverage.

This year BMF is charging $1,185 for only $300,000 liability and the remaining $75,000 coverage.

Other insurers are refusing to handle child-care policies following highly publicized allegations and convictions involving child abuse at day-care homes in Northern and Southern California.

The state Senate Monday approved an emergency measure requiring insurance companies to join a state-operated insurance pool for day-care centers. SB 1474 goes next to the Assembly.

Insurance costs for California physicians have eased somewhat since the state Legislature in 1975 imposed restrictions on medical malpractice suits.

Anderson's $10,000 malpractice premium insures him up to $1 million per lawsuit and a maximum of $3 million each year.

"High risk" specialists such as obstetricians, neurosurgeons and orthopedic surgeons are paying $35,000 to $38,000 for the same coverage. In New York that coverage would cost $100,000, says Anderson, a director with the Medical Insurance Exchange, which sells malpractice policies in Northern California, Nevada, Idaho, Alaska and Hawaii.

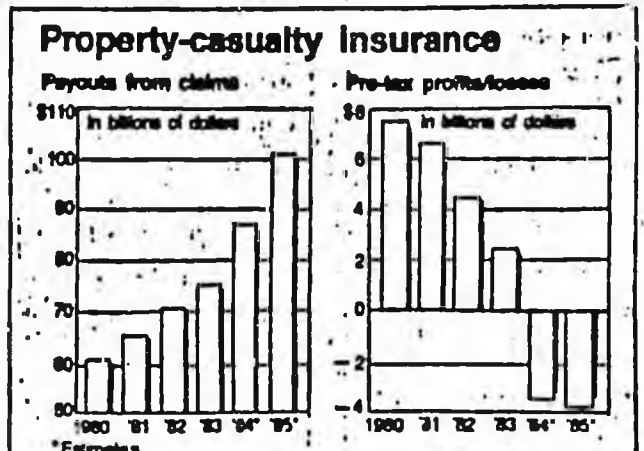
Also contributing to the rise in insurance premiums are increasingly generous court awards in personal-injury suits.

"The court system's broad interpretation ... encourages lawsuits where fiscally responsible, adequately insured individuals and businesses end up paying for the mistakes of uninsured or underinsured entities," Porter says.



Bob Oddone

Oddone has to find new, and probably more expensive, insurance for Le Club Moderne, one of Hayward's oldest bars.



In 1983 more than 400 personal-injury cases nationwide were settled with awards of $1 million or more, reports show.

California particularly "has had a lot of serious problems with the number of lawsuits in the liability area," says Dennis Jay, spokesman for the National Association of Professional Insurance Agents.

In 1982 there were 13 awards or settlements over $1 million statewide. A year later the number had risen to 19.

"We monitor insurance markets around the country ... these days when people fall on the sidewalk they no longer think 'I need better footing next time.' They think instead, 'I'll call my lawyer.'"

David Blakesley, an agent with Cooper McKenzie Murphy in Pleasanton, believes insurance companies are playing catch-up from the lowered premium rates they offered in the mid-'70s.

"What they are really doing is within 1 or 1½ years bringing in enough dollars to pay for their losses — they're making an increase quickly to make their financial statements look better."

The insurers are overreacting, Blakesley contends.

"If the insurance companies had stretched (the premium increases) over two or three years, it would have been a lot easier (for businesses), but they want to be profitable, now."

And insurance rates are not expected to drop anytime soon, Porter maintains.

"We've been in a buyers market for five years. Insurance rates are going up, and won't be coming down in the foreseeable future.

"Each company is taking a much closer look at individual risks and pricing the product accordingly," Porter says.

"Premiums are going up ... so insurance companies have the reserves and surplus to meet future claims expenses."

Exhibit XVI

Moraga

Let people pet animals

The Contra Costa County Animal Shelter is continuously beseeching the public to "adopt a pet." They pull at our heartstrings with the cutesy pictures labeled, "Adopt Me!" and heart-tearing messages. So, in searching for a puppy, the animal shelter was my first choice.

What an experience! Not only was it disappointing, but I came away very angry. Two children and I walked through the kennel looking for a blond labrador-mix puppy. We found one stall that contained several puppies all asleep. I asked one of the workers if we might pet a puppy. He responded with a "no" and the rationale that the puppy might scratch us and we in turn might sue. In addition, he added a puppy could not be petted prior to adoption but I could adopt the puppy and take him home for a two-week trial period. No other alternative was offered, such as taking the puppy out of its cage. How was I supposed to know if the puppy was right for us? A shrug of the shoulders was the only response.

I am sorry, but this is ridiculous. Surely some sort of controlled environment could be found to allow safe minimal contact to enable us to make such an important decision. Zoos, schools and pet shops all allow contact with young animals. I have been to other shelters in Morgan Hill and Monterey and not found this policy in existence.

CELESTE SHEEHAN
Pleasant Hill

EXHIBIT E VII

State insurance probe unlikely

Deukmejian sees 'no basis' to investigate rising premiums

By Sharon Bernstein
Times staff writer

SAN FRANCISCO — Gov. George Deukmejian said he was not prepared to authorize a state investigation of insurance practices, despite skyrocketing premiums that some fear could put new Contra Costa cities out of business.

The governor's remarks came during a question-and-answer session with reporters after a speech to the 1,200 delegates from 441 cities attending the League of California Cities annual conference.

Deukmejian compared the denial of liability insurance to cities, counties and large businesses to the medical malpractice insurance crisis that hit the state.

"It got to the point where insurance companies were raising the premiums so high" that the state was forced to step in, Deukmejian said. "There was some major legislation that was enacted and as a result of that the situation has improved somewhat."

But he said he would not support legislation that would force insurance companies to take on public agencies.

"I'm not sure we can legislate something like that — to make them insure somebody they don't want to insure," he said.

When insurance for the Contra Costa County Housing Authority went from $28,000 to nearly $400,000 last month, the state commissioner of insurance threatened to mount a formal investigation of insurance practices.

But Deukmejian said there was "no basis" for such an investigation.

At least one Northern California city — Tehama, 30 miles south of Redding — is considering disincorporating because it can't afford insurance, and Contra Costa officials say the high premiums could be a threat to newly incorporated cities here.

The governor said he would support legislation to overturn the so-called "deep-pocket rule of insurance liability (that) insurance companies cite as one reason they want to stop insuring local governments."

Under the rule, which was set up primarily by the courts, a party can be held liable for all the damages in an accident, even if the party is only 1 percent responsible.

That means someone can sue the city over a car accident if the other driver was uninsured and it can be proven, for example, that the city's stop sign was partially covered by trees, making the city partly responsible for the accident.

"We must reform the California Supreme Court's so-called deep-pocket rule," the governor said in his speech. "The ability of an injured party to sue and win damages, not based on fault but on the ability to pay, has reached absurd proportions."

Besides insurance problems, the governor also railed the Supreme Court for failing to implement the death penalty.

"We still face a Supreme Court that refuses to heed the will of the people and implement the death penalty," Deukmejian said. "Since I authored the state's death penalty law in 1976 (when he was attorney general) juries have imposed this punishment over 200 times, yet not one murderer has paid the ultimate price."

Los Angeles Mayor Tom Bradley 'misstates the facts', says governor — Page 15A



Gov. George Deukmejian ...
... against "deep-pocket" rule

Exhibit XVIII

Judgment has chilling effect on meteorology

$1.25 million award a precedent

Deep Pocket →

WASHINGTON (AP) — A judge's ruling that the National Weather Service must pay the families of men lost in a storm it didn't predict has given some meteorologists the chills.

The award of $1.25 million to the families of three lobstermen in Boston last week was the first ruling against the weather service in the memory of many meteorologists.

But the decision was based on the failure of the weather service to keep a weather-measuring buoy operating properly, not merely because the service had not predicted the storm that struck the men's boat.

The Boston ruling came just two weeks after another judge in Florida refused to hold the weather service liable in the 1980 Sunshine Skyway disaster, when a ship struck a bridge during a sudden thunderstorm killing 35 people.

Nonetheless, weathermen are concerned that the Boston case could become a legal precedent and start an onslaught of lawsuits over weather forecasts.

"We are going to appeal. It's not over yet," said Don Witten, a spokesman for the National Weather Service.

"It gave me the chills," said Frank H. Forrester, a retired forecaster who formerly was a television weatherman in New York, Jacksonville, Fla., and Washington.

"Despite all the computers and whiz-bang machinery, there is an element of art (in forecasting) that you have to recognize," Forrester said.

Weather predictions are improving regularly, but they are based on incomplete information and thus cannot be perfect, he said.

"If the Boston ruling prevails, we may have introduce caveats in forecasts, such as 'This was prepared with an incomplete data base' or something of the like," suggested Tom Reppert of the National Weather Service.

"This would have to be in every forecast, because there is no such thing as a total data base ... it would not be a public benefit but would satisfy the letter of the law," he said.

The available d a was the focus of the Boston decision.

In question was a wind sensor on a buoy in the ocean that was not working and had not worked for several weeks. Lawyers for the families of the lost men contended that negligence in failing to repair the sensor caused a wrong forecast.

"We weren't challenged on a forecast, whether the forecast was good or bad," said Witten. "We were challenged on negligence for failure to maintain a buoy. We have never lost a case on a forecast.

"A forecast is provided on the basis of what we know, and we don't know everything about the atmosphere," he said. "There is an element of uncertainty."

Forrester noted that several pa lawsuits ended with rulings in fav of the weather service.

Exhibit DS

Let's Say Goodbye to Joint Liability

Survival of our system of tort reparations by civil trial depends today on recapturing its original fairness, reasonable efficiency, and accessibility. Yet at the same time, public derision of that system is mounting, as distorted liability theories, excessive costs, and backlogs proliferate. Without reform, our system must inevitably collapse, to be replaced by bureaucracies processing inequitable benefits under complex formulae at ultimately unaffordable premiums.

Unfortunately, the clamor for reform has consisted mostly of diatribes against symptoms, rather than examinations of root causes. Legislators have proposed pre-suit screenings, abolition of contingency fees, or limits on verdicts, hoping they can somehow avoid the constitutional objections.

While headlines of runaway verdicts have provided emotional fodder for such suggestions, lawyers know the causes of problems in tort claims are the injustices which have resulted from a generation of procedural fads, such as joint liability and third-party practice in tort. These symptomatic treatments defy substantive tort concepts, and must simply be eliminated. "Joint liability," of course, is not a liability doctrine at all: it is a collectibility doctrine. Its perpetuation during the development of "comparative negligence" over the last quarter of a century has led to entirely artificial financial responsibilities, no longer based on faulty conduct, but rationalized on the transferrability of those judgments imposed against causally innocent parties.

Fairness in tort reparations provides an injured person with an enforceable opportunity to prove that a defendant's breach of a legal duty was causally responsible for the injury. Fairness does not contemplate for payment merely because an injury exists, nor, even worse, because someone else can't pay. These are functions of contracts or insurance — or of that future bureaucracy — but not of tort recovery. Yet "joint liability" not only creates such distortions, but does so in the guise of "distribution of the loss"!

As with Quasimodo, one would think nothing more could be wrong with "joint liability." But it has fathered the monstrous third-party practice in tort! This frequently mind-boggling procedure assumes that the cure to the harshness of joint liability is to require a party who has already been required to overpay his fair share to bring a second action against a party who has not paid his fair share. The abolition of such absurdities will follow routinely when tort judgments are again founded on the legal principle with which every fair-minded person agrees: a person should pay for damages he has caused, but not for damages he has not caused.

Elimination of joint liability will therefore at once make our tort adversary system well again. No longer will tort claims be handled on contract theories, but will be decided on the issues of tort law. Is there a legal duty *to the plaintiff*? Has it been breached? Did the breach proximately cause compensable damages? Each party will defend only itself. No longer will artificial, often theatrical alliances be paraded before juries in the guise of "trial strategies." The evasion of time-honored laws of immunity, abatement, or release will end. Even the present absurdly wasteful discovery abuses will cease. The courts will again be both accessible and economically available for the fair resolution of tort disputes.

Torts occupy 40 to 90 percent of the business of all our nation's courts. Eliminating joint liability will necessarily have an immediate, obvious and inevitably favorable impact on our troubled economy.

We defense lawyers must make this our single most important goal in all of tort law. Not to do so will simply speed the deterioration of the public's confidence in the legal system.

On The Record



John E. Guy
Chairman, DRI Practice & Procedure Committee

Exhibit XIX

End 'deep pocket' lawsuits

It was my privilege to preside over a critical workshop on municipal risk management at a League of California Cities' Executive Forum for mayors and councilmembers. The topics for discussion were the issue of "deep pocket" lawsuits which are threatening to bankrupt California cities and the importance of pending legislation, Senate Bill 75, which would make the current law more equitable (SB75 is vigorously opposed by the trial lawyers).

SB75, sponsored by Sen. John Foran, D-San Francisco, would put a stop to current practices that allow an injured party who wins a lawsuit to collect all damages from any named defendant who is just 1 percent at fault if other defendants are unable to pay. Juries too often appear to view the public entity as a ready, but unfortunately not willing, source of judgment funding.

Reviewing this information, the councilmembers and mayors came to the conclusion that it is vital to have immediate citizen-taxpayer input to the state Assembly Judiciary Committee. Letters from citizens urging support for SB75 could assist the cities of Contra Costa County to retain millions of public dollars. The city of Pleasant Hill is urging a massive, supportive letter-writing campaign.

I am very pleased with the recent Contra Costa Times editorial which urged citizen support of SB75. I hope that citizens will actively respond by the Aug. 19 committee hearing deadline. Every dollar that goes to pay high insurance premiums and unfair judgments ultimately reduces city services. It is critical that we let members of the Legislature know that we do not wish to finance the careers of "deep pocket" lawyers. SB75 plugs this hole in ths system by structuring "pain and suffering" payments based on degree of fault, not on perceived ability to pay.

PAUL L. COOPER
Councilman
Pleasant Hill

Small cities and the deep pocket

P.H. CC Times
14 Aug 85

Exhibit XXI

The open season on insurance companies in courtrooms all over the country has gone on so long that the insurers can no longer afford to play. Are you ready for . . .

A world without insurance?

By Jill Andresky with Mary Kuntz and Barbara Kallen

A 41-YEAR-OLD body-builder entered a [illegible] footrace with a refrigerator strapped to his back to prove his prowess. During the race, he alleged, one of the straps came loose and the man was hurt. He sued everyone in sight, including the maker of the strap. Jury award: $1 million.

Two Maryland men decided to dry their hot-air balloon in a commercial laundry dryer. The dryer exploded, injuring them. They won $885,000 in damages from American Laundry Machinery, which manufactured the dryer.

An overweight man with a history of coronary disease suffered a heart attack while trying to start a Sears lawnmower. He sued Sears, charging that too much force was required to yank the mower's pull rope. A jury in Pennsylvania awarded him $1.2 million, plus damages of $550,000 for delays in settling the claim. (Sears appealed but eventually settled out of court.)

Isolated cases of absurdly generous awards? Far from it. Last year the average product liability award in the U.S. was $1.07 million—up from $345,000 ten years earlier—and the average medical malpractice award was $950,000. In 1983 alone 360 personal-injury cases were settled with million-dollar awards or more, an incredible 13 times the number in 1975.

Americans now seem to look on a civil suit against a corporation or municipality as a kind of lottery—a lottery to be played whenever they can. Last year there was 1 private civil lawsuit filed for every 15 Americans. An estimated 16.6 million private civil suits were tried in state courts last year. Another 150,000 private civil suits were tried in federal courts, which is nearly twice the number ten years ago.

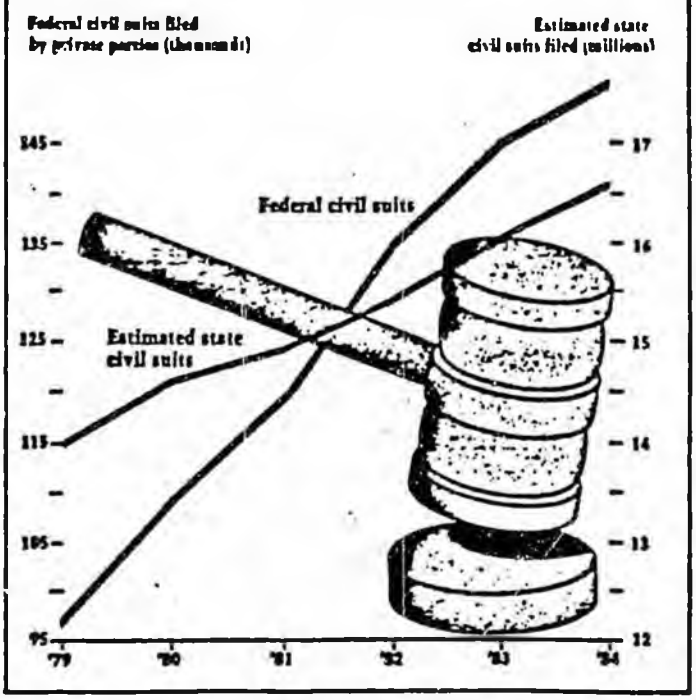
Just handling the paperwork probably cost taxpayers over $360 million on all these actions last year. It cost insurance companies far more. In 1984 the property and casualty insurance industry as a whole paid out $116.10 for every $100 received in premiums—the worst numbers since the San Francisco earthquake and fire. Reinsurers, who take the brunt of the unpredictable risks, paid out nearly $141 for every $100 in premium income.

No industry can keep that up for long. "It's impossible for insurance companies to price liability products when they have no idea what the settlements and risks are going to be," says David O'Leary, a Hartford-based insurance analyst with the London brokerage firm of Fox-Pitt, Kelton. "Courts have expanded the definitions of liabilities for accountants and other industries to such an extent that insurers have started saying, we don't need the business."

For example, obstetricians can now be sued for "wrongful birth" if, for instance, a sterilized woman conceives. Accountants can be sued under "third party liability" by anyone who might reasonably have relied upon numbers they audited. The list goes on and on, and why not? Insurers have been picking up the tab and covering costs in part through their investment income for so long

The litigation burden

There was 1 private civil lawsuit last year for every 15 Americans. And the beat goes on: Federal civil filings by private parties are up 50% since 1979, while state filings are up 20%.



13 insurers he does business with will be willing to write new commercial policies for anyone.

Companies will have to scramble for any type of coverage they can find. By far the most common strategy is to accept limits on coverage—higher deductibles, lower protection levels and, increasingly, exclusions for items such as legal defense costs and pollution liability. "We're paying more than double what we used to pay and we still haven't been able to replace all the coverage we lost," says Singer of Atlas Oil Co.

Insurers have also started pushing "claims-made" policies, which pay off only those claims filed during the policy term. Supporters of these insurance straitjackets argue that they will help insurers define their legal risks better and thus enable them to keep selling their products. But many are dubious. "Claims-made policies just postpone the problem," says Jon Harkavy, director of governmental affairs at the Risk and Insurance Management Society.

The last resort, of course, is self-insurance, either setting up a reserve fund to cover uninsured costs or, more commonly, paying them out of operating expenses. "Corporations of our size can afford to self-insure up to certain levels," says General Foods' risk manager Peter McDonough. "But that's not going to solve any of the major problems with the system."

Some companies are again setting up insurance captives, as they did in the mid-1970s. But captives are not very attractive from a tax standpoint (FORBES, *Nov. 19, 1984*), and they are risky to boot. Says O'Leary of Fox-Pitt, Kelton: "Many companies that set up captives ended up losing so much money that they have for the most part withdrawn."

But some see self-insurance as a curb on litigation. "I hope we're moving to the age of self-insurance," says Irving S. Shapiro, former chairman of E.I. Du Pont and now a partner at Skadden, Arps. "Once lawyers realize they're suing a defendant who doesn't have an insurance firm with deep pockets beyond them, they'll sue somebody else." Unless, perhaps, the company is as big as Du Pont.

For companies that aren't as big as Du Pont—and even for some that are—self-insurance today carries the risk of being pushed into Chapter 11 tomorrow. Shapiro's solution: a federal disaster-insurance fund for corporations, similar to the federal flood-insurance program. But wouldn't such a pot of gold be even juicier bait for plaintiffs' lawyers?

Marsh & McLennan is testing its own version of disaster relief—a stock insurance company for big firms known as ACE, for American Casualty Excess Insurance. ACE will provide the final $100 million in coverage—excess of at least $100 million in self-insurance or policies. Eleven firms have jumped at the opportunity to join up—but that's out of the reach of many companies.

Industry insurance pools are popular with utilities, lawyers, accountants, fuel distributors and others. Of course, the exposure for any insurer of a single high-risk industry is enormous, even when only claims-made policies are sold. So some companies, instead, try to spread their risk by setting up multi-industry insurance pools. Result: High-risk companies, again, are out of luck.

The fact is, the problem cannot be dealt with solely from the insurance side of the equation. It must be approached from the legal side. So long as judges keep expanding the definition of liability and juries keep handing out astronomically high awards, the chilling prospect of a world without insurance draws ever closer.

One simple but unpopular solution would be to prohibit—or at least severely limit—the contingency fee system that encourages lawyers to seek the highest possible damages. "You don't see any other country having the kind of insurance problems that we have, because none of them have the kind of jury awards or contingency system we've got," says James Corcoran, New York State's superintendent for insurance.

But there are problems with such a move. "We may be the only country that really has a contingency fee system," says F. Lee Bailey, a member of the three-lawyer consortium representing the Bhopal victims. "On the other hand, in most of the world, poor people go without any relief."

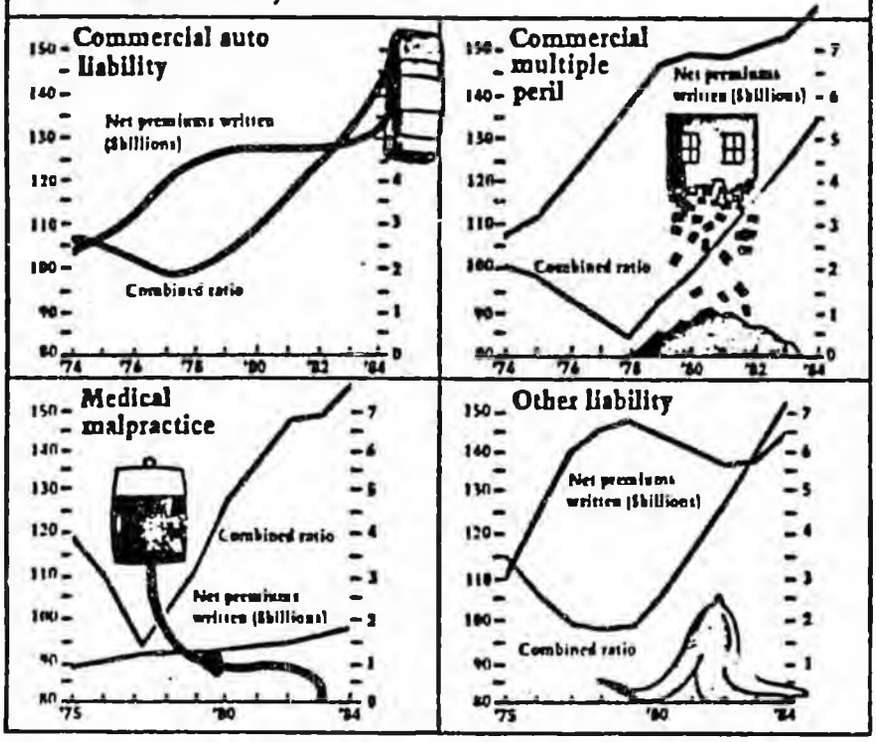
In the long run, maybe the only practical solution is legislative action to define liabilities and cap them at a fair and reasonable level. In New York, where obstetricians and neurosurgeons are turning away patients because of high malpractice insurance rates and where municipalities are scrambling for coverage, legislators have debated bills that attempt to cap liabilities for doctors and municipalities. Congress has contemplated a proposal by Senator Robert Kasten (R–Wis.) that would put a limit on corporate liabilities.

