

INSURANCE

INFORMATION

INDEX

The Crisis of Cost and Lack of Availability of
Liability Insurance

Tort Reform Support Letter from Lynden, Inc.

Malpractice Letter from Medical Insurance Exchange
of California

Omnibus Reinsurance Act

Articles from Periodicals and Newspapers

Report to the Washington State Legislature from the
Joint Study Committee on Insurance Availability and
Affordability

Department of Commerce and Economic Development
Information

Information from the Citizens Coalition for
Tort Reform


Index of Insurance Terms

Alaska MUNICIPAL League

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To: Senator Fred F. Zharoff, Chairman
Members of Senate Labor and Commerce Committee

From: Scott A. Burgess, Executive Director 

Date: March 12, 1986

Subject: Legislation Addressing Insurance Pooling (SB404 and SB377)

The Alaska Municipal League, representing 116 direct member municipalities, strongly supports legislation that would enable municipalities to pool their insurance costs, and losses. Currently, municipal insurance pools, sponsored by state municipal leagues, are operating in 23 states. Never has any municipal insurance pool gone into default. Never has any municipal insurance pool been unable to pay a claim. All have been very successful.

Municipal insurance pooling lowers costs, and increases availability of insurance to municipalities. Pools offer municipalities a chance to pay premiums based solely upon loss history. In addition, municipalities in an insurance pool can recoup a portion of that premium through a year-end dividend payment, based upon their success at controlling losses. Under a pool, the availability of insurance to municipalities would no longer be subject to the cycles of the general insurance market.

If legislation allowing the formation of a municipal insurance pool were passed, the AML would most likely obtain reinsurance from the National League of Cities, which will begin offering reinsurance on May 1 of this year through a reinsurance pool supported by the 23 state municipal league pools currently in operation. In addition, several other reinsurance opportunities would be available to an Alaska Municipal League insurance pool, due to the success, and past performance, of the League's current insurance program. Though not a pool, the League currently sponsors a program which is providing insurance to over 75 municipalities and school districts in the State for worker's compensation, general liability, business auto, and errors and omissions coverage for law enforcement, public officials, and school board members.

Senator Fred F. Zharoff, Chairman
Members of Senate Labor and Commerce Committee
March 12, 1986
Page Two

Regarding SB 377, the Alaska Municipal League supports legislation that would increase availability and decrease costs of insurance for municipalities. In addition, the Alaska Municipal League encourages careful consideration by the Legislature of this and all insurance legislation affecting municipalities. Attached please find copies of a resolution and policy statement language adopted by the Alaska Municipal League during its annual conference November 16, 1985.

Thank you for your consideration of this important issue. If the League may be of further assistance in any way, please feel free to call.

SAB:TRS:phl

Attachments

PART III
PUBLIC SAFETY

A. FINANCIAL IMPACT

1. State Public Safety Responsibility: The League strongly urges the Legislature to provide full funding of the Department of Public Safety so that, at the very least, the current level of services Statewide can be maintained.

2. Detention Costs: The League recommends that costs associated with prisoner care and prisoner transportation be borne by the State. When a municipal police officer makes an arrest for a violation of a state law, the State should continue to assume the legal and financial responsibility for the prisoner as soon as the prisoner is incarcerated.

3. Financial Impact: The League supports full financial assistance for programs impacted by mandatory services, enforcement, referral or sentencing.

4. Public Defenders: The League recommends the State resume full financial responsibility for the Public Defender Agency.

B. TRAINING

The League urges the Legislature to assure that local full-time and volunteer police, fire, and emergency medical personnel throughout the State have access to adequate facilities and program resources for training. Further, the League endorses public fire education and arson investigation, Village Public Safety Officers, and the Police Standards Council. The League urges full funding of these programs.

C. COURT SYSTEM

1. Use of TV Capacity: The League encourages the court system to make maximum use of TV capacity and other cost saving techniques for arraignment, grand jury, and similar court functions to release the burden on highly trained, public safety personnel.

2. Judicial Presence: The League supports the funding of a judicial system that would assure the presence of sufficient judicial officers in each community in the State when the need arises.

3. Local Trials: The League recommends local felony trials if adequate facilities are available in the community where the offense occurred.

D. STATE ASSISTANCE

1. Emergency Management: The League supports full State and federal funding of civil defense and emergency preparedness activities.

2. Fire Fighting Equipment: The League supports full funding for basic fire fighting equipment which meets minimum Insurance Services Office (ISO) or State criteria for small Alaska cities and fire service districts.

3. Substance Abuse Counseling: The League encourages state funding of positions for counseling on drug and alcohol programs, particularly in conjunction with the existing juvenile probation system

4. Substance Abuse and Domestic Violence: The League recognizes the serious individual and public safety problems that exist in all communities in Alaska as a result of substance abuse and domestic violence. It supports the enforcement of the domestic violence sections of Title 25, Marital and Domestic Relations (AS 25.35.010-AS 25.35.060), in all parts of the State as a public safety priority.

E. HAZARDOUS MATERIALS REPORT

The League supports legislation which would require producers, shippers, distributors, and commercial and industrial users to submit to all affected municipal governments, the Standard Material Safety Data Sheet on all toxic material physical agents being shipped to or through, or stored, manufactured, utilized, produced as a by-product, or otherwise found at any time, on the property or rights-of-way of any enterprise or site within the municipal boundaries.

F. TORT REFORM

The League urges the Legislature to review tort reform and to work for a viable municipal insurance system.

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, CHARR-affiliated businesses, doctors, and architects are in many cases unable to obtain any insurance, and

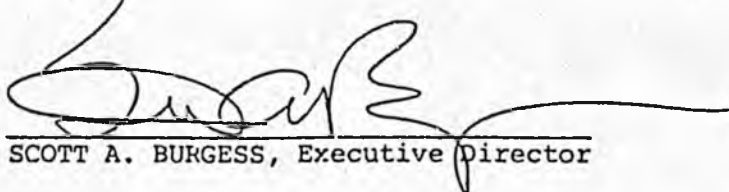
WHEREAS, the Alaska Municipal League feels strongly that an investigation into causes should be made and a solution to this problem must be found this year;

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

TESTIMONY

of

Scott A. Burgess
Executive Director
Alaska Municipal League

October 8, 1985

Testimony, presented on behalf of Alaska's municipalities, for the Governor's Special Task Force on Insurance

Commissioner Lounsbury, members of the task force:

The town of South Tucson, Arizona went bankrupt. A police officer in the town was accidentally shot in the back by his partner. The court awarded the officer damages thirty-six times the amount of liability insurance South Tucson was carrying, over \$1 million more than the city's entire annual budget.

If South Tucson was in Alaska, it would be among the five largest municipalities in the state. If South Tucson was in Alaska, they would still have gone bankrupt. Though several approaches to the problem experienced by South Tucson are being practiced in other parts of the country, none is being practiced here in Alaska.

The Alaska Municipal League certainly encourages the effort being made today, and we certainly encourage the task force to turn today's effort into relief for municipalities, and others experiencing insurance problems.

As far as municipalities go, the problem is pretty basic. Insurance companies consider them a high risk. When the market gets tight, it is insurance for municipalities that experiences the first premium increase, and, later, the first cancellations. It is not that municipalities are more negligent than anyone else that makes them a greater risk in the eyes of insurers, rather it is the court system's lessons to the public which teach citizens that for the greatest compensation, you sue whomever has the most money, the "deep-pocket" theory. In Alaska, the State is exempt(09.50.250), and that leaves municipalities as the target at the top for frivolous and marginal liability suits, with no restrictions on damages.

What can be done? There are several solutions, none of them the total answer, but all of them currently being used successfully somewhere in the U.S. First, there are statutory limits in other states on the fees of trial lawyers, which can dramatically reduce the final amount of liability awards.

Secondly, there are statutory restrictions on what, specifically, municipalities can, and can not, be held liable for.

Thirdly, Alaska could follow the lead of 28 states which have set reasonable dollar limits on liability judgments.

The fourth solution, is providing for "liability insurance pools" by statute. The State tried to address this in 1983, but fell a little short in my view. Because the League has an insurance program, I want to address this potential solution in greater detail.

A liability insurance pool is being used in several states to allow municipalities to create a pool of money to insure themselves through a representative entity such as the Alaska Municipal League. The entity, using the pooled premiums, pays first dollar coverage up to an agreed amount and buys any required excess insurance on their own. Each participant pays premiums into the pool, then, at the end of the year, receives back a dividend payment based on the premiums minus expenses and losses. Therefore, the ability of the members of the pool to reduce their losses, potentially, saves the municipalities, and their taxpayers, money in the future premiums they pay, and in the dividends they receive back.

While the League is still interested in the State sanctioning of a self-insured retention program or pool, minor amendments to the 1983 law providing for "reciprocals", may allow municipalities to help themselves to solve many of their insurance problems under Chapter 75., Reciprocal Insurers.

Alaska has in place the enabling Statutes, called "reciprocal insurance agreements", but the statutes set front-loading, financial requirements that could unnecessarily prevent such agreements from ever being formed, at least among municipalities.

There are two solutions to this problem, both of them within the scope of this task force. The first is legislation that would reduce the amount of capital required on deposit or in surplus by reciprocal insurers. That section, AS 21.75.050, needs some clarification regardless of the amount required. Even the experts in the insurance industry, as well as those within the State's Division of Insurance differ on what the language actually requires as a minimum surplus amount.

The second solution also involves legislation. That language would allow groups forming insurance pools to build up their surplus to the required level over some set period of time. That would permit the use of premiums to meet the State's surplus capital requirements. Without these changes, the only way such a program could get off the ground is through a one-time assessment against participants in the program, which could run as high as \$150,000 apiece. I can assure you, such a membership fee is a major deterrent to forming a reciprocal program under existing law.

The Alaska Municipal League has attempted to provide insurance for its municipal members, and to provide cost savings and some degree of stability to the participants by setting up the AML Insurance Program in April 1984. The League endorsed Frank B. Hall Company of Alaska to help the League set up the program. As of June of this year, the AML program has offered first dollar coverage for member municipalities from the Old Republic Insurance Company. Currently, 55 Alaska local government entities have signed up for coverage through AML.

Old Republic has a financial rating of A-15, and provides first dollar coverage on a basic Comprehensive General Liability policy form, up to \$500,000. Errors and omissions coverage is provided separately by Markel Service, Inc. for Law Enforcement and Public Officials and School Board Liability up to a limit of \$1 million. The AML program has topped \$3 million in premiums, and offers coverage for Workers Compensation, General Liability, Business Auto, Law Enforcement, Public Officials, and School Board.

The current AML program cannot provide municipalities with much stability, however. If Old Republic decides to stop providing coverage, which they can do at any time, the AML program comes to a screeching halt. The other major shortcomings of the our relatively young insurance program is our inability to provide first dollar coverage higher than \$500,000. That leaves a gap in coverage for most municipalities between \$500,000 and \$1 million, which is the lowest level at which they are able to purchase excess insurance coverage independently. Because the League's individually-participating, member municipalities are still subject to the current marketplace for first dollar coverage, the League program cannot offer the most stable, and lowest cost program to its members. The Board of Directors of the Alaska Municipal League believes a self-insured retention pool is the solution. If the League can accomplish the same result with revisions to the reciprocal insurer provisions of the Alaska Statutes, we would very much like to proceed in that direction.

The League appreciates the recognition of the insurance problems faced by the State, its political subdivisions, and others by the Governor and the members of this task force, and offers its assistance and support in finding solutions; those offered above and others. Thank you for your time.



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GROUP SELF-INSURANCE POOLS
 SPONSORED BY STATE MUNICIPAL LEAGUES

<u>State</u>	<u>Type of Risk Covered</u>				
	<u>Health & Accident</u>	<u>Workers Compensation</u>	<u>Liability</u>	<u>Unemployment Compensation</u>	<u>Property</u>
Alabama		x			
Arkansas	x	x		x	
Connecticut		x	(1)		
Florida	x	x		x	
Georgia		x			
Illinois		x		x	x
Iowa		x			
Kentucky		x			
Louisiana (3)		x		x	
Maine	x	x	(1)	x	
Massachusetts		x(2)			
Michigan		x		x	x
Minnesota	x	x		x	x
New Hampshire	x			x	
New Mexico		x			
North Carolina	x	x	(1)		
Oklahoma (3)	x	x		x	
South Carolina (3)	x	x			
Tennessee	x	x		x	
Texas		x		x	
Utah	x	(1)			x
Vermont		(1)		x	
Virginia		x			

- (1) Pool being developed (as of 8/85)
- (2) Fronted safety group program rather than pure pool
- (3) Not participating in NLC/RMPSP

Prepared by: National League of Cities
 December, 1985

THE "CRISIS" OF COST
AND
LACK OF AVAILABILITY
OF
LIABILITY INSURANCE

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December 9, 1985

Preface

Problems regarding the cost and lack of availability of liability insurance are affecting a variety of insurance consumers. The following article is based on testimony which the Pennsylvania Trial Lawyers Association presented on this important issue before several committees of the General Assembly.

The first part of the article reveals that the problem is not the result of a crisis in our legal system--there has been no sudden increase in claims or litigation. Further, the total cost of paying liability claims has done nothing more than keep pace with the underlying rate of inflation for the goods and services for which the compensation is paid. It goes on to demonstrate that tort "reforms"--restrictions on the rights of injured citizens--have no effect on the cost and availability of liability insurance. One of the best examples of this is what has happened in the area of municipal liability insurance despite the extremely restrictive Pennsylvania Political Subdivision Tort Claims Act of 1978.

The second part reveals that the root cause of the current problem is the cyclical economics of the insurance business and its relationship to underlying economic conditions. Competing insurance companies were engaged in a price war when interest rates were high and rising. When interest rates fell sharply, as a result of the economic recovery, the insurance companies began to raise prices dramatically and even cut off coverage in less profitable lines in order to increase their profitability. The following example demonstrates how this "crisis" of cost and lack of availability develops:

Hypothetical Insurance Company

Year	Surplus ¹	Total Permitted Written Premiums ²	(Cost) Average Premium Per Policy	(Availability) Number of Policies Which Can Be Written
1980	\$1,000,000	\$3,000,000	\$1,000	3,000
1981	\$1,000,000	\$3,000,000	\$900	3,333
1982	\$1,000,000	\$3,000,000	\$800	3,750
1983	\$1,000,000	\$3,000,000	\$700	4,286
1984	\$1,000,000	\$3,000,000	\$600	5,000
1985	\$1,000,000	\$3,000,000	\$1,500	2,000

1 Insurance industry jargon for net worth.

2 Based on the typical 3 to 1 written premiums to surplus ratio permitted in

Presuming that the 1980 average \$1,000 premium per policy represents adequate rates, this insurance company proceeded over the next several years to engage in a price war with competitors by cutting premiums to expand its market share. This caused the average premium to become progressively more inadequate. This company became increasingly over reliant on investment income to make up the difference. Such a strategy may be successful when investment yields are high or increasing, but when yields fall and claims must be paid on the increased number of policies which were sold at inadequate rates, profitability suffers. The result is that the average premium rises dramatically. This, in turn, causes an equally dramatic decrease in the number of policies which can be written.

Examining the cost side of the "crisis"--even if it were necessary for the average premium to go from \$1,000 to \$1,500 five years later, that should only have required a relatively tolerable 8.45% annual rate increase, instead of the average 150% one year increase from \$600 to \$1,500 to improve profitability because of previously unwarranted premium reductions.

Looking at the availability side of the "crisis"--when an insurance company is forced to reduce the number of policies it is writing due to changes in surplus or rates, it naturally looks at the profitability of each line of insurance it is writing in order to select where the cutbacks will occur. For example, if it writes six lines, each having a return on investment of 25%, 20%, 17%, 15%, 12% and 10% respectively, to improve profitability it will, wherever possible, stop writing those lines where the profit is lowest. It makes no difference what the claim history is of the individual policyholders in any of these less profitable lines. The company may also stop writing a few of its more profitable lines where it has relatively little data and some reason for uncertainty. For example, the company may be writing fifty insurance policies for day care centers yielding a 20% return with little or no claim history. Being aware of a case involving mistreatment of children in a day care center in California, it may choose to drop this line to help achieve the necessary overall reduction in policies, rather than drop 500 policies in lines, such as auto or homeowners insurance, which may be yielding a highly predictable and steady 17%.

There is simply no way to justify the abrupt increase in cost and lack of availability of liability insurance occurring in the current phase of the insurance cycle, except to suggest that there is a "crisis." Clearly, this problem could be avoided by better discipline in the insurance market exercised by both the companies involved in this conduct and those charged with the regulatory responsibility.

The third part of the article suggests some of the types of solutions which would provide prompt and effective relief. The accompanying exhibits will also be of particular interest.

Only by understanding the true nature of a problem can appropriate remedies be developed. This article was written in the hope of furthering that understanding.

Table of Contents

	<u>PAGE</u>
Table of Exhibits	11
I The Tort System and its Impact on Liability Insurance Costs	1
A. The Myth of Litigiousness	1
B. The Cost of Paying Liability Claims	5
C. "Easy" Answers: Ineffective and Inappropriate Solutions	8
II The Insurance "Crisis"	10 -
A. Factors Causing Periodic Fluctuations in Premiums	10
B. The Current Phase of the Insurance Cycle and the Outlook for the Future	15
III The Search for Effective Solutions	25
IV More on Pennsylvania's Experience	29
V Conclusion	30
Footnotes	32

Table of Exhibits

	<u>Page</u>
A "Stalking Burger's Wild and Elusive Litigation Flood" by John Guinther <u>The Barrister</u> , Vol. #XVI, No. 2, Summer, 1985	33-35
B The Hard Search for Property Insurance," <u>The New York Times</u> (7/7/85)	35
Letter to the Editor by Alfred I. Jaffe <u>The New Ycrk Times</u> (8/25/85)	35
C "Area Has the Nation's Fastest-Rising Medical Prices," <u>The Philadelphia Inquirer</u> (3/10/85)	36-37
D "Nader, Insurance Firms Differ on Need for Liability Rate Hikes" <u>Post-Gazette</u> (11/8/85)	38
E "Taming the Insurance Industry's Booms and Busts" <u>The New York Times</u> (10/20/85)	39
F "Study Analyzes Industry Woes" <u>Journal of Commerce</u> (6/20/85)	40
G "Rapid Return to Lack of Price Discipline Seen" <u>National Underwriter</u> (11/8/85)	41
H "Rather Hot Discussion on Capacity" <u>National Underwriter</u> (11/8/85)	42-43
I Remarks to the Florida Senate Commerce Committee on Property and Liability Insurance by Commissioner Bill Gunter	44-48
J Synopsis of the Pennsylvania Political Subdivision Tort Claims Act by Charles E. Evans, Esq.	49-52
K Letter from an attorney who represents municipalities	53
L "Quarterly Earnings Per Share Rise Again" Best's Insurance Management Reports (9/9/85)	54

I. The Tort System and its Impact On Liability Insurance Costs

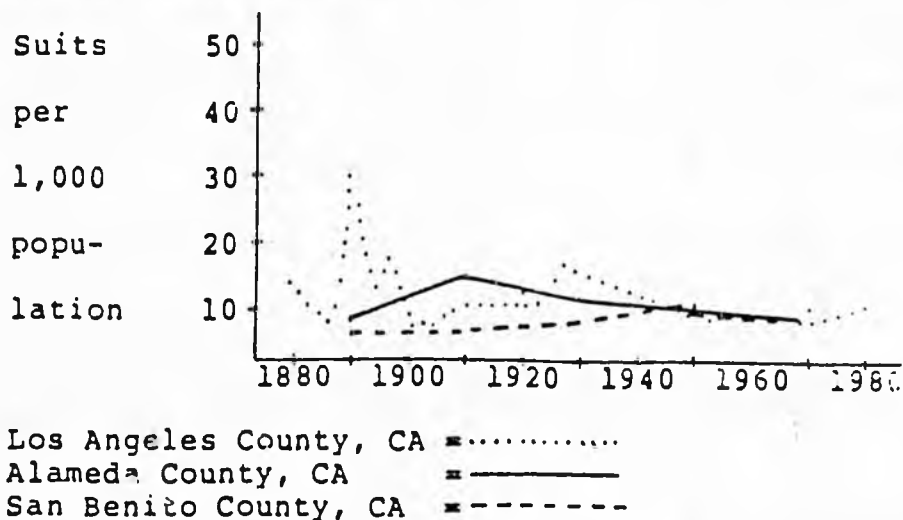
Whether it is an article or editorial on rising liability insurance costs for municipalities, day care centers, doctors, nurse midwives, tavern owners, manufacturers of various products from asbestos to autos, from chemicals to drugs, or the owners of commercial vehicles or private passenger automobiles, or any number of other areas, the focus always seems to be that we live in a "litigious society." The basic tenets of this perception are that we, as a people, are not only more likely to sue than other people, but that we are also more likely to sue than we used to be. Neither turns out to be true.

A. The Myth of Litigiousness

A recent survey by Professor Marc Galanter, published in the UCLA Law Review, of the litigiousness of citizens of major industrial nations clearly showed that Americans are really quite normal in terms of their tendency to sue:

"[T]he United States rate of per capita use of the regular civil courts in 1975 was just below 44 per thousand. This is in the same range as England, Ontario, Australia, Denmark, New Zealand, somewhat higher than Germany or Sweden, and far higher than Japan, Spain or Italy. ... According to a recent report, some five million cases are filed in Yugoslavia each year, an astonishing figure for a country of 22 million persons."¹

If we are not more likely to sue than the citizens of other major industrial nations, are we more likely to sue than we used to be? Again, the answer is no. There is no clear trend toward an increase in the tendency of Americans to bring a civil lawsuit. Recent articles by Stephen Daniels, Ph.D., "We're Not a Litigious Society: The Facts Do Not Support the Rhetoric Surrounding the Litigation Explosion," published in The Judges Journal, Spring 1985, and "Ladders and Bushes: The Problem of Caseloads and Studying Court Activities over Time," published in the American Bar Foundation Research Journal, Volume 1984, Fall, Number 4, support this. Also note the following graph, showing litigation trends in three major California counties, a state with a reputation for litigiousness.



Sources: Galanter, supra at fn (1), p.40; Selvin, M. and Ebener, P., *Managing the Unmanageable: A History of Civil Delay in the Los Angeles Superior Court*, The Institute for Civil Justice, Rand Corporation (1984), p.34.

As Professor Galanter explains, "the pattern of use [of the law to resolve disputes] is conservative, departing relatively little from earlier patterns."²

What, then, of such facts that nearly twice as many civil actions were filed in federal district courts in 1983 as in 1977?³ Doesn't that prove we are more likely to sue than we used to be? No, as Professor Galanter explains:

"[O]ne third of the whole increase consisted of a jump from 600 to 41,000 cases filed by the federal government to reclaim overpayment of veterans' or Social Security benefits or to collect on student loans. The next largest gain was an increase from 3,000 to 20,000 in claims to restore disability payments cut off by the Reagan Administration. ... These numbers reflect specific social and political events and don't point to any across-the-board increase or decrease in litigiousness."⁴

In Pennsylvania, noted Philadelphia author, John Guinther, found that filings of civil actions in Pennsylvania courts have risen at an average rate of 1% per year over the last five years, a rate of increase which is one-third of the national average. Further, most, if not all of this negligible increase can be accounted for by increases in those civil actions involving family law matters such as support, alimony, custody

and divorce which account for the overwhelming bulk of all civil proceedings in our courts. Whereas liability insurance comes into play in personal injury cases, which actually account for only a small percentage of the cases in the courts. There has been virtually no difference in the rate of filing personal injury cases from year to year since about the mid-1970's.⁵ (See Exhibit A)

While the overall rate of filing personal injury cases is stable, there will always be subtle changes in the types of cases brought. This would reflect the continuing evolution of the increasingly complex society in which we live. For example, there may be more pollution or drug liability cases now than there were fifty or one hundred years ago. Now there are thousands of complex chemical compounds being released into our environment and we are better able to determine the harm they can cause. In the past there were not nearly as many chemicals and it was far more difficult, if not impossible, to prove that they were the cause of the harm people suffered. Surely, there are less travelers involved in railroad accident cases per capita today, but more involved in airplane accident cases, and so on.