No longer do we have the luxury of pretending that the monster we have created will just go away.

It won't. ■

Losing propositions

In four big commercial liability lines, insurers paid out from $135 to $160 for every $100 of premium income taken in last year—a trend that has worsened steadily since 1978.



that the system has taken on the look of natural law.

But insurers are not in the business of losing money. Their losses have become so appalling that at this point they are either raising their rates out of sight or getting out of the business. In April, Utica Mutual Insurance informed some 220 New York State municipalities that it would not renew their policies. Transit Casualty, a large carrier for restaurants in Connecticut, canceled most of that group's liability coverage. Mutual Fire, Marine & Inland Insurance announced it would not renew the malpractice policies of about 1,300 midwives as of July 3.

"I can't get any kind of coverage for sand-and-gravel and cement companies," says David Brennan, president of the Insurance Management Center, a Manchester, Conn. agency. "I've got one client who is a distributor of frozen chickens. Last year he paid $25,000 for coverage. This year I can't get anyone to even give me a quote. It's the same thing with an insulated-wire manufacturer, a fish distributor and even a group of nuns who own real estate as investment properties."

If they are willing to pound pavements, most business people can still find insurance. But they are paying vastly more for much lower coverage. One supermarket chain, for example, saw its average rates go from $8,000 per store a year and a half ago to $40,000 per store. Florida Power & Light's premiums for general liability coverage doubled in 1984 over 1983. The coverage provided was halved, $200 million instead of $400 million.

Pricey, but at least it got protection. For industries that have been especially hard hit by lawsuits, prospects have gotten much worse. Consider Acmat Corp., a $50 million (sales) asbestos-removal firm based in East Hartford. According to the firm, Cigna notified Acmat last December that all its coverage was being canceled because of its asbestos exposure. When Acmat protested, Cigna agreed to renew—so long as Acmat pulled out of the asbestos-removal business entirely. Acmat agreed, even though it meant "cutting our revenues in half overnight," says Henry Nozko Jr., executive vice president. But even that drastic measure failed to satisfy Cigna, which canceled the company's account on Apr. 1.

Nozko approached over 30 carriers, including Lloyd's of London. All turned him down. Finally, he convinced Great American Surplus Lines and three other firms to give him coverage. The price, assuming last year's volume of business: $6 million to buy $6 million of general liability coverage, including only $1 million of asbestos protection. That compares with $300,000 last year for $10 million of coverage. Why didn't he just bank that $6 million instead? "The policy gives us a worthless amount of protection, but we couldn't bid on public jobs without it," says Nozko.

A note on retributive justice: Now that legal-malpractice suits are becoming trendy, even lawyers are having a tough time finding coverage. Reuben & Proctor, an 80-member Chicago law firm, lost its coverage on July 1 from Crum & Forster's International Insurance.

The flight of insurers and reinsurers is most visible where the risks of winding up in a courtroom are great—both gradual and sudden-and-accidental pollution, directors' liability, municipal liability, medical malpractice and accountants' malpractice. "Our agent notified us a couple of months ago that everybody in our business was being canceled," says Irwin Singer, president of Atlas Oil Co., a fuel distributor. "They didn't care how good our safety record was. In fact, the very company that canceled our coverage complimented us on it."

In some cases, the retreat can be gradual. "Our normal general liability policy used to exclude all pollution, unless it was sudden and accidental," says Chuck Henry, a second vice president at Travelers. "Then the courts started saying in some cases that if the insured did not intend to cause damage, it was 'sudden and accidental'—even if it took years for the stuff to seep out." Now Travelers completely excludes pollution coverage on its general liability policy and will underwrite environmental hazard coverage only at restricted levels and only for customers who also buy Travelers' general liability policy.

Even such restrictions aren't enough for some insurers. Since the beginning of the year frightened insurers have been pulling out of property and casualty lines like the British army at Dunkirk.

Property and casualty insurance has always been a boom and bust business, but the bust has never been this bad. Blame part of it on greed. After five years of cash-flow underwriting—that is, pricing products at a loss in underwriting terms in order to bring in extra dollars to invest at once-tempting interest rates—the industry has hit rock bottom. Last year it recorded a pretax loss of $3.8 billion.

Face it: There's no way that the insurance industry can fully recover from its current downswing until Congress—or state legislatures—step in and impose order on our self-destructive legal system. Pennsylvania has already made a start with legislation that curbs pain and suffering awards from municipalities. But it's only a start. Remedies in law will not become effective overnight.

In the meantime, property and casualty insurance is going to become much tougher to get, at any price. For example, insurance agent David Brennan expects that by September none of

A road to disaster?

For 8 of the last 11 years, property and casualty insurers have paid out more than they have gotten in premium income. Investment income had offset that worsening combined ratio until last year.

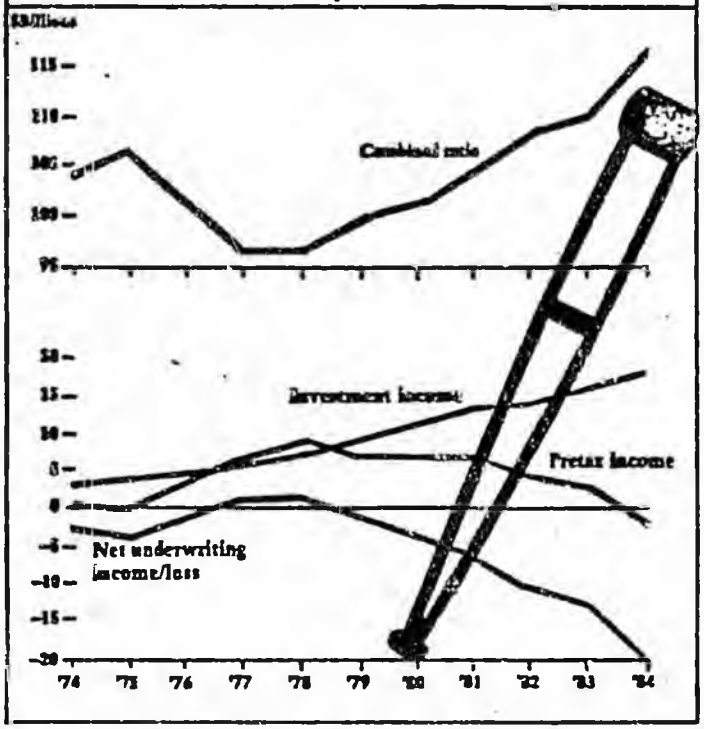


Exhibit XXII

Coke Is Right

W.S.J.
18 Sept. 85

Coca-Cola officials are ready to go to jail to protect one of the world's great secrets. A federal judge ordered Coke to divulge its soft-drink formula in connection with a lawsuit. Coke refused and now faces contempt-of-court charges. The soft-drink formula is the latest victim of a legal system gone berserk.

Federal Judge Murray Schwartz of Wilmington, Del., is the would-be secret-breaker. He has acceded to a favorite trick of American plaintiffs—demanding such unreasonable court remedies that the defendant has no choice but to settle. In this case, some Coke bottlers are objecting to the price they have to pay for Diet Coke syrup. Coke charges its bottlers more for the low-cal recipe than for its new, Classic and Cherry brands. The bottlers say Coke should charge them the same for all Coke syrups.

The plaintiffs' lawyers hit on a great scheme. They say that Coke should have to prove that the diet syrup is significantly different if the company is going to charge the bottlers more. The only way to know the relative costs to Coke, say the lawyers, is to see the formulas. They know how seriously Coke takes the 99-year-old secret. Only two executives know the equation and they're not allowed to fly on the same plane. Only a board resolution can ever release the magic formula from its bank vault. So, the lawyers no doubt figured, if they could get a judge to order Coke to hand over the formula then Coke would refuse and instead have to make a big out-of-court settlement, *regardless* of the merits of the case.

Enter Judge Schwartz. He told Coke that "nothing is sacred in civil litigation," not even trade secrets. He said he'd try to make sure no one got the formula except for the plaintiffs and their lawyers. Understandably, Coke doesn't have much faith in such good-effort pledges. The truth is that the judge understood perfectly well what game the plaintiffs were playing. Sure, the judge said, ordering disclosure "could be a bludgeon in the hands of plaintiffs to force a favorable settlement." But he figured that sticking to the letter of pre-trial discovery law was somehow more important than the legal system making any sense.

The real question about this case is what it's doing in court in the first place. Last time we checked, the U.S. was still a free-market country. If bottlers don't want to pay for Diet Coke, they don't have to order it. Likewise, if Coke can find bottlers who will pay the premium for diet syrup, Coke can switch bottlers. That's how markets work. And the only way the free market can continue is for judges to do their job of upholding the rule of law by protecting property rights such as trade secrets.

This case is another reminder that the Office of Management and Budget needs to take a very close look at the federal courts. Here are a bunch of Coke bottlers suing Coke at the taxpayer's expense. As we've said before, the broad public receives little if any benefit from subsidizing the civil litigation conducted by large companies and their highly paid lawyers. The taxpayers have even less reason to support civil courts when judges invite the most obvious abuses of the system.



EXHIBIT XXIII

W.S.J. 26 Apr 85

Judge Appoints 3 Lawyers To Coordinate Bhopal Suits

By a Wall Street Journal Staff Reporter

NEW YORK—A federal judge picked F. Lee Bailey, the prominent defense attorney, and Stanley Chesley, a Cincinnati lawyer with extensive experience in product liability cases, to serve on a three-man executive committee that will coordinate litigation arising from last December's gas-leak disaster at a Union Carbide Corp. plant in Bhopal, India.

In an order handed down yesterday, U.S. District Judge John Keenan said the third member will be Michael Ciresi, an attorney with the Minneapolis firm of Robins, Zelle, Larson & Kaplan, which is representing the Indian government in Bhopal litigation. The judge also named Jack Hoffinger, a New York lawyer, as liaison counsel. Mr. Hoffinger mainly will be responsible for communicating between the judge and the more than 80 lawyers whose cases have been consolidated in federal court here.

Messrs. Bailey and Chesley were leaders of two of the three factions of lawyers jockeying for control of the complex litigation stemming from the Dec. 3 Bhopal disaster in which an estimated 2,000 were killed and thousands of others injured. Both men have stated that they favor settling the case quickly (see story on page 29).

The members of the executive committee will, according to the judge's order, "frame and develop the issues" in the case and "prepare expeditiously for trial or settlement negotiations." They also are likely to receive the biggest legal fees, though Judge Keenan left that matter to be resolved later.

Mr. Chesley wouldn't describe what he believed an acceptable offer in the Bhopal case should entail. "It's premature," he said, "I'm not interested in assessing anything right now except the number of claims and their severity."

EXHIBIT XXIV

interface between product liability lawsuits and worker compensation benefits. He quoted the AFL-CIO as telling the Commerce Committee that "the section on the relationship between worker compensation and third party litigation, in particular, has been redrafted to answer prior criticisms..."

This section would deduct workers' compensation benefits from the amount of the award in a successful suit, and permit neither manufacturers nor insurers nor employers to sue each other to recover what each other had paid out. The idea is to cut down on legal costs without affecting the right of a worker to sue for genuine defects in machinery. Currently, workers often will sue manufacturers of old machinery even though the defects were really caused by a lack of maintenance by the employer.

"In addition to improving product safety in the United States, the bill will reduce the burgeoning legal costs that now drain the product liability system," Sen. Kasten said. "It is shocking that 59 cents for every dollar going to victims goes to defense lawyers. It is equally shocking that 41 cents of the victims's dollar is taken by his other attorney."

'Greed' of Attorneys

Sen. Kasten pointed out that in the recent settlement concerning Agent Orange "each injured person will receive a modest $20,000, while each of the plaintiffs' attorneys takes home over $2.5 million. The instability of product liability law fuels the greed of a few attorneys. This situation simply has to be put to a stop."

He argued against theories advanced by several attorneys' groups and some other senators that the legislation really would increase legal costs as cases in each state have to be tried against the new law instead of established state law. Sen. Kasten insisted that "as a matter of legal history, it is true that whenever uniform statutes have replaced a jumble of common law, our legal system has operated more efficiently."

He responded to cynics who question why manufacturers would support legislation that will help victims. "The fact is that there is no hidden agenda," Sen. Kasten insisted. "The corporations are tired of wasting money on attorneys." With his product liability law, Sen. Kasten said, "both outside and corporate counsel will, so to speak, be looking at the same hymn book—costs will be controlled and they will fall."

Superfund Also Passed Up

Along with product liability legislation, the Senate also failed to act on reauthorization of the Superfund law this year.

Proponents of the legislation insisted it needed to be done this year so the Environmental Protection Agency could gear up its agenda and personnel. But the Administration and many industry groups wanted Congress to await the results of studies due after the election.

For insurers, the lack of final legislation means they will be fighting all over again battles won this year against creation of a new federal cause of action allowing victims [illegible] they become ill with disea[illegible] associated with chemicals found at a Superfund site.

The legislation to clean up abandoned waste dumps will have to be reauthorized next year since funding will run out on September 30, 1985.

Insurers have been very concerned about the idea that a new right to sue would be developed even though there currently is no way for the medical profession to ascertain which cancers or other illnesses stem from exposure to Superfund sites and which from other factors. "Had the federal cause of action in the House Committee bill become law, my industry's ability to furnish or price environmental liability insurance protection for any business handling hazardous substances would have evaporated," Crum & Forster Insurance Companies Vice President, Leslie Cheek III, said in a speech earlier this month. That provsion was later removed on the House floor.

Similarly, Mr. Cheek wrote a letter to all senators urging that the Senate Environment and Public Works Committee's version of Superfund not be considered since it contained a victims' assistance demonstration program to establish five state experimental projects to compensate victims of illnesses associated with toxic wastes without any curtailment of the right to sue. This section of the bill, Mr. Cheek wrote, "constitutes a prototype national health and disability entitlement program whose costs and duration would be impossible to control or insure."

In other activities of note to the insurance industry, Manville Corp. announced it had agreed to join the Wellington Group, a consortium of asbestos producing companies and insurers which is trying to formulate a program to deal with claims of cancer and other illnesses by persons exposed to asbestos.

The group, named for Dean Harry Wellington of Yale Law School, wants to create a facility to pay claims without lawsuits, if possible, and to represent its members in lawsuits in order to cut the high costs of legal fees associated with each company maintaining its own team of legal experts. □

—Washington Correspondent

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EXHIBIT XXV

'Hordes of Lawyers, Hungry as Locusts'

LAW

BY PHILIP HAGER AND MICHAEL A. MITZIK

If you hurt your finger in a company softball game, you can go to court and win the right to sue for workers' compensation on the ground that the boss "expected" you to play.

You can run a stop sign, smash into a truck and — even if you were legally drunk at the time — sue and collect damages against the automaker that designed an allegedly faulty gas tank that exploded and burned you in the accident.

If the person you've been living with — but haven't yet married — is badly hurt in an accident, you can sue the responsible party for loss of consortium, provided you can show that your relationship possessed the "characteristics" of marriage.

These were not ordinary cases, but they serve to underscore the far-ranging nature of the thousands of lawsuits flowing through the courts. There has been a litigation explosion in the last decade. Last year, more than 240,000 new civil actions were filed in the federal courts — twice the number filed in 1975. It cost U.S. taxpayers about $2.2 billion to process the more than 8 million civil suits filed in state and federal courts in 1982.

The country seems awash in lawsuits. High-priced lawyers bring actions seeking millions in punitive damages. Small-claims courts brim with $1500 disputes. A single antitrust case — *U.S. v. International Business Machines Corp.* — occupied a single judge and dozens of lawyers for 12 years at a cost of millions of dollars before it was withdrawn following a change of national administrations. Nearly 170,000 divorce cases land every year in the courts of a single state — California — representing about one-third of the civil caseload.

One law professor projected the previous 10 years' caseload into the 21st century and predicted that the annual federal docket would reach 1 million new cases by the year 2010, requiring the services of 5000 judges.

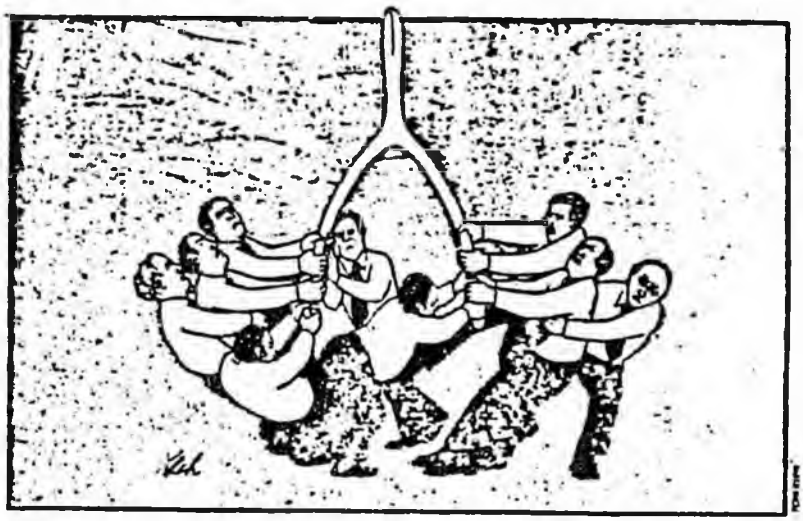
It is not simply the numbers that cause concern. Frivolous suits seem to become more common every year. A child sues his mother and father for "malparenting"; a student files suit against his school for his illiteracy; a patient sues her plastic surgeon for a belly-button left askew; a shooting victim chooses not to sue his assailant but this assailant's psychiatrist — on the theory that the doctor should have foreseen that his patient would run amok.

The law also intrudes into areas of society once seemingly beyond its reach, dictating how businesses are operated, whether a city can pick up trash more frequently in one neighborhood than another, how high school principals mete out discipline. Corporate executives, like hospital boards, are heard to complain that their every decision is governed by court-made rules, that they need lawyers looking over their shoulders just to get through the work day.

Many commentators ascribe the staggering caseload increase and the expanding reach of the law to the American impulse to transform every petty grievance into a full-blown lawsuit, aided and abetted by what Chief Justice Warren E. Burger calls "hordes of lawyers, hungry as locusts."

Is America an overlawyered society? Certainly there are enough lawyers. More than 620,000 are at work now, with 35,000 more graduating from law schools every year. That makes one lawyer for every 375 Americans. Two decades ago, the ratio was one lawyer for every 632 persons.

Philip Hager and Michael A. Mitzik wrote this story for the Los Angeles Times.



Former White House counsel Lloyd N. Cutler, now in private practice in Washington, has estimated that the legal profession accounted for 1.4 percent of the U.S. gross national product in 1980, a percentage exceeded only by oil, auto, steel and several other major industries.

In the final analysis, it is the average citizen who pays this staggering bill — mostly through the higher prices companies and others must charge to cover the cost of litigation and insurance against the threat of it. High legal costs also mean more government expense and lost tax revenues. While individuals' legal bills are usually not tax deductible, the legal expenses of businesses are.

It is undisputed that some attorneys bring unnecessary or harassing lawsuits, prolong litigation by filing superfluous motions and requesting continuances, and sometimes turn the adversary system into a courtroom "sporting event," financed by the fees they charged their clients. But most authorities agree that the actual responsibility for congested courtrooms and mounting legal bills is widely shared.

Legislators make the laws, often with little concern for the extra court workload that may be created. Chief Justice Burger, for one, has recommended that every time Congress enacts a new law, it should be required to include a statement of how many extra cases will be generated. So far Burger's suggestion has been ignored.

And, by evading some controversial issues, Congress and state legislatures have driven into the courthouses those parties demanding a solution for their problems and answers to their disputes. The law on abortion rights, school desegregation, job discrimination and other prickly subjects has been made incrementally — case-by-case by judges, not legislators.

"The judiciary steps in because legislatures have been too cowardly to take on the important social issues of our times," said Maxwell Blecher, a Los Angeles attorney. "The courts fill the vacuum."

"The public basically is insisting on a perfect system," said California State Bar president Dale Hanst of Santa Barbara. "People want a remedy for every wrong. And the price for that is a lot of money being spent on lawsuits and a lot of clogging the courts."

Despite increasing caseloads, many Americans still find that the courthouse doors remain closed to legitimate grievances, such as contesting an eviction, resolving a consumer dispute or challenging a restriction on government benefits. Legal assistance programs, introduced with substantial funding as part of the "Great Society," are being cut back in a time of deepening federal deficits. And there is some newly emerging evidence that many legal disputes go unresolved — and, that in fact, Americans may not be as litigious as popularly believed.

The Civil Litigation Research Project, a federally funded study conducted largely by researchers at the University of Wisconsin Law School, attempted to learn how often a dispute involving $1000 or more actually went to court. The study was based on random interviews of households and more than 1800 cases filed in state and federal courts in five states. The researchers found that only 11.2 percent of all grievances resulted in suits. Of those, the vast majority subsequently were settled or dropped before trial.

Nevertheless, the perception of America as a pathologically litigious society must come from somewhere.

According to surveys conducted in 1976 and 1977, the United States then had 1979 lawyers for every 1 million residents — nearly double the ratio of any other industrialized nation — but there were only 67.7 judges for every 1 million residents, putting the United States well behind France, Italy and West Germany. The ratio of lawyers to judges was the highest in the Western world, meaning that fewer judges were available to process the product of the world's largest legal community.

There is wide agreement among judges, lawyers and others that some reforms are long overdue — at the very least to remove from the court process the disputes that needn't be there.

"Congestion is inevitable if you only make cosmetic changes," warned Robert Gnaizda, an attorney for Public Advocates Inc., a public-interest law firm in San Francisco. "We've got to radically alter the incentives for going to court." ■

Exhibit XXVI

...cian almost nine years after the birth of the child but within three years from discovery of the alleged malpractice. The court found that the case involved misdiagnosis and/or improper follow-up treatment and that the "foreign object" exclusion did not apply because the obstetrician was not involved in the implantation.—*Dunaway v. Ball,* 453 N.Y.S. 2d 313 (N.Y. Sup. Ct., June 21, 1982)

Attorney's fees exceed award

A $20,000 award of attorney's fees to a patient who obtained a $15,000 malpractice award from a physician was not an abuse of discretion, a Florida appellate court ruled.

The physician contended that the award of attorney's fees was clearly excessive. The appellate court rejected the argument that the dollar amount of recovery controlled the award of attorney's fees. Noting the complexity of the litigation, the hours expended in preparation and trial, the skill and expertise of the patient's attorney, the court said the trial court did not abuse its discretion in awarding $20,000 in attorney's fees.—*Baker v. Varela,* 416 So. 2d 1190 (Fla. Dist. Ct. of App., July 2, 1982)

THE IMPACT OF FEE ARRANGEMENT ON LAWYER EFFORT

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PREFACE

This Paper focuses on the impact of fee arrangement on the amount of time lawyers are likely to devote to civil cases. Drawing on data collected by the Civil Litigation Research Project, the authors compare the behavior of lawyers working on an hourly fee basis with the behavior of contingent fee lawyers.

The contribution of Mr. Felstiner to this Paper, which is a reprint of an article appearing in Volume 19:2 of The Law and Society Review, is part of basic research conducted by The Institute for Civil Justice on the cost of settling disputes.