Finally, some critics have the idea that the increased number of lawyers is somehow meaningful in terms of litigation. What they overlook or forget is that a legal education has come to be viewed as having value beyond the practice of law. Thus, many lawyers today never practice law. Further, even for those who do, most of the modern practice of law does not involve litigation.

B. The Cost of Paying Liability Claims

Generally, the cost of paying all liability claims annually rises at a predictable rate, roughly parallel to the underlying rate of inflation in the economy for the goods and services the compensation is based upon, including medical expenses, lost income, etc. This is pointed out by a number of recent studies. For example, a Rand Corporation study of jury verdicts in Cook County, Illinois (Chicago), revealed that when inflation is considered, verdicts today are, generally speaking, no higher than they were in 1960. Mark Peterson and Audrey Chin, both of the Rand Corporation's Institute for Civil Justice were quoted in the National Law Journal of November 11, 1985, as follows:

"Our research shows that juries are usually sensible and that their decisions have been remarkably stable over 20 years."

It should be pointed out that verdicts account for only a small percentage of claims paid, but are generally thought to have the greatest potential for volatility in terms of cost.

Another example, a recent study of medical malpractice in Pennsylvania revealed that the Medical Professional Liability Catastrophe Loss Fund loss costs are precisely where they should have been predicted to be 10 years ago when the fund was started. This study, by Professors Alfred E. Hofflander and Blaine F. Nye, also revealed that there is no discernable trend in Pennsylvania in the number of malpractice claims (frequency) and the cost of paying those claims (severity) when the underlying rate of inflation in health care costs is considered. (Note: There is a phenomenon, called "pseudo-growth" by the authors of this study, which accounts for the current appearance of substantial growth in the number of claims, and, therefore, cost, because of the way claims are reported into the system and the fact that the bulk of malpractice insurance is handled by insurers which did not exist before the 1975 "crisis.")

Unfortunately, the media tends to report only extraordinarily large personal injury verdicts. This gives the public the distinct impression that the

exception is the general rule. It is never reported that the average of all awards, settlements and verdicts in personal injury cases of all types is probably less than \$15,000--with substantially less in many cases. Further, the overwhelming harm which justifies the rare big verdict is often overlooked. For example, a person who has been turned into a brain-damaged quadriplegic can require \$15,000 or more per month in care for the rest of his or her life. This can amount to many millions of dollars when the victim is young and has a long life expectancy. Likewise, when these large awards are appealed and reduced, or when the total reported represents the value of an annuity which actually costs a fraction of the reported amount, this is never mentioned. No evidence has ever been produced that Pennsylvania, when compared to other states with similar demographics, is a "big verdict" state, in fact, it is probably true that Pennsylvania produces, on a per capita basis, less "million dollar verdicts" than most other similar states.

Further, it is the total cost of paying all liability claims, not the cost of a single, or even a few, large claims, that is really important. As already pointed out, the total cost of paying all liability claims annually rises at a predictable rate, roughly parallel

to the underlying rate of inflation in the economy, for the goods and services the compensation is based upon.

C. "Easy" Answers: Ineffective and Inappropriate Solutions

When liability insurance premiums are soaring, it is just so easy to believe the simplistic notion that the problem is "all those lawyers, lawsuits and big verdicts." It just fits so neatly into the general perception of the way things are. Why should experts in the field give a detailed and lengthy answer to a complex problem when it is so easy and perhaps a little self-serving to give an answer which is likely to be accepted without question?

Worse, however, are the easy solutions to the problem of soaring insurance premiums which are all too readily preferred. The most frequently mentioned "solution" to liability insurance problems is placing limits on awards. Certainly, in the rare case which would exceed the limit, the attorney's contingent fee will be reduced, but the real cost of such solutions will be borne by the victims and the tax-paying public. This is because the only effect of a limit on awards is to shift the cost of harm in the most catastrophic cases away from the person or persons whose carelessness caused the harm and onto the backs of the victim and the victim's family. Ultimately a large share of the cost is shifted to the tax-paying public through

various public and medical assistance programs which end up picking up the burden, but only after the victim is forced into poverty to qualify for benefits. A poor solution indeed.

Importantly, such solutions do not prevent soaring insurance premiums. A study, "State Responses to the Malpractice Insurance 'Crisis' of the 1970s: An Empirical Assessment," published in The Journal of Health Politics, Policy and Law, Volume 9, Number 4, Winter 1985, found the following:

"Almost all states enacted legislation in response to the rapid rise in malpractice insurance premiums which occurred during the mid-1970s. After describing the types of statutory changes enacted, this study evaluates the influence of these changes on levels and growth of premiums paid by general practitioners, ophthalmologists, and orthopedic surgeons during 1974-78. The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, had their intended effects on premiums."

Likewise, Pennsylvanians need only examine what has happened to municipal liability insurance premiums in the face of the Political Subdivision Tort Claims Act of 1978, with its severe restrictions, including a limit on awards, for proof of the failure of such solutions to control soaring rates.

In the search to control periodic surges in the cost of liability insurance premiums, it must never be

forgotten that the purpose of liability is not only to compensate the victims of careless conduct, but also to deter such conduct in the future. In the absence of liability, carelessness and its true cost to society would likely be far greater.

II. The Insurance "Crisis"

What now follows is not intended to throw stones at the insurance industry, but to describe the phenomenon at the root of the current "crisis." A crisis that no one, consumers or insurers, should want.

A. Factors Causing Periodic Fluctuations in Premiums

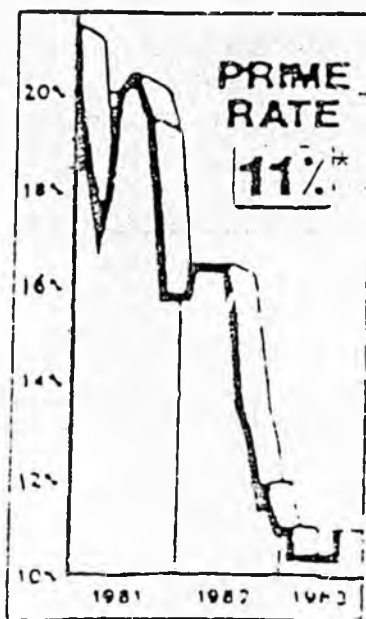
As we have seen, the recent, sometimes severe, increases in liability insurance premiums have virtually nothing to do with either the frequency with which claims are being filed, or with the size of jury verdicts. This perhaps has never been made more clear than this year, as the following statement from Best's, the insurance industry bible, reveals:

"In 1984, insurance industry's own estimate of incurred loss and loss expense payments increased by the smallest amount since 1977. Yet, at the same time as the rate of growth of losses was declining, premiums increased by the largest margin since 1976, over 13%." ⁸

Premiums should, over the years, have been rising steadily, in line with and controlled by the appropriate underlying rates of inflation, if they were to reflect accurately the underlying cost of the liability system alone. This has not happened. There are periods where rates stay level or even decline despite inflation and others where rates surge upwards far more rapidly than inflation. The reasons are to be found both in the nature of the property and casualty insurance marketplace and its relationship to general economic trends and, like the economy, the problem is cyclical.

Insurance claims are paid out of the total of premium income and the income earned in the investment of these premiums. Price wars among competing insurance companies to gain market share, hopefully increasing premium income, or at least investment income, when interest rates are high, create havoc when interest rates fall. Profitability declines and each insurance company is faced with a no-win choice: raise rates and lose market share to the competition, or continue to compete with increasingly inadequate rates in order to maintain or increase market share--hoping that the competition will be forced to raise their rates first so that it can then follow suit. It is tough to win back policyholders; it is a lot easier to

hope that investment income will rise to improve the corporate bottom line.



*NOTE: The prime rate is currently 9.5%.

As the chart above might indicate, property and casualty insurers have seen the income that can be earned on the investment of premium dollars cut in

half or more by falling interest rates during the current economic recovery, necessitating premium increases on top of those rate increases currently required to overcome previously inadequate rates which were the result of the competitive price wars within the insurance industry as interest rates rose to record heights earlier in the economic cycle.

The phase of the insurance cycle where property and casualty insurers become over reliant on investment income and premiums become increasingly inadequate has been euphemistically described as "cash flow" underwriting. As Professor Alfred Jaffe pointed out in a recent letter to the editor published in The New York Times on August 25, 1985:

"That phase of the cycle commenced about the fourth quarter of 1978 and turned around about the third quarter of 1984. We had close to six years...during which American businesses, institutions and municipalities got their insurance well below "manufacturers' costs" and saved billions of dollars on premiums....Premium growth is a function of population increase, G.N.P. growth, inflation and other economic and social factors. Premium rate level is what impacts on one's pocketbook, not overall premium growth. A more meaningful statement would be: 'Rate levels for commercial insurance dropped approximately 50 percent on average between 1978 and 1984.'" (See Exhibit B)

The current situation has also been exacerbated by the fact that health care costs continue to rise more

rapidly than other costs and the value of personal injury claims is, to a very large extent, quite understandably controlled by the underlying economics of health care costs. It should be noted that health care costs are continuing to rise in the greater Philadelphia area at the highest rate in the nation, 11.51 percent, double the national average, according to the U. S. Bureau of Labor Statistics as reported in The Philadelphia Inquirer on Sunday, March 10, 1985. (See Exhibit C)

In addition to all of the foregoing, other factors are also impacting on the property/casualty reinsurance market which include: 1) recent and enormous losses in the United States as a result of storms, airplane crashes and fires; and 2) the decline of the British pound and other foreign currencies relative to the strong U. S. dollar.

What is now happening with rates was summed up by Grover Czech, regional vice president of the American Insurance Association, as follows:

"Companies are doing what they feel they have to to get back to price adequacy...Competitive pressure drove rates down for many years. Generally prices today are coming back to what they were in 1977 or 1978 when adjusted for inflation." (See Exhibit D)

B. The Current Phase of the Insurance Cycle and the Outlook for the Future

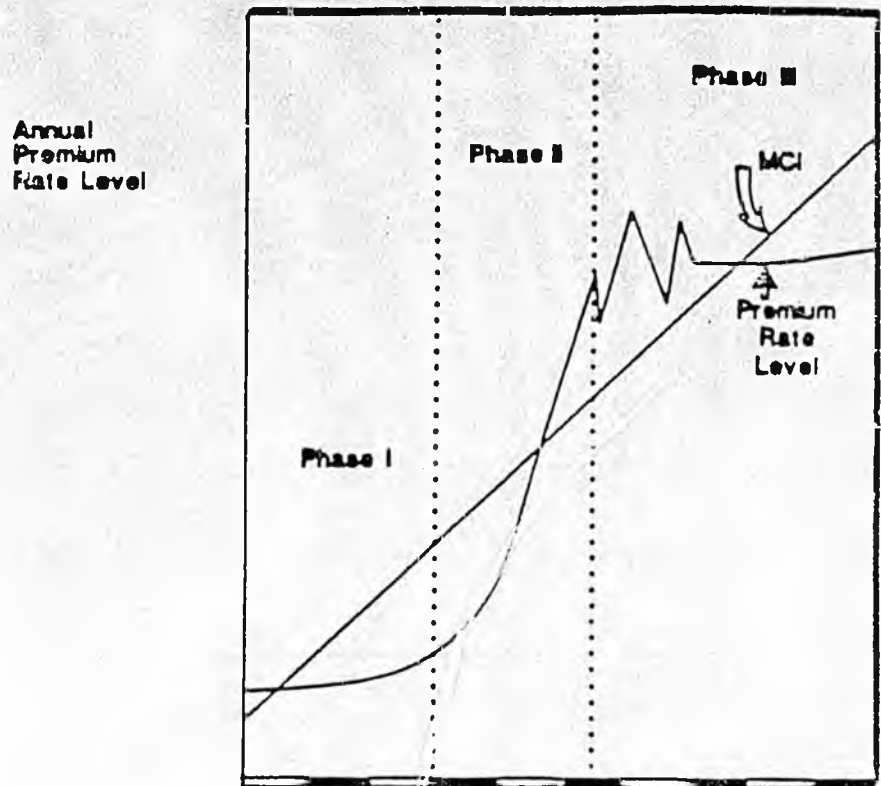
Because of declining profitability, insurance companies have become unwilling to utilize their capital (capacity) to insure risks, causing a "crisis of availability." In the competitive free market, investment capital tends to flow to those investments where profits are highest and most reliable. After all, "the business of business is profits." Unfortunately, this is not necessarily good for insurance purchasers or, in the long term, for many sectors of the industry itself. When profits are reduced, insurance companies become very selective. They naturally want to maximize profits. Therefore, they try to avoid insuring risks, preferring, instead, to invest in those lines which are a "sure bet" and, in any event, they will charge what the market will bear. In choosing which lines to write when profits are reduced in the insurance business cycle, certain property/casualty lines suffer from a lack of adequate data which prevents proper underwriting, including such things as the consideration of individual claim experience, in the rate making process. Potential purchasers of insurance in these lines are at a disadvantage relative to others under current market conditions.

When profits are down, insurers, like other businesses, will stick with the lines they know the most about and are the most profitable. It does not mean that insuring other lines is not profitable, but rather, that some lines are considered more likely to yield higher profits than others. The slightest indication of risk, any uncertainty or unanticipated event, can lead virtually the entire industry to radically increase prices, reduce or cancel coverage or withdraw from the market, whether or not such actions are justifiable by any objective standard.

Best's says it most succinctly; the net effect was to reduce the incentive of insurers to take risks and to increase the incentive to raise premiums - the dual crises of availability and cost.⁹ Observers of the industry, understanding this relationship between this "cycle of profitability" and premiums, predicted in the early 1980's that, once interest rates started to fall significantly, premiums would once again rise, probably sharply.¹⁰ An example of the correctness of this prediction can be seen when comparing the earlier chart depicting the fall of the prime rate to the following charts concerning medical malpractice insurance.

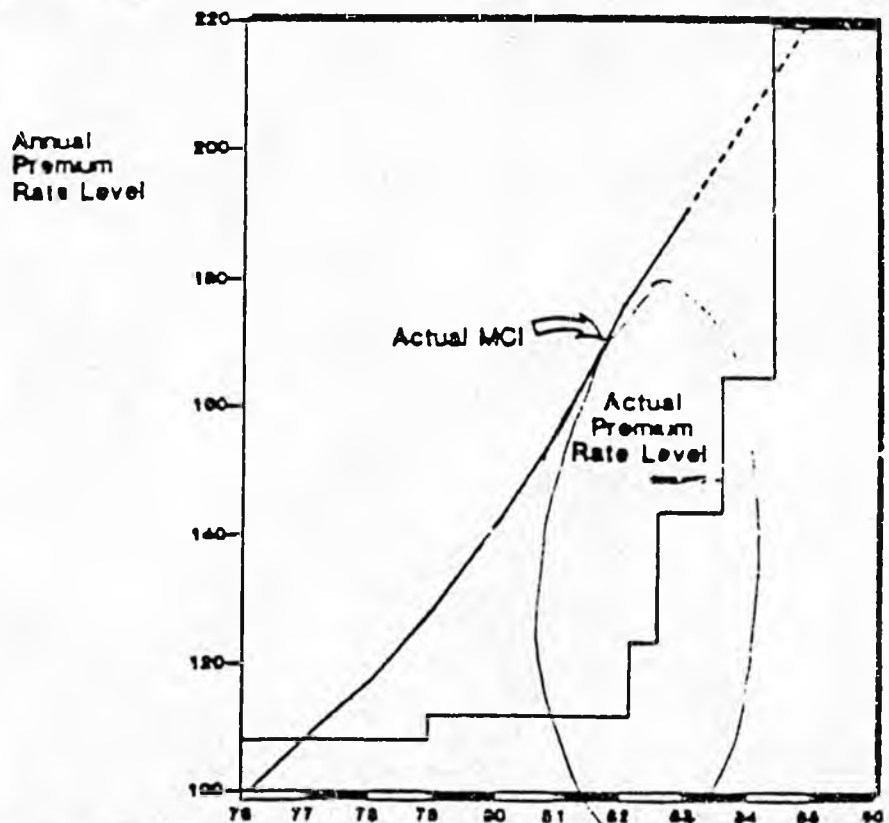
Theoretical Malpractice Premium Rate Cycle

FIGURE 1-1



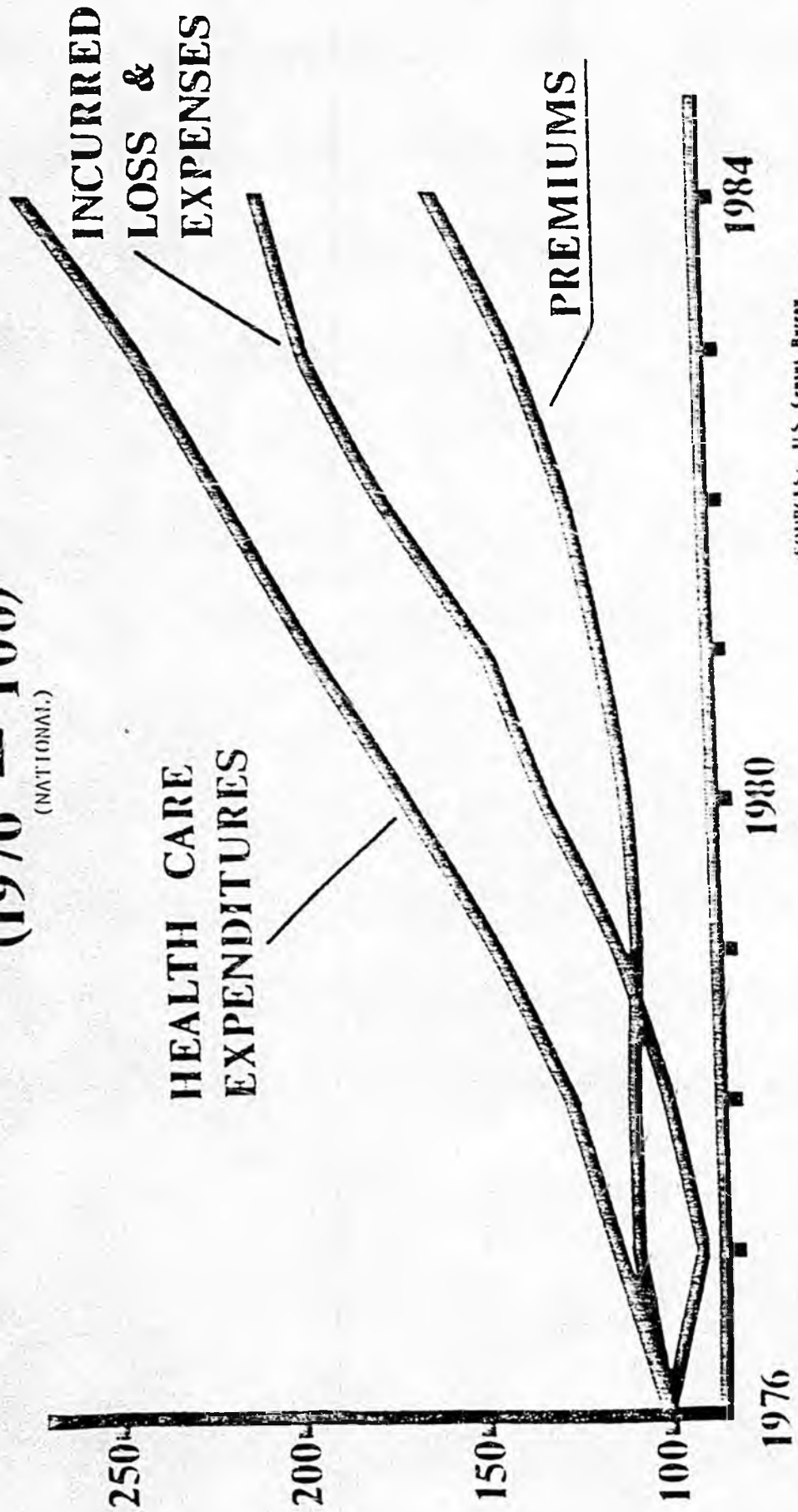
Stylized Actual Malpractice Premium Rate Cycle

FIGURE 1-2



PREMIUM GROWTH

MEDICAL MALPRACTICE (1976 = 100) (NATIONAL)



SOURCES: US Census Bureau
AMA Best

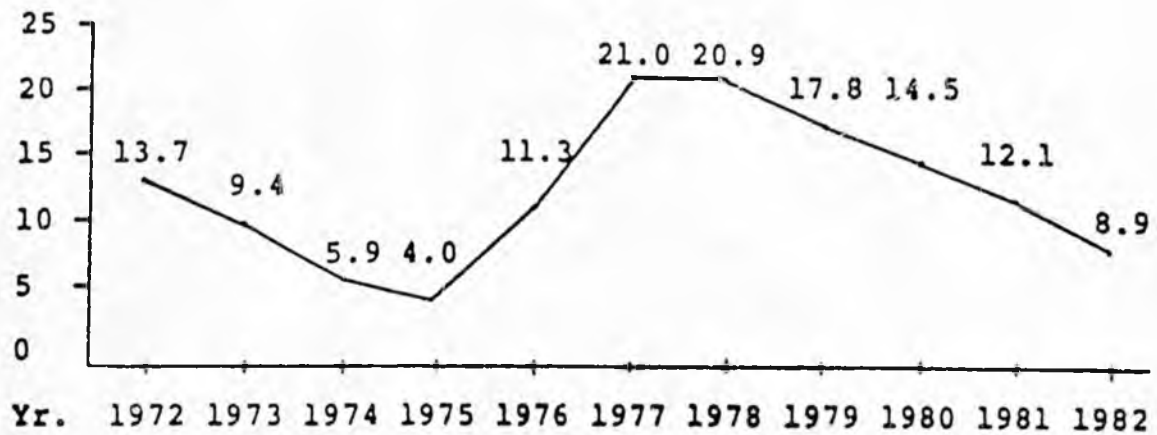
The "boom-bust" cycle in the insurance industry is reflected in the behavior of insurers:

"It is amazing to see what happens in an insurance cycle to the mental state of underwriters. At the top of the cycle, in 1981, insurers were willing to not only take all of the risks they are shunning today, but were willing to go so far as to insure the liability of MGM after their Grand Hotel burned down. Compare that with today's doomsday attitude toward risks that the underwriters have subjectively declared to be taboo."

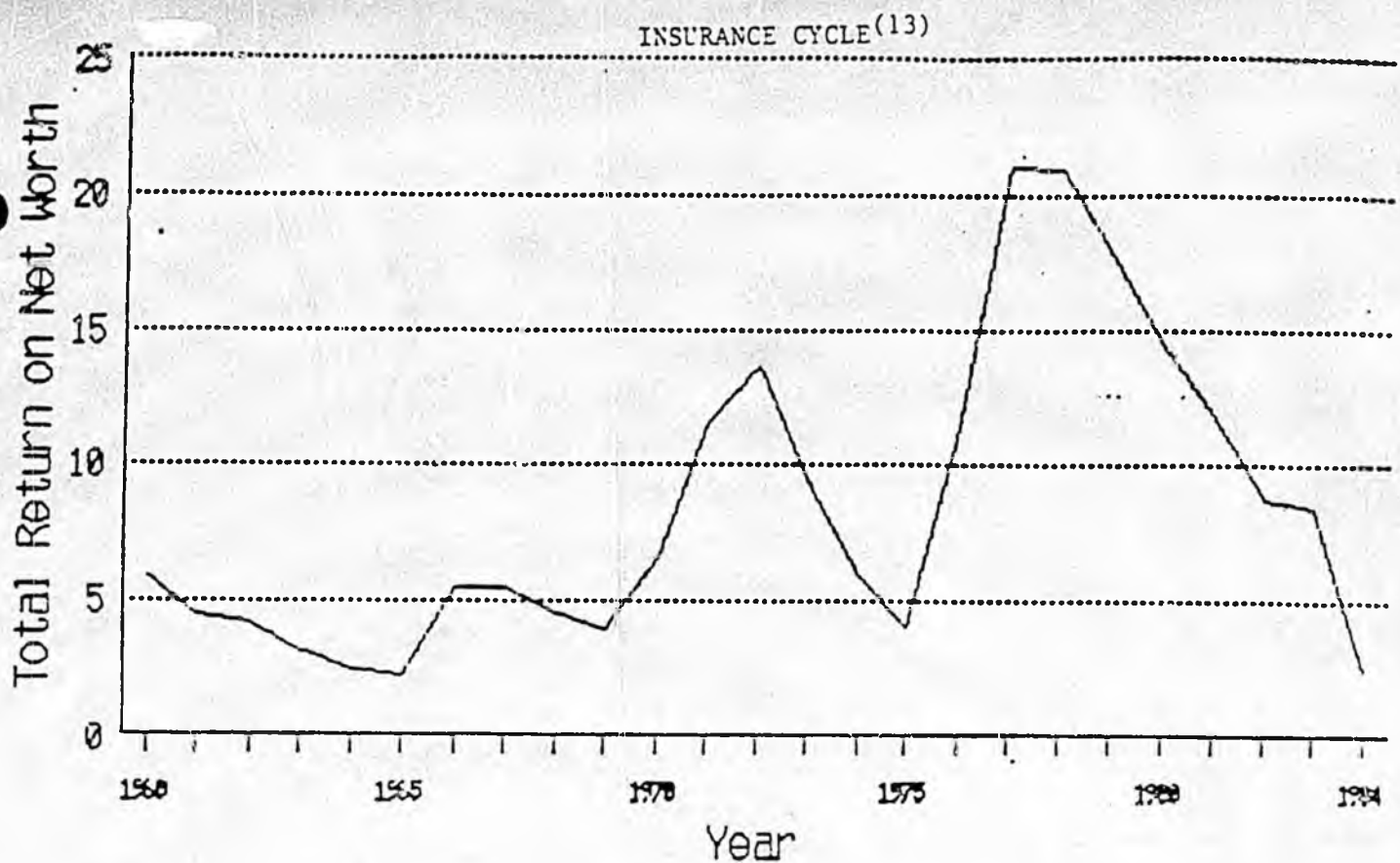
(See Also Exhibit E)

This cycle of profitability for insurers can perhaps best be seen in the following chart showing

Average Annual Rates of Return on Net Income After Taxes as a Percent of Net Worth 1972-82 (12)



A longer term look at this cycle can be seen in the following chart.



As the above charts demonstrate, insurance crises are both cyclical and predictable. What we are experiencing now in 1985 is just such a "crisis," a crisis in the insurance marketplace, created by the economics of the insurance business and its interrelationship with underlying economic trends and conditions, born from the struggle between competing insurance companies for market share and profits.

During the current phase of the insurance cycle, insurers are demanding and receiving substantial increases in rates in order to substantially increase their profitability. Once higher profits are restored, the current crisis of availability and cost will disappear and the next round of competitive pricing is likely to reemerge.

It is interesting to note that auto insurance policyholders in Pennsylvania were cushioned against the full impact of the present crisis by the state's new auto insurance law which took effect just as the current phase of the market cycle was beginning. For example, in 1985, State Farm, the largest auto insurer in both Pennsylvania and the United States, took a rate increase averaging 6% for the entire nation, but State Farm's increase was only 3.9% in Pennsylvania. The cost of insuring an automobile in the United States in 1985 has risen at an annualized rate of 18.2%.¹⁴ Pennsylvania appears to be below the national average for the first time in years.

Significantly, a recent article in the Journal of Commerce reported on a new study entitled "1985, A Critical Year," done by the insurance industry itself, through the Insurance Services Office and the National Association of Independent Insurers. The study concluded, "The property/casualty industry must accept the major responsibility for its current financial condition." (See Exhibit F)

However, it is not yet time to mourn for the property/casualty industry or fear for its demise. Dr. Michael E. Hogue, President and

Managing Director of the Philadelphia Insurance Research Group, in recent remarks to the annual convention of the National Association of Professional Insurance Agents, said:

"The property-casualty insurance industry today is in a stronger capital and surplus position than it has ever been in and it clearly has enough capital and surplus to meet the needs of the insurance industry today and in the near future." (See Exhibit G)

The National Underwriter reported that Dr. Hogue "also predicted a quicker than expected return to 'a period of a lack of price discipline'," in other words, a return to competitive price cutting.

The National Underwriter report continued:

"Dr. Hogue said A.M. Best reported consolidated policyholder surplus of \$64 billion as of Dec. 31, 1984, and then in a July 15, 1985, report indicated an adjusted surplus of \$92 billion. Thus, he said, Best saw an equity in the balance sheet of \$28 billion which he said arises out of undervalued assets and overstated liabilities. He said it comes primarily from the unearned premium reserve for that portion already paid out in acquisition costs and from the estimate of the loss reserves on a discounted basis.

"In general, what that means," he said, "is that the property-casualty industry, if it were put into a runoff situation and assuming the reserves are accurate, when the period of runoff is completed, not only would there be \$64 billion in capital and surplus, but there would be another \$28 billion left over."

"Even assuming a reserve deficiency of as much as 20 percent, he said, after the period of runoff, the industry would have not only the \$64 billion of reported surplus, but another \$8 billion or \$9 billion of undisclosed profits.

"It is for this reason," Dr. Hogue said, "that we believe the property and casualty insurance industry is overcapitalized; and that, frankly, is going to be a detriment, not an advantage."...

"It's for that reason," he continued, "that we maintain that the industry does not have a capacity problem."...

"...What it does indicate, he said, is that the insurance industry is not pleased with the profitability of the market and is unwilling to release the capacity in search of taking risk. 'There lies our major concern,' he said.

"When the profitability appears in the financial statements of the carriers, particularly in the regional and other small companies that have not had the extent of problems that many of the larger carriers have had, they will begin to release the surplus in anticipation of growth of market share.

"Dr. Hogue said Chubb and Ohio Casualty recently released nine-month results showing that earnings per share have already doubled in 1985.

"It is our concern," he said, "that we're going to find a more rapid release of that surplus in search of market share than is otherwise being predicted relative to when the markets will turn. It is our belief that that is going to result again in a period of lack of price discipline.

"We believe that the requirement to allocate the surplus because of the necessity to leverage that surplus against returns to meet the target return on investments of many of these corporations, we will begin to start the process of market competitiveness."

"He called it 'gross mismanagement' of a property-casualty insurance company to attempt to increase market share unless there are indicators available showing where the price and relative exposure are at any point in time. He said it has been his experience that there are few insurance companies in the U.S. market which are fully aware of the current price and exposure relationship in their portfolio on a recurring basis..."

(See Exhibit G)

In other words, Dr. Hogue apparently believes that the insurance cycle, with its peaks and valleys, is most likely to be repeated again in the future just as it has in the past. (For further discussion and other views on the capacity aspect of Dr. Hogue's remarks, see Exhibit H)

While it appears certain that the insurance industry will continue and profitability will improve, there will be some inevitable changes. The nature and extent of these changes remains to be seen. There may be increased government intervention to attempt to control the swings of the insurance cycle and to assure availability of coverage and provide adequate data for rate making purposes for certain lines, as well as to prevent such abuses as midterm cancellations. There will certainly be some structural changes in the

marketplace, including increased reliance on self-insurance. Insurance purchasers have much at stake. Will they continue to be at the mercy of the insurance cycle or will they take an active role in improving their situation? Changes are constant in our society and, just as the law adapts to these changes, so must insurance. So far, the competing insurance companies have apparently found it easier to agree among themselves to try to shift the blame for their problems onto the legal system than to agree on how to solve them.

III. The Search for Effective Solutions

As must be clear by now, the reality of the "crisis" is far different and more complex than is commonly perceived. The answers to these problems do not lie in cost shifting devices such as various arbitrary limitations on the rights of the citizens of Pennsylvania. The answers are numerous and what follows is not intended to be an all inclusive list. Part of the answer lies in assuring that the insurance industry does real underwriting, considers individual experience in rate making and has adequate data in order to do this job. Further, while competition may be desirable as a general rule, insurance companies cannot be permitted to charge rates which are inade-

quate or excessive. In some lines, the market in a state may be so concentrated as to not be conducive to open competition. This must be carefully examined. Also necessary is action to reduce dependence on the foreign reinsurance market and particularly the dominance of Lloyd's of London over the American insurance market. Another part of the answer lies in reexamining the investment laws governing property and casualty insurance companies so that they can engage in appropriate modern investment practices which might enable them to smooth out the effects of changing economic conditions on their corporate bottom lines. Pennsylvania's law governing insurance company investments dates from 1921. An additional answer lies in increased insistence on risk management on part of both insurance providers and consumers in order to prevent injuries from occurring in the first place. A further part of the answer lies in increased knowledge on the part of insurance consumers as to how to buy insurance and who to buy it from. This would include increasing use of self-insurance and pooling mechanisms.

Through the pooling of risks many groups needing insurance coverage, including Pennsylvania's political subdivisions, could accomplish several objectives.

First, they could collectively self-insure their low-

end exposure.

Second, they could use the strength of their numbers and the stability of risk inherent in such an arrangement to negotiate the most favorable rates from the private sector for their collective high-end exposure. Thus, the pooling mechanism would work very much like a group insurance plan with a high deductible.

Third, the pooling mechanism could provide a data base on all claims against its participants which would enable effective risk management--claim prevention--the only real way to cut costs.

Fourth, such a data base would provide its participants with the ability to determine if their insurance rates are fair and reasonable.

The pooling mechanism I am describing could be run by a private insurer with the appropriate expertise. Most importantly, such a program would effectively free groups such as Pennsylvania's political subdivisions from the vicissitudes of the insurance cycle. This is because they would have created their own capacity to the extent they self-insure, thus hoarding the sometimes extremely limited capacity available in the private sector for their high-end exposure. Further, it would give them the data necessary both to prevent claims and negotiate insurance rates far more effectively.

In remarks to the Florida Senate Commerce Committee regarding property and liability insurance on October 8, 1985, Florida Insurance Commissioner, Bill Gunter, supported the views expressed herein as to the solutions which would appear to be appropriate under the circumstances. (See Exhibit I)

In this regard, it should be remembered that insurance first began in England when the owners of merchant vessels decided that the best way they could handle the risks inherent in their business was to share that risk. Maybe it is time to return to the basics in insurance. Importantly, the solutions I am suggesting are applicable to others, besides political subdivisions, who are affected by this problem of cost and availability of liability insurance.

This cyclical problem with liability insurance rates will remain with us until decision makers in government, business and the professions, as well as the observers in the media, shift their focus. We must stop dealing with perceptions and begin to address reality. Prompt and effective relief can only be achieved by addressing the reality of the problem through the type of solutions suggested herein.

IV. More on Pennsylvania's Experience

The need for this shift of focus could not be any clearer in Pennsylvania than with the problem of municipal liability insurance. The Political Subdivision Tort Claims Act of 1978 is among the most restrictive laws with regard to tort law as has ever been passed in any state. For example, it contains an absolute bar on tort claims against local governments with only eight areas where exceptions are granted. In those areas where claims can be brought, there is an absolute limit, a cap, on the amount of liability and any compensation is further reduced because the victim cannot recover any damages which are paid or payable from any other source, with the exception of life insurance. This law even contains a "threshold" including the requirement that the injury be permanent, which must be met before a claim can be instituted. (For a synopsis of the Political Subdivision Tort Claims Act, see Exhibit J). Lawyers who represent political subdivisions throughout Pennsylvania have testified that there is not a crisis of claims here in Pennsylvania. There has not been some sudden or recent increase in litigation against political subdivisions. (See Exhibit K) Despite these facts, municipal liability insurance rates in Pennsylvania are currently soaring, just as

they are in other states without tort restrictions, demonstrating that so-called tort "reform," the restriction of the rights of our citizens, does virtually nothing to affect insurance rates.

It is interesting to note that the Political Subdivision Tort Claims Act grants the political subdivisions the authority to establish a pooling mechanism and help themselves as described above, (See 42 Pa. C.S.A. Section 8564), but they have failed thus far to act. Of course, they could wait until the current crisis is over and allow the cycle to recur, and there is evidence that this phase of the cycle is ending. Best's reports as follows:

"In the first half of 1988, property casualty stocks on Best's Index have advanced 31%, investor excitement being generated by a reasonable consensus that the longest industry down-cycle in history has finally turned, albeit by a small margin. They were rewarded on average, by advances twice the size as those reaped by the general stock market."(See Appendix I)

V. Conclusion

If solutions to the problems confronting those who need insurance coverage, including political subdivisions and others are to be effective, these solutions must address the real problems, not the common misconceptions, however popular they may be. These problems are the result of a "cycle of profitability" in the

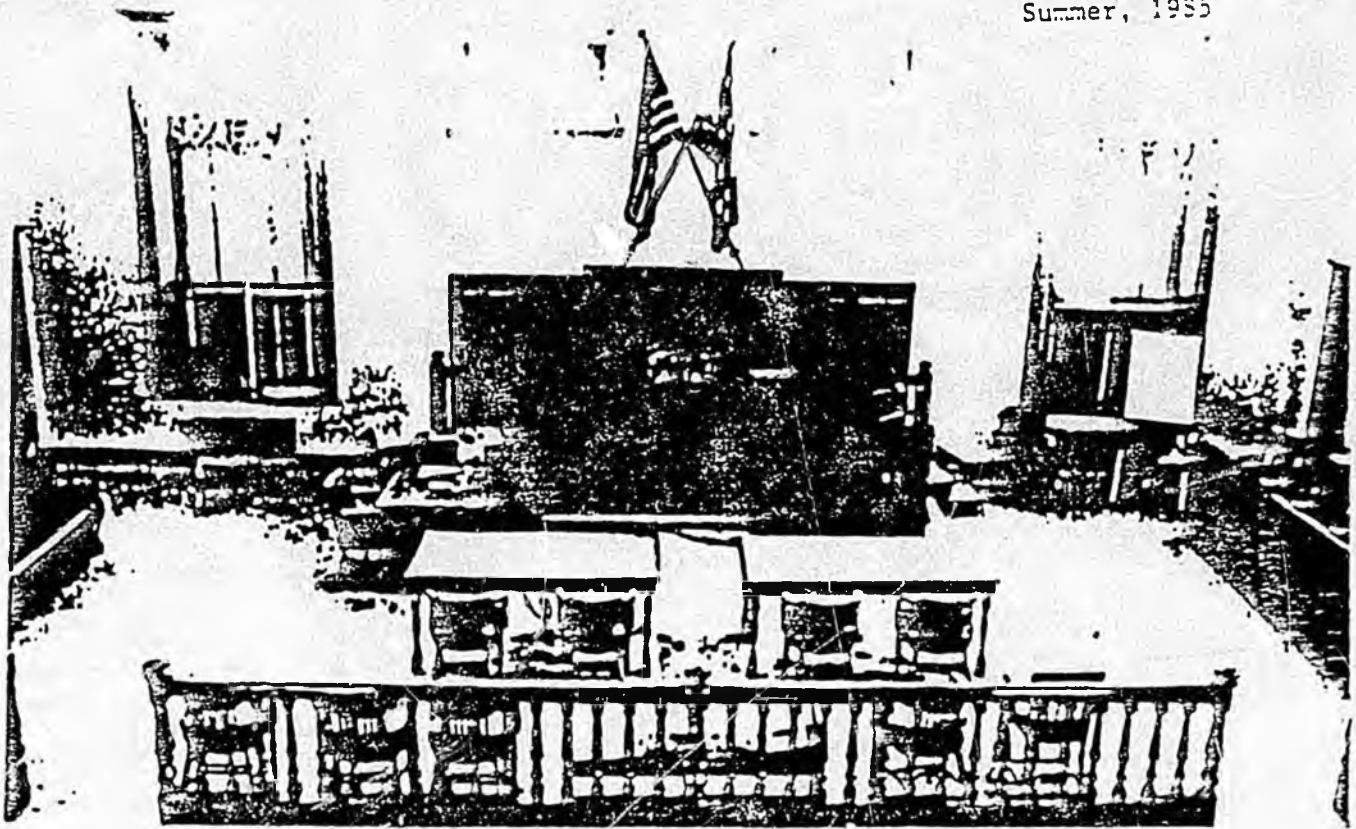
insurance industry born from the struggle between competing insurance companies for market share and profits. They are not the result of some sudden increase in litigiousness or in the total volume or cost (considering inflation) of claims.

The current phase of the insurance cycle, with its "crisis" of cost and availability, is apparently ending. Will this cycle be allowed to recur unabated?

This article was written in hope that it will not. The Pennsylvania Trial Lawyers Association is sympathetic to the problems confronting all groups of insurance consumers and is always willing to be involved in the search for constructive solutions.

Footnotes

- 1 Galanter, Marc, "Reading the Landscape of Disputes: What We Know and Don't Know (And Think We Know) About Our Allegedly Contentious and Litigious Society," 31 U.C.L.A. L. Rev. 4, 55-56 (October, 1983).
- 2 Galanter, supra at fn (1), at 70.
- 3 "Federal Judicial Workload Statistics During the Twelve Month Period Ended December 31, 1983," Administrative Office of the United States Courts, (1984).
- 4 "Americans' 'Litigation Binge' Is A Myth," U.S. News & World Report (November, 1984).
- 5 Guinter, John, "Stalking Burger's Wild and Elusive Litigation Flood," The Barrister, Vol. #XVI, No. 2, Summer, 1985.
- 6 M. A. Peterson and G. L. Priest, 1982. Rand Corporation, The Institute for Civil Justice, Santa Monica, CA Civil Jury, Trends in Trials and Verdicts, Cook County, Illinois, 1960 - 1979
- 7 Hofflander, Alfred E., and Nye, Blaine F., "Medical Malpractice Insurance in Pennsylvania," 1985, Management Analysis Center, Inc., Menlo Park, CA.
- 8 A. M. Best's Casualty Loss Reserve Development, 1985.
- 9 Id.
- 10 Id.
- 11 "The Insurance Crisis of 1985: What Can Be Done?" National Insurance Consumers Organization, Alexandria, VA (June, 1985), p.2.
- 12 Refers to capital stock property/casualty insurers only. Figures are from "Congress Should Consider Changing Federal Income Taxation of the Property/Casualty Insurance Industry," U.S. General Accounting Office, GAO/GGD/85/10, March 25, 1985, p.7.
- 13 Chart is from National Insurance Consumer Organization press release of August 15, 1985, which identifies the source of the data for the chart as Citibank Economics and Insurance Services Offices.
- 14 Testimony of J. Robert Hunter, President, National Insurance Consumer Organization, before the Subcommittee on Commerce, Transportation and Tourism, U. S. House of Representatives, on "Liability Insurance" which identifies the source as CPI data on "auto insurance," U. S. Bureau of Labor Statistics.



STALKING BURGER'S WILD AND ELUSIVE LITIGATION FLOOD

by John Gumber

Whenever someone in power announces that we Americans are facing a crisis—swine flu, for example—my experience has been that the crisis rarely exists, but the cure is likely to kill us.

Some crises have as their purpose to allow gentlemen-warriors to go shooting second-hand—(the blood spilled is ours, not theirs), in foreign climes, be they Vietnam or Nicaragua. Other crises, less sanguinary but no less lethal, seem designed to convince us to give up some Constitutional right that it is no longer convenient for us to have.

An adept practitioner of the latter variety of crisis-mongering has been the Chief Justice of the United States Supreme Court, Warren Burger. For about the past 10 years, he has been trooping through every Middlesex village and town (i.e., every American Bar Association

meeting) telling us we are in the midst of a great "litigation crisis" (that has so flooded our courtrooms that our right to free access to the courts and to a jury to hear our case should be sharply curtailed. He has found allies in the popular press, who write sensational articles about Americans indulging in an "epidemic of hair-trigger suing," causing our multi-billion-dollar multi-national corporations to weep with sheer vexation at the money they have to pay out when they put products on the market that maim people. All this has been caused, Burger says, by the "inherently litigious nature of Americans," who, in the rather elegant phrasing of another commentator, display "an abandoned eagerness to hall into court all and sundry."

Out of curiosity, I decided to take a look at the statistics, to see exactly how greedy we Americans are. Certainly, if we are as avid for money as Burger says

we are, then something ought to be done to stop us for our own good. After all, our suits force insurance companies to pay verdicts, their costs are passed on to their customers, who in turn pass them on to us—both the contentious and the passive among us.

The federal court figures seem to back Burger. They show that between 1980 and 1984, the number of civil cases filed jumped from about 170,000 to 260,000, more than a 50% increase which, if it doesn't mean a crisis, means something close kin to one.

That is, it did until I let my eyes wander down the long rows of figures that show where the increase in cases is coming from. I then learned that nearly two-thirds of the increase was brought about by cases in which the United States government was either the plaintiff or defendant. Of these, almost all the plaintiff cases were ones in which the government

was trying to collect defaulted student loans or alleged overpayments to veterans. Of the ones in which the government was the defendant, almost all of them involved people who were suing to stop the Reagan administration from cutting off their Social Security supplemental benefits.

Without arguing the merits of these governmental policies, such suits hardly come under the heading of "hair-trigger suing" by "an inherently litigious" citizenry.

But, thought I, since federal cases make up only about four percent of all those that are filed in the United States each year, what I should be looking at are state court statistics. I found them, too, in several huge volumes filled with hundreds of pages of tables which, when the browsing among those numerical thistles was complete, reveals that—since about the mid-1970's—civil case filings in state court have been increasing at about three percent a year, or one-quarter of the federal rate.

It's all a matter of perspective, no doubt, but to me that increase doesn't even amount to a kissing cousin of a crisis.

While I was at it, I thought I'd try to find out the origins of the increase, such as it was. Although it seems, no two states keep their statistics the same way, as nearly as I could tell—and I had a sample of states making up about 50% of the population—personal injury cases, the ones where we're supposed to be doing all that hair-trigger greedy suing—were strolling along with virtually no difference in the rate of filing from year to year.

I did, however, find one category in which there was a sharp increase, and a predictable one considering the doubling of the divorce rate in the United States between 1970 and 1980, and that was in domestic relations cases, including child custody matters. There, the rate had grown by a hefty 30%. Apparently,

if Americans are contentious, it's manifested mostly in their marriages.

I also learned that, if we Americans are litigious, we certainly vary a lot from state to state in that quality. The peaceful Pennsylvanians, for example, filed civil suits at a one percent increase in 1983 over 1978; the laidback Californians were right at the national average, while the big bad New Yorkers were way above it. In 1980, New Yorkers filed—according to their official statistics—about 730,000 civil suits; in 1983, a whopping 1.2 million. Now, there's a crisis of headline-making proportions, and headlines have been made of it. The only problem is that it is a false figure. A call to a New York court official revealed that the 1983 statistics included counts from two courts that previously had been omitted, and they weren't any small omissions, either—about 400,000 of them a year.

In other words, as the official noted, the real rate of increase in New York is about two percent a year since the late 1970's, not more than 70% in three years, as the published statistics seemed to indicate.

Perhaps, just perhaps, we should hang on to our right to trial and jury a wee bit longer and not let those who would save some money for insurance companies and big businesses scare us out of it. Perhaps our real crisis comes from the quality of those who advise us.

ABOUT THE AUTHOR

John Guttrick is one of the most able and distinguished journalists in the Philadelphia area. Long-recognized for his readable style and his careful research, Guttrick has often written on legal matters for such Delaware Valley publications as Philadelphia Magazine and the Welcome (where this article originally appeared).

The Hard Search for Property Insurance

To hold down costs, consumers may have to chase discounts. 'Bad risks' may be turned away altogether.

RECENT news reports have described the drastic rate increases inflicted upon business seeking property and casualty insurance, but little has been said about the prospects for individual drivers, homeowners and renters. Unfortunately, the huge losses that insurers have suffered recently are putting rate pressure on the so-called personal lines as well as on commercial insurance. Although the increases have been far less dramatic, personal premiums are continuing their steady climb, with auto rates leading the upward trend. Industry spokesmen also warn that insurance will be harder to get for "bad risks," including those people with poor driving records, for example, or whose homes are far from fire stations. Individuals who want to build down their insurance costs may find it necessary to do some sophisticated shopping, to assume more risks themselves, and to be aggressive about getting every possible discount.

The reason rates are under such pressure derives from a practice known as "cash-flow" underwriting. For a three-year period that ended last fall, insurers focused much more on investing premium income than on the quality of the risks they were insuring. Lured by very high interest rates, companies competed intensely for dollars to invest.