THE IMPACT OF FEE ARRANGEMENT ON LAWYER EFFORT

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This paper focuses on the impact of fee arrangement on the amount of time lawyers are likely to devote to civil cases ("effort"). Drawing upon data collected by the Civil Litigation Research Project, we compare the behavior of lawyers working on an hourly fee basis with the behavior of contingent fee lawyers. Like previous work on this issue, the paper finds that fee arrangement does influence the amount of effort lawyers devote to a given case. However, contrary to previous work, the analysis indicates that the effect is not a simple effect on hours worked but a more complex effect on a number of aspects of lawyers' behavior. Together these produce an effect on hours that varies by size of case. For modest cases (with stakes of $6,000 or less), contingent fee lawyers spend less time on a case than hourly fee lawyers. Yet we find no statistically significant evidence of a differential in effort for larger cases but rather an indication that, if there is an effect, it may be in the opposite direction.

In recent years there has been considerable discussion of the impact that various fee arrangements have on the nature of the services lawyers provide for their clients. In particular, a number of scholars have drawn on economic theory to model the effect of fee arrangements on lawyer behavior. Several of these theoretical studies reach the conclusion that lawyers paid on a contingent fee basis will spend fewer hours on a case than would be optimal for the client. They also suggest that lawyers paid on an hourly basis will put in more than the optimal number of hours. These analyses are used, in some cases, to draw policy conclusions about the contingent fee contract.

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* This is a revision of a paper presented at the Midwest Political Science Association annual meeting, Palmer House Hotel, Chicago, Illinois, April 12-14, 1984. The analysis is drawn from the work of the Civil Litigation Research Project, which was sponsored by United States Justice Department Contract JAOIA-79-0040; additional support was provided by the Research Committee of the University of Wisconsin-Madison Graduate School and by the University of Wisconsin Law School. We acknowledge editorial and other assistance from two anonymous reviewers and Felicity Skidmore.

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Except for Rosenthal's (1974) study of sixty cases, which does lend some support to the theoretical analyses, there have been no systematic empirical tests of these propositions. This paper presents an analysis of the effects of fee arrangement on lawyer behavior based on data drawn from interviews with 371 hourly fee lawyers and 267 contingent fee lawyers who worked on cases selected randomly from twelve state and federal courts.

I. THEORETICAL BACKGROUND

Lawyers are the primary mechanism connecting the citizenry to the legal order. Traditionally, they are pictured as neutral professionals who work only to advance the interests of their clients. This image has been called into question, however, by recent theoretical inquiries that focus on the economic incentives and personal goals lawyers bring to their work. Particular attention has been given to the effect of fee arrangement on the work that lawyers do for specific clients. Typically, the concern has focused on the implications of hourly versus contingent fee arrangements (see Franklin *et al.*, 1961; MacKinnon, 1964; Schwartz and Mitchell, 1970; Rosenthal, 1974; Clermont and Currivan, 1978; Danzon, 1981; See, 1984), though Johnson's (1980-81) recent discussion of the impact of fee arrangement extends the analysis to various forms of third-party payment.

The argument about fee effects typically uses a hypothetical benchmark to appraise the performance of lawyers under different fee arrangements. Johnson (1980-81: 570), for example, uses the concept of an "alter ego" lawyer—one who is motivated entirely by the client's best interest and will, therefore, provide the amount of effort a fully informed client would authorize the lawyer to make. In Johnson's words, the lawyer "will invest additional resources . . . in a given case [assuming complete information] until *maximum net benefits* are achieved for the client."

These theories suggest that hourly fee lawyers will tend to deviate from the alter ego standard by investing greater resources than is in the best interests of the client, whereas contingent fee lawyers will tend to deviate in the other direction, investing fewer resources than the client might want. The usual explanation for this postulated behavior derives from the economic incentives that lawyers who handle litigation are assumed to face. For example, an hourly fee lawyer who has surplus time is expected to spend more time on a case than the

case warrants (as measured by the alter ego benchmark) because she can charge the client for time that would otherwise produce no income. In contrast, the contingent fee lawyer with more work than time available is expected to underinvest in some cases in order to work more on other cases that promise greater financial rewards. Rosenthal's (1974) study of sixty personal injury cases in New York, the only published empirical evidence about the potential conflict of interest created by different kinds of fee arrangement, appears to support the view that contingent fee lawyers "underinvest."[1]

There are some fundamental problems with this over/under investment hypothesis. The first is that the analysis assumes too simple a model of how lawyer behavior and fee arrangement may interact. Lawyers are seen as agents who are exclusively motivated by economic self-interest and whose efforts in a given case (measured by the hours they spend) are *directly* and solely affected by the economic incentives presented by the fee arrangement under which they work. These assumptions are questionable.

While all (or most) lawyers are sensitive to economic concerns, and some no doubt fit the image of self-interested income maximizers at the heart of the over/under investment hypothesis, such a picture is a gross oversimplification. Certainly, lawyers may and frequently do temper economic interest with other competing values, including professional standards and a sense of responsibility to the client (cf. Kritzer, 1984). Thus, hourly fee lawyers may be well aware of the costs to the client of their services and incorporate the client's financial concerns into their time-allocation plans, even if formally they are free to bill as many hours as the case demands. On the other hand, contingent fee lawyers are not necessarily going to take short cuts and omit important activities just because, on the narrowest cost-benefit calculus, they themselves may not gain as much from the marginal effort in this case as in another they are handling. Even if they were tempted to do so, the necessity to secure client consent to follow certain courses of action would limit such inclinations.[2]

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[1] This situation arises because there is a tendency for the return per hour of lawyer time to decrease rapidly after a certain threshold is reached. For example, a lawyer might be able to get a $6,000 settlement after 20 hours of work; going to trial might double the recovery but might easily require another 40 hours of work. In this example, assuming a one-third contingent fee, the settlement would yield an hourly rate of $100 while going to trial would produce an hourly rate of $67.

[2] A client's ability (or inability) to pay a substantial fee may check the amount of effort the lawyer devotes to the case. Furthermore, hourly fee

Furthermore, when economic incentives do have an impact on lawyer effort, the effect may be less direct than the literature implies; fee arrangement may affect other factors, which themselves directly influence effort. If such is the case, it is impossible to understand fully the significance—or lack thereof—of a fee arrangement unless one takes into account the mediating effect of the other factors. Thus, it has been suggested that clients' attitudes toward the amount of time lawyers spend on cases should differ with the fee arrangement they employ. Where the lawyer is hired on a contingent fee, the client, it is said, should exercise control to be sure that *enough* time is spent on a case (Rosenthal, 1974). Where an hourly fee is used, however, clients are advised to make certain that lawyers do not put in *too much* time (Wessel, 1976). Were clients actually to follow such advice, fee arrangements would play a role in determining lawyer effort, but only through their influence on the nature and degree of the control exercised by clients.

The second problem with the over/under investment hypothesis is with the idea of using the "alter ego" lawyer's effort as the benchmark against which to measure contingent fee versus hourly fee hours. The additional resources that Johnson's alter ego lawyer decides to invest are measured by the marginal "costs to the litigants"—with more resources invested as long as their expected return is greater than those costs (Johnson, 1980-81: 570). This is, in principle, a relatively straightforward proposition with respect to the hourly fee lawyer. But for the client who has retained a lawyer on a contingent fee basis it is less satisfactory because there are no marginal costs to the litigant. Johnson's conclusion that the client's gains in such a circumstance are greatest when the recovery is greatest simply reflects the fact that lawyer hours are not a cost to such a client.[3]

Thus, we do not believe that the concept of the alter ego lawyer is helpful in analyzing the relative amounts of effort hourly fee and contingent fee lawyers devote to cases. An alternative approach to looking at the question of the impact of

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lawyers may have other clients they charge at a higher rate (or who are repeat clients), and they will not overinvest on client A's case because they would prefer to spend more time on client B's.

[3] This analysis represents something of a simplification because the client typically must pay expenses in addition to the contingent fee, and each marginal increase in time may involve some marginal increase in expenses. However, we have shown elsewhere (Kritzer *et al.*, 1984) that in most cases expenses represent less than 10% of the overall lawyer's bill.

fee arrangement on lawyer effort is to start with the simple hypothesis that if the argument about over and under investment is correct, we would expect a contingent fee lawyer to expend less effort than an hourly fee lawyer, *all other influences on effort being held constant.* If such an effort gap could be found, it would lend support to concerns about too much or too little effort, though one would not be able to state definitively whether the contingent fee lawyer was underinvesting, the hourly fee lawyer was overinvesting, or some combination of the two was occurring.[4] Nonetheless, we would be much further along in our efforts to understand how fee arrangement affects lawyer effort. This is the analysis that we present below.

The next two sections describe the data and methodology we have used, followed by the results of our analysis of the relationship between fee arrangement and lawyer effort.

II. DATA

The data used in our analysis are drawn from court records and from hour-long interviews with the lawyers involved in the cases represented in the court records. Since we are interested in lawyer behavior, the lawyer rather than the case is the unit of analysis, and each case may be included more than once if interviews were conducted with more than one lawyer in that case.[5] The interviews were conducted about two years after the close of the case discussed. Even though the attorneys were

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[4] We should point out that the "services" provided by the contingent fee lawyer may differ in important ways from those of the hourly fee lawyer. First, the contingent fee lawyer is providing a "risk-bearing" service. That is, a part of the contingent fee can be seen as payment for assuming the risk that there will be no (or very low) recovery in the case; alternatively, one might argue that the risk is a part of the overhead that the lawyer must bear, and hence the effective hourly rate must include that element of overhead. Second, the contingent fee lawyer virtually never receives any compensation until the case is completed and thus can be said to provide a financing service; while it is not uncommon for hourly fee lawyers to defer billing until a case is concluded (we have no specific information on the frequency of this practice), it is likely that on the average, the financing aspect of the hourly fee lawyer's charge is significantly lower than for the contingent fee lawyer.

[5] There are a relatively small number of cases where more than one respondent is included for the same side of a case. Replicating the analyses "within" each side while randomly excluding the "extra" cases produced no change in our findings (see Trubek *et al.*, 1983b: II-103). When we contrast the two fee types, there is more of a problem since there are many cases with both a contingent fee plaintiff's lawyer and an hourly fee defendant's lawyer. However, we believe this is a nonproblem because the thrust of our findings is that the regression models for the two fee arrangements are different, and the inclusion of respondents from the same case should tend to pull the two equations together; thus we have, if anything, understated the differences in the regression coefficients.

asked to review their case files, the interview information may have been influenced to some degree by the recall process. The cases are drawn from twelve courts in five federal judicial districts: Eastern Wisconsin, Eastern Pennsylvania, Central California, New Mexico, and South Carolina. This analysis sample includes interviews with 371 hourly fee lawyers[6] and 267 contingent fee lawyers from cases randomly selected from the twelve state and federal courts.[7] Detailed information on the data collection can be found in Kritzer (1980-81), Kritzer *et al.* (1981), or Trubek *et al.* (1983b).

In order to analyze the data we had collected, we needed to deal with a number of "missing data" problems. First, we had to drop a substantial number of respondents (and thus cases) from the analysis. Naturally, we could not include cases where we lacked information on the number of hours the lawyer spent on the case (79 respondents). We also decided to drop cases where the respondents could, or did, not supply us with a money value for the amount at stake (our "stakes" variable—388 respondents).[8] The result of our decision to drop cases with "missing" stakes data is that the regression subsample used below differs from our overall lawyer sample.

A comparison of the included and excluded cases showed that on many parameters the regression subset is not significantly different from the overall sample. However, there are some differences worth noting: the set of cases that have monetary stakes information and are thus included in the regression sample (1) are weighted more heavily toward tort and contract cases and include fewer divorce, regulation, and public law cases; (2) contain more state cases; and (3) include a higher percentage of lawyers who represent plaintiffs and work on a contingent fee basis. Our conclusions are drawn only from this subset of cases and should be interpreted accordingly.[9]

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[6] A small number of lawyers in our sample (about 1%) were paid on some combination of percentage and time; they were treated as hourly fee lawyers for purposes of the analysis below (see Clermont and Currivan, 1978).

[7] Data were originally collected on 1649 cases; from these cases, we obtained hour-long, detailed interviews with 1382 lawyers (plus 430 very brief interviews covering additional cases in the sample; see Kritzer, 1980-81: 520, for more detail on why this was done).

[8] We felt that stakes were sufficiently important in explaining hours that an analysis which omitted this variable would be of little value (and we were unable to find a way to fill in missing data on stakes). As we discuss below, we needed the stakes variable to adjust for a methodological problem inherent in data on litigation.

[9] We did not have data on all the other variables for all the cases that remain in the regression subset. Since we could not eliminate all cases with missing data and retain an adequate sample, we estimated these missing items using means or medians. We omitted 26 respondents for whom we had

Although our analysis follows previous work in focusing on two types of fee arrangement—hourly fee and contingent fee lawyers—there are at least three "pure" types of fee arrangements for litigation-related work: the hourly fee, the contingent fee, and the flat, or fixed, fee, which is set in advance of the work.[10] By and large individuals, who are usually plaintiffs,[11] hire lawyers on a contingent fee basis (with the major exception of divorce cases); organizations usually hire lawyers on a straight hourly basis. Only a small proportion of cases—typically small, simple ones involving individuals or small organizations—involve flat fee arrangements. Reflecting their relative scarcity in practice, the incidence of flat fee cases in our sample was too small for separate analysis.

III. METHODOLOGY

The methodology used in our analysis first tests the assumption that if the type of fee arrangement had no effect on the amount of lawyer effort, we should find that, controlling for the other factors that influence lawyer effort, hourly fee and contingent fee lawyers spend the same amount of time on a case. The basis of that test, and of the rest of our analysis, is a general model of the time allocation process. The model on which the analysis is based includes five clusters of variables: (I) the process of interaction among the parties, (II) case characteristics, (III) participant characteristics, (IV) participant goals, and (V) processing and case management characteristics. These clusters include a total of 30 variables. The individual variables are described in capsule form in Table 1; more detail may be found in the Appendix.

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missing data items we did not feel that we could "fill in." To avoid artificially depressing the variance in our data, we added a normally distributed random number to each of the means or medians that replaced missing data. Missing data were filled in this way for 1% or fewer of our cases except for the lawyer specialization variable, where 4% of the respondents had missing data.

[10] A fourth arrangement, which few lawyers admit to using, might be described as "what the case is worth" (i.e., a subjective judgment regarding what the client is willing to pay). In addition to the "pure" types of fee arrangements, there are many combinations (e.g., hourly fee adjusted for results, which combines the hourly and the contingent arrangements). These may or may not be made explicit to the client.

[11] An early study of litigation suggested that individuals were usually defendants (Wanner, 1974; 1975). A more recent analysis indicates that if uncontested collections cases and divorce cases are omitted and if insurance companies are treated as the real defendant in tort cases where insurance is present, individuals are almost always plaintiffs (Grossman *et al.*, 1982).

Table 1. Summary Descriptions of the Variables in the Lawyer Effort Model

Cluster	Variable	Type	Description	means (and standard deviations) hourly	means (and standard deviations) contingent	expected direction[a]
PARTY INTERACTION (measures of pretrial activities by the other side)						
1	Pleadings	count[b]	number of pleading documents filed by other side	1.47 (1.13)	1.30 (1.29)	+
2	Motions	count	number of motions initiated by other side	0.83 (1.19)	0.86 (1.60)	+
3	Discovery	count	number of discovery events (depositions, motions, etc.) initiated by other side	2.14 (3.13)	2.18 (3.21)	+
4	Briefs	count	number of briefs filed by other side	0.70 (1.30)	0.62 (1.37)	+
CASE CHARACTERISTICS						
5	Stakes[c]	lawyer's estimate	lawyer's estimate of what her client should have been willing to accept or to do to settle the case	$11,449 ($7,334)	$14,390 ($6,587)	+
6	Complexity	lawyer's estimate	lawyer's subjective estimate of the complexity of the case (five-point scale)	2.39 (1.11)	2.53 (1.19)	+
7	Duration	count	number of days from filing to termination	422.84 (283.48)	418.97 (295.46)	+
PARTICIPANT CHARACTERISTICS						
8	Client Type	dummy	1 for individuals; 0 for organizations (as indicated by the court record)	0.29 (0.45)	0.34 (0.37)	−
LAWYER CHARACTERISTICS						
9	Specialization	factor score	indicator of degree to which the case fell within an area that the lawyer considered to be her specialty	0.08 (0.90)	0.06 (0.85)	+
10	Law School Performance	factor score	indicator of lawyer's performance based on rank in class and participation on law review	0.05 (0.69)	−0.03 (0.65)	−
11	General Experience	count	number of years lawyer has been practicing law	11.46 (8.93)	10.03 (9.06)	−
12	Litigation Experience	——	proportion of time devoted to litigation	68.31 (27.39)	66.26 (23.95)	−
13	Personal Capacity	factor score	measure based on items taken from Robinson and Shaver's (1969: 102-5) scale	0.04 (0.67)	−0.04 (0.65)	−
14	Craftsmanship	lawyer's estimate	lawyer's sense of professional craftsmanship (three-point scale)	2.51 (0.69)	2.50 (0.68)	+
PARTICIPANT GOALS						
Client Goals						
15	Get Most/Pay Least	dichotomy	client sought to get the most or pay the least (coded 1); client did not have this goal (coded 0)	0.44 (0.50)	0.32 (0.47)	+
16	Get Fair/Pay Fair	dichotomy	client sought to get a fair amount or pay a fair amount (coded 1); client did not have this goal (coded 0)	0.32 (0.47)	0.49 (0.50)	−

Table 1
(continued)

Cluster	Variable	Type	Description	means (and standard deviations) hourly	contingent	expected direction[a]
Lawyer Goals (as measured by reasons lawyer took the case)						
17	Challenge	factor score	lawyer took case because it presented a challenge	−0.09 (0.85)	0.08 (0.88)	+
18	Public Service	factor score	lawyer took case because it provided an opportunity to serve the public or because of sympathy for the client	−0.15 (0.71)	0.06 (0.67)	0
19	Professional Visibility	factor score	the case would increase the lawyer's community standing or improve her position in the firm	0.03 (0.72)	0.05 (0.68)	+
20	Making Money	factor score	the case was taken because of the amount of money that could be earned	−0.08 (0.59)	0.25 (0.66)	−
21	Service to Regular Client	dichotomy	the lawyer took the case to provide service to a regular client	0.62 (0.48)	0.16 (0.36)	0
PROCESSING AND CASE MANAGEMENT						
22	Type of Court	dichotomy	federal court (1); state court (0)	0.56 (0.50)	0.45 (0.50)	0
23	Settlement Discussions	dichotomy	did occur (1), did not occur (0)	0.90 (0.30)	0.90 (0.30)	−
24	Trial	dichotomy	case did go to trial (1); case did not go to trial (0)	0.12 (0.32)	0.12 (0.32)	+
25	Pretrial Events SOP	factor score	use of standard operating procedures for pretrial activities such as pleadings, motions, and discovery	0.01 (0.99)	−0.64 (1.01)	−
26	Estimating Case Value SOP	factor score	use of standard operating procedures for estimating the value of the case	−0.02 (0.97)	−0.05 (1.02)	−
27	Plan for Motions	dichotomy	lawyer used a plan for motions (1); no plan used (0)	0.19 (0.40)	0.13 (0.34)	−
28	Plan for Settlement	dichotomy	lawyer used a plan for obtaining a settlement (1); no plan used (0)	0.70 (0.46)	0.68 (0.47)	−
29	Plan for Discovery	dichotomy	lawyer used a plan in conducting discovery (1); no plan used (0)	0.60 (0.49)	0.64 (0.48)	−
30	Client Control and Participation	factor score	client sought to exercise control over the lawyer's activity and to participate actively in decision-making regarding the case	0.20 (0.72)	−0.23 (0.71)	+ or −

[a] A "+" indicates that a positive relationship is expected; a "−" indicates a negative relationship; and a "0" indicates that the direction of the relationship is not hypothesized in advance.

[b] "Count" indicates that the variable was a simple count of some type of event or some other discrete entity (e.g., days—for duration).

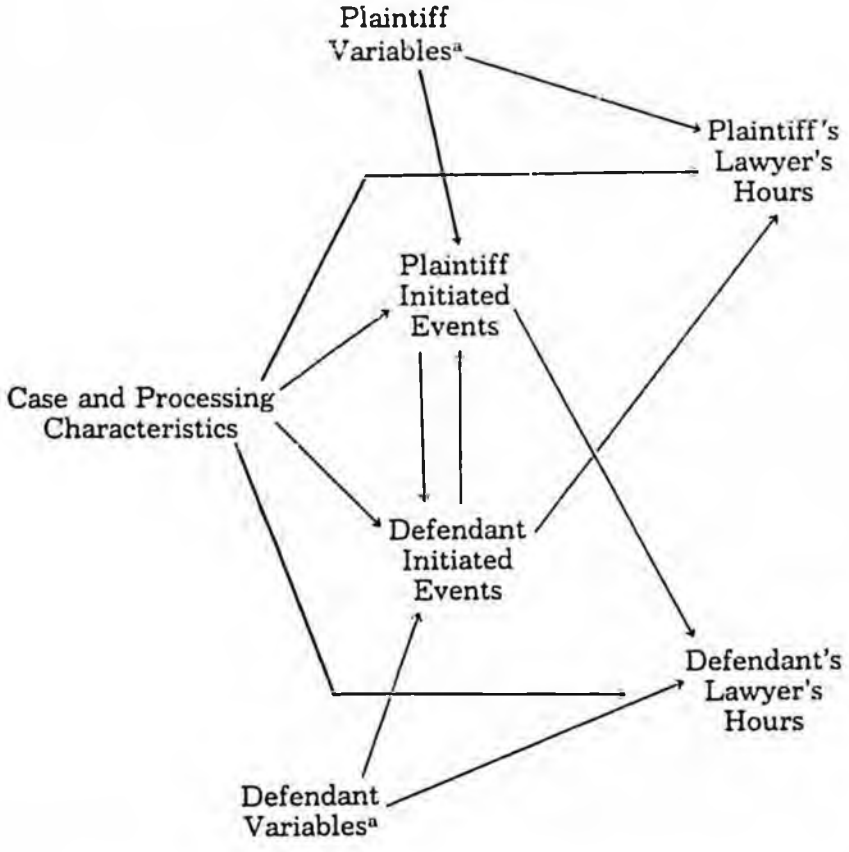
[c] In the actual analysis, stakes was adjusted for nonlinearity; the particular adjustment used was to take the square root of stakes.

Although common sense would suggest that the amount at *stake* in the case should be the most important determinant of the amount of time spent on the case by lawyers, we do not treat stakes as the *primary* determinant of the level of lawyer effort (although we do recognize its importance and include it as one of the case characteristics).[12] Lawyers often fail to spend

[12] At the start of our research, we did see stakes as the primary factor, with the other variables serving as modifiers of the basic relationship (Trubek, 1980-81). See Trubek *et al.* (1983b) or Kritzer *et al.* (1984) for a discussion of how this view came to be modified.

as much time on a case as the stakes may seem to warrant because the case settles before that effort has been expended. As we see it, therefore, stakes do not push the investment process along; rather they tend to place a cap on it.

Figure 1. Interaction Model of Lawyer Effort



[a] The "party" variables include nature of participants, participant goals, and case management indicators.

It is not the stakes but the action of side A that is the primary determinant of the action of side B, and vice versa. Figure 1 suggests an image of this action-reaction model. Each lawyer's effort is a function of (1) the other side's action, (2) case and processing characteristics, and (3) "party" variables (i.e., goals, characteristics, and management efforts). A full analysis of this model would seek to account for each side's level of lawyer effort, each side's "initiatives," and each side's

goals and management decisions. The notion of interaction built into this model is intuitively pleasing because it is consistent with dispute processing in an adversary process like the American civil justice system. Because our purpose is to explain the "end variable," effort, we need focus only on the linkages in the model leading directly to the hours lawyers put in.[13]

We tested our theoretical model by linear regression analysis.[14] This statistical technique allows us to measure the

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[13] The analysis of initiatives would be greatly complicated by the two-way linkage shown in Figure 1. It would also require a type of data set that is almost impossible to obtain (see Kritzer, 1980-81: 506, 520-21).

[14] Before applying linear regression, we checked our independent variables for curvilinear relationships with the dependent variable, hours worked. The only variable for which curvilinearity appeared to be a significant problem was stakes. A curvilinear form made intuitive sense because one would expect, for example, that the difference between the time taken by two cases, one with $2,000 at stake and the other with $10,000 at stake, would be greater than the difference in the time taken by two cases, one with $102,000 at stake and the other with $110,000 at stake. A number of transformations were examined to adjust for this curvilinearity. Using the square root of the "raw" stakes measures seemed to work best; thus, all the analyses reported below use the square root of stakes rather than the original value.

We also checked our data for multicollinearity, outliers, and heteroscedasticity and found all three. We examined all our predictor variables for possible multicollinearity (high intercorrelations) and found problems only for our original standard operating procedure indicators (which included separate indicators regarding SOPs for estimating case value, discovery, motions, and pleadings). The SOP variables used in the analysis, (25) pretrial events SOP and (26) estimating case value SOP, were factor scores created in order to alleviate this problem (we started with four SOP indicators).

To examine the impact of outliers (occasional "big cases" picked up by our random sampling procedure) on our results, we performed the regression analysis with and without the outliers in the data set. Outliers were defined as those cases requiring more than 500 hours of lawyer time, involving more than $250,000, taking more than 1500 days from filing to termination, or having more than 20 discovery events, 10 motions, or 10 briefs. For the hourly fee lawyers the inclusion or exclusion of the outliers had minimal impact on our results, but for the contingent fee lawyers the impact of outliers was clearly noticeable. For the sake of consistency, we omitted outliers for both hourly and contingent fee lawyers.

The last problem we had to deal with was heteroscedasticity, a violation of the assumption in regression analysis that the variance of the equation "error term" (i.e., the difference between the observed and predicted values of the dependent variable) be constant for all systematically identifiable subsets of observations. Heteroscedasticity tends to lower severely the power of significance tests. Common sense suggests that one should expect a greater range of predictive error for big cases than for small cases: this is consistent with the notion that stakes serve to "cap" the level of investment of time (and money) in a case. To adjust for the heteroscedasticity in our data, we applied an adjustment factor to each observation; this yielded a set of "corrected" regression equations. The specific adjustment used was to divide all of the variables for each case by the square root of stakes. For more detail on the rationale for the procedure, see Hilton (1976: 95-100). For most analytic purposes, the "corrected" results were employed, and it is these results that we generally report below.

independent effect of each explanatory variable holding the effect of the other variables constant. The dependent variable is lawyer's hours. The independent variables are the variables in the clusters specified in our model. It is important to note that the number of lawyer hours we report in our analysis below represents estimates based on our statistical model. Since we could not obtain samples with identical cases (except for fee arrangement), we have "created" such cases statistically using linear regression.

It became clear almost from the start of our analysis that hourly fee lawyers behaved rather differently from contingent fee lawyers—so differently, as reflected in the coefficients of many of our dependent variables, that it is statistically inappropriate to include fee arrangement as just another variable in our regression equations.[15] We thus estimated two separate equations—one for hourly fee lawyers and the other for contingent fee lawyers. The amount of variance explained by the models was very similar for the two sets of lawyers. As shown in Table 2, R^2 is .494 for hourly lawyers and .525 for contingent fee lawyers.[16] Also, three clusters of variables have important influences on hours for each group; two of these are the same for both types of lawyers (party interaction and participant goals). However, the third important variable type differs for the two (processing decisions for hourly fee lawyers and case characteristics for contingent fee lawyers). The

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[15] If it were not for the fact that the coefficient sets for hourly and contingent fee lawyers differed significantly, we could have tested the hypothesis that one group of lawyers spent significantly more time than the other by simply adding a dummy variable for fee arrangement to the equation. In the course of the analysis, we did this just to see what would happen; the t-statistics for the corrected and uncorrected forms (606 degrees of freedom) were 0.35 and 0.41, respectively, neither of which indicates statistical significance.

Given that the coefficients are in fact different for the two subgroups of lawyers, the effort gap will vary depending upon the specific values the other predictor variables take on. Consequently, one cannot speak of a single value for the effort gap, but must talk about the effort gap for a given situation. If there were only one predictor variable, say stakes, then one could talk about ranges of stakes where the gap does exist and about ranges where there is no gap. See Rogosa (1980) or Friedrich (1982) for more detail on the issues involved. Suffice it to say that there is no way to vary systematically the 30 variables we use; consequently, we will focus on a more limited set of situations.

[16] Since our goal in assessing the overall fit is to look at the "best" fit we can get, we have used the R^2 from the uncorrected (ordinary least squares) regression estimates. Because of the mathematics of the correction for heteroscedasticity, the uncorrected estimate of the equation will always yield a better fit for the equation than will the "corrected" (weighted least squares) regression estimates (see Hilton, 1976: 100). On the other hand, the corrected estimates yield the best information regarding the significance of the contribution of individual variables or groups of variables.

relative importance of the influence of the different explanatory variables is also often substantially different. These differences can be seen in Table 3, though we will defer discussion of the specific differences until later.

Table 2. Summary of Regression Results for Hourly and Contingent Fee Lawyers

Main Group Subgroup	df	Hourly[a]				Contingent[b]			
		F	p	R^2 change	R^2 change per df	F	p	R^2 change	R^2 change per df
I. PARTY INTERACTION (A)	4	11.01	.0001	05506	.015	4.43	.0018	.05530	014
II. CASE CHARACTERISTICS (B)	3	7.37	.0001	02679	.009	13.97	.0001	.11602	039
III. NATURE OF PARTICIPANTS	7	2.48	0170	.02289	.005	1.05	.3953	.02290	003
C. Client Type	1	0.26	.6123	.00034	.000	4.70	.0312	.01467	.015
D. Lawyer Characteristics	6	2.65	.0158	.02098	.003	0.40	.8762	.00756	.001
IV. PARTICIPANT GOALS	7	11.04	.0001	.10194	.015	2.67	.0111	.05843	.008
E. Client Goals	2	15.41	.0001	04063	.020	3.84	.0229	.02395	.012
F. Lawyer Goals	5	9.28	.0001	.06117	.012	2.15	.0606	.03352	.007
V. PROCESSING AND MANAGEMENT	9	6.52	.0001	07748	.009	0.74	.6740	.02072	002
G. Processing Decisions	3	6.36	.0003	.02517	.008	1.09	.3561	.01016	.003
H. Case Management	6	7.85	.0001	06216	.010	0.71	.6457	.01321	.002
R^2		.49362				.52535			

[a]N = 371
[b]N = 267

These differences mean that the cases in our samples for the two types of fee arrangements are not generally equivalent, making a comparison between the two groups, other things being equal, more difficult. We make our initial hourly fee/ contingent fee comparison, therefore, using three separate estimates: we estimate (a) the time expended by both groups on the "average" contingent fee lawyer case (i.e., the difference between the hours spent by the two groups when each of the explanatory variables is set at its mean value for contingent fee lawyers); (b) the time spent by both groups on the average hourly fee lawyer case (estimated the same way); and (c) the time spent by both groups on the "average" case for the two groups of lawyers combined.

Before presenting the results of these procedures, we must discuss a final methodological complication. As we said earlier, contingent fee lawyers usually represent plaintiffs. Hourly fee lawyers are somewhat more evenly divided: in our sample 71 percent of the hourly fee lawyers represent defendants. This difference raises the question of whether our efforts to measure the effects of fee arrangement might reflect, at least in part, differences between how plaintiffs' and defendants' counsel approach cases. Since contingent fee defendants' counsel are

rare or nonexistent, we cannot carry out the analysis with strict controls for side. We can, however, compare three groups—contingent fee lawyers, hourly fee plaintiffs' lawyers, and hourly fee defendants' lawyers—to try to sort out this question. If hourly fee plaintiffs' lawyers more closely resemble hourly fee defendants' lawyers than contingent fee lawyers, we can tentatively attribute the difference more to fee arrangement than to side.[17]

Table 3 presents, in addition to regression results for both sets of lawyers, the equivalent results for hourly fee lawyers broken down by side. Unfortunately, the implications of the breakdown are not clear. In part this reflects the small sample size for hourly fee plaintiffs and collinearity problems (i.e., correlations among the independent variables) that appear to exist *within* these two subgroups.[18] The results for hourly plaintiffs' lawyers appear to fall somewhere between those of hourly defendants' lawyers and contingent fee lawyers. For some variables, hourly plaintiffs' lawyers are closer to hourly defendants' lawyers while on others they are closer to contingent fee lawyers. Consequently, although our observed effects may reflect some influence of side, we can say with a high degree of confidence that there is a fee arrangement effect in addition to any effects of side.[19]

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[17] One might at first glance be concerned that the results we have presented represent the peculiarities of personal injury litigation since common wisdom is that contingent fees and personal injury cases "go together." This is in fact true, but in a different way than is commonly believed. The table below shows tabulations for the number of respondents by area of law, fee arrangement, and side (for hourly fee lawyers).

	Torts only	Contract only	Both Tort and Contract	Neither Tort nor Contract
Contingent Fee	210	64	20	42
Hourly Fee Plaintiff	14	90	4	35
Hourly Fee Defendant	142	95	15	54

As the table shows, while most tort plaintiffs hire lawyers on a contingent fee basis, many cases not involving torts are handled by contingent fee lawyers as well (see also MacKinnon, 1964: 25-28). Thus, the results reported above for contingent fee lawyers do not simply reflect the peculiarities of personal injury litigation.

[18] The problem of multicollinearity accounts for some of the apparently bizarre results in Table 3 (e.g., the large negative coefficient of the trial variable for hourly plaintiffs' lawyers).

[19] This conclusion is reinforced by a global hypothesis test, also known as a Chow test (see note 26 below). The test showed that hourly fee plaintiffs' lawyers differed in a statistically significant way from both of the other two groups. The significance tests were done with both corrected and uncorrected data:

Table 3. Detailed Regression Results for Hourly and Contingent Fee Lawyers

	Contingent		All Hourly		Hourly Plaintiff		Hourly Defendant	
	b	std. error	b	std. error	b	std. error	b	std error
I. PARTY INTERACTION								
A. Party Interaction								
1. Pleadings	−2.004	1.684	−2.675	1.875	−4.274	2.782	−4.248	3.022
2. Motions	.145	1.744	−1.085	1.739	5.650	4.151	−.412	2.027
3. Discovery	2.865***	0.881	2.731***	0.832	4.527**	1.787	4.225***	1.046
4. Briefs	4.119*	2.262	8.851***	1.912	4.205	4.589	7.590***	2.201
II. CASE CHARACTERISTICS								
B. Case Characteristics								
5. Stakes	.310***	0.048	.232***	0.051	.234**	.086	.203**	.062
6. Complexity	5.963***	1.798	3.780**	1.465	20.729***	4.222	1.777	1.612
7. Duration	.012*	.005	.013*	0.006	−.002	.018	.001	.007
III. NATURE OF PARTICIPANTS								
C. Client Type								
8. Individual/ Organization	−9.440*	4.354	−1.949	3.843	−15.742*	8.134	−5.506	4.531
D. Lawyer Characteristics								
9. Specialization	2.455	2.143	1.872	1.791	−8.048	4.738	3.420	2.014
10. Law School Performance	2.710	2.733	3.442	2.118	−1.336	4.291	6.076**	2.578
11. General Experience	−.038	0.182	−.009	0.179	−.135	0.458	−.070	0.205
12. Litigation Experience	−.036	0.069	.037	0.062	.034	0.128	.068	0.073
13. Personal Capacity	1.144	2.354	−1.226	2.388	−10.770	7.238	1.950	2.694
14. Craftsmanship	−.052	2.170	7.026**	2.357	6.637	6.761	9.447***	2.702
IV. PARTICIPANT GOALS								
E. Client Goals								
15. Get Most/Pay Least	−9.931*	4.359	−18.352***	3.718	−22.539*	13.644	−21.165***	4.223
16. Get Fair/Pay Fair	0.983	3.551	−20.498***	4.259	−13.909*	7.855	−27.496***	5.665
F. Lawyer Goals								
17. Challenge	2.540	2.089	.909	1.898	0.176	5.983	3.659	2.124
18. Public Service	2.944	2.483	−11.017***	2.309	−3.252	4.993	−13.550**	2.805
19. Professional Visibility	0.620	2.578	6.165***	2.043	−5.463	6.087	8.180**	2.363
20. Make Money	3.165	2.480	1.165	2.043	10.020	6.916	0.741	3.022
21. Service to Regular Client	−13.238**	5.119	3.214	3.394	−14.267	9.423	11.037**	4.088
V. PROCESSING AND MANAGEMENT								
G. Processing Decisions								
22. State/Federal	0.341	4.161	14.116***	3.373	0.583	8.785	13.314***	4.005
23. Trial	−.055	6.705	4.637	5.714	−52.295**	21.483	2.372	5.971
24. Settlement Discussions	10.842	6.094	3.022	5.739	15.318	17.935	−1.371	6.895
H. Case Management								
25. Pretrial Events SOP	0.966	1.708	2.676*	1.505	−2.644	3.844	1.763	1.773
26. Estimating Case Value SOP	0.972	1.562	1.397	1.590	−4.251	3.746	.045	1.870
27. Plan for Motions	−11.389	6.725	11.109**	4.029	6.603	11.443	9.127**	4.429
28. Plan for Settlement	−3.467	3.755	−7.281*	3.671	−3.711	8.942	21.423***	3.910
29. Plan for Discovery	−1.179	3.466	15.921***	3.325	5.066	16.545	−9.131*	3.993
30. Client Control and Participation	1.750	2.404	−4.691*	2.192	2.936	4.916	−6.804**	2.519
CONSTANT	−3.335		−21.473		−36.993		−19.098	

*p<.05 **p<.01 ***p<.001

		corrected		uncorrected	
	df	F	p	F	p
Contingent versus (hourly plaintiff)	31/313	1.509	.0441	2.039	.0013
Hourly defendant versus (hourly plaintiff)	31/309	2.274	.0002	2.005	.0011

IV. RESULTS

Our estimates[20] of the number of hours an hourly fee lawyer and a contingent fee lawyer will spend on the three prototypical cases—the average hourly fee case, the average contingent fee case, and the overall average case—are shown in Table 4. As can be seen, the differences are not substantial. Nor is the direction of effect consistent. For the average contingent fee case, the contingent fee lawyer is expected to spend slightly more time than the hourly fee lawyer (51 versus 48 hours). For the average hourly fee case, the hourly fee lawyer is expected to spend substantially more time (51 versus 42 hours) than the contingent fee lawyer. The overall average is a reflection of the other two combined—the hourly lawyer spends somewhat more time, but not as much more as for the hourly fee average case (50 versus 46 hours).

Table 4. Predicted Number of Hours for the "Typical" Case

	Hourly Fee Lawyer	Contingent Fee Lawyer
"Average" Hourly Fee Case	50.6	42.1
"Average" Contingent Fee Case	47.9	50.7
Overall "Average" Case	49.5	45.7

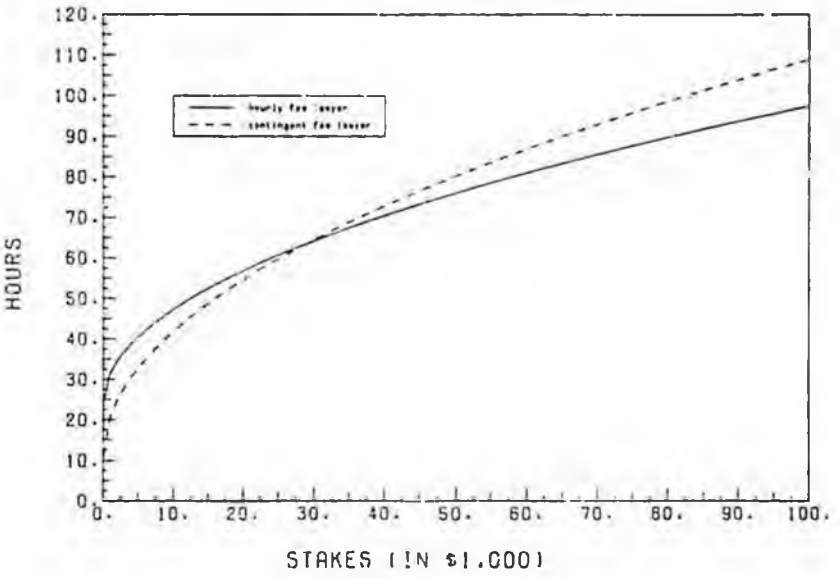
When we disaggregate the impact of fee arrangement by size of stakes (holding all other variables at their mean value for both types of fee arrangement taken together), the interesting pattern shown in Figure 2 appears.[21] The solid line represents our estimate of the average time investment of hourly fee lawyers, controlling for the other variables in our model, and the broken line represents the estimate for

[20] In making our estimates, we have retained our original model rather than discarding the nonsignificant variables in Table 3. We have chosen to do this for theoretical reasons; namely, we believe that our basic model is correct on theoretical grounds, and we prefer not to risk the problems created by misspecification arising from the omission of variables, particularly since there is less danger from misspecification by inclusion than from misspecification by exclusion (see Deegan, 1974; 1976).

[21] We have selected stakes as the case characteristic to vary because it seemed to us that in most discussions of litigation, the first question that is typically asked is, "what's at stake?" Moreover, most discussions relating to "access to justice" raise the question of "modest" cases (typically under $10,000), and the problem of providing legal services and other dispute processing services in such cases (see, for example, Johnson *et al.*, 1978).

contingent fee lawyers.[22] What Figure 2 suggests is that contingent fee lawyers put in less effort for small cases than do hourly fee lawyers, but they put in *more* time for "big" cases. Such behavior would be economically rational. The contingent fee lawyer's potential return is closely related to the potential recovery (i.e., stakes), and if a greater effort with a "big" case will substantially increase the recovery, lawyers would be behaving rationally in expending more effort.

Figure 2. Expected Lawyer Time by Stakes



Before we can draw any conclusions with confidence, we must see whether the differences shown in the figure are statistically significant.[23] To do this we relied upon the

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[22] The reason that the lines curve even though the regression equation is linear is that the predictive equation uses the square root of stakes, whereas Figure 2 uses the untransformed version of stakes.

[23] There is another problem with this interpretation as well. While it is rational for the contingent fee lawyer to spend more time on a big case than she would spend on a small case, it is not altogether clear why she would spend more time than the hourly fee lawyer. It may be that the contingent fee lawyer spends more time on big cases because she does not have to justify her time expenditure to the client and can behave in a risk-neutral fashion while the hourly fee lawyer has clients who are more likely to be risk-averse and thus unwilling to risk having to pay for all the time that the lawyer might reasonably spend on the case. The problem with this explanation is that the hourly fee lawyer is very likely to be representing an organization, which, as a "repeat player" (see Galanter, 1974) in the litigation game, should behave in a risk-neutral fashion. Also, one could argue that it is the contingent fee lawyer who should be risk-averse, since the lawyer stands to receive no compensation if she loses the case (though if she has no other cases to work on, the value of the lost time is minimal).

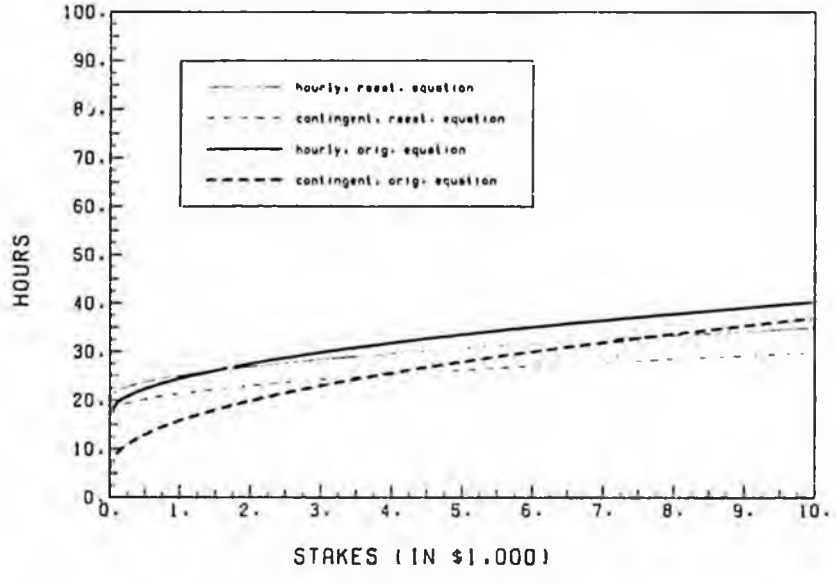
sampling errors of the estimated means for lawyer hours for $1,000 increments in stakes (from zero to $100,000). These sampling errors are a function of the deviation of the particular stakes value from the mean of stakes; the sampling errors are smallest near the mean and increase rapidly as the distance from the mean increases. Let us denote the estimated mean of lawyer hours for fee lawyers as $\hat{\mu}_H$ and its sampling errors as $\hat{\sigma}_H$; the corresponding estimates for contingent fee lawyers are $\hat{\mu}_C$ and $\hat{\sigma}_C$. The test statistic for a given value of stakes is a t-statistic:

$$t = \frac{\hat{\mu}_H - \hat{\mu}_C}{\sqrt{\hat{\sigma}_H^2 + \hat{\sigma}_C^2}}$$

A separate test statistic is computed for each value of stakes.

Using the test, we obtain significant differences only for stakes of $6,000 or less. At the last point of statistical significance, $6,000, the gap in lawyer effort is about 7 hours—32 hours for hourly fee lawyers versus 25 hours for contingent fee lawyers. To look more closely at the stakes range for which fee arrangement does have a significant effect on overall hours, we recomputed the value for the two curves using the mean values for cases $10,000 and under. The revised curves, shown as the heavy lines (solid for hourly, broken for percentage) in Figure 3, are essentially the same as for the equivalent portion

Figure 3. Expected Lawyer Time by Stakes for Small Cases



of Figure 2, since the shape of the curve is determined by the coefficient for stakes. We then reestimated the regression equations using $10,000 and under cases only, and once again recomputed the curves (shown as the lighter pair of lines in Figure 3). This pair of lines differs from the other pair in two regards. First, they are virtually parallel to one another (i.e., the gap between the lines changes little as stakes move from zero to $10,000). This is because there is little difference in the stakes coefficients in the $10,000 and under regressions. Second, they rise at a much slower pace. Elsewhere we have reported that we found little or no relationship between effort and stakes when the analysis is limited to cases involving $10,000 or less (Kritzer *et al.*, 1984), and this is what is showing up here. Nonetheless, for both pairs of curves, the line for contingent fee lawyers falls below that for hourly fee lawyers, which is consistent with our finding that there is an "effort gap" for cases in the lower stakes range.