The insurers were gambling that the cash flow from their investments would be great enough to cover their underwriting losses. But unexpectedly high commercial losses and dropping interest rates combined to bring about an industry underwriting loss last year of \$2.3 billion, according to the A. N. Best Company, the widely respected insurance industry rater and analyst. In a year-end report, Best said, "The penalty for trying to substitute finance for underwriting is now being paid."

For businesses, at least, the pursuit of cash flow underwriting brought substantial premium savings. Individuals, however, enjoyed no such bargain, points out J. Robert Hunter, president of the National Insurance Consumer Organization. From 1981 through 1984, premiums on commercial lines of property and casualty insurance went up only 10 percent, on average. Premiums for personal lines rose 20 percent over that period, notes the Insurance Services Office, an industry organization that tracks trends and issues rate guidelines.

This 20 percent increase was what the I.S.O. had said was needed, according to a spokesman, David Ostwald. Similarly, the I.S.O. had recommended commercial increases of 30 percent, but the industry ignored that recommendation. Now, with the property/casualty companies facing severe losses and needing to rebuild their reserves against future claims, some commercial customers face premium increases of 200 percent to 500 percent.

Fortunately, individuals face no such budget-breaking changes, partly because their rates have risen all along. The average premium for individual drivers nationally was up 8.1 percent for the first quarter of 1985 from a year earlier, according to the I.S.O. Homeowners premiums over the same period went up 5 percent. Experts expect near-term increases to stay within a similar range.

However, Mr. Ostwald advises that auto rates may move up somewhat faster. The number of auto collisions is up, and with it came a 6 percent rise in the number of claims for physical damage in the fourth quarter of 1984 compared with the period a year earlier. More important, he says, there will be pressure on the industry to "limit the availability of insurance to people in less desirable risk categories" for all types of coverage.

Individual insurance buyers who want to control their insurance costs can take the following steps:

- When policy renewal time approaches, shop for comparison prices. Be sure to get a quote from at least one company that does only limited commercial business — because it will probably not be facing such serious losses. This group includes such companies as State Farm, Nationwide, Geico, Allstate and Safeco.

- On auto policies, consider accepting a deductible as high as \$1,000. Mr. Hunter, of the National Insurance Consumer Organization, points out that this form of self-insurance is nearly always worth the risk. Among other reasons, he says, someone with a \$250 deductible who suffers a \$500 loss often decides not to file the claim because the action might force up future premiums. Over the years, the premium savings from the larger deductible

should more than outweigh the cost of paying for a minor accident yourself. "Get time to be your insurance company," Mr. Hunter advised.

- If you have a poor driving record, ask an independent insurance agent to check the Assigned Risk Plan rates. They are sometimes cheaper than those available from individual companies.

- Check to make sure you are getting the benefit of all possible homeowner or renter discounts. Although only a few companies advertise discounts for homeowners who have smoke alarms, for example, almost all companies offer them. Discounts are also commonly offered to senior citizens and to people with dead-bolt locks protecting their homes.
- Co-op owners should take advantage of new policies available to them. Until recently they were restricted to tenant policies, but now they can purchase the same kind of policy that homeowners have — often at a 30 percent to 40 percent saving over the old coverage, according to Anthony Glaccone, an agent in Huntington, L.I.

- In the past, some companies have been charged with "redlining," or refusing to write insurance coverage within a given neighborhood, usually one in the inner city. Companies deny these charges, but Mr. Hunter advises that individuals who live in such areas and find themselves unable to get coverage for reasons that seem illogical should consider complaining to their state insurance department.

INSURANCE is a cyclical industry, but the current downturn is more severe and prolonged than most, and some companies may go under. Consumers are protected by state law if their insurer or company fails. New York, for example, created a guarantee fund to honor consumer claims against bankrupt companies. However, payment can be much slower than normal. As a precaution, consumers should check company ratings in Best's Insurance Reports, available in libraries, or with an agent. Best's top rating is A-plus; industry experts advise that consumers deal only with companies rated B-plus or better.

LETTERS

Insurance

To the Editor:

Francis Carter made some misleading statements concerning commercial insurance ("The Hard Search for Property Insurance," Personal Finance, July 28). She referred to the period of "cash-flow" underwriting as "a three-year period that ended last fall." That phase of the cycle commenced about the fourth quarter of 1978 and turned around about the third quarter of 1984. We had chaos in six years — not three — during which American businesses, institutions and municipalities got their insurance well below "manufactured" costs and saved billions of dollars on premiums.

She stated that premiums on commercial lines went up only 10 percent on average, from 1981 to 1984. Premium growth is a function of population increase, G.N.P. growth, inflation and other economic and social factors. Premium rates level in what impacts on one's pocketbook, not overall premium growth. A more meaningful statement would be: "Rate levels for commercial insurance dropped approximately 80 percent as average between 1978 and 1984."

Finally, Ms. Carter stated that co-op owners "can purchase the same kind of policy that homeowners have." Not so; but change "homeowners" to "condo owners," and you have it.

ALFRED I. JAFFE
Associate Professor (retired)
The College of Insurance
New York, July 28

The Philadelphia Inquirer

business

Sunday, March 10, 1985

Area has the nation's fastest-rising medical prices

By Gilbert M. Gaul
Inquirer Staff Writer

The prices consumers pay for medical care in the eight-county Philadelphia area are rising faster than anywhere else in the nation.

Not only that, but they are rising from levels already considered among the highest in the nation and at a time when the pace of price increases for medical care in other cities appears to be slowing.

From January 1984 to January of this year, the price of medical care in the Philadelphia area increased by 11.51 percent, double the national average of 5.8 percent.

The data, gathered by the regional office of the Bureau of Labor Statistics, have left health-care experts groping for explanations.

"Why we're going up while the other cities are slowing, I can't say," said Charles Scott, the bureau's regional economist.

"That's hard to rationalize," agreed Wharton School professor Robert A. Zeiten.

The only city whose health-care price trend mirrors Philadelphia's is Houston, which, like Philadelphia, has a high concentration of medical schools, teaching hospitals and medical research centers. Prices for medical care in the Houston area rose 11.5 percent, a whisker behind Philadelphia's rate.

In many cities commonly thought to have higher costs of living than Philadelphia, medical-service prices rose at much slower rates.

For example, in New York, often considered the nation's most expensive city, medical prices rose 7 percent; in Boston, prices climbed 7.7 percent; in Los Angeles, 6.7 percent; San Francisco, 5.3 percent, and in Washington, prices rose 2.9 percent.

The rapid price increase here comes at a time when the rise in medical-care prices elsewhere is slowing. In January 1984, the medical-price index for Philadelphia stood 3.1 percent higher than the national figure. A year later, the index in Philadelphia was 10.7 percent higher than the national average.

When compared with other components of the Consumer Price Index (CPI), which measures price changes on a broad range of goods and services, the rate of increases in medical care stands out starkly.

Housing prices in the region, for example, increased 5.03 percent in 1984. Food and beverage prices rose 1.59 percent. Transportation prices were up 3.49 percent, and clothing prices inched up just 0.39 percent.

The overall CPI for the Philadelphia region — Philadelphia, Bucks, Chester, Delaware and Montgomery Counties in Pennsylvania and Camden, Burlington and Gloucester Counties in New Jersey — rose 4.04

percent in the year ended January 1985. In the same period, the national Consumer Price Index climbed 5.57 percent.

Why are prices for medical care here rising so quickly? And, more particularly, why is the Philadelphia region out of line with price trends in the rest of the country?

"We think we know why it has increased in Philadelphia. But I don't know why with other cities," said Labor Statistics economist Scott.

Scott said prices for services from hospitals, nursing homes and dentists here all had increased at a rate greater than the national average. Also rising quickly were premiums for health insurance. But price increases for prescription and nonprescription drugs and medical equipment did not exceed the national average, Scott said.

"We record what the increase is, but the reason why, we really don't know. There could be an element of 'this is just our year,'" Scott said.

Scott and others at the Bureau of Labor Statistics caution that the regional CPI survey is subject to some distortion because it uses a small sample. But those distortions tend to be smoothed out when viewed over longer periods, the BLS officials say.

CONTINUED

CONTINUED

Medical prices here are nation's fastest-rising

"We always tell people not to place much emphasis on a monthly shift because it could be wrong. But over long periods of time those things tend to wash out. Looking over a calendar year you expect to see a consistent pattern," said Daniel Ginsburg, supervisory economist for the BLS in Washington.

Officials here and in the 27 other BLS regions use the same methodology to gather the price data. Starting with the main components of health care — hospitals, nursing homes, physician fees, drugs — they survey prices of individual items at varying locations. The same items are selected each month so economists can measure the rise in prices from the index base of 100, the price level in 1967.

The weight given to each component of the CPI varies from city to city, reflecting the diversity of their medical-care economies. The CPI here, for example, reflects the high concentration of hospitals.

What the CPI does not purport to measure is the cost of goods and services. "We're measuring the changes in the prices of those goods, not the costs," Scott said.

Since the Bureau of Labor Statistics began keeping the medical-care index, prices here have climbed 133 percent as of January. The only metropolitan area in the nation where prices have risen more quickly is Houston, where medical-care prices have increased 352 percent since 1967.

"I think there's several explanations for that," said Sharon Cohany, a BLS economist in Dallas. "One is that since 1967, Houston has been one of the fastest-growing areas in the country. That phenomenal growth has put upward pressure on all prices, including those for medical care."

A second explanation offered by Cohany is one that also might apply to the Philadelphia medical marketplace.

"Houston is at the forefront of medical technology," the economist

said, "and that also is very likely to put upward pressure on prices. As technology expands, the cost of developing those services also grows. A tremendous financial cost is associated with that."

Albert Zenilinski, managing partner in charge of health care for the Philadelphia accounting firm of Laventhol & Horwath, offered a view similar to Cohany's.

"My feeling in a speculative way is that ... it could be a function of our highly developed medical area here," he said. "It is a highly intensive medical community in terms of physicians per capita and specialists per capita. They are all selling higher-cost services. Prices don't go up unless costs go up."

Other health-care experts, economists and officials offer other reasons why prices for medical care in Philadelphia and its surrounding counties are rising much faster than those in other areas, including many cities with sophisticated medical complexes, such as New York, Boston and Cleveland.

"Many cities have different ways of containing health costs. That may have something to do with it," said Kay Ford, a BLS economist in Washington.

Carol M. McCarthy, president of the Delaware Valley Hospital Council, which represents more than 90 hospitals, said medical institutions here increased their charges by 23 percent last year to make up for \$207 million worth of uncompensated care — a 25 percent increase — that they provided to poor and uninsured people.

McCarthy said that blaming the hospitals for the region's increase in prices would be a mistake. In fact, she said, annual increases in hospital spending here have dropped sharply, from 20.7 percent in fiscal year 1982 to 6.6 percent in fiscal year 1984.

Moreover, McCarthy said, hospital profits rose only 6.06 percent in fiscal 1984. "At least from the hospital side, what we're saying is that we

think we have a pretty good story to tell. We think we have expenditures pretty well under control."

Another partial explanation for the price increases might be the aggressive building programs recently undertaken by many hospitals and nursing facilities in the area, said Zeltin, an assistant professor of insurance and health-care systems at the Wharton School.

Between March 1982 and February 1984, more than \$467 million worth of new construction was approved for the five Southeastern Pennsylvania counties by the Health Systems Agency of Southeastern Pennsylvania, a federally mandated planning agency. Hospitals increase room rates to cover the costs of new construction.

POST-GAZETTE: Fri., Nov. 8, 1985—9

Nader, insurance firms differ on need for liability rate hikes

By Gary Rotstein

Post-Gazette Harrisburg Correspondent

HARRISBURG — Ralph Nader, the spokesman for consumer causes who built his reputation attacking the auto and oil industries, branded insurance companies worst of all yesterday for driving up liability coverage costs.

Although insurers contend huge increases in liability premiums this year were necessitated by \$3.8 billion in industry-wide operating losses in 1984, Nader told the House Insurance Committee the losses had been exaggerated.

"Never in economic history has there been such a precipitous increase," the maverick activist said. "We're seeing increases and cancellations at a level totally unsupported on an actuarial basis."

Nader claimed the dramatic price jumps are designed to aid insurers' political goals of pressuring lawmakers to restrict consumers' rights to sue for damages.

"Horsefeathers — they're being paranoid," an industry representative said when informed of the

remarks by Nader and J. Robert Hunter, federal insurance administrator in the Carter administration.

Grover Czech, regional vice president of the American Insurance Association, said, "Companies are doing what they feel they have to get back to price adequacy... Competitive pressure drove rates down for many years. Generally prices today are coming back to what they were in 1977 or 1978 when adjusted for inflation."

Nader and Hunter, who now heads the National Insurance Consumer Organization, acknowledged the industry had inadequate revenue last year.

They contend, however, that it would have taken just a 5 percent boost in premiums across the board to meet standard profitability levels. They based the estimate on a U.S. General Accounting Office report that companies showed a 3 percent return on net worth last year when investments, depreciation and other factors were added to operating costs.

Instead, liability insurance costs are going up 100 percent or more for

many local governments, transportation firms, day care providers, taverns and others.

Representatives from those areas in previous Insurance Committee hearings, appealed for state help in controlling those increases. They also complained of being denied coverage at any price because of insurers trying to keep only the most profitable lines of business.

"The key point is... this crisis is a crisis generated by the industry as a reaction to low profits," Hunter said.

"If the profit potential is there that you say, I can't believe there aren't [insurers] going out there to write it," commented Rep. Robert Godshall, R-Montgomery County.

Nader and Hunter pointed to solid stock market performance of insurance companies this year as another indicator that the industry is not in the dire straits it says it is.

Czech countered that a 30 percent increase in stock prices of insurance companies is related to their low value last year and assumptions that they will be able to return to proper profitability with price increases.

6/20/85 Journal of Commerce

Study Analyzes Industry Woes

By JAMES NOLAN

Journal of Commerce Staff

NEW YORK — The property/casualty insurance industry's woeful financial state recalls a story from the old pushcart days along Delancey Street on New York's Lower East Side.

A merchant cut his prices sharply on ladies' boots and put up a huge charcoal lettered sign to tell the world.

Across the street, his competition cut prices lower, and said so with signs.

On the price war raged. Finally, the first entrepreneur posted a sign which declared: "Ladies' Boots. I sell below cost."

How can you do that, asked the competition? Sell below cost?

"I can sell below cost," the reply came, "because I buy below cost."

It was just this sort of a mindless price war which brought the property/casualty business to its present low and sorry state.

And no one knows it better than the industry itself. Witness a new study done by the Insurance Services Office and the National Association of Independent Insurers.

"The property/casualty industry must accept the major responsibility for its current financial condition," the study concluded. "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."

The study, "1985, a Critical Year," pulls together a story that has been told piecemeal for the past 18 months.

It compares the industry in 1984 with back years, using all of the familiar ratios: rates of return, premiums compared to

'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.'

losses and expenses, combined ratios and the like.

In some cases, the economic data from the insurance industry has been plotted on graphs, laid over similar data from The Fortune 500 industrials and U.S. bond yields. In all cases since mid-1981 the insurance industry graph lines — reflecting profitability — turn down where others rise.

The sponsors want the 31-page document to "help the public and state insurance regulators understand why premium increases are needed to assure the future financial stability of the insurance industry."

Casting back to the origins of the price war, the study notes that "since 1979, while underwriting results have declined, the industry's net investment income has grown continuously.

"In an attempt to generate cash flow for investment, insurers competed aggressively for premium dollars, knocking prices more and more out of line with loss costs," the study said.

But it was poor management strategy. The \$1.7 billion in annual investment income could not be stretched far enough to cover the \$3 billion annual growth in underwriting losses the industry suffered.

Closer to home, the 10 percent

climb in investment income of \$1.6 billion in 1984 fell far short of the 60 percent increase in underwriting losses of \$8 billion for that year.

Such a financial climate worries the industry on several scores.

First, industry actuaries are predicting that in the next few years, corporate America will find soon that it cannot insure all of its assets.

The conclusion flows from operating results for 1984. The study says that during the year, policyholder surplus fell by 3 percent to \$63 billion.

The industry measures its ability to write property/casualty coverage by this surplus figure. "Indicating," the study said, "that capacity may not be sufficient to meet the insurance needs of an expanding U.S. economy."

Still a more urgent worry is the continued financial solvency of a substantial number of companies. The study said that the ratio tests approved by the National Association of Insurance Commissioners and the A.M. Best Co. show that "the the number of financially impaired insurers has increased."

While the study did not total the number of such companies, in September of last year, the NAIC said that 319 of the 2,477 Property/casualty insurers it keeps tabs on were in bad enough financial shape to require "immediate attention" by state insurance regulators.

The NAIC warning came after it had finished desk audits on the financial results filed by the companies in the spring.

Such audits are in various stages of completion at the moment.

RATHER HOT DISCUSSION ON CAPACITY

By LOIS J. LYONS

NEW YORK—Superintendent James P. Corcoran rolled up his sleeves, looked the industry in the eye and said, "There is no capacity crisis." Donald Kramer, president of Kramer Capital Consultants, took a similar stance, looked the superintendent in the eye and said, "There is a capacity shortage, and it is severe."

Mr. Corcoran, somewhat outnumbered in his opinion and certainly in his ideas of how to handle the situation, was also opposed by David B. Mathis, chairman, president and chief executive officer of Kemper Re, who said unequivocally that there is a "real capacity crisis that is likely to remain at least through 1987," and by Mitchell J. Cole, vice president and principal of Tillinghast, Nelson & Warren Inc., who hedged only a little, saying there is certainly a "restructuring of property casualty markets," which might not be a crisis but a "revolution."

James B. Stradtner, managing director of Alex Brown & Sons, investment bankers, never really joined the fray but, taking a third position, said the problem is that capacity is never quite "in sync" with what the industry needs and that insurance companies have never been able to cope with excess or even adequate capacity. "Given the rope," he said, "they will succeed in hanging themselves," but he said he is optimistic about the future of the industry.

The speakers made up a panel discussing "New Capacity, New Players" at a seminar at the annual "I" Day meeting of the New York Chapter of the Society of CPCU. The panel was moderated by Joseph S. Diamond, executive editor of the National Underwriter Co.

Mr. Corcoran said he feels he has been patient with the industry, but is losing his patience. He said the legislators are "funous" and feel that the industry has "overplayed its hand."

Difficult position

"Now I'm in the difficult position of trying to make sure that we don't get reactive legislation," he said.

But, he added, such legislation may come about, "and it is what the industry has created."

"When you talk about new players and new capacity," he said, "you are talking about an essential and permanent change in the way this industry does business. I don't agree that this is a cycle. I think it is a natural change."

He said the capacity shortfall the industry is experiencing now is the worst it's been in 50 years and "it's not going to be solved by the stock market investing new capital." He said, "We're not sure where that capital is going to go. We're concerned about the financial guarantee products that we're going to see. It might well attract new capital but is it going to go into lines of insurance that we think are essential for the marketplace?"

While adverse court decisions have contributed to the crisis, he said, if there had been adequate pricing of products over the last 10 years, the situation would not exist today.

He warned the industry that some of the new players and new capacity "might well not be what they want."

To ease the crisis in his jurisdiction, he said, he will look into granting greater underwriting authority to the state insurance fund; creating joint underwriting associations for coverages required to operate a business when such coverage is not available in the voluntary market; and encouraging self insurance pools and reciprocals.

He said life insurers do not appear to have a capacity problem at this time and perhaps they can be encouraged to form property casualty subsidiaries to fill the void.

"Otherwise," he said, "that void might well be filled by the banking industry. Banks have the resources available to write property/casualty insurance and the governor supports allowing banks to write all lines of insurance." He added that "banks would certainly add new players to the marketplace to write business currently being avoided or overpriced by the property casualty insurers."

He accused property/casualty insurers of "irresponsible behavior" and said that this behavior will possibly

Cont'd on Page 58

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serve as the "linchpin for enactment of those recommendations."

After this cycle is over, he said, "there won't be a return in the marketplace to business as usual." He said, "A lot of these companies will find themselves in a very difficult time reentering the market when things are 'good.'"

Mr. Kramer said the current crisis is a "period of dislocation," caused by price changes but that capacity would return when returns on equity improve but for the present the industry is going to suffer.

He observed that in recent Congressional hearings on capacity, Consumerist Robert Hunter made headlines when he talked about the "conspiracy of the industry." But, Mr. Kramer said, "no one seemed to ask the question of Mr. Hunter of how the industry managed to conspire to lose \$3.5 billion last year. That never made the press."

He said much of the problem today is a lack of capital. Some of the reasons for this, he said, are that it is no longer as easy to enter as it was in the past, citing such difficulties as needing a creditworthiness rating and admissibility. He added that foreign reinsurers will not fund letters of credit for IBNR (Incurred But Not Reported), that letters of credit are harder to obtain because banks have been burned by the recent failure of offshore insurance companies, that domestic companies are less willing to reinsure abroad and that Lloyd's has lost its retrocessional market.

"Someday," he said, "when returns on equity improve, there will be capacity back in this industry, but during this period of dislocation we're going to suffer through a period when reinsurance rates are going to escalate dramatically, as the premiums on which the reinsurers base their reinsurance go up and as the rates the reinsurers charge for the premiums go up. We're going to

have a dramatic increase in reinsurance demand without necessarily an increase in reinsurance capacity until some form of profitability returns. When it does the capacity will be there."

Mr. Stradtner's view of capacity is somewhat different, though also somewhat more optimistic. "Capacity is fluid," he said, "always in motion, thus leading to an industry with overcapacity or undercapacity...never perfectly in sync with its needs."

Scenario is simple

Today, he said, the "scenario is relatively simple. Excess capacity produces underwriting losses. Underwriting losses drive out capacity. Property/casualty stock prices rise because institutional investors believe the time to buy the shares is when the earnings are at their lowest level. Higher stock prices enable insurance companies to sell securities to investors on very attractive terms. Prosperity returns, more capacity comes in. The additional capacity raised will bring back price competition, underwriting losses and a diminution of capacity."

RAPID RETURN TO LACK OF PRICE DISCIPLINE SEEN

By ALFRED G. HAGGERTY

RENO, Nev.—"The property-casualty insurance industry today is in a stronger capital and surplus position than it has ever been in and it clearly has enough capital and surplus to meet the needs of the insurance industry today and in the near future," a specialist in insurance research said here.

Dr. Michael E. Hogue, president and managing director of Philadelphia Insurance Research Group, also predicted a quicker than expected return to "a period of a lack of price discipline" in his remarks to the annual convention of the National Association of Professional Insurance Agents.

Dr. Hogue said A.M. Best reported consolidated policyholder surplus of \$64 billion as of Dec. 31, 1984, and then in a July 15, 1985, report indicated an adjusted surplus of \$92 billion. Thus, he said, Best saw an equity in the balance sheet of \$28 billion, which he said arises out of undervalued assets and overstated liabilities. He said it comes primarily from the unearned premium reserve for that portion already paid out in acquisition costs and from the estimate of the loss reserves on a discounted basis.

"In general, what that means," he said, "is that the property-casualty industry, if it were put into a runoff situation and assuming the reserves are accurate, when the period of runoff is completed, not only would there be \$64 billion in capital and surplus, but there would be another \$28 billion left over."

Even assuming a reserve deficiency of as much as 20 percent, he said, after the period of runoff, the industry would have not only the \$64 billion of reported surplus, but another \$3 billion or \$9 billion of undisclosed profits.

"It is for this reason," Dr. Hogue said, "that we believe the property and casualty insurance industry is overcapitalized; and that, frankly, is going to be a detriment, not an advantage."

He said his firm studied a group of seven companies representing about

PIA Convention Report

one-third of policyholder surplus and concluded that by the end of 1985 they would be writing at slightly over 1.25 to 1.4 times their surplus position.

"It's for that reason," he continued, "that we maintain that the industry does not have a capacity problem. It clearly does not have the same problem it had in 1974 and 1975, when at this time in the cycle we were at about 1.4 to 1.5 times surplus."

What it does indicate, he said, is that the insurance industry is not pleased with the profitability of the market and is unwilling to release the capacity in search of taking risk. "There lies our major concern," he said.