Although we have found a statistically significant difference in effort only for cases with relatively modest amounts, this finding is not unimportant. First, as we have reported elsewhere (Trubek *et al.*, 1983a), the median case in state courts (based on cases terminated in 1978), where well over 95 percent of civil cases are filed (cf. Flango *et al.*, 1983: 5), involves about $4,500 (even after eliminating "small claim" type cases involving less than $1,000). Thus, our analysis indicates that for something over 50 percent of the civil suits for money damages filed in the United States, lawyers working on a contingent fee basis would put in significantly less time than would lawyers working on an hourly fee basis.[24] Second, as we noted in our discussion of the significance test we employed, the power of the test is greatest in the range in the vicinity of the mean, and thus the lack of significant differences for larger cases may be an artifact of the reduced power of the test.

The absolute size of the gap is not great—7 hours. In relative terms, however, it is sizable—nearly 22 percent of what hourly lawyers spend on a typical $6,000 case. Should we be concerned about this difference? The answer depends on whether the time differential makes a difference in case

[24] Some lawyer activity produces costs other than fees; for instance, medical examinations unconnected to treatment or the stenographic and travel costs of depositions. If such costs were generally relevant in small cases, which we doubt, plaintiffs might secure larger net recoveries with lawyers who did less for them if the difference in effort avoided such costs.

outcome.[25]

Whether or not the "effort gap" is important in terms of outcome, it is clear that fee arrangement has an important impact on lawyer behavior. The kinds of variables influencing lawyers differ depending on the fee arrangement, even though the overall ability of our model of lawyer effort to account for that effort was about the same for hourly fee and contingent fee lawyers.[26] These differences were summarized in Table 2 (which shows the relative influence of the variable clusters). Let us now turn to a more detailed examination of the results shown in Table 3 (looking at the coefficients for contingent fee lawyers and the overall coefficients for hourly fee lawyers).

Both groups of lawyers are influenced by party interaction variables and by participant goals. However, there are major differences *within* the clusters (i.e., which individual variables are important and how important they are). For example, the variable in the party interaction cluster that has the biggest impact for hourly fee lawyers, the number of briefs filed by the other side, also has the largest impact for contingent fee lawyers, but the impact is only half as large in the latter case. In the case characteristics group, all the variables are significant for both groups, but the impact of both stakes and complexity is larger for contingent fee lawyers. Few of the nature of participants variables have an influence for either group of lawyers, but the ones that do are different. Client type is significant for contingent fee lawyers while craftsmanship is significant for hourly fee lawyers. Participant goals are much more important for hourly fee lawyers, both in terms of the number of statistically significant coefficients and in terms of the magnitude of the effects of the individual variables. For example, both the indicators of client goals are significant for hourly fee lawyers, whereas only one is significant for contingent fee lawyers (and that one is about half the size of the corresponding coefficient for hourly fee

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[25] We have conducted some analyses of case outcomes (see Kritzer *et al.*, 1985) and have been unable to detect any relationship between outcomes and effort for contingent fee lawyers. This analysis has not explored, to date, the influence of relative effort (i.e., the impact of the opposing party's lawyer's effort).

[26] Even though the differences are quite clear, it is worthwhile to test formally the hypothesis that the set of coefficients for hourly fee lawyers differs from the set for contingent fee lawyers. This was done using the method described by Specht and Warren (1976), which is also known as the Chow test. The test was done for both the corrected and uncorrected form of the equation. Both tests produced highly significant F statistics (30 and 576 degrees of freedom), 2.118 for the corrected form ($p < .001$) and 1.378 for the uncorrected form ($p < .01$).

lawyers). None of the processing and management variables are significant for contingent fee lawyers whereas most are significant for hourly fee lawyers; furthermore, the values of the coefficients differ sharply for the two groups.[27] The one variable that was expected to have different effects for the two groups of lawyers, client control, has the expected effect for hourly fee lawyers, but has no significant influence (though the sign is in the predicted direction) for contingent fee lawyers.[28]

The time allocation of hourly fee and contingent fee lawyers is dependent on different factors. Contingent fee lawyers appear to be highly sensitive to the potential productivity of their time and are less affected by craft-oriented factors. This effect can be seen in two variables: craftsmanship and response to opposing party's briefs. The contingent fee lawyer does spend time in response to the opposing side's briefs, but that response involves half as much time per brief as the response of hourly fee lawyers.[29] While the hourly fee lawyer is strongly influenced by commitment to craftsmanship, the contingent fee lawyer is not. On the other hand, the level of effort of contingent fee lawyers goes up at a faster rate as the level of stakes increases than that of hourly fee lawyers. In other words, the contingent fee lawyer appears sensitive to the potential return to be achieved from a case, which is closely related to the stakes. The hourly fee lawyer's return from a case is not as tied to stakes, and other types of considerations (e.g., the client's goals, the nature of the forum, etc.) have a greater influence.

Before turning to our conclusions, we should briefly explore the *side* versus *fee arrangement* question as reflected in the results shown in Table 3. As we noted previously, the effect of some variables is dissimilar for hourly fee defendants' and plaintiffs' lawyers while for other variables it is the contingent and hourly plaintiffs' lawyers who have dissimilar

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[27] We should note that the difference in significance cannot be attributed to the smaller sample size for contingent fee lawyers. With one exception, even if the contingent fee lawyer sample were as large as the hourly fee sample (and everything else were unchanged), the coefficients would not differ significantly from zero; the one exception is *plan for motions*, and there the sign of the coefficient is different.

[28] One variable that we have not considered in this analysis is area of law; one might expect that defense lawyers in personal injury cases would differ from other hourly fee lawyers. Where we included area of law as a variable, we found that it exerted no significant influence over and above the effects represented by the other variables in the model (Kritzer *et al.*, 1984).

[29] We should note, however, that this might be a "side" effect; as shown in Table 3, the contingent fee coefficient is virtually identical in magnitude to that for the hourly plaintiff, though the latter is not statistically significant.

coefficients. To be more specific, we find substantial differences based on side for court (state versus federal), plan for settlement, client control and participation, and briefs; we find substantial differences based on fee arrangement for discovery events, stakes, and client goals (get most/pay least and get fair/pay fair). For this latter set, the differences are consistent with what the arguments about fee arrangements would lead one to expect: contingent fee lawyers are more sensitive to stakes (which determine their expected return), put in less time on discovery (i.e., try to reduce their time), and are less concerned with their clients' goals. At the same time, the side-based dissimilarities tend to muddy the picture: e.g., where we had strong theoretical reasons to expect contingent fee lawyers and hourly fee lawyers to be influenced differently by client control and participation, the differences we find seem to be side-related; although we found that contingent fee lawyers put in less time than hourly fee lawyers responding to discovery, when it comes to briefs, the differences that we seem to find are between defendants' lawyers and plaintiffs' lawyers (irrespective of fee arrangement). Despite this "haziness," Table 3 shows some clear differences between hourly and contingent fee lawyers, and those differences make theoretical sense.

V. CONCLUSIONS

Simple hypotheses about the relationship between fee arrangements and the way lawyers handle civil cases are misleading, at best. Where such models predict that, other things being equal, contingent fee lawyers would always spend less time on a case than hourly fee lawyers, our data show that this effect occurs only in cases involving less than $10,000; above that level (if anything) the opposite effect appears to be occurring. Moreover, where simple models suggest that fee arrangements affect lawyer behavior directly, we have found that the effects, when they exist, are more indirect and work through other variables, which themselves must be taken into account before one can understand what difference fee arrangements will make in any particular case.

Second, our analysis suggests that even if contingent fee lawyers and hourly fee lawyers spend similar amounts of time on cases, the factors that affect time allocation differ. Thus, contingent fee lawyers seem to be more sensitive to the productivity of their time and are less influenced by purely craft-oriented considerations. As the amount of money at stake

in a case goes up, the contingent fee lawyer seems to be willing to invest relatively more time in cases.

More than anything else, our study points to the need for additional conceptual and empirical work on fee arrangements before anything definitive can be said about the policy issues that are typically addressed in the literature. We have pointed out that the assumptions underlying some of the criticisms of the contingent fee are questionable. Even if contingent fee lawyers do spend less time on cases than would hourly fee lawyers, the client is still benefited by a low cost, low risk opportunity to pursue a claim which would otherwise be unavailable. When one finds, as we did, that the alleged effort gap may not always exist, there is further reason to question the policy conclusions that have been drawn so far.[30]

This rationale does not lead to an unqualified defense of the contingent fee against the criticisms that have been leveled at it. We do find an effort gap for many of the cases brought in civil courts. But we do not know whether this gap affects case outcomes, nor do we know whether any lesser outcomes can be justified by offsetting advantages of the contingent fee to the client. Thus, while the study clarifies some empirical and policy issues in the debate over fee arrangements, it certainly does not settle them.

APPENDIX: VARIABLE MEASUREMENT

The specific indicators for each of the variables that our model suggests would be important in accounting for lawyer effort and their construction have previously been reported in detail (see Kritzer *et al.*, 1984). Here we simply summarize the indicators used for each of the clusters.

The variable to be explained is the number of hours that the lawyer(s) reported having worked on the case; if more than one lawyer within a firm had worked on a case, we combined the time for all of the lawyers to arrive at a single figure.

The independent variables were grouped into five separate clusters. The first cluster of explanatory variables was designed to measure *party interaction*. As indicators of interaction, we used counts of each of four types of court events that were initiated by the *other* side; these indicators were chosen because a principal vehicle of the action-reaction process is the formal initiation of activities such as discovery and motions (both procedural and substantive). Our

[30] Another policy question concerns the propriety of the fees earned by contingent fee lawyers in "big" cases (see Grady, 1976). Our analysis does not speak directly to that question.

assumption was that each event required a response that would result in the expenditure of lawyer time. Four separate measures were created by counting four distinct types of events: *pleadings* (1),[31] *nondiscovery motions* (2), *discovery events* including depositions, interrogatories, discovery motions, and the like (3), and *briefs* (4).

The second cluster of explanatory variables measures *case characteristics*. These include measures of the amount of money at stake, the complexity of the case, and the length of time from the date of filing to the date of termination (through judgment or dismissal by whatever means and/or for whatever reason). We have already noted the reasons why we expected *stakes* (5) to be an important determinant of the time invested. The implications of *complexity* (6) also appear intuitively obvious: cases vary in the ease with which questions of law may be answered and proof made. The more complex the law involved, or the more difficult the problems of proof, the more time it should take to conduct the litigation. Our measure of complexity was based on lawyer responses to a question in which they were asked to rate the complexity of the case on a five-point scale. Finally, we expected that the length of time a case took from the filing of the complaint to the termination of the suit would have an independent effect on the number of hours lawyers put in. Cases that stretch over long periods of time may require a lawyer periodically to refresh her memory and may also lead her to "find" things to do. We measured *duration* (7) as the number of days that elapsed from the filing of the case to its termination.

Our third cluster of independent variables deals with the *nature of the participants* (i.e., the lawyers and their clients). We classified clients—*client type* (8)—as individuals or organizations because the literature suggests (Galanter, 1974) that organizations will devote more resources to litigation than individuals. This may, at least in part, reflect the ability of organizations to subsidize legal fees by deducting them as a business expense from taxable income, which is not ordinarily possible for individual litigants.

With respect to lawyers, our information was more extensive. We created six separate indicators designed to measure variation in lawyer characteristics. *Specialization* (9) measures whether the case in our sample fell within the lawyer's specialty or not. *Law school performance* (10) is the lawyer's self-report performance as a law student (i.e., rank in class and participation on the law review). Amount of *general experience* (11) is the number of years the lawyer had been practicing law. *Litigation experience* (12) is the proportion of the lawyer's time devoted to litigation. *Personal capacity* (13) is a measure of the lawyer's feelings of efficacy based on a standard measure. Lastly, *craftsmanship* (14) is the likelihood (self-reported) of spending extra time to make marginal improvements on legal documents; the more likely this was, the higher the "craftsmanship" score. We expected the first five lawyer characteristic variables, which measure ability and self-confidence, to be inversely related to the amount of time lawyers spent on cases. More experienced,

[31] The numbers and letters in parentheses are variable numbers and subset flags that we use to index the tables.

specialized, and confident lawyers should not have to spend as much time on cases as attorneys who were newer to the field of law, the courtroom, or to practice in general. The craftsmanship variable was expected to work the other way. One would expect lawyers who are more oriented toward "craftsmanship" to spend more time on their cases, other things equal.

Our fourth cluster of independent variables relates to the *participants' goals*; these we measured for both lawyers and clients using data from the lawyers. We asked lawyers what they thought their *clients' goals* were in the case. The "goals" variable, in a sense, modifies the "stakes" variable. We expected the lawyer whose clients wanted to get the most (or pay the least) to put in more time on a case than the lawyer in an otherwise identical case whose client only wanted "fairness." We assumed that those clients (about 24% of our respondents' clients) who mentioned neither "*get most/pay least*" (15) nor "*get fair/pay fair*" (16) but did mention something else (in response to the open-ended question that we had asked) were primarily concerned with goals other than money.

Since lawyers may have their own motives, which might affect the amount of time they spend on cases, we also asked our respondents why they had taken the case in question. From their answers, we constructed five *lawyer goal* variables designed to measure the predominance of different factors in the lawyer's decision to take the case. These are:

> *challenge* (17)—did the case present a challenge; was it intellectually interesting?
> *public service* (18)—did it provide an opportunity for service to the public; was it taken because of sympathy for the client?
> *professional visibility* (19)—would the case increase the attorney's community standing, improve her position in the firm, create publicity for the firm?
> *making money* (20)—was the case taken primarily for the amount of money the lawyer would earn?
> *service to regular client* (21)—did the lawyer take the case simply to service a regular client?

We felt that variations in these goals were likely to affect hours worked, but we did not have strong expectations concerning the nature of some of the other goals. For example, we thought that the professional visibility and challenge goals might lead to more hours than the making money goal, but we had no *a priori* expectations about the direction of the "public service" variable's effect.

The final cluster of variables we constructed related to the processing and management of the case. During a case a number of key *processing decisions* are made which might affect lawyer effort. The decision whether to file in *state or federal* (22) court, assuming a choice exists, can have an effect because different courts may have different rules and norms that affect the amount of effort required to process a case. Decisions to engage in *settlement discussions* (23) and to take a case to *trial* (24)[32] may also have an impact on lawyer effort.

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[32] The trial variable is taken from the court record and indicates whether a trial was started, even if the case settled during trial.

We expected lawyers to vary in the *case management* techniques they used and that these differences might affect the hours they put in. We used three indicators: standard operating procedures (SOPs), plans, and client control. We thought that the lawyers who developed standard operating procedures (e.g., the use of preprinted forms, computer programs, and the like) for *estimating case value* (26) and for *pretrial events* (25) would be able to reduce the number of hours spent on a case, other things being equal. Explicit planning should also increase lawyer efficiency and thus decrease time spent: *plans for motions* (27), *plans for settlement* (28), and *plans for discovery* (29) indicate whether or not the lawyer reported planning in advance for the activities in question.

We thought *client control and participation* (30) would influence hours spent, but that the effect would differ for hourly fee lawyers and contingent fee lawyers. Following Johnson (1980-81), we thought that hourly fee clients would most often want to reduce the hours spent by their lawyers and contingent fee clients would try to increase the time spent by their lawyers. For these reasons we expected that a high level of client control for hourly fee lawyers would reduce the number of hours those lawyers worked on a case, other things equal. In contrast, we expected that for contingent fee lawyers high client control would lead to an increase in the number of hours the lawyer would work on the case (see Rosenthal, 1974). We measured the client control variable using the lawyers' descriptions of (a) reporting procedures to the client and (b) the client's participation in the key decisions in the case.

Our complete model includes the dependent variable "hours" and the 30 independent variables that we thought might explain variation in hours expended. In developing our model, we had to rely on "empirical feel" as well as on existing theory since the available theory was incomplete and largely untested. Table 1 sets forth all the variables described above, including measurement method, summary statistics, and the expected direction of the relationship (0 designates variables for which we had no expectation of the direction of the possible effects).

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Punitive Damages and the Civil Justice System

The Case for Reform and a Plan of Action

National Association of Independent Insurers

Punitive Damages and the Civil Justice System

The Case for Reform and a Plan of Action

National Association of Independent Insurers

The National Association of Independent Insurers, founded in 1945, is a non-profit trade association of 500 property-casualty insurers, comprising companies of every size and type. Its members write approximately 40 per cent of the auto insurance in the U.S., a quarter of the homeowners coverage, and lesser portions of other property-casualty lines.

Lowell R. Beck, President

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I. Introduction

There is growing consensus that we are in need of substantial civil justice reform in the United States, and rightly so. We are presently experiencing unprecedented growth in the number of lawsuits and their attendant costs. In 1982 alone, the federal courts faced 26,000 more civil cases than in the previous year, a 14 per cent increase. The explosion of civil cases and the consequent docket backlog have resulted in substantial costs to taxpayers just to process these suits. The Institute for Civil Justice (ICJ), a nonprofit research group dedicated to analyses of various problems in the civil justice system, estimated that the cost to taxpayers to fund cases in 1980 exceeded $380,000,000. The backlog reflects fundamental problems in our civil justice process. The system simply is not working well. Cases are taking too long to reach resolution, at a tremendous cost to the parties and, ultimately, to society. The majority of the U.S. citizenry is being turned off by what it perceives as a litigation system perpetuated by and for the benefit of its primary participants, i.e., lawyers and a litigious minority of plaintiffs.

The civil backlog has been accompanied and indeed may be caused by major problems within our personal injury law. It is these defects in the civil justice system which command our attention. The liberalization of product liability law, abuse of the contingent fee system, the development of bad faith litigation, the spreading of pre-judgment interest statutes, and the crisis in medical malpractice have all combined to bring turmoil to our civil justice system. In many respects we have lost our focus on the fundamental purposes of the civil litigation structure: justice, fairness, and equitable compensation.

Perhaps nowhere is the need for tort reform greater than in the law of punitive damages. Punitive or exemplary damages are those damages which may be recovered in addition to a compensatory award where the defendants' conduct was willful or wanton. The number and amount of punitive damages awards have reached mind-boggling proportions. Seven and eight-figure awards, which were unheard of in the not too distant past, have become relatively common. The number and size of punitive awards in Cook County, Illinois doubled from the late 1970s to the early 1980s. As a result, the total amount awarded to plaintiffs increased 400 per cent. The surge in punitive verdicts has been documented and criticized in a plethora of commentaries.

The outbreak of punitive awards and its direct and indirect effects on society may be attributed to severe inequities within the law of punitive damages. Standards of conduct warranting the assessment of punitive verdicts have been dramatically liberalized. Those standards also vary considerably from state to state, creating uncertainty as to obligations and liabilities. Many courts have discarded the once prevalent prerequisite of a compensatory award and the requirement that exemplary damages bear a reasonable relation to the compensatory award. The vagueness and diversity within and among the standards for punitive conduct exemplify the lack of coherent rationale for these damages in today's civil justice system. Due to the absence of a consistent rationale, punitive awards have continued to grow in number and size. Insufficient standards and the unbridled nature of the awards have caused an explosion in punitive assessments. Plaintiffs' lawyers seeking to boost their contingency fees emotionally exhort jurors to "punish" the corporate defendant. The punitive damage award is open-ended, and may be reversed or reduced on appeal only where contrary to the manifest weight of the evidence. The result: a windfall for the plaintiff and his attorney, a windfall for which we all must ultimately pay.

The crisis in punitive damages law has tremendous importance for all of us. The costs incurred by society through application of the doctrine far outweigh the minimal benefits achieved. The most common rationales offered for punitive damages are punishment and deterrence. By punishing the defendant and deterring him and others from similar action, society is supposed to benefit. But as the following analysis reveals, these purposes are no longer really served through the law of punitive damages as it is applied today. Huge verdicts against product manufacturers and their insurers mean that the public, the intended beneficiaries of the doctrine of punitive damages, pays the ultimate price through higher costs for consumer products, services and insurance premiums.

A brief analysis of various aspects of the punitive damages doctrine in the U.S. illustrates the compelling need for reform.

II. The Law of Punitive Damages in the U.S.

Historical development

Punitive damage awards had their origin in 18th century England. It was there that the courts began to recognize, in limited circumstances, the availability of damages in addition to compensatory awards. Three theories have been proffered for the genesis of these additional exemplary awards:

Courts reluctant to grant new trials due to excessive damages began to justify their affirmance based on the defendant's malice, or willful or wanton conduct.

Punitive damages evolved as a means to compensate a plaintiff for damages which were formally uncompensable under the law at that time.

Various gaps in the criminal law caused the need for the evolution of a form of punishment in civil cases.

Actually all three strands of thought combined to play an important role in the development of the doctrine in the United States. Under American jurisprudence, punishment and deterrence serve as the predominant purposes, though substantial conflict exists among the states as to the proper justification for punitive awards.

Modern Rationale and Application

Today punitive damages may be recovered, in addition to compensatory awards, in the vast majority of states. Only four states (Louisiana, Massachusetts, Nebraska and Washington) as a rule prohibit punitive damages. These states authorize exemplary awards only in a limited number of statutorily prescribed circumstances (e.g., wrongful death actions).

The forty-six states that allow punitive damages differ substantially in their application of the concept. It is generally conceded that punishment and deterrence are the purposes of exemplary damages, yet a survey of purposes proffered in each jurisdiction for punitive awards reveals that the rationales are far from uniform. Though punitive damages are not supposed to compensate, but to punish and deter, four jurisdictions have limited punitive damages and the circumstances warranting their assessment in such a manner that they have been interpreted as treating these damages as compensatory in nature.

1. The **Connecticut** Supreme Court has long adhered to the view that the purpose of punitive damages is neither punishment nor deterrence, rather they are designed to provide additional compensation for the plaintiff's injuries. Thus punitive awards "may not exceed the amount of the plaintiff's expenses of litigation, less taxable costs." *Collens v. New Cannan Water Company*, 234 A.2d 825 (Conn. 1967).

2. **Georgia** Code Ann. Section 103-2002 provides: "In every tort there may be aggravating circumstances either in the act or intention, and in that event the jury may give additional damages either to deter the wrongdoer from repeating the trespass or as compensation for the wounded feelings of the plaintiff." This section provides additional damages to compensate for wounded feelings or to deter, but **not** for both purposes. Georgia does not allow punitive damages in the traditional sense, but allows limited additional recovery, usually for "injured feelings." *Smith v. Miliken*, 276 S.E.2d 35 (Ga. 1981).

3. **Michigan** similarly provides additional exemplary damages "to compensate for the plaintiff's injured feelings." But the state has specifically prohibited the use of punitive damages for the purpose of punishing the defendant. *Jackovich v. Bureau Inc.*, 326 N.W.2d 458 (Mich. 1982).

4. **New Hampshire** still adheres to its traditional distaste for punitive damages. This state, like Michigan, provides additional compensation, not to punish or deter, but to increase compensatory damages "to compensate for the vexation and distress caused the plaintiff by the character of defendant's conduct." *Rahaim v. Psaras*, 448 A.2d 401 (N.H. 1982).

The diversity of purposes of punitive damages does not end with these four states. Disagreement

exists among the remaining forty-two punitive damage states as to whether punishment, deterrence or both rationales will support punitive awards. In Alaska, Georgia, Idaho, Maine, Oregon, Rhode Island and Utah, deterrence provides the sole basis for a punitive award. Delaware on the other hand authorizes punitives solely for the sake of punishment. The remaining jurisdictions espouse both rationales. Finally, note that in the "deterrence" jurisdictions, courts are further divided as to whether general or specific deterrence is the goal. In Arizona, Georgia, New Jersey and Rhode Island, controlling decisional authority lists deterrence as intended only for the defendant, while the remaining jurisdictions hold that general deterrence is the aim of punitive damages.