"When the profitability appears in the financial statements of the carriers, particularly in the regional and other small companies that have not had the extent of problems that many of the larger carriers have had, they will begin to release the surplus in anticipation of growth of market share."

Dr. Hogue said Chubb and Ohio Casualty recently released nine-month results showing that earnings per share have already doubled in 1985.

"It is our concern," he said, "that we're going to find a more rapid release of that surplus in search of market share than is otherwise being predicted relative to when the markets will turn. It is our belief that that is going to

result again in a period of lack of price discipline.

"We believe that the requirement to allocate the surplus because of the necessity to leverage that surplus against returns to meet the target return on investments of many of these corporations, we will begin to start the process of market competitiveness."

He called it "gross mismanagement of a property-casualty insurance company to attempt to increase market share unless there are indicators available showing where the price and relative exposure are at any point in time. He said it has been his experience that there are few insurance companies in the U.S. market which are fully aware of the current price and exposure relationship in their portfolio on a recurring basis and, therefore, any move to begin to increase their prices is done so without an eye to what the effect is going to be on their financial statements or surplus.

"In other words," he said, "I expect to see the same effectiveness in dealing with excess capacity that took place coming out of the 1964 and 1974 pricing turns." ♦

This situation, he said, is in place today. Only the length of the capacity cycle is open to debate.

Capacity, he said, is "innocent" or "dumb" but it can be gathered at just the times when it is needed most, but that insurance company management has never been able to cope with excess or even adequate capacity.

He added that excess capacity did not completely disappear in 1984, it just diminished.

"Add to this," he said, "the new money raised through securities sales and you are well on the way to restoring excess capacity in the next two to three years. Remember, future earnings will be tax free, thanks to substantial tax loss carryforwards, and we have been blessed with reasonably good stock and bond markets."

Because of his optimism for the industry, he said, he hopes for a return to stable economics producing a typical cycle of three good years followed by three poor, but not devastating years.

"The industry," he said, "in my opinion, is prepared to live prosperously under this type of scenario."

Mr. Mathis discussed some of the ways the present capacity shortfall is different from previous ones such as a lack of an alternative market to Lloyds, the litigious atmosphere surrounding the U.S. casualty business, the withdrawal of the retrocession market, the shortage of underwriting talent, and the slowness of the positive impact on the bottom line of changes in price and terms.

Therefore, he said, he sees the following as a "likely scenario" for the industry: continued equity investor interest in experienced companies, on the assumption that the industry is on the road to recovery, but little interest in new ventures unless they are staffed with proven management, a sort of "back to basics" philosophy—emphasis on underwriting profit resulting in not only higher prices, but restricted contract terms; more net line underwriting for insurer and reinsurer alike; and a longer period of tight market conditions that has been typical of the past as companies not only improve the profit picture, but also make up for deficiencies of the past.

Mr. Cole said that while it is unclear whether the current situation is a crisis or a revolution in the way corporations, health care institutions, philanthropics and governmental entities buy insurance, "if the unavailability and unaffordability of insurance persists...it is my contention that one-third to nearly one-half of all commercial insurance premiums will be financed by non-traditional sources."

He said he predicts that by year-end, self-insurance will represent slightly more than one-third of all commercial insurance premiums which will increase by 44 percent to 50 percent by 1987, that self insurance will play an even more important role in this market than it did in the recovery of 1976-77 and "it may well revolutionize the way insurance is purchased."

He said, "The industry needs to heed the warning that this significant expansion of non-traditional capacity and determine how it can co-exist with these new players and capacity."

EXHIBIT I

Remarks to the Florida Senate Commerce Committee on
Property and Liability Insurance

By Commissioner Bill Gunter

Mister Chairman and members of the Committee, over the past several months, we have seen some alarming developments in the insurance industry in Florida and across the United States, they include the rapid and significant increase in the cost of commercial property and liability insurance, and the reluctance or outright refusal of many insurance companies to assume certain kinds of property and liability risks.

In order to look at the problem first hand, I have held public meetings around the state. I have asked the business community to come forward with their experiences and ideas. The reaction has been gratifying and the testimony we gathered can serve as a valuable resource and standard against which to measure any proposed solutions to the problem.

Time after time the people told horror stories that left no doubt of the breadth and seriousness of the problem...like the Orlando man whose taxicab coverage went from \$8,000 to \$80,000...or the owner of a small Orlando garbage company who told me that coverage for his vehicles will increase more than a thousand percent this year. He said, and I quote, "This business will not survive under these tremendous cost increases."

There was the Fort Lauderdale day care center operator who saw her general liability premium go from \$5,000 to nearly \$15,000 in one year with additional exclusions in the policy, even though the center had no claims whatsoever during its three years of operation. A Dade county children's program director told us that at least 5,000 children are on their waiting list for care, while liability insurance for many child care facilities is being cancelled.

A north Miami Beach Condominium Association's insurance went from \$21,000 in 1984 to more than \$105,000 in 1985, on two days notice. A homestead C.P.A. said he may have to refuse to sit as a trustee on a self-insurance health trust because directors' and officers' liability coverage as of this date has not been obtained.

A Jacksonville dentist is paying a 300% premium

increase from 1984 to 1985. He told us of others who are paying even more. An auto dealers association officer told us that some car dealers in the panhandle can't find garage liability coverage. He spoke of dealers receiving nonrenewal notices three or four days before their policies expired.

All over Florida we are hearing the same stories: people whose insurance is cancelled though they haven't had a single claim; small business people forced to sell out to larger firms because they can't afford insurance. They are telling us that when the state mandates coverage, it has the duty to see that coverage is available and affordable.

What's at stake here is not just the years of hard work it took small business men and women to put their businesses on a paying basis...but the jobs they provide, and the well-being of local economies. A vast number of Floridians are in a situation that is difficult for some and impossible for others.

For that reason, my department is drafting proposed legislation for the 1986 session to address these issues. I believe the need is clear, the only question is what other steps can be taken in the interim to ease the pain brought on by these cataclysmic changes. In the legislation, I think we need to address these points:

First, to get Florida policyholders off the rollercoaster ride of peaks and valleys in pricing. The insurance industry owes its business customers the kind of pricing stability so they can plan their expenditures, yet somehow the insurance industry has become addicted to a boom and bust, feast and famine approach to setting premiums.

Second, to make sure that the premiums charged bear a proper relation to the risks and losses experienced by the industry. I don't want to see the insurance industry playing catch-up on losses of previous years by demanding premiums that are completely out of line with current losses. I want premiums based on defensible loss experience, not on speculation.

Third, to put the control back into the consumers' hands, I'd like to see small insurance consumers get together and use their combined numbers to their advantage. Just as health care coalition members negotiate health care costs directly with hospitals to make sure

their employee health benefits provide the best care for the dollar, they should also be able to use their collective purchasing strength to get the best deal in property and liability insurance.

Fourth, to find creative ways to increase the capital that is available for reinsurance. The investors that in normal times stand behind companies that write property and liability insurance have backed away from that market. I believe there is capital out there, willing and able to provide the back-up for the kinds of insurance that are too expensive and too hard to find at present.

The Miami-based Insurance Exchange of the America's can be an instrument to expand the reinsurance market in this state. I am convinced that additional expansion is entirely possible with the right kind of encouragement.

Finally, businesses need to perfect the art of risk management in Florida. We're used to thinking that if you manage to avoid losses, your insurance premiums will go down. Lately it seems that rule hasn't worked. We need to see that there are incentives for risk management, and that insurance consumers with low losses are preferred customers.

I believe the preceding five points pretty well describe the solution we want to find. I think that proper responses to most of them can be found in well-considered legislation.

I'm sure you remember the problems we had a few years ago in workers' compensation, and before that in automobile insurance. In both of those areas appropriate legislation was enacted and although insurance costs are rising in nearly all areas, rates in auto and workers' compensation have been substantially more stable than the lines outside the authority of the Department of Insurance.

More recently, we have the example of hospital costs which had been rising at a frightening rate for more than a decade. In 1979, the Florida legislature established a Hospital Cost Containment Board and in 1984, granted it the power to reject dangerously inflationary hospital budgets. In the first year since that second step, we cut rising costs by well over half, so legislation is a tool we have used successfully in the past.

their employee health benefits provide the best care for the dollar, they should also be able to use their collective purchasing strength to get the best deal in property and liability insurance.

Fourth, to find creative ways to increase the capital that is available for reinsurance. The investors that in normal times stand behind companies that write property and liability insurance have backed away from that market. I believe there is capital out there, willing and able to provide the back-up for the kinds of insurance that are too expensive and too hard to find at present.

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Some companies like Eastern airlines have taken the route of self-insurance. It normally takes a big company to make self-insurance work, but if a number of smaller companies band together and create a large pool, that approach can also work for them. If we are to expand the parameters for allowing this approach -- for instance to professional-like engineers, architects and accountants -- then we must revise our eligibility rules.

This option is a real possibility -- especially for risks like professional liability, day care and commercial fishing boat coverage, that are hard to place -- and for "main street" commercial insurance consumers, whose rates are out of sight. So self-insurance is also a tool that we can use.

I firmly believe Florida can take steps to attract more capacity. Through incentives, we can promote the establishment of a state of Florida reinsurance facility that will make reinsurance more available for Florida risks. This facility could provide reinsurance to both commercial and self-insurers. So expanding reinsurance capacity is also a tool.

Preventing losses is one of the most effective actions we can take to reduce insurance industry costs. From time-to-time, strings of disasters around the world, from air crashes, to child abuse, to chemical leaks, to lost satellites in space, raise insurance costs of all of us. On the other hand, risk management close to home is a positive response to the current crisis.

It sometimes happens that companies do not reap the rewards of good risk management until after the fact...in some cases not at all. It may be that we need to establish incentives -- possibly tax incentives -- to encourage business and industry to practice good risk management. So risk management is also one of our tools.

I am glad to say there is one thing we have already done that I believe will be of great value to those who feel that they have nowhere to turn for affordable insurance coverage. This is the market assistance plan passed by the legislature during the last session. I believe that in supporting that legislation, you in the Senate showed a vision that is now beginning to yield its reward.

The Market Assistance Plan (MAP), as we call it, is a clearinghouse for hard-to-get insurance coverage. Commercial insurance consumers or their agents call MAP when they can't find insurance. MAP shops all the available markets to place that risk at the best possible price. The most attractive feature of the plan is that it is entirely funded and staffed by the industry. I want to add they have been very cooperative in working with us to set it up.

The draft proposals that we are putting together today will constitute a major step toward helping Floridians deal with what I perceive to be a serious threat to business and professional people across the country.

Our proposals will be ready in 30 days. In the meantime, my staff and I stand ready to help and provide information to you as needed. If any questions are raised by the material before you or anything that I have said, I will be glad to answer them now.

Thank you.

sidewalks and a real property area.

c. there are two separately designated areas which impose liability for dangerous conditions of certain items such as traffic controls, street lights, water, gas and electrical systems, and;

d. the remaining two areas have little practical effect and very little meaningful application as they provide for liability dealing with personal property of another which is mishandled or lost by a political subdivision and the care and control of certain animals, and;

The Act not only limits potential recovery to the enumerated areas, but creates a more stringent burden of proof for the victim. Where the action is for recovery of dangerous conditions pertaining to streets, sidewalks, traffic controls, street lights or utility systems, the victim, in order to recover, has to establish not merely that the political subdivision had notice of the dangerous condition before the incident, but also that there was sufficient equipment and manpower available in view of other needs that the situation could have been corrected. Frankly, this provision has the effect of granting virtually complete discretion to a political subdivision as to when it would even decide to correct a known danger under its control and maintenance.

Because of the grant of immunity, the following are examples of the types of actions which cannot be brought or claimed against a political subdivision:

- a. Negligent use of firearms or weapons such as by police, jail personnel or a school district security force, and;
- b. Negligent supervision of school classes, shop classes, sporting or coaching activities, and swimming pools, such as negligent life-guarding, and;
- c. Actions arising out of overzealous police actions such as injuries arising out of arrests or "police brutality" cases.
- d. Negligent use or supervision of machinery and power tools such as in vocational departments

of school systems;

- e. Inspections of real and personal property such as the negligent issuing of occupancy or building permits in violation of various codes;
- f. Actions for medical malpractice such as arising out of a county owned hospital.

It should also be noted that there is not a reasonable federal equivalent cause of action to provide for recovery for some of the immunity areas. Although federal civil right actions certainly exist, the standards for recovery and burden of proof are far different from the ordinary common law standards for personal injury actions and, under recent decision, require more than a showing of mere negligence in order to impose liability.

Damages

Under the Pennsylvania statute, even in those cases where a claim is permitted and the claim can be proved, the innocent victim is limited in the items and amounts which can be recovered. The negligent or liable political subdivision receives the full benefit of any private insurance which was available to the innocent victim meaning that in those instances where private insurance paid property damage, medical bills or work loss, no claim or recovery for those items can be made against the political subdivision. General damages in the form of pain, suffering, disfigurement and inconvenience can be had only where there are at least \$1,500.00 in medical or dental expenses and there is a permanent injury. These provisions would permit no recovery in a case where, for example, an innocent victim with medical insurance sustained thousands of dollars of medical expenses and severe injuries but made a recovery without a permanent injury.

Finally, there is a cap or ceiling of \$500,000.00 placed on all claims, regardless of the number of victims involved, arising out of any one occurrence. Hence, where one incident, accident or occurrence results in catastrophic injuries or death of a number of persons, the political subdivision can be held to pay only a maximum of \$500,000.00 for all victims.

Miscellaneous

This statute contains certain other roadblocks for the claimant. There is a six-month statute of limitations provision which requires that a victim provide a certain form of written notice to the political subdivision of his intention to file a claim. Should that action not be taken, suit would be barred even if filed within the otherwise applicable general limitation period. Additionally, the statute prohibits the entry of "pre-judgment interest" against a political subdivision. This constitutes yet another privilege in that all other wrongdoers in Pennsylvania lawsuits for personal injury, death and property damage can be held liable for "delay damages" should they fail to make a proper offer of settlement and force the victim to try his case in court.

Conclusion

Pennsylvania's "closed-end" immunity statute totally abolishes a substantial number of meaningful claims for death or injuries sustained by innocent persons, victimized by negligence. It further makes proof of liability more difficult even in the areas where claim can be made dramatically restricts the recovery of damages.

EXHIBIT K

law offices

hamburg, rubin, mullin & maxwell

a professional corporation

gerald hamburg
edward rubin
j. edmund mullin
j. scott maxwell
steven h. lupin
robert a. hanamirian
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800 east main street
lansdale, pa 19446-3098
(215) 368-3600 line no

October 22, 1985

Express Mail

William A. K. Titelman, Esquire
Pennsylvania Trial Lawyers
Legislative Counsel
240 North Third Street
P.O. Box 413
Harrisburg, PA 17103

Dear Mr. Titelman:

I was hoping to be able to clear my schedule so that I could be with you on Wednesday, October 23, 1985, to testify before the Senate Banking and Insurance Committee, especially since that Committee is chaired by Senator Holl, who is from Lansdale.

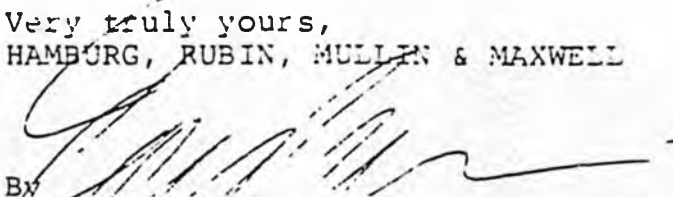
Unfortunately, my schedule does not permit me to be in Harrisburg. However, I would like to report to you and the Committee that my firm represents seven municipal subdivisions in Montgomery County.

We have experienced no increase in claims or litigation involving these Political Subdivisions in the last several years, which we find to be surprising, in light of the fact that our clients have experienced difficulties in obtaining liability insurance and the commissioners and employees have experienced difficulty in obtaining errors and omission insurance.

Our experience verifies the conclusion reported in the New York Times of Sunday, October 20, 1985, which indicated that claims experience is not what influenced the insurance market at the present time, just as the passage of the Political Subdivision Tort Claims Act did not result in reduced insurance premiums.

Very truly yours,
HAMBURG, RUBIN, MULLIN & MAXWELL

By


Edward Rubin

ER/mdd

BEST'S INSURANCE MANAGEMENT REPORTS

Supplement To Financial News

September 9, 1985

A M Best Company
Oldwick, N.J. 08858
201-439-2200

Financial News

Washington Review

Perspectives

On-Line Reports

Quarterly Earnings Per Share Rise Again

With many investors evidently reading recent industry results as a sign indicating smoother sailing ahead, the stocks on Best's Insurance Index were up overall more than 25% for the second quarter of 1985 when compared with the corresponding quarter of the previous year. This composite gain, the best in more than seven years, follows first-quarter gains of 16%. For the first time in more than three years, all four components of Best's Stock Index showed per-share earnings gains for the quarter.

Life/Health Stocks Continue Three-Year E.P.S. Trend

The life health index posted the smallest of the quarterly gains, up 8.1%. Buoyed by year-end news of renewed premium growth among life/health companies, particularly in the annuities and universal life fields, life/health stocks have demonstrated a steady if not spectacular popularity with investors, recording gains in 10 of the last 11 quarters. The lone exception was the fourth quarter of 1984, which reflected some write-offs not related to the new tax law that several companies chose to make in the quarter of the tax reserve adjustment.

The second quarter was close to a carbon copy of the first for the life health index, with three times as many stocks advancing as declining. Large gains were not quite as numerous—10 stocks achieved double-digit increases as opposed to 13 in the preceding period.

Jefferson National Life led in second-quarter earnings growth, up nearly 66%. Other top performers were Torchmark Corp. and Monumental

Corp. Six stocks had declines in earnings per share, the largest of which were those of Northwestern National Life and Equitable of Iowa, off 37% and 34%, respectively.

Property/Casualty Index Posts First E.P.S. Gain in Eight Quarters

In the second quarter of 1985, property/casualty stocks on Best's Index staged a turnaround in the longstanding downward direction of operating earnings per share, even though there were slightly more decliners than gainers. Property casualty stocks posted an overall gain of 13.6% when compared with the previous corresponding quarter.

In the first half of 1985, property/casualty stocks on Best's Index have advanced 30%, investor excitement being generated by a reasonable consensus that the longest industry down-cycle in history has finally turned, albeit by a small margin. They were rewarded, on average, by advances twice the size as those reaped by the general stock market.

The largest calculable percentage gain for the quarter was by Hartford Steam Boiler, with an earnings-per-share increase in excess of 156%. Another strong performer was SAFECO Corp., with a gain of almost 51%. Two stocks—Kemper Corp. and St. Paul Companies—followed up a quarterly operating loss in last year's second quarter with a gain in the current time period.

During the second quarter, Mission Insurance's already considerable per-share operating loss plunged still lower. The losses of Fremont General Corp. and Orion Capital Corp. went further

into the red, and USF&G recorded a small loss in the second quarter of 1985 after a 60-cent gain a year earlier.

Multiple Lines Stocks Achieve 60% Gain

Among the multiple lines stocks on Best's Index, only one—Travelers Corp.—posted a small decline in earnings per share in the second quarter. CNA Financial Corp. flirted with doubling its per-share earnings and Aetna Life & Casualty actually did so. CIGNA Corp. pulled its previous second quarter earnings out of the red. Overall, the multiple lines index was up 60.7% over the comparable quarter, setting a seven-year record.

Brokers and Agents Enjoy Impressive Earnings Gains

The brokers and agents component of Best's Index was up 50% for the quarter and more than 300% for the first six months of 1985. However, this percentage gain derives from comparison with very low prior year figures, particularly in the case of Alexander & Alexander, whose second quarter 1984 earnings per share was eight cents, and Marsh & McLennan, which recorded operating earnings of only two cents per share in the first six months of 1984 due to losses sustained from unauthorized investment activities.

IN B's per share figures, where applicable, refer to the common and convertible shares for all time periods. Where applicable, convertible issues are outstanding even though they may not be exercisable for some or all time periods when compared. Data obtained from using the common share only base figures for Mission Capital Corp. and Alexander & Alexander are preliminary figures due to lack of complete data. Data shown reflect the elimination of reported operating earnings of the parent company and its subsidiaries and affiliates and the sum of some other related items for the time period covered by the same share data.

LYNDEN INCORPORATED

670 W. Fireweed, Suite 239
Anchorage, Alaska 99503
(907) 279-7501

January 23, 1986

Fred Zharoff, Senator
Pouch V (MS 3100)
Juneau, Alaska 99811

Subject: Lynden Incorporated support for Insurance
and Tort Reform

Dear Senator Zharoff:

The Alaska Trucking Industry is confronting a crisis which is "Life-or-Death" for many operators. The already slim operating margins that the industry has had to adjust to over the last few years has now become non-existent with insurance premiums raising anywhere from 100 percent to 600 percent.

Lynden, with a history of successful operations that extends over 75 years, contracted over 30 insurance companies to underwrite our insurance needs for 1986. Only two of these 30 companies expressed any interest at all, and only then if the premiums were substantially escalated. As a matter of fact, our 1986 insurance premiums are 2.8 times our 1985 premiums. Further deterioration of the insurance supply will mean Lynden and others will be unable to buy insurance and will consequently be out of business.

If action is not taken to effect a reduction of these premiums, all Alaska trucking operations, large or small, will be faced with the decision of either continuing operations at a loss or bankruptcy.

Lynden requests your support for Tort Reform as shown on the attached Coalition Agenda, as well as any insurance industry reforms that may be necessary.

Tort Reform must clearly include provision for a sliding scale for contingent fees so that the injured parties receive a larger proportion of the fees than the attorneys that represent them.

Insurance industry reforms include mandatory cancellation clauses requiring 60 days notice of Intent to Cancel a liability insurance

Tort Reform
Page Two
Jan. 23, 1986



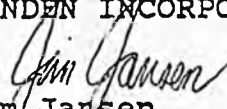
policy. Additionally, we support full disclosure of insurance data wherein insurance companies servicing policies in Alaska implicitly agree to accept the provision of full disclosure of taxes, settlements, costs, defense attorneys, commissions and overhead.

The disclosures must be of sufficient detail so that the appropriate state authorities can verify accuracy.

In summary, Lynden cannot overemphasize the importance of taking action on insurance and Tort Reform issues. The problem is immediate, serious, and if not dealt with, will have serious consequences for the trucking industry as well as the total economy of the State of Alaska.

Very truly yours,

LYNDEN INCORPORATED


Jim Jansen
President

JJ:am

Attachment

cc: All Legislators

THE CITIZENS COALITION FOR TORT REFORM
PROPOSES THESE
IMPROVEMENTS TO ALASKA LAWS



--TORT REFORM--

- Limit non-economic (paid and suffering) awards to \$250,000.
- Structure periodic payments in cases where the award exceeds \$50,000.
- Set a sliding scale for contingent fees that encourages early resolution of claims while providing fair compensation for attorneys while reserving a larger proportion of the award or settlement for the injured party.
- Require those filing liability complaints to affirm that they believe all claims are true.
- Require courts to direct damage payments proportionate to a defendant's degree of fault.
- Instruct juries to itemize award verdicts.
- Allow juries to know about insurance or other benefits paid to victims of negligence.
- Require that punitive damages (which punish defendants for negligence beyond their liability for actual damages) are paid to the State of Alaska, that is, to the whole society
- In instances of wrongful death, allow for death benefits only to spouses, children or other current economic dependents
- Require that a lawsuit be filed within two years of the date of the act or omission on which the complaint is based.
- Encourage settlements that avoid costly trials.