Standard of Conduct

Many of the problems with punitive damage awards stem from the uncertainty in each jurisdiction as to the conduct necessary for a punitive award. Note the vague standards permeating the various delineations of punitive damages among the several states:

Alabama: "malice, willfulness, or wanton and reckless disregard rights of others," *Ex Parte Smith*, 412 S.2d 1222 (Ala. 1982).

Alaska: "outrageous... acts done with malice or bad motives or a reckless indifference to the interests of another," *Stum, Ruger & Co., Inc. v. Day*, 594 P.2d 38 (Alas. 1979).

Arizona: "gross, wanton, malicious, and oppressive conduct...," *Salt River Valley v. Giglio*, 549 A.2d 162 (Ariz. 1976).

Arkansas: "malice,... willfulness, wantonness, or conscious indifference to consequences," *Satterfield v. Rebsamer Ford, Inc.*, 485 S.W.2d 192 (Ark. 1972).

California: "oppression, fraud or malice," Cal. Code Civ. pro. §3294.

Colorado: "fraud, malice or insult, or a wanton and reckless disregard," Colo. Rev. Stat. §13-21-102.

Connecticut: "reckless indifference... or intentional and wanton conduct," *Collens v. New Cannan Water Co.*, 234 A.2d 825 (Conn. 1967).

Delaware: "wrongful act...committed willfully and wantonly," *Malcolm v. Little*, 295 A.2d 711 (Del. Super. 1972).

Florida: "malice, moral turpitude, gross negligence to the rights of others, wantonness, oppression, outrageous aggravation or fraud," *Stinson v. Center*, 416 So.2d 1183 (Fla. Supp. 1982).

Georgia: "willful misconduct, malice, fraud, wantonness, or oppression," *General Refractories Co. v. Rogers*, 239 S.E.2d 795 (Ga. 1977).

Hawaii: "willful, malicious, wanton or aggravated wrongs... (or) reckless indifference," *Goo v. Continental Cas. Co.*, 473 P.2d 563 (Haw. 1970).

Idaho: "wanton, malicious, or gross and outrageous (acts)," *Gandall v. Ganz*, 537 P.2d 65 (Id. 1975).

Illinois: "fraud, actual malice, deliberate violence or oppression... gross negligence... or wanton disregard," *Kelsay v. Motorola*, 284 N.E.2d 353 (Ill. 1978).

Indiana: "fraud, malice, gross negligence or oppression," *Hibschman v. Batchelor*, 362 N.E.2d 845 (Ind. 1977).

Iowa: "malice,... (indifference) or feeling toward the person injured," *Meyer v. Nottger*, 241 N.W.2d 911 (Iowa 1976).

Kansas: "fraud, malice, gross negligence or oppression," *Newton v. Hornblower, Inc.*, 582 P.2d 1136 (Kan. 1978).

Kentucky: "wanton, reckless, malicious, or offensive (acts)," *Harrod v. Fraley*, 289 S.W.2d 203 (Ky. 1956).

Maine: "intentional, wanton, malicious, reckless, or grossly negligent (acts)," *Oliver v. Martin*, 460 A.2d 594 (Me. 1983).

Maryland: "fraud, malice, evil intent or oppression," *General Motors v. Piskor*, 352 A.2d 810 (Md. 1976)

Michigan: "malice, willful, or wanton misconduct, carelessness, or negligence," *Bailey v. Graves*, 309 N.W.2d 166 (Mich. 1981).

Minnesota: "willful indifference to the rights or safety of others," M.S.A. §549.20.

Mississippi: "willful and intentional wrong, or... gross negligence and reckless negligence," *Seals v. St. Regis paper Co.*, 236 So.2d 388 (Miss. 1970).

Missouri: "whether defendant did a wrongful act intentionally without just cause or excuse," *Musselman v. Anheuser-Busch*, 657 S.W.2d 282 (Mo. 1983).

Montana: "oppression, fraud, or malice, actual or presumed," Mont. Code Ann. §27-1-221.

Nevada: "oppression, fraud or malice, express or implied," Nev. Rev. Stats §42.010.

New Jersey: "actual malice... or wanton and willful disregard," *Sandler v. Lawn-A-Mat Co.*, 358 A.2d 805 (N.J. 1976).

New Mexico: "maliciously intentional, fraudulent, oppressive... reckless... or wanton (acts)," *Loucks v. National Back*, 418 P.2d 191 (New Mex. 1966).

New York: "malice, fraud, oppression, insult, wanton or reckless disregard," *Le Mistral, Inc. v. Columbia*, 402 N.Y.S. 2d 815 (1978)

North Carolina: "fraud, malice... reckless indifference... oppression, insult, rudeness, caprice, willfulness," *Newton v. Standard Fire Ins. Co.*, 229 S.E.2d 297 (1976).

North Dakota: "oppression, fraud, or malice, actual or presumed," N.D.C.C. §32-03-07.

Ohio: "intentional, reckless, wanton, willful and gross acts or... malice," *Rubeck v. Huffman*, 374 N.E.2d 411 (Ohio 1978).

Oklahoma: "oppression, fraud or malice, actual or presumed," 0.S.A. tit. 23 §9.

Oregon: "aggravated disregard of the rights of others," *Senn v. Bunick*, 594 P.2d 837 (Ore. 1979).

Pennsylvania: "malicious, wanton, reckless, willful, or oppressive conduct," *Franklin Music v. ABC*, 616 F.2d 528 (3rd Cir. 1979).

Rhode Island: "willfulness, recklessness or wickedness," *Shorman v. McDermott*, 329 A.2d 195 (R.I. 1974).

South Carolina: "malice, ill will, conscious indifference to the rights of others," *Tieg v. Allstate Ins. Co.*, 251 S.E.2d 194 (S.C. 1979).

South Dakota: "oppression, fraud, or malice, actual or presumed," S.D.C.L. §321-3-2.

Tennessee: "fraud, malice, gross negligence or oppression," *Inland Container Corp. v. March*, 529 S.W.2d 43 (Tenn. 1975).

Texas: "wanton and malicious (act)," *Ogle v. Craig*, 464 S.W.2d 95 (Tex. 1971).

Utah: "malicious and willful conduct or knowing and reckless indifference," *Behrens v. Raleigh Hospital*, 675 P.2d 1179 (Utah 1983).

Vermont: "willful and wanton or fraudulent tort," *Shortle v. Central Vermont Public Service Corp.*, 399 A.2d 517 (Vt. 1974).

Virginia: "actual malice or. . . recklessness or negligence," *Jordan v. Saure*, 247 S.E.2d 739 (Va. 1978).

West Virginia: "intentional wrong or malice, willfulness, or wanton disregard," *Addair v. Huffman*, 195 S.E.2d 739 (W.Va. 1973).

Wisconsin: "wanton, willful or reckless disregard," *Jeffers v. Nysse*, 297 N.W.2d 495 (Wis. 1980).

Wyoming: "aggravated disregard of another's rights," *Sears v. Summit Inc.*, 616 P.2d 765 (Wyo. 1980).

The diverse verbiage among the relevant standards is consistent only in that something more than simple negligence must be proved. Gross negligence will support a punitive award in most jurisdictions. Apart from these general guidelines, jurors are confronted with the broad and often ambiguous language ("moral turpitude, evil intent, caprice, malice") contained in the various statutory and common law definitions. At this point, the vague guidelines combine with emotional pleas from plaintiff's counsel and lead, in some cases, to runaway awards.

In most states the standard of conduct is delineated in controlling Supreme Court precedent. However, eight states have statutorily prescribed the requisite conduct for punitive awards. The statutes generally accord in that they allow punitives "where the defendant has been guilty of oppression, fraud, or malice, actual or presumed," (South Dak. Comp. Laws Section 21-3-2). The statutory definitions tend to be simpler, less cumbersome and more easily applied than their common law counterparts. Therefore, one positive reform in punitive damage law would entail the enactment of coherent statutory specifications in other states.

Guidelines for the Amount of Awards

The Demise of the Reasonable Relation Rule

Though juries receive only very broad guidelines as to punitive conduct, they are given even less guidance in determining the amount of the exemplary award. The problem arises from the difficulty in assessing with accuracy the amount necessary to punish and deter a particular defendant. One previous guideline for punitive verdicts was the requirement that they bear a reasonable relation to the compensatory damages awarded. A majority of states, however, have now rejected this once prevalent rule. Opponents of the reasonable relation rule argue that a large verdict to punish and deter should be available even though actual damages may be relatively insignificant. The reasonable relation rule, however, does serve as one check on outrageous and unwarranted verdicts. The answer to the problem in assessing punitive damages lies not in scuttling the reasonable relation rule but enacting more precise and reasonable limits on punitive awards. One such limit could consist of a monetary cap, or a specified ratio to compensatory damages.

Wealth of Defendant

One of the most controversial and problematic aspects of punitive awards is the use of defendants' wealth as a measure for punitive verdicts. Currently jurors in most jurisdictions are instructed to consider the wealth of the defendant in assessing a punitive award. Proponents of this instruction argue that a "punishing" verdict cannot be entered absent evidence of the defen-

dant's financial status. But this deceptive logic ignores the tremendous problems created for corporate defendants by the rule, undeniably punishing them for their profits. The overkill presently underway in punitive awards against major corporations punishes not only those defendants but their consuming public as well.

It is argued that the trial and appellate courts' power to reduce or reverse an excessive punitive award provides a check on excessive punitive damage verdicts. The courts' authority has, in some cases, served as a check on excessive punitive damage awards. This safeguard, however, is limited by the presumption of validity which attaches to every verdict. Particularly in jurisdictions abrogating the reasonable relation rule, appellate courts will set aside a verdict only where it shocks the conscience of the court or utterly lacks support in the trial record.

Prerequisite Actual Damages

Other departing limits on punitive awards involve the once formerly uniform prerequisite of the recovery of actual damages. Jurisdictions have divided in the past on the question of whether nominal damages alone may support a punitive award. The majority of of states addressing the question have by now held that nominal damages will support a punitive count (Alaska, Georgia, Colorado, Florida, Idaho, Kentucky, Maryland, Missouri, Montana, New Jersey, New Mexico, North Carolina, Oklahoma, New York, South Carolina). The clear trend is toward the majority "nominal is sufficient" rule. More importantly, it should also be noted that four states (Montana, Florida, New Jersey, West Virginia) have gone even further by dispensing entirely with the requirement of actual damages.

Punitive and Vicarious Liability

The lack of coherent rationale for punitive awards is exemplified by, in addition to the mixture of purposes enunciated by the states, the application of punitive damages to vicariously liable tortfeasors. Punishment and deterrence cannot logically stand as coherent rationales for punitive awards against one who never even committed the tort. Yet the universal rule holds that vicariously liable tortfeasors may be required to pay punitive damages. A bare majority of the states follow the Restatement rule which provides that vicariously liable tortfeasors may be liable for punitive damages only where the tortfeasor ratified or authorized his agent's conduct. But a growing and substantial minority of jurisdictions follow the so-called liberal approach, holding employers equally vulnerable to compensatory and punitive awards. The application of the punitive damages doctrine in the vicarious liability setting provides ample food for thought with respect to the punitive damages doctrine in general. There is no reasonable basis for assessing punitive damages against a vicariously liable defendant who did not ratify or authorize his agent's conduct.

Realistically does the possibility of a punitive award affect an employer's choice of employee or the instructions given to that agent? The answer has to be in the negative. Why then, do we allow assessment of punitives against a vicariously liable tortfeasor? This is the type of fundamental inquiry we must make in order to restore reason and balance to our civil justice system in general, as well as in the law of punitive damages.

Punitive Damages and Product Liability

Conceptual incompatability also pervades the awarding of punitive damages in product liability cases. First, note that the law of product liability itself has been liberalized substantially in recent years. We have, in many respects, evolved from fault evaluation into an absolute liability system.

According to the Institute for Civil Justice, product liability judgments accounted for almost one-fourth of the entire amount awarded to plaintiffs in the 1970s. This liberalization of product liability law, combined with the same trend in punitive damage law, has led to tremendous problems for American manufacturers and their insurers. The admissability of the corporate defendant's wealth has further contributed to the escalation in punitive product liability verdicts. Add to this the fact that a product liability manufacturer may be hit with a string of punitive damage judgments for a single act or course of conduct, as evidenced by the asbestos cases. As a result the price tag of many American-made products includes an increase due to product liability verdicts, defense costs and product liability insurance premiums.

All this has occurred in spite of the initial conceptual incompatability of punitive damages and product liability actions. Most product suits are grounded on strict liability, which involves no consideration of the wrongfulness of the defendant's conduct. Punitive damages, however, are supposed to punish the defendant and deter him and others from similar conduct. Once again, we see the rationale of punishment and deterrence is no rationale at all.

An analysis of the laws of product liability and punitive damages, separately and as they interrelate, reveals the need for reform. More important than the theoretical inconsistency of granting punitive damages in strict product liability suits is the aggregate harm inflicted on our manufacturing and consuming sectors by recent trends in punitive awards. Undoubtedly we need a forum to redress injuries caused by defective products. We must, however, consider whether the present law, with respect to product liability punitive damages, really serves the public interest. Is not deterrence already achieved through the panoply of substantial compensatory damages available to product liability plaintiffs and the costs to defend such cases? We need to strike a more reasonable balance between the need to compensate injured consumers and the interests of society as a whole.

Inconsistent standards and multi-million dollar punitive product liability verdicts provide no additional incentive to make safer products. They do, however, result in higher prices of consumer goods. One of the more serious effects of the wave of punitive damages and product liability suits is the passing of the costs to the consumer. In addition, as the cost of product liability insurance policies increases, the cost is reflected in the products of all manufacturers, not just those hit by major punitive product liability awards.

Insurability of Punitive Damages

Another problem resulting from the liberalization of the law of punitive damages is the growing trend toward holding them insurable. The majority rule holds that punitive damages are included in the standard "all sums" policy, and their insurability violates no public policy. In this respect we see again that the purported rationale for punitive damages will not hold water. How can punishment and deterrence be achieved when a wanton tortfeasor can pass his liability onto his insurance carrier?

Cases holding for insurability generally are based on (1) the reasonable expectations rationale; (2) the fact the insurer could have excluded such coverage; and for (3) the unlikelihood that the denial of coverage for punitive damages would deter anyone. A more recent and admittedly realistic rationale espoused by the Montana Supreme Court holds that absent coverage for punitive damages, many policies would become worthless in light of the recent explosion of punitive claims.

First Bank v. Transamerica Insurance Corp., 679 P.2d 650 (Mont. 1984). Note there is no technical legal basis for this holding, but it merely reflects a philosophy that punitives have become so common and so costly that insurance companies should bear the risk.

A shrinking minority of courts has denied insurability since neither punishment nor deterrence would be served by holding punitive damages insurable. The leading case denying coverage noted the "especially strong public policy reasons for not allowing socially irresponsible defendants . . . to escape . . . punishment." *Northwestern National Cas. Co. v. McNulty*, 307 F.2d 432, 441 (5th Cir. 1962).

The public interest is no more served by the insurability of punitive damages than by the explosion of the awards themselves. Holding punitive damages insurable in no way answers the problem of punitive awards, and in many respects exacerbates the turmoil. As a result, the insurance pool must absorb the added cost.

Bad Faith Suits

Punitive damages and bad faith suits present perhaps a greater threat to the insurance industry than any other civil justice problem. The ongoing liberalization of the general law of punitive damages combined with the explosion of insurance bad faith litigation have resulted in a tremendous increase in the number and amount of awards assessed against insurers in bad faith suits. "Bad faith" allows a cause of action by the insured or a third-party claimant if the carrier violated what the courts have termed the insurer's duty of good faith and fair dealing. Through the recent development of the bad faith action, insureds may receive substantial awards where their insurer denies their claim in "bad faith."

The genesis of the bad faith action occurred in third-party excess liability suits. Then the cause of action was extended to first-party insureds who were wrongfully denied benefits under their policy. Cases around the country cited with approval California decisions imposing strict claim standards on insurers, and assessing severe punitive damages for a breach of that duty. The final step taken in California and other states allowed a third-party a direct cause of action for bad faith against an insurer for a violation of a state unfair claims practice statute. *Royal Globe Insurance Company v. Superior Court*, 23 Cal.3d 880, 592 P.2d. 329, 153 Cal. Rptr. 842 [1979]. Until *Royal*, bad faith causes of action were available only to a first-party insured or a third-party via assignment. *Royal*, however, held that the California Unfair Claims Practices Act could trigger a direct action against the insurer for bad faith by a third-party claimant, despite the fact that the insurer's contractual duty runs only to the insured. In addition, the *Royal* court held that a single prohibited act could serve as a basis for suit, though the law indicated a **course** of unfair conduct was necessary to constitute an unfair claims practice.

Royal and its progeny in several jurisdictions at least required that the insureds' liability be determined prior to the initiation of the bad faith suit by the third-party. The Montana Supreme Court recently discarded this requirement by holding that the third-party action may be filed and tried before, concurrent with, or after liability has been determined. "We see no problems with the possibility of contrary findings in the two actions. . . . Public policy calls for a meaningful solution." *First Bank v. Transamerica Insurance Company*, 658 P.2d 1065 (Mont. 1984). The meaningful solution suggested here means that an insurer may be liable for refusing to settle a claim which in fact proves to be invalid.

Under various bad faith theories the insured or third-party claimant may recover damages for economic loss, pain and suffering or emotional distress, and last but not least, punitive damages.

It is the punitive awards which have caused vexatious problems for many insurers. Most states recognize the first and/or third-party suit as sounding in tort rather than in contract, and thus allow the assessment of punitive damages in such cases. Five jurisdictions which characterize bad faith suits as contractual in nature have followed the common law rule that punitive damages may not be recovered in contract actions, and denied them in bad faith suits (Iowa, Kansas, Michigan, Oregon, South Dakota). Unfortunately, three states have held that the contractual nature of a bad faith suit provides no bar to punitive damages (Idaho, Indiana, Mississippi).

The judicial genesis and liberalization of bad faith remedies present tremendous problems for insurers, and ultimately their policyholders. Insurers walk a tightrope between paying valid claims and weeding out fraudulent demands. Carriers now face claims handling standards tantamount to strict liability. Any incorrect denial of a claim, whether reasonable or unreasonable, opens the door to substantial extracontractual damages. Ambiguous standards of conduct in unfair claims practice statutes and the general "bad faith" guideline serve as an open invitation to litigation. Case law has failed to differentiate reasonable and unreasonable insurer conduct. Failure to toe the line subjects insurers to huge punitive awards over and above full compensatory damages. Underwriting becomes a nightmare, if not impossible under such circumstances.

Theoretically, something in addition to bad faith must be shown in order to justify punitive awards. That is, the plaintiff must show the insurer's actions demonstrated not only bad faith, but also recklessness, malice, etc., so as to support a punitive verdict. Realistically in jurors' minds it is a very short jump from bad faith to malice. As with the bad faith standard in general, jurors and insurance companies are left with extremely vague guidelines. Malice, recklessness, etc., "may be inferred from the circumstances of the case." *Richardson v. Employers Liability Assurance Corp.*, 25 Cal. App.3d 232, 245, 102 Cal. Rptr. 547, 556 (1972). The difference between bad faith and malicious behavior justifying punitive damages is ignored in practice. The point is jurors and defendants alike lack sufficient guidelines as to what constitutes punitive conduct. This lack of standards, the trial lawyers' emotional pleas to the jury, and evidence of the defendant's wealth have all combined to produce the present explosion of bad faith punitive damages claims.

A crucial, yet unsettled factor in many bad faith punitive damages verdicts has proved to be admission of evidence of the insurer's wealth. Witness *Neal v. Farmers' Insurance Exchange*, 582 P.2d 980 (Cal. 1978): "(A)n award equal to one week's earnings was required to effect the necessary punishment." Such evidence theoretically comports with the punishment rationale of punitive damages. The ultimate impact of admission of such evidence, e.g., outrageous verdicts, rather than justifying admission of such evidence, reveals the need for abolition of punitive damages in bad faith cases.

Commentators from the plaintiff's bar have hailed the "social reform potential of punitive damage awards in bad faith cases." Judicially sanctioned bad faith punitive awards have been applauded as serving a most desirable regulatory function. Such comments are on target at least as to the fact that we now have courts regulating the insurance industry's claim practices.

Is this is a desirable way to establish regulatory policies? It is well known that courts lack the factfinding, oversight and implementation capabilities of legislatures and administrative agencies, as well as the constitutional authority to set social regulatory policy. Undeniable negative fiscal impact results from judicial regulation of insurance claims practices. First, insurers spend substantial time and money (as much as $9,000 per case) to avoid or defend against judicially created bad faith punitive damage claims. The actual cost of punitive verdicts along with defense and avoidance costs must be absorbed by the company, eventually funneling down to the

insurance pool. Perhaps the gr atest economic impact however, entails increased settlements. Increasingly, companies pay claims based less on their validity than on the realistic possibility of a bad faith suit. They must choose between settling a claim for more than it is worth or facing the economic realities of a bad faith suit. Like consumers injured by defective products, policyholders wrongfully denied coverage deserve a forum for redress for their injuries. But the recent snowballing of bad faith litigation has presented a compelling need for restoration of the rule of reason to the claim handling scenario.

In terms of public policy, it is impossible to justify the punitive damages windfall to the bad faith plaintiff when such a cost is borne by the aggregate insured public. The law of punitive damages needs to strike a better balance between the interest of the insured, the insurer and society in general. Punitive claims have become more of a problem than a solution to the claims practice issue. The solution lies not in *ad hoc* judicial regulation, but in the strengthening of legislative and administrative controls through unfair claims practice statutes. Illinois and other states have enacted so-called penalty statutes providing for an award of attorney's fees and a monetary penalty against an insurer for wrongfully denying policy payments (See Ill. Rev. Stat. Ch. 173 Par. 767, in appendix). In some states these statutes have been held as constituting an insured's exclusive remedy, thereby barring an action for punitive damages. The enactment of similar statutes, particularly if amended to include exclusivity clauses, could be a meaningful solution to the problem of first-party bad faith and punitive damages by providing a remedy to aggr eved claimants without the unreasonable societal cost of windfall punitive awards. These reforms would strike a more reasonable balance in the claims handling scenario. Along with the strengthening of bad faith penalty statutes, such laws should be amended to prohibit third-party causes of action as enunciated in *Royal Globe*.

III. The Case for Reform

The staggering increase in the number and amount of punitive damages and the problems caused thereby have led many judges, lawyers, legislators, and industry leaders to call for reform in the law of punitive damages. In terms of political theory, the status quo of punitive damage law pours concentrated benefits to the plaintiff's bar, and spreads costs to the public. The beneficiaries include the individual plaintiffs and, more importantly, the effective plaintiff trial lawyers who have a vested interest in liberal punitive damage law. Thus we have a substantial group of vocal and powerful lawyers seeking to protect their interest in liberal punitive damage law. However, those who pay the disbursed costs of these awards often have no idea that such costs are hidden in the price of their consumer products and insurance policies.

Various members of the trial bar in opposing punitive damage reform argue:

1. ***Punishment and deterrence provide valid bases for the present doctrine.*** Note however, that eight states have already rejected these rationales and the remaining states dif-

fer in the weight to be given each factor. There is a surprising lack of evidence as to the extent to which large punitive verdicts really deter.

In the vicarious liability setting and where held insurable, there is no way a punitive award can punish or deter, nor can multiple punitive awards assessed against a product manufacturer. Assuming *arguendo* that punishment and deterrence do provide a coherent rationale, is it not apparent that the costs to society outweigh the benefits, while the plaintiff's bar stands as the principal beneficiary?