A COMPREHENSIVE SOLUTION TO:
* PROTECT VICTIMS
* LIMIT COSTS TO CONSUMERS
* RE-INTRODUCE FAIRNESS TO ALL PARTIES

--TORT REFORM--

Medical Insurance Exchange of California
Medical Underwriters of California Attorney-in-Fact

FEB 5 1986

January 28, 1986

TO: MIEC Board of Governors
MUC Board of Directors

FROM: Ron Neupauer *Ron*

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/cor11

cc: Dave Wille t
Jim King
Tom Hermes
John Griffiths

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

els 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						
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	1,084,151	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	151.89	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		114.84	10.25	125.10	130.42	-80,512
1982		139.57	11.21	150.78	154.13	-140,814
1983	317,849	139.62	12.21	151.83	155.68	-167,224
1984	353,630	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	-894,770
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

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 mod-

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,

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

Medical Insurance Exchange of California

Medical Underwriters of California Attorney-in-Fact

De 21-5-6

February 4, 1986

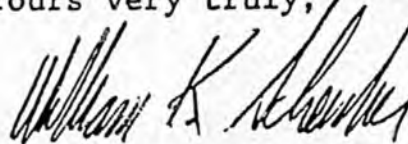
The Honolulu Advertiser
ATTN: John Griffin
Editorial Page Editor
P.O. Box 3110
Honolulu, HI 96802

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

The Honolulu Advertiser

Established July 2, 1856

Thurston Twigg-Smith *President & Publisher*
George Chaplin *Editor*
Buck Buchwach *Executive*
John Griffin *Editorial Page Editor*
Mike Middlesworth *Managing Editor*
Gerry Keir *City Editor*

11-11-86
M.I.E.C.

Friday, January 31, 1986

11-11-86 1986

UNDERWRITING

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 case-load 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.

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BERNARD P. KELLY
PAUL COSSMAN

December 12, 1985

Senator Fred F. Zharoff
P.O. Box 405
Kodiak, Alaska 99615

RE: INSURANCE CRISIS

Dear Senator Zharoff:

I am enclosing herewith a copy of the omnibus reinsurance bill that was discussed by J. Robert Hunter, the President of National Insurance Consumers Organization, on Friday, December 6, 1985, at the Captain Cook Hotel at our meeting.

This omnibus proposal could be adapted to state law. We have enlisted the support of Avrum Gross, former Attorney General, to aid us in any efforts directed toward legislative drafting. We believe that this omnibus reinsurance proposal could constitute a safety net for reinsurance and for insurance itself for such needy businesses as daycare centers and the smaller cities which are having trouble with insurance, as well as other aggrieved insureds. We believe such a proposal, to the extent of state involvement, could make the state profit if it were properly priced. For help in this effort, we would need to enlist the aid of an actuary, such as Mr. Hunter. We believe the State Department of Insurance should be armed with such an individual, anyway, and some of our proposals would be greater degree of factual reporting by the insurance companies and a rate-making procedure that could be honestly evaluated based upon the data submitted by insurers, such as details of their investment income, combined premium and investment income, together with their proposed rate increases when they propose them.

We would be willing to help in the drafting of such legislation. We favor more reporting by the insurance companies. In fact, we believe that the problem here is insurance reform, not tort reform. We believe that our state needs a property casualty actuary capable of rate analysis for decisions in rate-making cases and capable of auditing and

December 12, 1985
Page Two

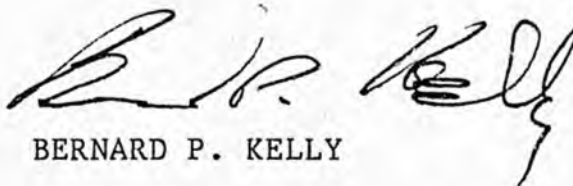
monitoring the degree and comprehensiveness of reporting by the insurance industry. We would like to propose such measures at the forth-coming Legislature but stand ready and willing to help in supporting any affirmative effort directed toward a true solution to the insurance crisis.

For the reasons stated at our meeting the other day, we do not believe that taking away the rights of innocent victims is such a solution. The insurance industry has not promised reductions on a quid pro quo basis, based upon certain specific changes in the tort law. We believe they never will do so, and that the threat of the insurance industry pulling out of the state is a hollow one that they are making in all states. As pointed out by Mr. Hunter this is a national problem, that the insurance industry never had it so good as they have it in Alaska. They have made double the profits here that they have made anywhere else and insurance companies are coming into our state rather than pulling out. As you know, we submitted data to that effect at the time of our conference.

Thank you very much for your interest in this matter.

Sincerely yours,

BERNARD P. KELLY & ASSOCIATES

A handwritten signature in dark ink, appearing to read "B. P. Kelly", with a stylized flourish at the end.

BERNARD P. KELLY

BPK: amm

1849A

OMNIBUS REINSURANCE ACT OF 1985

Section -[1]- (a) Within 30 days after the receipt of an application by any manufacturer, service provider or any group or association representing such manufacturers or service providers, the Commission shall conduct a hearing on the reasonable availability and affordability of adequate commercial general liability insurance and other lines of insurance for that manufacturer or service provider or the members of any group or association of manufacturers or service providers.

(b) The Commission may in its discretion hold hearings to investigate the reasonable availability or affordability of commercial general liability insurance and other such lines of insurance as from time to time become unavailable or unaffordable thereby threatening the health, welfare or commerce of the United States and the various states by making some manufactured good or provided service unavailable or available only at an unreasonable cost.

(c) Within 30 days after the hearing required under subsection (a) or conducted under subsection (b) the Commission shall determine in writing, based upon the record of the hearing conducted pursuant to subsection (a) or (b), whether the insurance described in subsection (a) or (b) is, and will be, reasonably available or affordable to affected manufacturers, service providers or the members of any group or association representing manufacturers or service providers to cover anticipated claims. Such determination, and the basis therefore, shall be published in the Federal Register.

(d) (1) If the Commission determines at any time that:

(A) the insurance described in subsection (a) or (b) is not available or reasonably affordable from the private sector to applicants under subsection (a) or the affected parties described pursuant to subsection (b) to cover anticipated claims;

(B) in order for an applicant under subsection (a) or affected party described pursuant to subsection (b) to have regular operations in the United States, assistance under any of the programs authorized under sections [2] or [3] is necessary; and

(C) the availability of such goods or services from that applicant under subsection (a) or affected party under subsection (b) is essential to promote the public health, welfare or the general commerce of the United States, the Commission is authorized to implement the insurance pool described in section -[2]- and the reinsurance coverage described in section -[3]- with respect to such goods or services. If at any time the Commission determines that one or both of the programs provided for in section -[2]- or -[3]- reasonably assures the availability or affordability of such goods or services in the United States, the Commission may implement the operation of the programs described therein.

(2) to further the purposes of this act and in recognition of the critical situation facing both day care centers in insuring for the specific peril of child abuse and nurse-midwives in obtaining medical malpractice insurance, the Congress makes the necessary determination for the Commission to implement section [2], [3] or both and any other pertinent section under this title for these affected parties. Affected party eligibility under section [1](d)(2) shall not be subject to review by the Commission until 90 days after the enactment of this title.

(3) To the extent feasible, the programs provided for under this title shall be implemented in a manner to insure that:

(A) such programs will not act as a disincentive to improvements in product safety or safe service delivery, and shall operate to promote product safety and safe service delivery through the establishment of models for risk management as may be agreed upon by the Commission, the insurers and the insureds as a prerequisite for eligibility for any of the programs under this title.

(B) each manufacturer or service provider which benefits from such programs will agree that such goods or services shall remain available to the public during the period in which such product manufacturer or service provider or the insurer of such product manufacturer or service provider participates in such programs.

(C) each insurer which benefits from such programs will agree that such insurance as is written during the period in which such insurer or its insured product manufacturer or service provider participates in such programs shall have premiums which are based upon an experience rate.

Section-[2]-[a) After making findings under section [1], the Commission shall encourage and otherwise assist any insurance companies which meet the requirements of subsection (c) and any others set out in this title to form, or otherwise join together in insurance pools for the purpose of assuming, on such terms and conditions as may be agreed upon, such financial responsibility as will enable such companies and other insurers, with federal financial and other assistance under this title, to assume a reasonable portion of responsibility for the adjustment and payment of claims arising from product or service induced injuries, disabilities, illnesses and deaths.

(b) Funds from such insurance pools shall be available only to pay claims resulting from product or service related actions in excess of such amounts as are established each year by the Commission. The Commission may establish differing amounts for each manufacturer or service provider or insurer and each good or service based upon the needs of the manufacturer or service provider or insurer and other relevant factors.

(c) any insurer licensed to operate as such by any state, territory or possession of the United States shall

be eligible for participation in such insurance pools.

(d) Such insurance pools may be funded by premiums paid by manufacturers or service providers to insurers approved by the Commission. If the Commission finds, after notice and public hearing, that the premiums charged by such insurance pools make the insurance from such insurance pool unavailable for manufacturers or service providers, the Commission may amend the terms and conditions of reinsurance under this title to lower premiums to be paid by such manufacturers or service providers.

Section [3](a) In order to further the purposes of this title, the Commission may take such action as may be necessary to make available, to the insurance pools formed otherwise created under section [2], reinsurance coverage under this section to any insurer or pool for losses assumed by such insurers or pools in accordance with the agreements entered into under subsection (b).

(b)(1) Following the date of enactment of this title, the Commission is authorized to enter into any contract, agreement, treaty, or any other arrangement with any insurer or pool for reinsurance coverage, in consideration of payment of such premiums, fees or other charges by insurers or pools which the Commission deems to be adequate as required under Section-[5]- of this title to obtain aggregate reinsurance premiums and charges for deposit in the Omnibus Reinsurance Fund established under Section-[5]- in excess of the estimated amount of insured product or service induced losses in 1985, and thereafter the Commission may increase or decrease such premiums or charges if it is found that such action is necessary or appropriate to carry out the purposes of this title.

(A) Reinsurance offered under this title shall reimburse an insurer or pool for its total proved and approved claims for covered losses resulting from product or service induced injuries, disabilities, illnesses and deaths during the term of the reinsurance contract, agreement, treaty, or other arrangement, over and above the amount of the insurer's or pool's retention of such losses as provided in such reinsurance contract, agreement, treaty, or other arrangement entered into under this section.

(B) Such reinsurance contracts, agreements, treaties, or other arrangements may be made without regard to section 3679(a) of the Revised Statutes of the United States (31 USC 665(a)), and shall include any terms and conditions which the Commission deems necessary to carry out the purposes of this title. The terms and conditions of such contracts, agreements, treaties, or other arrangements with insurers or pools, throughout the country, in any one year shall be uniform: Provided, that where necessary to further the purposes of this title, pro rata and other such forms of reinsurance may be included on such terms and conditions.

(C) Such reinsurance shall be provided upon such terms and conditions subject to such deductibles

and other restrictions and limitations, as the Commission deems appropriate, but no reinsurance shall be available to a product manufacturer, service provider, insurer or pool of insurance which the Commission determines to be uninsurable or to any product manufacturer, service provider, insurer or pool of insurance with respect to which reasonable protective measures to prevent loss, consistent with standards established by the Commission under section [1](d)(3)(A), have not been adopted.

(D) Any contract, agreement, treaty, or other arrangement for reinsurance under this section shall be for a calendar year.

Section 4(a) The Commission shall take such action as is necessary or appropriate to make reinsurance available directly to insurers which participate in pools created under this title for that portion of their business which is related to any distressed line as determined under section [1](d) which is written and not within a pool created pursuant to section [2] of this title.

(b) Such reinsurance may be made pursuant to contract, agreement, treaty, or other arrangement, and pursuant to such regulations as may be reasonably prescribed by the Commission.

Section 5(a) To carry out the programs authorized under this title, the Commission may establish in the Treasury of the United States an Omnibus Reinsurance Fund which shall be available without fiscal year limitations--

(1) to pay reinsurance claims under the reinsurance coverage provided under section [3]; and

(2) to pay reinsurance claims under section [4];

and

(3) to pay such administrative expenses as may be necessary or appropriate to carry out the purposes of this title; and

(4) to repay to the Secretary of the Treasury such sums, including interest thereon, as may be borrowed from him for purposes of such programs under section [5](b).

(b) The reinsurance fund under this section may be financed by:

(1) such amounts as may from time to time be advanced to the fund from the general fund of the Treasury in order to maintain the fund in an operative condition adequate to meet its liabilities; and

(2) premiums, fees, or other such charges which may be collected in connection with the reinsurance coverage provided under section [3]; and

(3) premiums, fees, or other such charges which may be collected in connection with the reinsurance coverage provided under section [4]; and

(4) such amounts as may be raised by the establishment of an uniform surcharge upon premiums paid to

property and casualty insurers.

(A) the Treasury shall, no later than 120 days after the enactment of this title, collect a .0025 (.25 percent) surcharge upon all premiums paid to property and casualty insurers which revenues shall go to maintain the reinsurance fund created under this section in an operative condition adequate to meet its liabilities.

(5) interest which may be earned on investments of the fund; and

(6) receipts from any other source which may, from time to time, be credited to the fund.

Section [6](a) If at any time the Commission makes the determinations described in section [1](d), the Commission may, in carrying out its responsibilities under this title, utilize—

(1) insurance companies and other insurers, insurance agents and brokers, and insurance adjustment organizations, as fiscal officers of the United States,

(2) officers and employees of the Federal Trade Commission, and such other officers and employees of any executive agency (as defined in section 105 of title 5 of the United States Code) as the Commission and the head of any such agency may from time to time agree upon, on a reimbursement or other basis, or

(3) both of the alternatives specified in paragraphs (1) and (2), or any combination thereof.

Section [7](a) The Commission may in the interest of furthering the purposes of this title delegate authority to administer any portion of this title to other appropriate officers and employees of any executive agency (as defined in section 105 of title 5 of the United States Code) as the Commission and the head of any such agency may from time to time agree: Provided that any action taken by any such agency officer or employee shall not be inconsistent with any portion of this title.

(b)(1) The Commission through its Bureau of Competition shall periodically review each plan under this title and the methods and practices by which such plan is actually being carried out in order to—

(A) Assure that such plan is effectively making commercial general liability and other essential lines of liability insurance readily available to such product manufacturers and service providers as is intended and is otherwise carrying out the purposes of this title, and in order to identify any aspects of the operation or administration of such plan which may require revision, modification, or other action to carry out such purposes.

(B) Report to the Congress at least once a year the findings of any such investigation under subsection b(1)(A), or from time to time as may be requested by the Congress to report on the current status of all plans under this title.

Section [8](a) Within 90 days after the enactment of this title and before implementation of the program contained therein for the benefit of any applicant, affected party, insurer or pool of insurance, the Commission shall prepare and transmit a report to the Congress which shall—

(1) indicate the nature and extent of anticipated use of the insurance industry in the delivery under this title of reinsurance to product manufacturers, service providers, insurers, and pools of insurance.

(2) identify anticipated costs of provision of such reinsurance to product manufacturers, service providers, insurers, and pools of insurance under this title.

(3) identify any potential applicant which has made query to the Commission about such programs as have been authorized under this title and, in the case of affected parties, those which preliminarily might benefit from participation under the programs authorized under this title.

Section [9](a) The Commission, or any agency officer or employees which administer portions of this title as authorized under section [6] and [7], in a suit brought in the appropriate United States district court, shall be entitled to recover from any insurer the amount of any unpaid premiums lawfully payable by such insurer to the Commission or its delegated agent.

(b) No action or proceeding brought under this section may be brought for any amount in excess of that lawfully payable by any insurer to the Commission or its delegated agent and any such action shall be brought within five years of when the right to such payment accrued, except ^{where} ^{any false or fraudulent conduct warrants, the claim shall not be deemed to have accrued until its discovery.} ^[Provided]

(c) Any recovery had pursuant to any action or proceeding under this section shall be deposited to the credit of the reinsurance fund created under this title.

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 long-standing 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,



FINANCIER WHITMAN BELIEVES MISSION "COULD BE ANOTHER GEICO"

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 O'Leary, an analyst at Fox-Pitt Kelt 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

ROB KRUMHOLTZ

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 Hulin, 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 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 judg-

ment, 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

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 Consoli-

dated 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



GATES: HOLDING A STAKE OF \$200 MILLION IN MICROSOFT

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.

UNDOING STEEL'S WAGE UNIFORMITY

The United Steelworkers opened negotiations on separate contracts with three of the nation's six major steel-makers. 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 conces-

sionary 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 industry-wide 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.

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?

A 41-YEAR-OLD body-builder 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.

By Jill Andresky with Mary Kuntz and Barbara Kallen

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

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

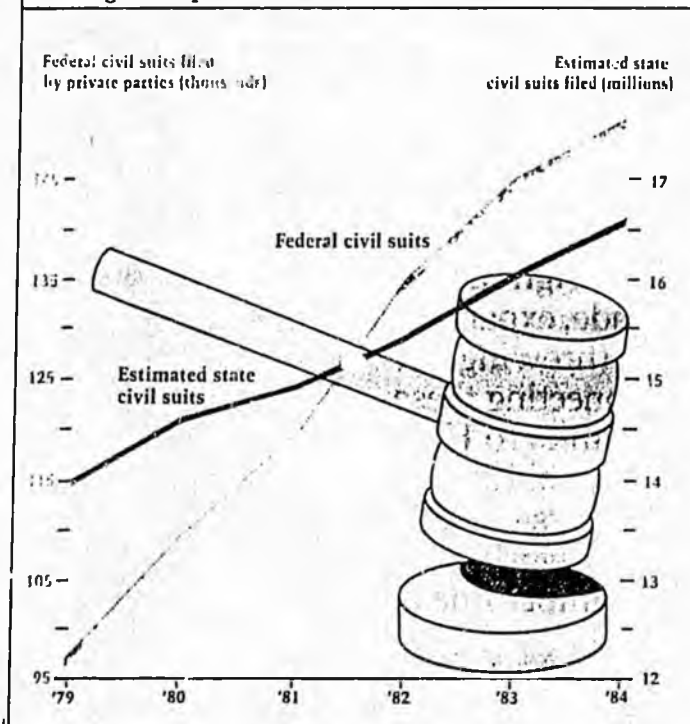
out \$116.10 for every \$100 received in premiums—the worst numbers since the San Francisco earthquake and fire. Reinsurers, who take the brunt of the unpredictable risks, paid out nearly \$141 for every \$100 in premium income.

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%.



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

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

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

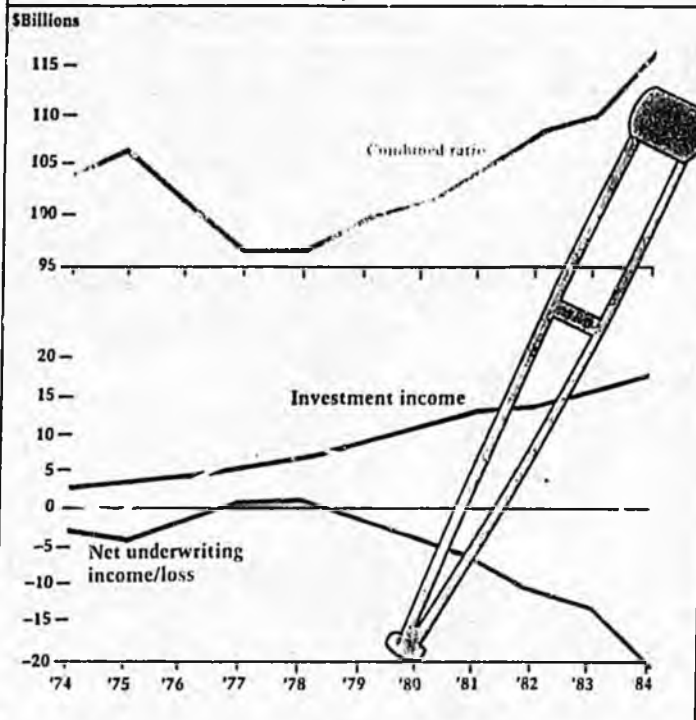
rock bottom. Last year it recorded a pretax loss of \$3.8 billion.

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.



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

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

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

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."

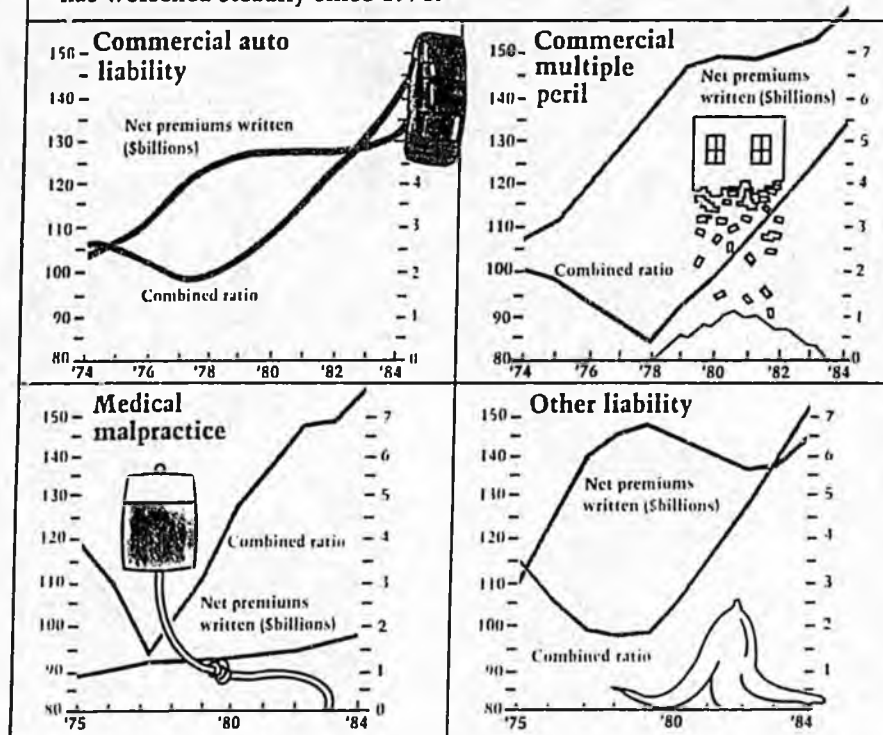
In the long run, maybe the only practical solution is legislative action to define liabilities and cap them at a fair and reasonable level. In New York, where obstetricians and neurosurgeons are turning away patients because of high malpractice insurance rates and where municipalities are scrambling 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 place 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.



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'

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

Seattle Post-Intelligencer

THE VOICE OF THE NORTHWEST SINCE 1863

EDITORIALS

Hold horses on insurance

There's no question that this state's insurance-liability or tort laws need revision to put the brakes on runaway damage awards and out-of-court settlements. Insurance rates have soared to astronomical heights in some areas of coverage, such as medical malpractice, and in some categories have become prohibitive.

The problem is described as a crisis. That may be no exaggeration, but the legislative response ought to be carefully considered, not rushed, and based on solid and reliable data.

While a formidable liability-reform coalition — composed of local government agencies, physicians, child-care organizations, school districts and large corporations — is pressing the new session of the Legislature for immediate legal revisions, a new state task force was named this week to gather more information and to review the many factors involved including insurance company profits and losses.

Retired King County Superior Court Judge Francis Holman, a widely respected jurist and lawyer, is chairman. Members, appointed by State Insurance Commissioner Dick Marquardt, are three lawyers who specialize in defending against liability suits and three whose speciality is representation of plaintiffs or damage claimants. Creation of the task force was suggested by a bipartisan legislative committee last year after a series of hearings throughout the state. It was decided that more hard information is needed, before state laws are revised, and the task force was proposed as the vehicle for obtaining it.

Key issues the task force will address are limits on non-economic damages — awards for such nebulous items as pain and suffering and mental anguish; the payment of awards over time rather than in lump sums; limits on the proportion of damages that can be assessed against secondary defendants, such as cities and counties, when primary defendants are unable to pay, and limits on contingency fees charged by claimants' attorneys.

It may be that this session of the Legislature can begin the process of reform by correcting the most glaring deficiencies in state laws, although some lawmakers have expressed dismay over a lack of credible data on which to base their decisions. Before sweeping changes are enacted, the Legislature would be wise to await recommendations of the newly appointed task force.

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.

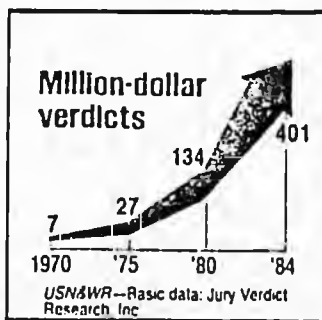
"We are in the midst of an unprecedented liability crisis," says Barry Bauman of the U.S. Chamber of Commerce. To cope, insurance firms have been raising premiums sharply since 1984—sometimes by 1,000 percent or more at a clip—drastically reducing coverage and sometimes pulling out altogether. Companies 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'Keefe, 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 culprit 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.

Employees 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 Daikon Shield.

For professionals: A malpractice meat grinder

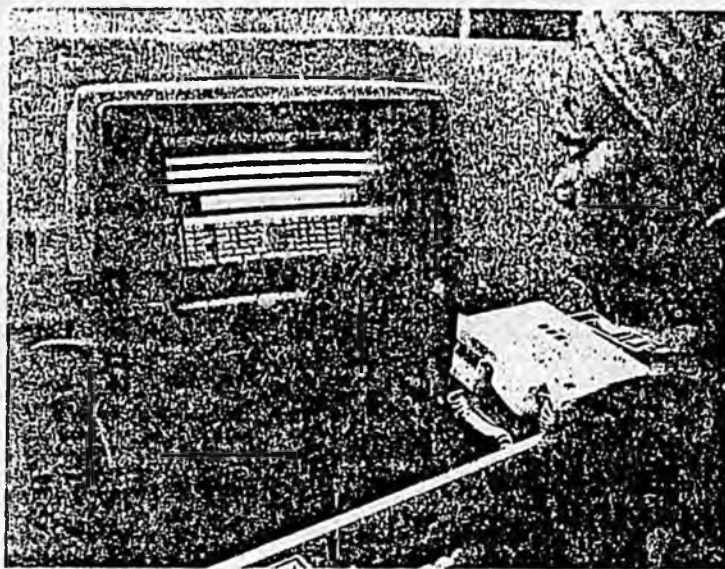
Major corporations usually have vast resources to draw upon in combatting the litigation wave, but few doctors, lawyers, accountants or other professionals dragged into court have that cushion. Malpractice claims against physicians have more than doubled in a decade, reports the American Medical Association. 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'Keefe of Glens Falls, N.Y., said enough was enough. He hasn't lost a case, but, O'Keefe 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 Rosenbergs 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 Rosenbergs 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



Suit over backyard injury shocked the Friedmans

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.

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. Employees 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 Francis won from a motel where she was raped, such cases are so widespread that they produced more than \$1 million in damages in the last three years, reports lawyer Frank Carrington.

Whenever new concerns develop in society, they end up in court. The latest example is AIDS. An lover of the late actor Rock Hudson has sued his ex on the ground that Hudson failed to disclose that he had the deadly disease. Suits also have been brought against people for spreading herpes and other infectious ailments.

Another rapidly expanding tactic is to go beyond compensation for actual harm—such as payment for medical bills and missed work—and to demand damages for emotional distress. States for years have allowed money



Agent Orange



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, usual-

ly 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

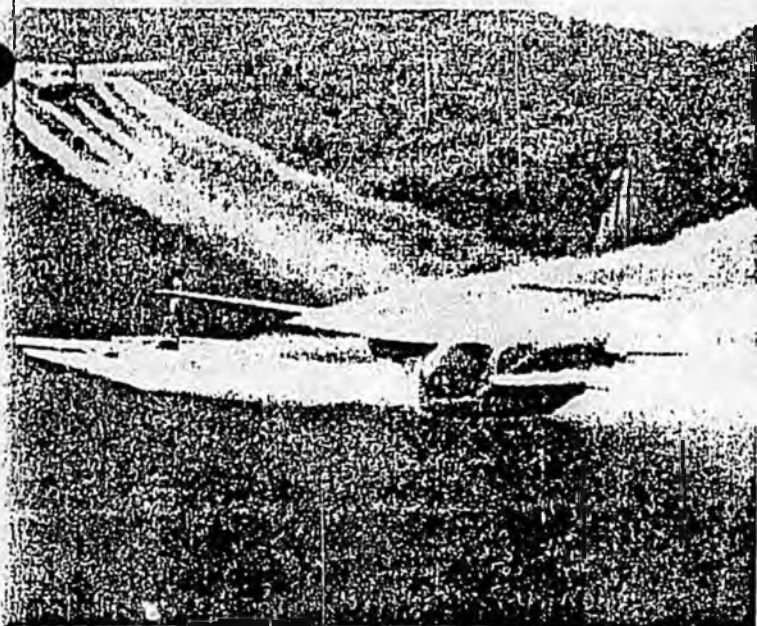
lawyer. You could make a mission damaging to you. Report any contacts by the other side to your insurer.

• Keep any notes or documents that you may have taken at the time of the incident leading to the suit. If it was an auto accident, get as much information as you can about the other cars.

• If you have no insurance, your insurance does not cover the matter for which you are being sued, you need to find your own lawyer. Ask friends and associates for their recommendations and interview your prospective lawyer, discuss



DAMAGE SUITS



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



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



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

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 pole. 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.

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



Lawyer Melvin Belli has earned fame in injury cases

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 Gost and Clemens P. Work with the magazine's domestic bureaus

Should lawyers' contingency fees be limited?

Interview with Grant DuBols, chairman, National Coalition for Litigation Cost Containment

PRO

Q Mr. DuBols, 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.



GRANT DUBOLS

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.



PETER PERLMAN

Editorials

Restoring balance to the liability system and to federal budgets.

Civil Justice Reform: The Way Out Of The Liability Crisis

A legal system that works hardship on those who have done no wrong is obviously in need of correction. That is why individual businesses and the organizations that represent them are pressing for major reforms in the civil justice system based on tort law.

Traditionally, an individual who suffered from the actions of another could ask the civil courts to order the person at fault to pay money damages and/or stop the actions.

But something different has been happening in recent years. Lawsuits seeking money damages have been initiated more on the basis of the defendant's ability to pay than on the basis of responsibility for causing an injury.

This month's cover story, beginning on page 22, documents what is happening in the liability insurance field. Companies with little or no responsibility



ILLUSTRATION: MICHAEL PERRY

for injuries, rather than the parties directly responsible, are being subjected to costly lawsuits. Those companies and their insurers are, in too many cases, being ordered to pay enormous damage awards.

The result has been major increases in premiums for virtually all types of liability insurance, curtailment of coverage and, in some cases, inability of businesses to obtain liability insurance at any price.

As one business leader quoted in the article puts it, "Businesses in every region of the country have experienced extreme hardship." And, he adds, "small businesses are bearing the brunt of the present crisis" in liability insurance.

Though other factors, such as changes in the investment climate, have affected insurance company earnings, the explosive increase in the number of massive damage awards remains the major factor in the liability crisis. Courts and juries are holding companies responsible for actions far beyond the scope of insurance coverage and, indeed, of the principle of tort law.

Richard K. Willard, an assistant U.S. attorney general, asks a question being widely echoed these days by business people hard put to find liability coverage at reasonable rates: "How did we get in this mess?" He also offers this explanation: "Increasingly, tort law punishes those who have done nothing wrong, simply because they often have the resources to compensate the unfortunate."

The answer, he says, is "a return to a view of tort law premised on a concept of fault."

Businesses seeking insurance at affordable rates, and the insurance industry itself, support that view strongly and are pressing for relevant reforms to the civil justice system.

Realization of those goals would bring about a liability system that works much more effectively on behalf of companies that need liability coverage and companies that provide it

The Right Strategy For Winning This Budget-Cutting Battle

President Reagan faces one of the most difficult domestic challenges of his tenure as chief executive in the fiscal 1987 budget he sends to Congress early this month.

The budget must offer enough spending cuts to meet the constraints of the newly enacted Gramm-Rudman-Hollings law, which was enacted late last year with strong support from business. The law to impose long-needed fiscal discipline on Congress requires elimination of the federal deficit over the next five years.

But the proposals to curtail or eliminate federal programs must be presented in a manner that is both fiscally and politically realistic.

Suggesting budget actions with little or no chance of enactment would not meet that test. Congress might refuse to consider seriously, for example, a budget reduction plan that exempted

major spending areas, like defense and agriculture. Advocates of programs targeted for cuts would have a ready-made claim of unfairness if the administration approach to eliminating the deficit is not evenhanded.

It would be a major strategic mistake for the White House to send Congress a narrowly focused plan that kept major spending areas out of consideration. That could shift the emphasis of the deficit elimination debate to the one area the administration wants to avoid—tax increases.

The administration will surely be mindful, in its approach to implementing the Gramm-Rudman-Hollings law, of the fact that some members of Congress do not see the law as an ultimate source of fiscal discipline. They see it instead as a way of demonstrating that higher taxes are the only way the federal deficit can be eliminated.

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."

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



PHOTO: T. MICHAEL KEZA

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 \$1.13 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." ■

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.

COVER STORY

Liability: Trying Times

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.

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

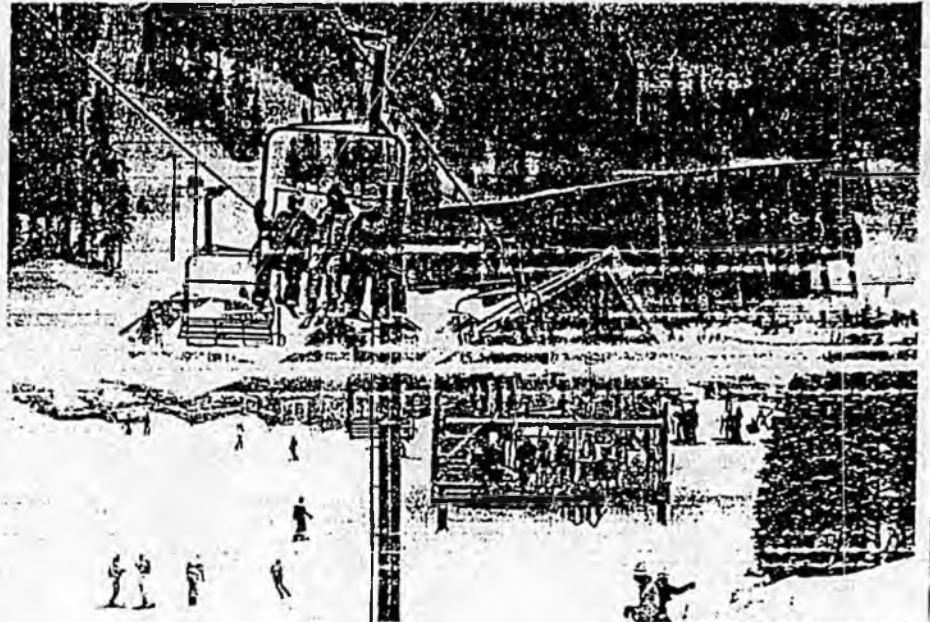


PHOTO: MICHAEL PHILIP MANHEIM—FOCUS

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-

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.

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.

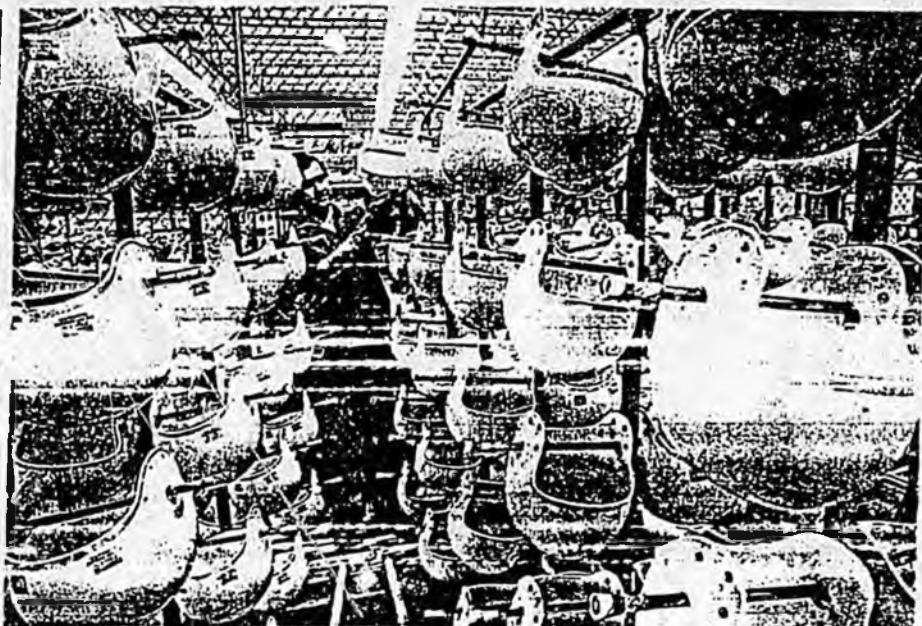


PHOTO: JON RILEY—FOLIO



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.

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

Banks may require liability insurance before they will make a loan."

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-

COVER STORY

Liability: Trying Times

David and Ruth Hampe—paying bills for their Somerset, Pa., auto salvage yard—needed a bank loan after their liability insurance premium nearly doubled.

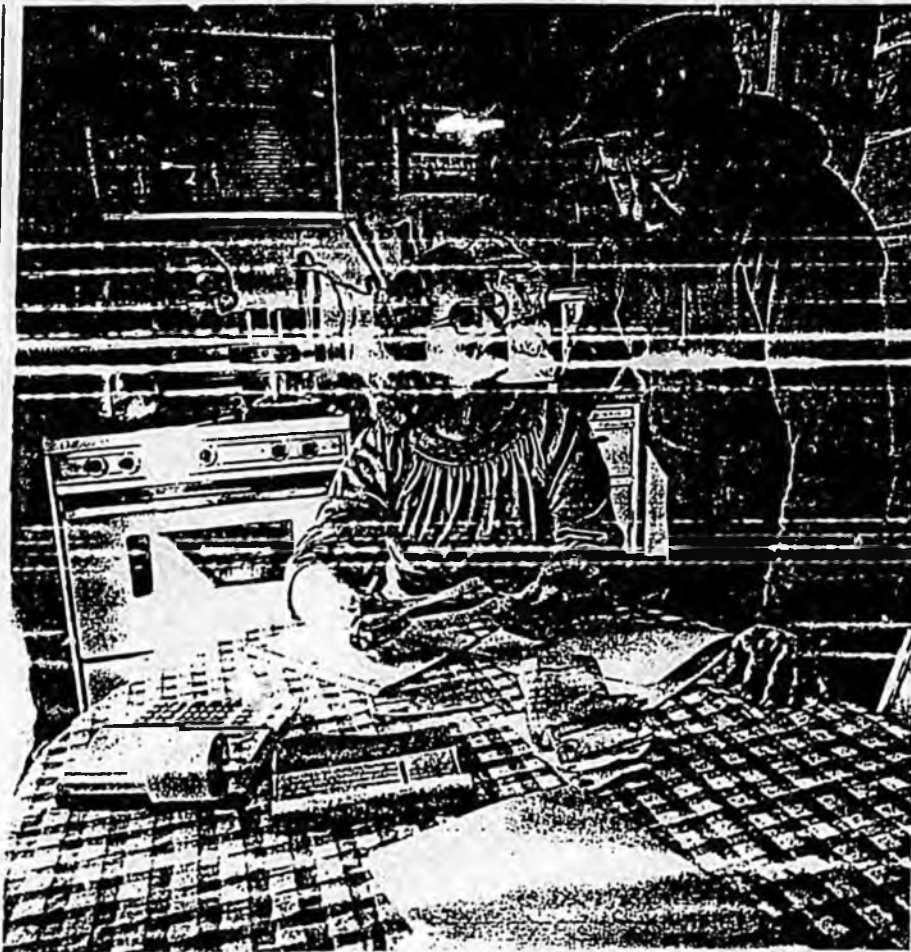


PHOTO: LYNN JOHNSON—BLACK STAR

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—in 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

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.

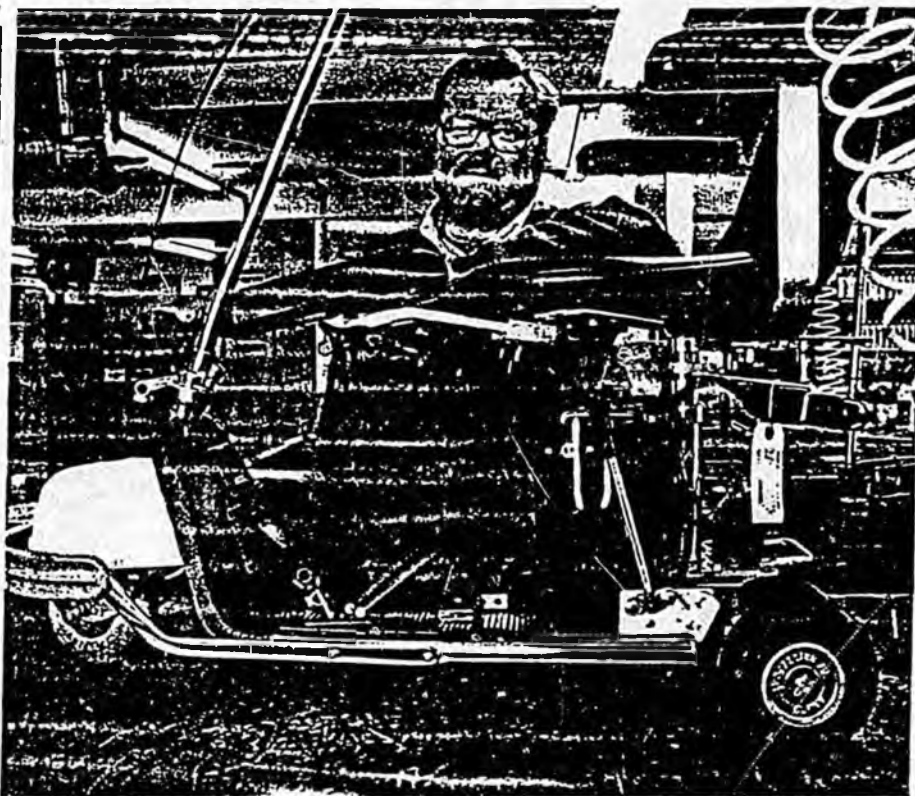


PHOTO: CURTIS LEEZE

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 in-

sureance 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.

Dieb Taylor, a Salt Lake City insur-

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-

"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.



Jack Hayes, a free-lance writer based in Roswell, Ga., also contributed to this article.

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.

JAMES G. FRIERSON, J.D., is a professor of management at East Tennessee State University, Johnson City, Tenn.

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

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 pu-

nitive 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.

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. As 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

AWARDS RECEIVED BY PLAINTIFFS

A Libel Case:

\$6,700,000	Compensatory Damages (loss of business)
2,500,000	Punitive Damages
<u>\$9,200,000</u>	Total
-3,069,666	Attorney's Fee
- 50,000	Costs
<u>\$6,083,334</u>	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
<u>\$2,000,000</u>	Total
-668,666	Attorney's Fee
- 10,000	Costs
<u>\$1,323,334</u>	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
<u>\$297,000</u>	Total
-99,000	Attorney's Fee
- 1,000	Costs
<u>\$197,000</u>	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
<u>\$345,000</u>	Total
-115,000	Attorney's Fee
- 3,000	Costs
<u>\$227,000</u>	Net Recovery; \$182,000 more than the actual loss to the plaintiff

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 suc-

Radical changes, as long as they are fair, are the only method through which the problems can be solved.

cessful plaintiff deserves to win and keep the amount of money necessary to pay all economic losses.

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 par-

ties cannot agree upon a fair attorney fee, the judge can serve as a referee to make the final decision. Alternatively the law could provide that the fee for the winning plaintiff be entitled to a predetermined amount, such as \$100 per hour. The exact amount could be based upon average time charges for attorneys, adjusted periodically for inflation.

At this point many lawyers argue that they should be paid 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 a lawyer in bringing a lawsuit. And they will argue that large fees, even a 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 liability lawsuit. The payment of large 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 the lawyer fully for the risk of losing. After all

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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Aviation Product Liability

A House subcommittee held hearings on aviation product liability and its effect on technology applications. Clifton von Kann, president, National Aeronautic Association, testified that "product liability may be slowing down the adoption of technological improvements and discouraging small, innovative aviation business." He said that "from the standpoint of aviation, product liability is a perfect example of a socio-economic trend that has run amuck, and must be reversed. Product liability litigation has created an insurance crisis; punitive damages need to be limited." He warned that "there is not enough insurance capacity in the U.S. to cover the expanded risk. Meanwhile the reinsurance market in Europe has dried up, and will remain so until the product liability picture in this country makes more sense than it does today."

Milton R. Copolos, senior analyst, The Heritage Foundation, testified that "despite a safety record that is above reproach, the cost of liability insurance for small planes is literally threatening the existence of the general aviation industry in the U.S. today; if some action is not taken soon, it may be too late for America's general aviation industry. The real solution to the problem, of course, is a sweeping reform of the tort law system in the U.S." He proposed:

1) "A restoration of the requirement that a tangible linkage exist between an alleged injury and the award of damages";

2) "The creation of a statute of repose, i.e. a time limit after which a product's manufacturer could no longer be held liable for accidents resulting from that product's use";

3) "The concept of contributory negligence must be reintroduced into the law";

4) "Introduction of new or improved safety devices or equipment should not be admissible in court as evidence of an inherent defect in an earlier version of the product."

For the Aerospace Industries Association of the United States, Malcolm T. Stamper told the subcommittee:

"Because claimants are innocent in virtually every air crash and clearly due compensation from some source, it would make sense to establish a system under which the aviation community automatically and promptly compensates the victims or their beneficiaries. Such a system would avoid the costs of protracted litigation, speed-up compensation payments, and restore balance and justice to the currently confusing and increasingly complex procedures of determining liability and awarding damages. Claimants could still have access to a jury trial, if desired, but compensation would be accelerated by deferring fault-finding until later.

"Therefore, we recommend the establishment through legislation of a relatively simple procedure that would require, in the case of an air crash, for example, only the filing of a plea that damages were sustained. No fault would have to be alleged or proven. Damages would be determined by rules established by the new law, but generally limited to "economic losses." Without contest on the issue of fault, settlement could be reached either between the plaintiffs and the aviation defendants, or the plaintiffs — as I have already suggested — could seek trial by jury on the amount of damages. In any event, the process would be much faster and fairer than the present system without elimination of the adjudicatory system altogether.

"Such legislation could also consider the question of catastrophic events, including crashes resulting from acts of God, acts of war, or terrorist attacks. The legislation might also address the highly unlikely, but mathematically possible, catastrophic type of air accident where multiple planes and buildings might be involved, with the best interests of the flying public in mind."

National Safety News
News - January



Dealing with the Insurance Disaster

There are several new remedies for Congress to consider

By Susan Pollack
Staff Writer

After months of study, congressional hearings and consultation with fishing industry leaders, insurance company representatives and government agents, the National Council of Fishing Vessel Safety and Insurance (NCFVSI) has issued recommendations to help combat the country's marine insurance crisis. The proposals, drafted by marine insurance specialist Dennis W. Nixon, with input from several other insurance analysts, are included in a preliminary report that was issued this past Oc-

tober. A final report is due in January 1986, though Congress is not expected to take any action on the proposals until later in the winter, following further discussion and at least one more congressional hearing.

During the past five years, marine insurance rates both for hull and for protection and indemnity (P&I) coverage have risen 100% to 300% and more, according to Nixon.

Nixon, who is a professor at the University of Rhode Island, offers these examples

of escalating costs:

- A Massachusetts or Rhode Island vessel owner who previously paid \$1,100 per crewman for P&I insurance is now likely to be paying \$3,000 to \$3,500 per man.

- A New Englander with a well-maintained vessel less than 10 years old and with no record of accident claims or lawsuits today faces a more than twofold increase in hull and P&I coverage. Last year, this boat owner paid \$19,000 for the combined coverage; thus far the best quote he has

A disabling accident aboard a fishing vessel, the nation's most hazardous work place, can leave the affected crewman little recourse outside of suing to recover lost wages and pay medical bills. The number and size of personal injury settlements in recent years has created a crisis for both the insurance and the commercial fishing industries.

received for renewed coverage is \$41,000.

In today's tight insurance-underwriting market, companies have become increasingly reluctant to underwrite the nation's most hazardous occupation — commercial fishing.

Aggravating matters are substantial vessel losses in both Gloucester, Mass., and in the Alaska crab fleet in recent years. Even more worrisome is a recent dramatic increase in the number and size of personal injury settlements, according to Nixon.