2. ***There are gaps in the criminal justice system which allow certain types of egregious conduct to go unpunished.*** Concededly, not every socially reprehensible act falls within the purview of criminal law. But determination as to the proper standards of behavior, particularly for corporations, is the legislature's responsibility. The judiciary lacks the necessary factfinding and oversight capabilities required to determine and implement guidelines for corporate conduct. Some have nevertheless attempted to regulate major product manufacturers and insurers through the punitive award. It is the business of the legislature to clearly differentiate between the permissible and the impermissible, to set reasonable penalties. The judiciary has neither the authority nor the ability to effectively fill in the gaps in the criminal code.

3. ***The punitive award constitutes a strong silent consumer advocate and social reform mechanism.*** This presents a distorted view of punitive damages. Exemplary damages evolved to provide, in limited cases, punishment and deterrence. Now they are supposed to effect major social reform! It must be remembered that social reform and consumer advocacy, like determinations as to punishable conduct, are supposed to occur in the legislature, rather than the courtroom. The use of judicially imposed punitive damages on a case-by-case basis, without the benefit of coherent policy foresight or perspective can have only deleterious effects on the U.S. economy.

4. ***Existing controls on punitive verdicts are sufficient.*** Leaders of the plaintiff bar have argued that there are sufficient guidelines for the jury at trial and the appellate court on review so as to prevent excessive punitive awards. But we have seen how vague the standards for punitive conduct are. Juries are merely told to consider the wealth of the defendant and award enough to punish him. The appellate courts have authority to reverse an excessive award but will only do so if contrary to the manifest weight of the evidence.

The irrationality of the social reform rationale speaks for itself. Whatever benefits from punitive damages (questionable punishment and deterrence) are far outweighed by the disadvantages, to-wit:

1. ***Punishment has no logical place in the civil law, whose historical function is compensation, not punishment.*** This theoretical inconsistency, however, is overshadowed by the real problems caused by having civil courts determine what conduct warrants punishment and how much punishment should be be inflicted on a case-by-case basis.

2. ***The modern array of available compensatory remedies provide total compensation to the plaintiff.*** Injured parties may now recover for pain and suffering and emotional distress as well as every type of pecuniary loss. There is no need, as there arguably was under the common law, for an "extra" assessment to compensate for generally uncompensable damages.

3. ***The impact of the full spectrum of modern compensatory damages sufficiently deters a defendant and others from similar conduct.*** The size of modern compensatory verdicts and the tremendous cost of defending a lawsuit in the 1980s add up to a substantial fiscal impact on defendants. The additional assessment of punitive awards provides only an insignificant deterrent function.

4. ***Punitive damages as awarded under present law violate a number of constitutional provisions.*** Liability for compensatory damages is sufficiently delineated in case law, and their amount is governed by the plaintiff's actual damages incurred. But the insufficient guidelines for jurors in determining liability for punitive damages and their amount lack the precision required by due process. In addition, as courts use defendants' wealth as a measure for punitive damages, the more prosperous defendant is made to suffer an award much greater than a less affluent defendant, for the same conduct, in violation of the equal protection mandate.

5. ***There is a woeful lack of adequate standards as to the conduct warranting a punitive damage penalty.*** Case law provides no workable standard against which a defendant may judge his or her conduct, or a jury may make a judgment thereon. For this reason, emotion plays an even greater role in the jurors' decision. Vague guidelines as to what constitutes "punitive" conduct and the proper amount in a given case, coupled with the open-ended nature of punitive awards, have led to excessive, inconsistent and unpredictable verdicts.

6. ***Punitive damages amount to a windfall for the plaintiff and his attorney.*** Exemplary awards are designed to punish and deter for the public good. The plaintiff receives complete reimbursement for his injuries through a compensatory award. No logical reason exists for allowing the plaintiff and his attorney to collect the punitive award. The plaintiffs' bar through contingency fees frequently exceeding thirty three per cent, has a vested interest in liberal punitive damages law. Their lobbying, rather than the rule of reason, is one major cause for retention of the doctrine in modern jurisprudence.

7. ***The increasing frequency of punitive awards in turn affects the settlement process particularly in the product liability and bad faith scenarios.*** Insurance companies must frequently choose between settling a claim for more than it is worth or face the economic severities of a punitive verdict.

8. ***Though punitive damages allegedly punish and deter for the good of society, the cost to society of present punitive damage law far outweighs any benefit from deterrence.*** Huge punitive awards which are designated to benefit society funnel back down to haunt the American consumer. The ripple effect of individual awards has an adverse effect on the business climate. A substantial portion of the price tag on consumer products and insurance policies represents past, present and future punitive damage liabilities.

The above list points out a number of flaws in our system of punitive damages. Clearly the overall problem lies in the system itself. It is those flaws that command our attention and call for a meaningful solution. The scales of justice are out of balance. Punitive damages serve no valid purpose and indeed have primarily adverse effects on society. Then why not eliminate, or at least reform the concept? Two compelling forces resist change with respect to punitive damages. First, plaintiffs' lawyers naturally oppose reforms due to their interest in the status quo. Second, punitive damages have become embedded in our legal system, and are thus supported by the

doctrine of *stare decisis*. In fact, a number of courts such as the Wisconsin Supreme Court have expressed a desire to eliminate punitive damages but have refused to do so because of *stare decisis*. Neither *stare decisis* (or "the status quo for the sake of the status quo"), nor the benefits accruing to trial lawyers justifies retention of a doctrine lacking fundamental legal basis, and which simply on balance does more harm than good to society. The status quo must yield to fundamental insight and the rule of reason.

IV. In Search of a Balance

The foregoing analysis reveals the need for reforms in the law of punitive damages. A number of remedies have been offered in search for coherence, stability, fairness and reason in the civil justice system.

1. ***Total abolition of punitive damages.*** The fundamental flaws inherent within the present application of punitive damages justify total abolition of these awards. Eight U.S. states have already rejected the traditional notion of deterrence based punitive damages. Realistically, due to the trial bar's influence, this option may be politically impossible to achieve. But the interests of society do call for this better reasoned result. It is time to reconsider who benefits from punitive damages, who pays for them, and whether this system has any reasonable basis.

2. ***Payment of punitive awards to the state.*** Since punitive damages are designed to punish the defendant for society's benefit, and not to punish the plaintiff, there is no basis for awarding them to the plaintiff and his attorney. As the plaintiff has been made whole through compensatory damages, society should obtain the benefit of the punitive award. Punitives are penal in nature and like other penal assessments should be paid to the state rather than a private litigant and his lawyer.

3. ***Bifurcated trials.*** One of the critical problems with punitive damages lies in the fact that jurors are given few guidelines as to the proper punitive amount. They receive prejudicial evidence of the defendant's wealth prior to determining his liability for the compensatory and punitive award. One solution to this problem lies in the proposal for bifurcated punitive damages trials. In phase one of the trial, the trier of fact would determine the defendant's liability for punitive damages. In the second phase, if the defendant was found liable for a punitive award, the judge would set the proper amount. Allowing the jury to determine liability for punitive damages, but have the judge set the specific amount, would produce many benefits. First, the procedure would preclude presentation to the jury of evidence of the defendant's wealth during the liability phase of the trial. Second, it would prevent needless trials on punitive awards where no actual damages were found by the jury and actual damages are prerequisite for a punitive award in that jurisdiction. Third, trial judges are better equipped than juries

to ascertain the proper punitive award in a given circumstance, due to their knowledge, experience, and lesser vulnerability to an emotional, eloquent plaintiff's lawyer.

4. ***Statutory limits on punitive awards.*** An even more effective and reasonable resolution to the runaway verdict problem would be to establish a cap on punitive awards. Such a cap could limit punitive awards to, for example, no more than the compensatory award, or a specific monetary amount, i.e., $100,000, or, no more than 25 per cent of the compensatory damages or $5,000, as has been proposed by Project Justice. Note that providing a cap would retain the punishment and deterrence principles of punitive damages, while restraining the excessive awards. The cap would eliminate the volatile open-ended nature of punitive verdicts.

5. ***Multiple awards.*** Under present law a string of cases based on one particular wrong or course of conduct can all result in a punitive verdict. Yet according to the proponents of punitive damages, the initial punitive award should adequately deter and punish the defendant for his wrong. Punishment and deterrence are not further served by multiple punitive awards. This is particularly true with respect to product liability defendants, who have suffered the most under the multiple award rule. Additional punishment of defendants through multiple awards only results in punishment to society. Punitive damages should thus be awarded only once for any particular act or course of action.

6. ***Beyond a Reasonable Doubt.*** The uncertainty and vagueness clouding the punitive damage award point to the need for a higher standard of proof for a punitive award than mere preponderance of the evidence. A plaintiff seeking punitives should have to prove the defendant's liability beyond a reasonable doubt, or at least by clear and convincing evidence. Adopting such a standard would provide more fairness in the process and help the jury differentiate more clearly between merely negligent conduct and actions justifying a punitive award. One state has already adopted this type of reform. Montana *HB-363*, enacted in 1985, requires that punitive damages can only be based on clear and convincing evidence.

7. ***Contingent fee reform.*** The crisis in the contingent fee system is perhaps best represented by the Bhopal, India incident. Plaintiff lawyers flocked to the disaster area in an effort to drum up business. In our society those unable to afford an attorney deserve access to an advocate in order to obtain just compensation. Abuse of the contingent fee system has, however, led a number of commentators to call for reform of our presently unlimited contingent fee system. One way to resolve the problem with contingent fees would be to totally prohibit payment of a contingent fee out of a punitive award. In the alternative, a sliding scale contingent fee system would provide a check by decreasing the percentage going to the plaintiff's attorney as the plaintiff's total award increases. Three states, California, Florida and New Jersey, have already adopted this approach. The sliding scale at least introduces a reasonable check on contingent fee abuse.

8. ***Vicarious liability.*** The inherent incompatability of punitive damage awards with vicarious liability mandates reform in this regard. Punitive damages should be imposed on a principal for the acts of his agent only when the principal ratified or authorized the specific conduct. Only in this instance can a punitive award foster any deterrence or punishment. Such a limit would bring balance and reason to punitive damages in the vicarious liability setting.

V. Call to Action

Fundamental changes are needed in the civil justice system to do away with present inefficiencies and excessive verdicts. The financial structure of the insurance industry and other corporate entities is in jeopardy. Few companies can afford to ignore the implications of current trends in tort litigation. It is up to leaders in the insurance industry and other businesses to inform the public of the need for substantial reform of the civil justice system. Substantial tort reform cannot be accomplished through any single solution. But we must not be deterred by those who say that reform cannot be achieved. Effective pressure on the system can be generated through coordination of efforts. The strength of the plaintiff's bar and the doctrine of *stare decisis* are not insurmountable.

Rather than responding to modern tort law in a defensive posture, rewriting policies and reforming claims practices, insurers should join with other industry leaders and assume a more proactive stance. How well insurers respond to the current civil justice law crisis will determine the future success and viability.

VI. Coalitions

The cornerstone of an effective tort reform strategy must include the strength of coalitions. The sustained cooperative efforts of broad-based coalitions provide the most effective tool for improvement in our civil justice system. The benefits of the cooperative approach speak for themselves. Coalitions foster the exchange of information and avoid duplication of efforts. Most important, coalitions allow for the pooling and concentration of resources and a more intelligent concerted attack. Legislators respond much more positively to the voice of a broad base and widely supported political opinion rather than a single interest group.

Project Justice in Illinois provides an excellent example of how an effective tort reform coalition can evolve. The Project Justice coalition includes representatives from business, manufacturing, health care, construction, and the professions in addition to the NAII, the Alliance of American Insurers, the American Insurance Association, and other insurance industry representatives. Their aim is to resolve many of the problems within the Illinois civil justice system. The coalition serves largely as an informational network to promote cooperation and coordination of resources.

Project Justice formed several task forces to deal with the tort reform issues of greatest concern, including:

1. Pre-judgment interest and punitive damages;

2. Professional malpractice and health care costs;
3. Alternative dispute resolution mechanisms;
4. Product liability and municipal liability;
5. Various litigation issues such as class actions, discovery abuse, and forum shopping;
6. Litigation costs.

One major obstacle impeding current tort reform efforts is the lack of public awareness of the extent which deficiencies in the civil justice system negatively impact on their daily lives. Project Justice thus established a public affairs subcommittee to promote greater public awareness and understanding of the problems within the civil justice system as well as possible solutions.

The first issue confronted by Project Justice was a pre-judgment interest bill introduced in Illinois in 1983. A number of coalition members testified against the measure, revealing the broad opposition to the bill, and this, plus valuable data from the Institute for Civil Justice contributed to the demise of the proposal.

Project Justice illustrates the potential of coalitions as a tort reform mechanism. Other tort reform coalitions are now active or are being planned in California, Florida, Georgia, Indiana, Kansas, Louisiana, Mississippi, Minnesota, Michigan, Pennsylvania, and other states.

The NAII took a leadership role in the formation of the Punitive Damages Reform Coalition, an intra-industry tort reform coalition which includes the Alliance of American Insurers, the American Council of Life Insurers, the American Insurance Association, and the Farmers Insurance Group. The participants in this coalition, formed in 1984, agree that a united industry effort holds the key to the success of legislative tort reform initiatives. At the end of 1984, the coalition resolved to attempt to abolish punitive damages where possible or at least initiate reforms. The coalition targeted a number of states for possible legislative action in 1985 and outlined proposals for reform in the law of punitive damages.

Substantial consensus exists as to the need for tort reform. There is also considerable agreement as to various specific reforms in the area of punitive damages. There is, however, diversity of opinion as to strategy and as to more specific reforms. This can have only deleterious impact on any reform effort. The insurance industry must develop a consensus on punitive damages. It is therefore a cornerstone of NAII's tort reform strategy that broad-based and cohesive coalitions must be developed to provide inter and intra-industry consensus on punitive damages.

VII. NAII Model Legislation—The Flexible Approach

. In addition to its participation in various coalitions, NAII has formulated a number of model

laws addressed to punitive damages reform on a state-by-state basis. Model laws have several advantages. If enacted, they foster uniformity and consistency among the various jurisdictions. They also can unite interested groups behind a single reform bill and prove to be politically successful. But in light of (1) the number of proposals for the reform in punitive damages; (2) the number of sponsoring groups; and (3) the diverse political climates among the several states, it appears that commitment to a single model bill would be a detriment to the reform effort. Rigidly adhering to a single tort reform proposal may imply a non-conciliatory posture. In certain jurisdictions various components of the model may not be needed, or may be politically impossible to achieve. The key therefore lies in a united effort behind a diverse and flexible approach. This philosophy underlies the NAII's fundamental legislative strategy. A number of legislative proposals have been formulated which will be introduced in accordance with particular problems and needs in particular states.

The essential components of NAII model legislation (reproduced in the appendix) include:

1. Abolition of punitive damages if possible;
2. Requiring that plaintiffs prove defendants' punitive damage liability beyond a reasonable doubt or at least by clear and convincing evidence;
3. Mandating that liability for punitive damages be determined by the jury but the amount set by the judge;
4. Limiting punitive damages to an amount not to exceed the compensatory damages awarded;
5. Directing that punitive awards be paid into the state's general revenue fund; and
6. A prohibition on the assessment of attorney fees against a punitive damages award.

Note that Project Justice has also drafted legislation (see appendix) which would (1) limit the amount of punitive damages to 25 per cent of the compensatory award or $5,000, and (2) establish a sliding scale contingent fee system. The NAII and Project Justice statutes provide for flexibility to adapt to given problems and political climates in particular jurisdictions.

VIII. Rounding Out the Reform Effort

A successful tort reform strategy requires not only the commitment of broad-based coalitions supporting essential components of reform measures, but also a well-rounded attack on a variety of fronts. Coalitions and model legislative activity mark only the beginning of NAII action directed toward reform in punitive damages and other problem tort areas. NAII has also sponsored a number of inter-association meetings and seminars on the issue of punitive damages. Such meetings reap a number of tangible and intangible benefits. They foster the exchange of information and sow the seeds of more effective coalitions. Most important, however, they draw together an industry which is disunited relative to the magnitude of this problem.

The most successful of such conferences thus far was the NAII House Counsel/Punitive Damages Seminar in April, 1985. The seminar focused on the impact of punitive damages on the insurance industry, and included a number of enlightening speakers In addition to its membership in specific tort reform coalitions, NAII also participates in a number of other groups directly or indirectly interested in civil justice reform. Such groups include (1) the Defense Trial Lawyers Task Force on Litigation Cost Containment, composed of insurance claims executives, defense attorneys and others sharing concern as to rising litigation costs; and (2) Insurance Arbitration Forums, Inc., which is dedicated to the use of arbitration, mediation and other alternatives to litigation. NAII interaction with such groups provides, like NAII's punitive damages seminar, an exchange of information with respect to punitive damages and general tort reform.

Getting the information out is the primary purpose of the NAII *Litigation Reporter.* The *Litigation Reporter,* written and published by the NAII staff, summarizes major tort and insurance case law as well as developments in the tort reform effort. First, the *Reporter* explains cases of major impact to the insurance industry, including appeals in which NAII participates as *amicus curiae.* Second, it describes the activities of tort reform oriented groups such as Project Justice Illinois. Third, the publication tracks developments on the research side of the reform effort, particularly current and past studies conducted by the Institute for Civil Justice. The *Reporter* also includes NAII staff research products and other notes of tort reform interest.

As stated above, another way in which NAII has assumed a leadership role in the insurance industry and taken the initiative with respect to civil justice reform includes participation in an *amicus curiae* capacity in a number of major punitive damages cases. As Ellis J. Horvitz, noted California appellate advocate, has pointed out, in the past the insurance industry lagged behind and was disunited and unorganized in its amicus activity. To fill this void the NAII has spoken as industry leader, in support of the insurance point of view, in a number of major supreme and appellate court cases. The impact of any amicus activity is inherently difficult to assess with precision. Yet it is clear that in light of the substantial volume of law being handed down from the appellate and supreme courts, there must be a strong voice for the insurance industry in cases of major importance to its members and their policyholders.

The final element of NAII's punitive damages strategy is the development of factual data to support industry initiatives in tort reform. Perusal of the regional case law reporters reveals the magnitude of the punitive damages problem and the need for reform. Yet there is an unfortunate lack of hard statistical evidence as to the specific number and aggregate amount of punitive awards in the U.S. and their resultant impact on society.

Concrete data as to the extent of the punitive problem is vital to support a successful reform effort. To develop the consensus required to break the status quo hammerlock of the trial bar, the citizenry and their legislators must be educated with unequivocal data as to the actual effect on our society of runaway punitive verdicts. Thus NAII has supported the research efforts of organizations such as the Rand Corporation's Institute for Civil Justice, the Defense Research Institute and the All-Industry Research Advisory Council.

The importance of tort reform in the 1980s led the NAII to include it on its agenda at the NAII's Annual Meeting in San Francisco in November of 1984. The topic discussed was, "Courts and their Economic Impact: What Price Justice?" The noted speakers on this subject represented a variety of backgrounds and points of view, and effectively illustrated compelling considerations with respect to civil justice reform. Donald Schaffer, Sr., Vice President, Secretary and General Counsel of Allstate Insurance Company, noted that many substantial tort reforms in the last

twenty years have been promulgated by the judiciary. Mr. Schaffer raised the fundamental question as to when legislative inaction justifies judicial activism, a question underlying many judicially promulgated tort "reforms" including comparative negligence and bad faith causes of action. Such judicial activism often occurs without foresight as to the ultimate effect on society, due to the courts' limited investigative and policymaking capabilities.

Fred Graham, Law Correspondent for CBS News, candidly spoke of the problems within the legal system itself. Such problems include continuing and unchecked growth in the number of lawyers, which in turn exacerbates current trends toward excessive litigiousness. The growing number of attorneys has a tremendous impact in expanded litigation and liberal tort law. As a result major sections of the legal system itself have been resistant to tort reform efforts thus far. Such sectors, particularly the plaintiff bar, must be dealt with for any tort reform to succeed.

Finally, Ellis J. Horvitz (Horvitz & Levy, Encino, CA), pointed out that trends toward liberality in judge-made tort law reflect increasing concern for a source of compensation for plaintiffs and decreasing interest in the issue of fault. Such decisions may also be attributed to the lack of insurance background on the part of judges, who may fail to grasp the ultimate effects caused by a given holding. The comments of Mr. Horwitz, *et.al.*, were compelling in that they effectively illustrated the major factors which culminated in the tort law debacle witnessed by the 1980s.

IX. Conclusion

We are experiencing unprecedented growth in the number and amount of punitive damages awards. The open-ended nature of the awards, the eloquent plaintiffs' attorneys with a vested interest through the contingency fee system, the demise of all reasonable limits on punitive verdicts and a growing deep pocket mentality have combined to produce grossly excessive punitive damages awards. There no longer exists any coherent rationale for the application of punitive damages in the U.S. The doctrine's negative impact far outweighs its advantages. The only beneficiaries of the status quo are the individual plaintiffs and their attorneys. The deterrence originally fostered by less frequent and more moderate awards has evolved into punishment imposed on society by the runaway awards of the 1980s.

The verdicts in product liability and bad faith cases are particularly troublesome. Insurance companies, manufacturers and consumers can no longer ignore the aggregate negative impact on U.S. society of the cost of punitive damages. Neither the plaintiffs' bar nor the doctrine of *stare decisis* should prevent changes called for by the rule of reason and the damage done to society through the status quo. Conceptually there must be a point at which punitive damages begin to do more harm than good to society. Realistically we have crossed that line.

How well insurance companies react to the punitive damages problem and other deficiencies in the civil justice system will in many respects determine their future. Serious tort reforms can only be realized through a comprehensive attack on many fronts by broad-based coalitions. The changes of tomorrow can only be born in the initiatives of today through the coordinated efforts of coalitions and organizations such as the NAII.

Appendices

Sample Statute I

Punitive Damages

1. In any civil action where counts for punitive or exemplary damages are included, or in any separate action for punitive or exemplary damages, the plaintiff shall have the burden of proving the defendant's liability for such damages beyond a reasonable doubt, and the amount of such damages shall not exceed an amount equal to the judgment entered against any such defendant for actual damages.

2. Liability for punitive or exemplary damages shall be determined by the jury. The amount of such damages shall be established by the judge.

3. All punitive or exemplary damages recovered shall be paid into the state general revenue fund. The provisions of this act shall not be construed to grant the state or any political subdivision thereof a cause of action to recover punitive or exemplary damages, nor may the state or any political subdivision thereof be a party to any action in which punitive or exemplary damages are sought; except however, the state shall have a right to an action to collect such damages after determined payable by the judgment of a court of record.

4.(a) Upon motion of the defendant and after a hearing, should the court determine that a claim for punitive or exemplary damages was brought without reasonable or just cause or excuse and without knowledge of sufficient facts and evidence to reasonably entitle the plaintiff to a judgment for such damages, or if a claim for punitive or exemplary damages is maintained after it is reasonably evident that there are insufficient facts and evidence to reasonably entitle the plaintiff to such damages, the court may award to the defendant such costs, expenses and reasonable attorney fees as the court deems fair and equitable and may grant judgment therefore against either the plaintiff or the plaintiff's attorney or both.

(b) In the event the motion in Section 4(a) is not granted to the defense, should the plaintiff proceed with the action and fail to recover, the costs of the defense including attorney's fees shall be assessed against either the plaintiff or the plaintiff's attorney or both.

5. In no event shall attorney's fees be assessed against awards for punitive damages.

6. This act shall not apply to causes of action which arise prior to its becoming law.

7. This act shall take effect immediately upon its becoming law.

Sample Statute II

Damages Other Than Compensatory Damages

1. (a) In any civil action where counts for damages other than compensatory damages as hereinafter defined are included, or in any separate action for damages other than compensatory damages, the plaintiff shall have the burden of proving the defendant's liability for such damages beyond a reasonable doubt, and the amount of such damages shall not exceed an amount equal to the judgment entered against any such defendant for actual compensatory damages.

(b) "Compensatory damages" are defined as those which will compensate the injured party for the injury sustained, and nothing more; such as will simply make good or replace the loss caused by the wrong or injury.

2. Liability for damages other than compensatory damages shall be determined by the jury. The amount of such damages shall be established by the judge.

3. All damages other than compensatory damages recovered shall be paid into the state general revenue fund. The provisions of this act shall not be construed to grant the state or any political subdivision thereof a cause of action to recover such damages, nor may the state or any political subdivision thereof be a party to any action in which such damages are sought; except however, the state shall have a right to an action to collect such damages after th y are determined payable by the judgment of a court of record.

4. (a) Upon motion of the defendant and after a hearing, should the court determine that a claim for damages other than compensatory damages was brought without reasonable or just cause or excuse and without knowledge of sufficient facts and evidence to reasonably entitle the plaintiff to a judgment for such damages, or if a claim for damages other than compensatory damages is maintained after it is reasonably evident that there are insufficient facts and evidence to reasonably entitle the plaintiff to such damages, the court may award to the defendant such costs, expenses and reasonable attorney fees as the court deems fair and equitable and may grant judgment therefore against either the plaintiff or the plaintiff's attorney or both.

(b) In the event the motion in Section 4(a) is not granted to the defense, should the plaintiff proceed with the action and fail to recover, the costs of the defense including attorney's fees shall be assessed against either the plaintiff or the plaintiff's attorney or both:

5. In no event shall attorney's fees be assessed against awards for damages other than compensatory damages.

6. This act shall not apply to causes of action which arise prior to its becoming law.

7. This act shall take effect immediately upon its becoming law.

Sample Statute III

Punitive Damages

1. In any civil action where counts for punitive or exemplary damages are included, or in any separate action for punitive or exemplary damages, the plaintiff shall have the burden of proving the defendant's liability for such damages beyond a reasonable doubt, and the amount of such damages shall not exceed an amount equal to the judgment entered against any such defendant for actual damages.

2. Liability for punitive or exemplary damages shall be determined by the jury. The amount of such damages shall be established by the judge.

3. Upon motion of the defendant and after a hearing, should the court determine that a claim for punitive or exemplary damages was brought without reasonable or just cause or excuse and without knowledge of sufficient facts and evidence to reasonably entitle the plaintiff to a judgment for such damages, or if a claim for punitive or exemplary damages is maintained after it is reasonably evident that there are insufficient facts and evidence to reasonably entitle the plaintiff to such damages, the court may award the defendant such costs, expenses and reasonable attorney fees as the court deems fair and equitable and may grant judgment therefore against either the plaintiff or the plaintiff's attorney or both.

4. In no event shall attorney's fees be assessed against awards for punitive or exemplary damages.

5. This act shall not apply to causes of action which arise prior to its becoming law.

6. This act shall take effect immediately upon its becoming law.

Sample Statute IV

Punitive Damages

1. Punitive or exemplary damages shall not be recovered in any civil action.

2. This act shall not apply to causes of action which arise prior to its becoming law.

3. This act shall take effect immediately upon its becoming law.

State Chart of Major Issues

State	Punitive Damages May Be Awarded	Punitive Damages Insurable	Punitive Damages Insurable If Liability Is Vicarious	Duty To Defend	Punitive Damages Allowed In Wrongful Death Suits	Government Bodies' Liability Includes Punitives	Reasonable Relation To Compensatory Damages
Alabama	yes	yes	yes	yes	yes	no	no
Alaska	yes				no	no	no
Arizona	yes	yes	yes	yes	yes	no	yes
Arkansas	yes	yes	yes	yes	yes		yes
California	yes	no	yes		no	no	yes
Colorado	yes	no			no	no	yes
Connecticut	yes	yes	yes	yes			
Delaware	yes				no		yes
Florida	yes	no	yes	yes	yes	no	no
Georgia	yes	yes	yes	yes	no		yes
Hawaii	yes				no	no	
Idaho	yes	yes	yes	yes	yes	no	yes
Illinois	yes	no	yes		no	no	no
Indiana	yes	no	yes			no	no
Iowa	yes	yes	yes	yes	yes	yes	yes
Kansas	yes	no	yes	yes	yes	no	no
Kentucky	yes	yes	yes	yes	yes		no
Louisiana	no				no	no	
Maine	yes	no			no	no	
Maryland	yes	yes	yes	yes	no	no	no
Massachusetts	no				yes	no	
Michigan	yes	yes	yes	yes	no	no	
Minnesota	yes	no			no	no	
Mississippi	yes	yes			yes	no	
Missouri	yes	no	yes		yes	no	no

State Chart of Major Issues

State	Punitive Damages May Be Awarded	Punitive Damages Insurable	Punitive Damages Insurable If Liability Is Vicarious	Duty To Defend	Punitive Damages Allowed In Wrongful Death Suits	Government Bodies' Liability Includes Punitives	Reasonable Relation To Compensatory Damages
Montana	yes	yes			yes	no	no
Nebraska	no				no	no	
Nevada	yes	no			yes	no	
New Hampshire	yes	yes	yes	yes	no	no	
New Jersey	yes	no	yes	yes	no	no	yes
New Mexico	yes	yes	yes	yes	yes	no	
New York	yes	no	yes	yes	yes	no	yes
North Carolina	yes	yes			yes	no	
North Dakota	yes	no			no	no	
Ohio	yes	no			no	no	yes
Oklahoma	yes	no	yes	yes	yes	no	no
Oregon	yes	yes	yes	yes	yes	no	
Pennsylvania	yes	no	yes		no	no	yes
Rhode Island	yes	yes	yes	yes		no	
North Carolina	yes	yes	yes	yes	yes	no	no
North Dakota	yes				no	no	no
Tennessee	yes	yes	yes	yes	yes	no	no
Texas	yes	yes	yes	yes	yes	no	yes
Utah	yes				yes	no	yes
Vermont	yes	yes	yes	yes		yes	
Virginia	yes	yes		yes	no	no	
Washington	no				no	no	
W. Virginia	yes	yes	yes	yes	yes	no	yes
Wisconsin	yes	yes	yes	yes	no	yes	
Wyoming	yes	yes			yes	no	yes

FIRST DRAFT

83rd GENERAL ASSEMBLY
STATE of ILLINOIS
1983 and 1984

INTRODUCED _____, BY

SYNOPSIS:

(Ch. 110, par. 901)

Amends the Code of Civil Procedure by adding certain provisions with respect to punitive damages in civil actions; defines the scope of punitive damages; establishes the burden of proof for punitive damages; limits recovery for punitive damages; forbids contingent attorney's fees based upon punitive damage awards; provides for punitive damages to be paid into the State General Revenue Fund; provides that the State has a cause of action to collect punitive damages after final judgment; and provides for vicarious liability where the principal or a managerial agent of the principal ratified or approved the act or acts. Effective immediately.

A BILL FOR

PROJECT JUSTICE

AN ACT to add paragraph 901 to the Illinois Code of Civil Procedure, approved July 1, 1982, as amended.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Add paragraph 901 to the Illinois Code of Civil Procedure, approved July 1, 1982, as amended, to read as follows:

(Ch. 110, par. 901)

PUNITIVE DAMAGES

Par. 901. Punitive damages—Limitations on recovery

§1. As used in this paragraph, 'punitive damages' includes exemplary damages.

§2. In any civil action where counts for punitive damages are included, or in any separate action for punitive damages, the plaintiff shall have the burden of proving the defendant's liability for such damages beyond a reasonable doubt.

§3. In any civil action the amount of punitive damages shall be an amount not to exceed any one of the following amounts:

(a) 25 per cent of the actual or compensatory damages which the court or jury finds that the plaintiff is entitled to recover exclusive of all costs; or

(b) $5,000.

§4. All punitive damages recovered in a civil action shall be paid into the State general revenue fund established under Chapter 127, Paragraph 140 of the Illinois Revised Statutes.

§5. No attorney may collect a contingent fee based on an award for unitive damages.

JOINT INDUSTRY RESOLUTION ON PUNITIVE DAMAGES

WHEREAS, Punitive damage awards have grown in recent years to the point where society can no longer afford to ignore their adverse impact on the civil litigation process, and

WHEREAS, The purpose of the law of civil remedies is to compensate individuals injured by the wrongful conduct of others and not to punish or deter wrongful conduct, and

WHEREAS, The law of compensatory damages is demonstrably adequate to insure that the injured plaintiff is made whole, and

WHEREAS, The most appropriate process for deciding what social conduct is punishable and who should be punished is the criminal justice system and not the civil justice system, and

WHEREAS, The success of a few plaintiffs in obtaining large punitive damage awards has led to widespread demands for punitive damages in nonmeritorious cases, and

WHEREAS, The insurance industry has a responsibility to seek improvements to the efficiency, fairness and cost of the civil litigation process on behalf of its policyholders and the general public, and

WHEREAS, Consistent with this responsibility, several model laws have been developed and advocated by insurance industry sponsors as means to reduce the adverse effects of excessive punitive damage awards and punitive damage abuses, and

WHEREAS, Even though widespread differences exist in the legal climates, demographics, political environments and public attitudes found in the several states, success in achieving meaningful punitive damages reform greatly depends on the ability of the insurance industry to speak with a united voice on various reform proposals;

NOW, THEREFORE, BE IT RESOLVED, that the undersigned insurance industry organizations strongly support the substantial limitation or elimination of punitive damages from the civil justice system, and

BE IT FURTHER RESOLVED, that where the total elimination of punitive damages is not feasible, the undersigned insurance industry organizations commit themselves to the goal of achieving meaningful punitive damages reforms, and

BE IT FURTHER RESOLVED, that no single approach will be advocated as the sole "solution" to punitive damages, but that remedial efforts will be adjusted to the particular circumstances of individual states and limited to states where meaningful reform is politically possible, and

BE IT FINALLY RESOLVED, that consideration will be given to the following categories of proposals as possible remedial approaches to punitive damages reform in the upcoming legislative sessions of the various states:

(a) Maximum limits on the number or amount of punitive damages awards that can be assessed for any single course of conduct,

(b) Limitations on the type of conduct that can give rise to punitive damages,

(c) Procedural modifications that enhance fairness in the process used to award punitive damages,

(d) Affirmative defenses to punitive damages allegations,

(e) Restrictions on attorney fees that can be collected for punitive damage awards, and

(f) Provisions requiring punitive damage awards to be paid under certain conditions to governmental units or charitable organizations.

Alliance of American Insurers
American Insurance Association
American Council of Life Insurance
Health Insurance Association of America
National Association of Independent Insurers
Farmers Insurance Group
Approved Nov. 1, 1984

Pending Reform Measures

ARIZONA

Punitive Damages/Limitations
H-2435 (Herstam, et al)
This bill would prohibit a judgment for a plaintiff to be entered which awards damages in excess of those proven based on the defendant's conduct. An exception would be made if no sooner than 60 days before filing the action, the plaintiff either served written notice on the defendant which identified the conduct and demanded satisfaction of a nature specified and which, before the filing of the action, had resulted in non-compliance by the defendant or sought to have the dispute with the defendant resolved by a hearing before any appropriate administrative body or if the plaintiff had established by creditable evidence that the defendant knew or should have known that the conduct had no reasonable support in fact or law.

Punitive Damages
S-1114 (Corpstein, et al)
This bill would: (1) provide that a jury civil action involving a claim for punitive damages would be bifurcated; (2) require the plaintiff in each punitive damage claim to prove that the defendant acted with fraud, malice and oppression; (3) provide that punitive damages recovered, except 5%, would be paid to the state general fund; (4) provide that 5% of the damages awarded would be distributed to the plaintiff and the plaintiff's counsel, in a proportion determined by the judge; and (5) provide that a defendant in a civil action involving a claim for punitive or exemplary damages could make a motion and the judge could hold a hearing, at any time after the action was commenced in a non-jury trial or after a jury finds that punitive damages could not be awarded, to determine if the claim was brought with sufficient facts or evidence to reasonably entitle the plaintiff to the damages.

CALIFORNIA

Punitive Damages Repeal
A-1739 (Felando)
This bill would repeal punitive damages in all civil actions.

Punitive Damages
A-2227 (Wyman)
This bill would require the trier of fact to take into account specific factors when making a determination as to whether a defendant is liable for punitive damages. These factors include whether the defendant has discontinued the conduct, the duration of the defendant's conduct, the financial condition of the defendant, the effect of other punishment imposed upon the defendant, and the extent to which the plaintiff's injury was the result of the plaintiff's own reckless disregard for his or her personal safety.

Punitive Damages/Bifurcated Trials
S-840 (Beverly)
This bill would provide for the bifurcation of trials in which punitive damages are claimed.

Punitive Damages Insurability
S-969 (Robbins)
This bill would authorize a local public entity to insure against liability for a claim for punitive damages.

COLORADO

Punitive Damages
H-1256 (Grant, et al)
This bill would provide that the jury, in civil actions, determine whether an injured party was entitled to receive exemplary damages for personal injury or for injury to personal or real property. The court would be required to determine the amount of exemplary damages to be awarded. The amount awarded would be limited to an amount no greater than the actual damages awarded. One-half of all exemplary damages awarded would be paid to the injured party and one-half would be paid into the Crime Victim Compensation Fund. Exemplary damages for an injury attended by insult would be prohibited.

CONNECTICUT

Damages/Study on Pain and Suffering Awards
H-5110 (Chase)
This bill would require the joint standing committees on judiciary and insurance to conduct a study on the imposition of limits on pain and suffering awards and contingency fees collected by attorneys.

Punitive Damages/Limitation
H-6578
This bill would authorize a court to award punitive damages in an amount designed to punish the defendant, but not to exceed the plaintiff's actual litigation expenses less taxable costs.

HAWAII

No-Fault/Medical Charges
S-1402
This bill would provide that no person rendering medical services for which a patient was insured under no-fault motor vehicle insurance could charge a fee for a service which was higher than the amount the physician would charge for the same service if the patient were not insured. Any insurer who pays a fee which violates this provision could bring an action against the violator for the amount of the overcharge. In addition, the insurer would be awarded attorneys' fees and costs and could be awarded for not more than $10,000 in punitive damages for each overcharge. Administrative penalties of not more than $10,000 could also be imposed on the violator.

ILLINOIS

H-01788

H-02203

Unfair Claim Settlement Practices/Punitive Damages
S-60 (D'Arco)
This bill would provide that a court could allow punitive damages where it appears that an insurer has been unreasonable and vexatious in refusing to pay a claim.

Punitive Damages/Unfair Practices
S-726 (Berman)
This bill would provide for assessing fees for the attorneys of insureds and beneficiaries in successful ac-

tions against insurers and would provide that no order to cease and desist directed to any person, or subsequent administrative or judicial proceeding to enforce the same would in any way relieve or absolve the person from any administrative action against the license or certificate, civil liability under common law or criminal penalty arising out of the methods, acts or practices found unfair or deceptive. In addition, the bill would provide for punitive damages where an insurer has committed an unfair claims practice.

S-01068

S-01208

INDIANA

Punitive Damages/Maximum Awards
H-1297
This bill would limit the amount of punitive damages awarded in a civil action to three times the amount of actual or compensatory damages awarded.

IOWA

Punitive Damages/Financial Condition of Defendant
H-197 (Platt)
This bill would provide that in a civil action in which exemplary or punitive damages were sought, unless the plaintiff produced evidence of a prima facie case of liability for exemplary or punitive damages, or ordered by the court, the plaintiff could not conduct discovery of and could not introduce evidence of the profits of the defendant gained by virtue of the alleged wrongful conduct or the financial condition of the defendant.

Punitive Damages/Financial Condition of Defendant
S-203 (Drake)
Same as H-197, reported above.

KANSAS

Punitive Damages
H-2457
This bill would: (1) require that a civil action including a claim for punitive damages be bifurcated; (2) prohibit punitive damages from being assessed if compensatory damages were not awarded, if only nominal damages were awarded or if no actual damage was found by the trier of fact; (3) provide that punitive damages would not be levied in certain other cases; (4) provide that the plaintiff in a civil action including punitive damages would have the burden of proving the defendant's culpability beyond a reasonable doubt; (5) provide that it must be proven that the defendant acted toward the plaintiff with willful misconduct, fraud or malice; and (8) provide that 95% of the punitive damages awarded would be credited to the state general fund and the remaining 5% to the plaintiff.

Punitive Damages
S-110
This bill was amended on 3/7/85. This amendment would delete the provisions relating to professional liability and provide that in any action in which punitive damages were recoverable, the trier of fact would determine whether the damages would be allowed. If the damages were allowed, a separate proceeding

would be conducted to determine the amount of damages. No award of punitive damages could exceed the lesser of: (1) 25% of the annual gross income earned by the party against whom the damages were awarded; or (2) $3,000,000. In addition, the total amount of damages recoverable for pain and suffering by a claimant for personal injury in a medical malpractice liability action could not exceed $250,000.

LOUISIANA

Punitive Damages/Actions Against Insurers
S-316 (Kelly)
This bill would provide that an insurer would owe a duty of good faith and fair dealing to its insureds and would authorize the award of exemplary damages for violations of that duty.

Punitive Damages/Civil Cases
S-325 (Kelly)
This bill would provide that exemplary damages could be awarded in certain civil cases if it was proved that the conduct of the defendant was intentional, fraudulent or was in wanton or willful disregard of the injured person's rights. The award could be three times the amount awarded for general and special damages.

Punitive Damages/Actions Against Insurers
S-326 (Kelly)
This bill would create a duty of good faith and fair dealing between insurers and any person with whom they contract for insurance and award to insureds or plaintiffs exemplary damages in amount not to exceed three times any award for general or special damages when the insurer was found to have arbitrarily or intentionally violated the duty. The award of exemplary damages would be granted in lieu of any other penalties which could be granted when the award was found to be in excess of those penalties.

MINNESOTA

H-00500

MISSOURI

Punitive Damages/Employees
H-382 (Scoville, et al)
This bill would provide that any insurance company duly authorized to do business in this state could provide insurance coverage for liability for punitive or exemplary damages assessed against the insured as the result of acts or omissions, intentional or otherwise, of the insured's employees, agents or servants, or of any other person or entity for whose acts or omissions the insured is or could be liable without the actual prior knowledge of the insured.

MONTANA

Punitive Damages/Limit
H-363 (Marks) **Enacted as Chapter 507, Laws 1985.** Approved 4/16/85, effective 4/18/85.
This law provides that a jury could not award exemplary or punitive damages unless the plaintiff has proved all elements of the claim by clear and convincing evidence. Clear and convincing evidence means evidence in which there is no serious or substantial doubt about the correctness of the conclusions drawn from the evidence; it is more than a preponderance of evidence, but less than beyond reasonable doubt.

Punitive Damages/Amount
H-400 (Grady)
This bill would provide that a jury could not consider a defendant's financial worth when determining the amount of exemplary or punitive damages to be awarded.

Punitive Damages/Limit
H-511 (Hannah)
This bill would provide that punitive damages could be awarded to a plaintiff in an amount equal to the amount of actual damages awarded to the plaintiff or $50,000, whichever is more, but would limit the damages to $500,000.

H-00533

Punitive Damages/Definition of Conduct
H-536 (Ramirez)
This bill would provide that punitive damages are allowed if the defendant has been guilty of fraud or actual malice or has violated a statute knowingly and purposely or with actual malice.

Punitive Damages/Limit
S-200 (Lane, et al)
This bill would provide that a jury could not award exemplary or punitive damages in excess of three times the amount of actual damages awarded or 5% of the net worth of each defendant, whichever is less.

NEW JERSEY

Punitive Damages/Limit
S-1112 (Hurley)
This bill would establish a limit of $100,000 on the amount of damages which may be awarded for pain and suffering.

Punitive Damages/No-Fault Law
S-2754 (Bubba)
This bill would authorize the recovery of punitive damages in an action for the payment of personal injury protection coverage benefits under New Jersey's no-fault law. If it is shown that the insurer failed or refused to pay the benefits in good faith, it would be subject to damages not in excess of twice the amount of benefits awarded to the injured party. These damages would be awarded in addition to interest, court costs and reasonable counsel fees, in the court's discretion. No punitive damages would be awarded in a dispute submitted to arbitration.

NEW MEXICO

Punitive Damages/Unfair Claims Settlement Practices
H-537
This bill would provide that punitive damages would be awarded for various unfair claims settlement practices.

Punitive Damages/Personal Injury
S-229
This bill would prohibit the award of punitive damages in any civil action except in actions for personal injury. 'Personal injury' would mean injury to the body of a human being, including death, and would include incidental claims arising from the same treatment or occurrence.

NEW YORK

Payment for Future Pain and Suffering
A-3237 (Sullivan)
This bill would provide that damages for pain and suffering in excess of $100,000 would be placed in an investment fund with the plaintiff receiving the income from that fund at least every three months for the rest of his life. The principal would be returned to the defendant upon death of the plaintiff.

WC/Punitive Damages
S-2398 (Connor, et al)
This bill would provide that an action to recover damages for personal injury, illness or death caused by the latent effects of exposure to a substance could be commenced within two years from the date of the discovery of the illness or injury, the date of death, or the discovery of the cause of the injury, illness or death, whichever is later. Punitive damages could be awarded if the plaintiff shows by clear and convincing evidence that the injury, illness or death suffered was the result of the defendant's reckless disregard for the safety of product users, consumers, or any other persons who might be harmed by the product. Punitive damages could not be awarded in the absence of an award for compensatory damages.

OKLAHOMA

Punitive Damages/Insurance Protection
H-1441 (Osborne)
This bill would authorize a person to obtain insurance protection for punitive or exemplary damages.

OREGON

Punitive Damages
H-2934
This bill would limit the liability of licensees, permitees and social hosts to third parties injured in motor vehicle accidents. The bill would define responsible business practices as a defense to liability and sets the liability limits at $50,000. In any dram shop action, punitive damages would not be recoverable unless it was proven by clear and convincing evidence that the party against whom punitive damages was sought has shown wanton disregard for the health, safety, and welfare of others. In addition, the bill would create the Liability Fund from a portion of liquor license fees, vehicle operator licenses and fines for offenses involving liquor to pay the judgment over the limit.

Punitive Damages/Civil Actions
H-2942
This bill would establish the restrictions, conditions and procedures for the award and recovery of punitive damages in civil actions. In addition, the bill would provide that punitive damages could be recoverable by an injured party in a product liability civil action according to those restrictions and conditions established.

Punitive Damages
S-550
This bill would provide that in any civil action to recover punitive damages, evidence of financial condition of the defendant could not be admitted unless there is a prima facie showing of conduct sufficient to support an award of punitive damages.

TEXAS

Punitive Damages
H-2264 (Hilbert)
This bill would provide the conditions and restrictions for the award of punitive damages, including: (1) that the plaintiff would have the burden of proving the defendant's liability; (2) that the award of punitive damages in certain cases could be prohibited; (3) that the amount of award of punitive damages could not exceed the lesser of either three times the amount of the actual compensatory damages exclusive of costs or $25,000; and (4) for the distribution of damages.

VIRGINIA

Punitive Damages/Exlusions from Coverage
S-666 (Parkerson)
This bill would exclude insurance coverage for punitive damages arising out of death or injury of any person as a result of negligence, including willful and wanton negligence.