"The major complaint of insurance companies . . . is that with wildly varying awards for the same injury, they have no way to predict their losses and adjust their premiums on a sound, actuarial basis. An award for a fractured arm can be as low as \$5,000 or as high as \$500,000."

Some insurance companies have boosted premiums to levels that are virtually prohibitive to commercial fishermen. Others have canceled their policies or pulled out of the fishing business altogether. This has left vessel owners with the option of paying through the nose for insurance — if they can get it — fishing without it or tying up at the dock.

James Costakes, general manager of the New Bedford, Mass., Seafood Producers' Association, warns: "It's a question of survival. The insurance companies are falling by the wayside. If we don't get some sanity back into the system to entice them back, the vessels and crews in every salt-water state will be out of work."

Costakes is also president of NCFVSI, whose study was underwritten by a \$76,000 Saltonstall-Kennedy grant. The 35-page report, "Fishing Vessel Injury Alternative Compensation Analysis," offers some fresh solutions to the P&I problem, say fishing and insurance industry representatives. However, the report has drawn vigorous opposition from personal-injury lawyers and some union representatives, since it recommends limiting liability under the Jones Act, a 65-year-old federal statute guaranteeing seamen's rights (see sidebar).

Nixon's recommendations are based on

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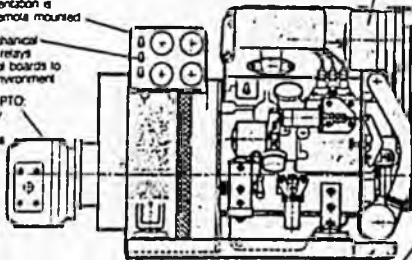
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Proposal draws mixed reaction from industry

Fishing industry leaders from the East, West and Gulf coasts have voiced support for Dennis Nixon's proposals for alleviating the nation's marine insurance crisis and improving medical and disability coverage for injured fishermen, although a few say the measures do not go far enough.

Jim Salisbury, president of the Maine Fishermen's Cooperative Association, ex-

presses a common view: "It seems like a viable strategy," he says, adding that members of his association have shown "a fair amount of enthusiasm for it." Members' support "the idea of providing a crewman with ready access to medical coverage and wages without suing," Salisbury says.

Similarly supportive sentiments are

voiced by Lucy Sloan, executive director of the National Federation of Fishermen; Kris Vehrs of the Texas Shrimp Association; and Thom Smith, executive director of the North Pacific Fishing Vessel Owners' Association.

Insurance industry representatives like Ward Mauck, president of the American Institute of Marine Underwriters, and

Howard Candage, a Rockland, Maine, broker, agree that the proposals represent a good start and are worthy of serious consideration.

Dave Burney, executive director of the U.S. Tuna Foundation, disagrees. After considering the testimony of insurance brokers for the U.S. tuna fleet at a hearing in San Diego, Calif., in October, he said: "The only way underwriters will be in a position to lower premiums would be through a compensation scheme similar to the state workmen's compensation programs. That would lend predictability to the amount of awards."

Sam Parisi, executive director of the Gloucester, Mass.-based Cape Ann Vessel Owners' Association, agrees. "In my opinion, the insurance companies are not going to come back into the market as long as people can sue for \$1 million for a back injury. Why not establish guidelines under the Jones Act for the amount that can be awarded for each kind of injury?"

Nixon says he originally supported the idea of developing a federal workman's compensation program for fishermen. But an investigation revealed that awards for the same injury varied radically from state to state. He says the only consistent schedule of payments he found was under the national Longshoremen's Act, and "the award scale was so high, it would end up costing more than current P&I coverage. It would be like jumping from the frying pan into the fire."

"The Association of Trial Lawyers of America has taken no stand as yet on the Nixon recommendations. But two of New

(Continued on Next Page)

an examination of 500 P&I cases from 1980 to 1984 and an analysis of current troubles facing both the fishing industry and the liability-insurance industry, along with a review of past proposals to remedy the P&I dilemma — including a 1975 bill that would have created a federal program for fishermen similar to the one for workmen's compensation.

His investigation reveals that the most significant problem involves cases of temporary but total disability. Some 80% of the claims filed under the Jones Act during the past five years were for injuries involving disabilities whose duration averaged 14 weeks, Nixon found.

One objective is to reduce attorney involvement in such cases. Nixon claims, "There has been a likely causal relationship" between increased awards and attorney involvement in recent years. According to his findings, the attorneys' fees amount to 33% of the total award in cases settled before trial and 50% in those that go to trial.

On another front, the 1981 closing of the nation's longstanding Public Health Service program for seamen aggravated the medical

insurance crisis, according to Nixon. He recommends amending the Jones Act to bar claims by fishermen for a disability that lasts for less than a year. (Fishermen could due for compensation related to long-term injuries.)

Secondly, he proposes reducing an injured fisherman's incentive to sue by establishing an immediate no-fault remedy consisting of total medical coverage and full compensation for lost income for up to a year.

To achieve this remedy, Nixon proposes raising P&I maintenance pay to \$30 a day. It now ranges from \$8 to \$30 a day. The \$30 a day would amount to \$11,000 a year, or roughly half the average fisherman's annual income of \$24,000 a year.

To supplement this, Nixon calls for the creation of a disability-income insurance program similar to one in effect in the United Kingdom (see sidebar). Under such a program, a vessel owner would buy policies for his crew at the beginning of the year and deduct the premium from their shares.

Nixon contends that this proposed pro-

gram would:

- cover the vast majority of injury cases fairly, predictably and without need for an attorney to demonstrate fault;

- be affordable to vessel owners, since the most abusive cases would be eliminated and the crew would be sharing in the insurance costs, as a legitimate independent contractor should; and

- make more sense to the insurance companies, since their liability would be limited to medical expenses and lost wages in the vast majority of cases.

Nixon concedes, "There is no guarantee a reduction in claims will mean an automatic reduction in premiums."

In his view, the renewed health of both the fishing and the liability insurance industries is also critical to turning the P&I problem around. "The reason the health of the fishing industry is so important is that fishermen don't get hurt as often in profitable fisheries. When a vessel's profits have been low or nonexistent," Nixon observes, "fatigue of both personnel and equipment becomes a major factor . . . maintenance is delayed and equipment is more likely to fail and cause injury."

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United Kingdom's system kills incentive to sue

Sunderland Marine Mutual Insurance, the major insurer of fishing vessels in the United Kingdom (U.K.), has expressed interest in extending its 30-year-old program of personal accident coverage, or disability insurance, to U.S. fishermen. So reports Dennis Nixon, the U.S. insurance specialist who drafted the report for the National Council of Fishing Vessel Safety and Insurance (see main story). Nixon says that Ocean Marine Underwriters, a Warwick, R.I., firm, and a West Coast broker appear to be interested in making Sunderland's program available to U.S. fishermen.

How does the U.K. program work? The vessel owner buys personal accident in-

sureance for his whole crew, skipper included. The policies do not bear the names of individual crewmen; thus, if there is a change in crew, all the men remain covered. Some vessel owners "charge out the costs to crewmen; others bear the costs themselves," explains Tom Watson of Sunderland Marine. The annual cost of a policy amounts to a week's wages.

The policy provides 24-hour coverage to a crewman, Watson notes, "whether the insured is at work or not. It would, for example, cover the insured in the event of a car accident and also when on holiday." Apart from immediately compensating an injured fisherman with what would amount

to lost wages, the U.K. policy covers up to 15% of medical expenses. The remainder of those expenses are picked up by the government, since the United Kingdom has a national health insurance program.

Despite the personal accident policy, the United Kingdom does not bar an injured fisherman from suing a vessel owner. "But why should he?" asks Watson. "There is no incentive to sue; also, the court awards for industrial injuries are much lower in the United Kingdom than they are in the United States."

— Susan Pollack

Reaction

(Continued from Page 3)

England's leading personal injury lawyers, Michael Latti of Boston and Joseph Orlando of Gloucester, have voiced strenuous objections to the proposal to limit liability under the Jones Act.

"To deprive a fisherman of the right to sue is a simplistic and dangerous solution that places money over men," says Orlando. "Let's reduce injuries. The safety of men should be the No. 1 priority. The only way to reduce claims is to reduce injuries." He urges that consideration be focused on the creation of a mandatory vessel safety inspection program, instead.

Latti does not think removing temporary disability claims from the Jones Act would do anything to lessen litigation. Moreover, he argues that it would be "unconstitutional to take away one right without replacing it with something equal to or greater than it." Although Nixon's proposed remedy guarantees an injured fisherman full medical coverage and wages, "it totally ignores his right to compensation for pain and suffering and mental anguish," Latti says.

"East and West coast representatives of the Seafarer's International Union offer opposing views. Jack Tarantino, the union's vice president on the West Coast, calls attention to the fact that in the port of

"The insurance companies say, 'Don't bother us . . . If you got a problem, take it to court.' So that's what a lot of guys are doing."

San Diego alone, a half-dozen 250-ton clippers are tied up and 100 men are out of work because of canceled Protection and Indemnity (P&I) policies. He suggests revamping the Jones Act so that an impartial government board would preside over cases of sickness or injury.

On the other hand, Mike Orlando, the union's East Coast vice president and attorney Joseph Orlando's father, maintains that the proposal to limit a fisherman's right to sue smacks of the "bias of boat owners and insurance companies. It's a way to economize on the people who work on the deck, the people whose lives they're gambling with."

Some fishermen say they would be willing to bear the costs of a disability-income insurance program; others say they would not. A crewman on an Alaska joint venture boat says, "I'm against having to pay for any insurance myself. I think that's more the responsibility of the boat owner. I understand the problems of the boat owners, but the insurance protects them." He adds, "The guys I know that have been hurt have been seriously hurt and deserve to be paid off. I haven't seen any of the abuses that are being discussed these days."

Another view is offered by a crewman on a Gloucester boat. Julio Pumar, who works on the dragger Peter and Linda, says he favors the creation of a no-fault plan. "The skipper on this boat is my friend. Now how do you think I'm going to feel if I get hurt and the only way to get any help is to sue my friend?" Pumar says he does not mind bearing the cost of what would probably be a \$300 annual premium, but he says it would be easier if it were deducted from his crew share on a weekly, rather than an annual, basis.

In Pumar's view, the insurance companies are mainly responsible for the rise in lawsuits because, he says, they frequently have not been willing to pay a man's lost wages when he's injured. "They say, 'Don't bother us . . . If you got a problem,' they say, 'take it to court.' So that's what a lot of guys are doing."

— Susan Pollack

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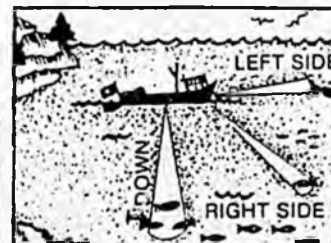
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Insurance 'drought' threatens every facet of American life

PART I

Note: Across the country, liability insurance is protecting from the economic ruin of its customers. When it is available, its cost is a of 500 to 1,000 percent. In the first story of series, "Insurance Drought," AP national ed Boyle outlines the crisis and its several

By FRED BOYLES
The Associated Press

In Albany, N.Y., closes its doors. A Miami small Pennsylvania town orders police off common denominator in each case is a sudden drought in liability insurance.

Once routinely purchased by business and government as protection against the economic ruin of lawsuits, liability insurance has become scarce and expensive. The growing list of those left out in the cold includes municipalities, professionals like engineers and architects, day-care centers and businesses ranging from large chemical companies to small manufacturers.

This crisis is more pervasive and has occurred more suddenly than the well-publicized rise in medical malpractice insurance rates that have hobbled hospitals and doctors. The drought also has different causes.

Roger Slinger, Massachusetts' deputy insurance commissioner, says his office is flooded with calls from people who can't get insurance or who face rate increases of 300 percent and more.

"It's everybody from some of the biggest companies in the state to an individual chimney sweep who can't get coverage," he said.

The crisis touches all society. The New Mexico Retail Liquor Dealers Association estimates 75 percent of its membership can't get or afford insurance. South Carolina officials are trying to persuade an insurer to continue coverage for hundreds of churches.

"I would expect the churches to be the better risks, and if the company starts ransacking the better risks, then other companies would follow, and we would have chaos," said state insurance Commissioner John Richards IV.

Hindman says and small are affected. Steve Semmell, risk manager for GAF Corp., a chemical company in New Jersey, expects a 400 percent increase in insurance costs.

Herbert Smoot, owner of Southern Missouri Towing, is selling his six wreckers and going out of business because of a 300 percent rate increase.

"I just flat had to shut them down," he said. "It's not feasible when it's a losing proposition."

The drought's impact is widespread. When Mission Insurance Co., a carrier in California, dropped its specialty day-care insurance, the ripples reached across the country. Hundreds of day-care centers went hunting for new policies.

In Michigan, premiums for day-care policies increased an average 400 percent. "Parents are being Continued on Page 12

Insurance...

Continued from Page 1
priced out of the market," said Bill Hankins, a spokesman for the state Department of Social Services.

It affects everyday life. Northeast ski operators will raise the price of lift tickets a few dollars to cover the cost of higher insurance. Denver Girl Scouts may have to cancel summer camp for want of coverage.

The Chicago suburb of Mount Prospect leveled its popular boggan run after its insurer threatened to cancel the town's policy.

The insurance drought follows the worst year in the liability insurance industry — a loss of \$1.8 billion.

Insurance executives blame the red ink on the steady increase in the size and scope of lawsuits. Laws expanding the definition of liability and court interpretations of policies have left insurers with hefty judgments on claims they say they never intended to cover.

The industry points to a \$15.8 million judgment in Jackson Township, N.J.

Two insurers were ordered to pay damages for the slow contamination of town wells by chemicals from a landfill even though its policy excluded pollution cover-

age, except for "sudden and accidental" incidents.

"The courts have interpreted our contracts to such an extent that we no longer know what is covered," said Warren Levy, a spokesman for the Insurance Information Institute.

Insurers and their customers also are paying for nearly seven years of "interest rate underwriting" — a time when companies sold policies at bargain basement prices while bolstering profits through investments paying 14 percent or better.

Some say insurance rates fell below realistic levels as competition raged for the premium dollars. When interest rates dropped abruptly, insurance companies were caught between shrinking investment income and soaring legal judgments.

"The companies are not making the investment return that had helped prop up the bad underwriting," said James Chastain, a professor of insurance at Howard University's School of Business and Public Administration.

The losses have cut into insurance reserves — the money set aside to cover future claims. They have also scared away money invested by reinsurance companies, foreign carriers like Lloyd's of London that basically insure the insurance companies.

Insurance: An industry full of ups and downs

PART II

Patton's Note: Insurance people agree that it is a business of ups and downs, reacting to more people buying insurance, but the current low-riding premiums, just the current dip in the insurance rate, is a sign that the industry is in a recession, says a spokesman for the industry.

BY FRED DAVILES
The Associated Press

In 1980, the MGM Grand Hotel in Las Vegas, partly gutted by fire and reeling from the deaths of 87 guests and employees and injuries to 700 other people, was able to buy a unique first-year insurance policy for \$170 million package to cover eventual settlements with victims and their families.

Five years later, times have changed. Dorothea Olsen with a Stenmetz, Wash., in insurance on her day-care center in Pasco, even though it hasn't had a claim in 10 years.

"We are faced with losing the children, the old state insurances. The new state insurances are the least-favorite industry that goes from periods of frenzied competition and low rates to tight markets and high prices.

But this latest cycle in liability insurance is unprecedented. Economic and social factors cost insurers a collective \$1 billion in 1980. The industry's record and did up insurance for steady customers.

Those able to buy insurance face rate increases of 300 percent to 1,000 percent even when they have never

filed a claim. Consumer advocates like Ralph Nader say the industry has become more liberal in its policies, but it has lost control. Twenty insurance companies have been declared insolvent this year, the highest number in 11 years.

"The mood is excited," said Charles H. Jones, president of the National Association of Insurance Commissioners.

The insurance industry has ridden a roller coaster of cycles since the 1920s. When insurance money is plentiful, rates fall as companies compete for premium dollars to invest in stocks, bonds and real estate. When costs can no longer support them, the cycles reverse and rates climb.

The latest cycle began in the late 1970s when insurers cut rates to lure additional dollars for high interest investments. Foreign insurers, banks and brokerage houses, all entered the business.

"The industry is naturally competitive," said Warren Levy, a spokesman for the Insurance Information Institute. "With new money coming in and everybody looking to increase market share, companies cut rates to get business."

Although the results looked good — the industry recorded a net gain of \$7 billion in 1981 — experienced hands began to worry.

"We were very reluctant players under ground rules that we knew were wrong and were going to lead to disaster," said William D. Trachtenberg, president of the American Insurance Association. "It was pretty hard to cry wolf."

The MGM Grand story was an example of the times.

But, industry critics say recent rates have been more than compensated for past mistakes.

But while income has remained stable, losses have climbed. In 1980 the industry paid \$70.2 billion in claims; last year, losses were \$101 billion.

Richard E. Perry, an assistant vice president for the American Insurance Association, said court rulings had saddled insurance companies with claims they never intended to cover.

In Jackson Township, N.J., for example, two insurance companies were ordered to pay \$15.8 million to residents suing over water contamination. The industry's policy reserves, though, had included pollution incidents, ex-

cept for "sudden and accidental." "Traditionally we felt we could develop a contract that stated when our liabilities were and what happened. We were increasing that over the time we got in the courtroom."

This uncertainty has scared insurers away from potentially high-risk customers.

Many home-day care centers already paid a few extra dollars for a rider on their homeowners policy. But when a California company dropped the line, other insurers shunned the reports of actual claims. Although no such claim has ever been filed, more selective about customers because it has less money for insurance.

Under most state regulations, insurers are required to set aside a surplus of \$3 of insurance. That means for every \$1 of reserve lost, the companies have to cut sales by \$3. Moody's, the insurance information industry, said the industry's surplus had fallen nearly \$2 billion, reducing its capacity to write insurance.

The industry's capacity has also been reduced by cuts in reinsurance

funds — money provided by reinsurers like Lloyd's of London and other firms. Many of these reinsurers are now being bought by insurance companies.

Andre Malinowski, president of the re-insurer American International, said companies now are cautious. He said that 11 percent has generated losses that have virtually wiped out its foreign reinsurance funds.

"Joynt is saying that 12 percent of its premium is U.S. business and that 11 percent has generated losses that have virtually wiped out its foreign reinsurance funds."

David Wells, an analyst for Gordon, Brown, Ruder and Hunter say the stock market forecast backs up their contention that insurers are exploring the situation. But Levy of the information institute said, "We have no quarrels about saying the industry will be profitable again."

But the industry that comes out of this will be a tougher, smarter industry.

Big hikes in litigation add to insurance industry crisis

Editor's Note: U.S. courts have seen a growing tide of liability suits against manufacturers, municipalities and individuals. The cost of the litigation is being blamed in part for a severe insurance crisis. This third installment of a four-part series, "The Insurance Drought," examines this litigation.

By FRED DAYLES
The Associated Press

Henry Lowd jokes about it. "People come from miles around to fall on our property," said the executive secretary for Randolph, Mass., a Boston suburb sued for \$65,000 by a New Hampshire woman who fell at the town's police station.

The threat of lawsuit is no laughing matter to growing numbers of municipalities, manufacturers, bars and others. The rise in litigation is a special burden to the nation's troubled insurance industry, which suffered a record \$3.8 billion loss last year, a loss blamed in part on the constant drain of lawsuits.

Insurers recorded \$101.1 billion in losses last year, up from \$70.2 billion paid in 1980. As a result, insurers have raised rates and cut coverage. The impact is felt everywhere, from local government to child-care centers.

"People want to use the civil justice system to resolve the smallest dispute," said Richard Marrs, head of The Travelers Cos. claims department. "Neighbors who may have had a disagreement many years ago might have gotten together and worked it out. Today they want to get a lawyer."

Courts around the country have recorded an increase in the number and size of lawsuits:

- 1,580 product liability suits were filed in federal district courts in 1974. Last year, the number was 10,745.
- The New Mexico Public Liability Fund reported that of \$8 million in claims paid since 1976, \$6.2 million was awarded in the past two years.
- In 1975, New York civil courts handled 12,842 liability cases. Last year the number reached 19,613. New York City paid \$46.5 million in liability claims in 1980; this year the figure is \$87.9 million. Comptroller Harrison Goldin has warned the city's liability costs might soon rival expenditures for police and firefighters.

Mark Peterson, a senior researcher with the Institute for Civil Justice, an affiliate of the Rand Corp., said civil cases in San Francisco and Chicago involving automobile accidents and "slips and falls" were giving way to more expensive product and government liability suits.

"These are high-stake suits that are increasing in frequency," said Peterson. "That is meaningful because of the risks insurance companies face."

Peterson also notes jury awards have nearly doubled since the 1970s.

"There are a growing number of million-dollar awards," he said. "The typical jury awards have remained surprisingly stable over the past 20 years. But the big awards are driving up the average, and the insurance companies worry about the average."

Many point to court interpretations that have expanded the definition of liability.

"Joint and several," a legal concept rooted in English common law, says an injured party may recover losses from anyone with some responsibility for the injury.

In recent years, many courts have held that "deep pocket" defendants, government and businesses with large financial resources, can be held liable for all damages even if they are only minimally responsible.

PART III

The California Supreme Court, in 1975 and 1978 rulings, held that injured parties who share the blame could still sue another responsible party that was only partially to blame.

San Diego County recently was ordered to pay \$2.5 million to a man paralyzed when a friend's car crossed a curve and rolled over. Although the two men were judged at fault for speeding, drinking and smoking marijuana, the county, judged 10 percent at fault for failing to install curve markers, had to pay all damages because the driver had no insurance.

Louisiana saw liability judgments go from \$5 million to \$55 million in a decade following a state Supreme Court decision that held government liable for defects occurring in anything under its jurisdiction, whether or not government officials knew.

Kevin Reilly, a state legislator from Baton Rouge, described a large award paid to a man whose car ran off the road and hit a tree.

"The record was clear that he was speeding and drinking, but the court said the tree was too near the highway," said Reilly. "We didn't know about that tree, but it didn't make any difference."

Reilly sponsored legislation that now holds the state liable only if it fails to correct a reported defect.

Social issues are also clamoring for their day in court. The national concern over drunk driving has brought rulings, like one from the Arizona Supreme Court, that liquor establishments are responsible for actions of patrons who become intoxicated and later are involved in accidents.

Hank Graham, president of the Arizona Licensed Beverage Association, said the ruling persuaded him to sell his share in a tavern and liquor store.

"I'd like to have an ice cream store," he said. "I haven't heard of anybody suing an ice cream store yet."

Plaintiffs now take alternative routes to sue state and local officials who are often protected against suits by state law.

Joe Seat, executive director of the Tennessee Municipal League, said police departments were routinely subject to federal civil rights suits over suspects' treatment, police shootings and other incidents.

"Anytime we get a slaying involving a policeman, no matter what the circumstances, I can guarantee we eventually will get a civil rights lawsuit filed," he said. "The officer may have been protecting his life, but he is going to get a civil rights suit."

A majority of defendants settle out of court. But some are beginning to fight back. William Fleming, general counsel for the Municipal League of Arkansas, said the group had established a legal defense program that has won dismissals for several cases.

"Most of the time we play hardball and fight it all the way," he said.

But even successful legal fights are costly. Randolph, Mass., won the \$65,000 suit filed by the New Hampshire woman who fell in the police station. But the town's insurer spent \$16,000 defending the suit. The company later canceled the town's insurance.

Some states are trying to limit the size of court awards.

Changes certain in troubled insurance industry

PART IV

Editor's Note: The crisis in liability insurance has many dimensions. In this series of articles we will examine the way they write policies; consumer and state efforts to regulate; state official study ways of controlling the industry. The final story in a series, "The Insurance Through," examines what today's problems spell for the future.

By FRED HAVLES
The Associated Press

The sudden, sweeping impact of the nation's insurance drought has raised questions for change. Insurance executives, frightened by reports bleeding from the industry, are looking for ways to control the crisis. The industry is in a state of emergency, and the industry is in a state of emergency.

For the first time, one of the top underwriters for the industry, the Casualty Co., recent reports that the industry will be more cautious about who it insures. Even experienced customers in high risk areas like municipalities, city centers and industrial companies may suffer.

"You've got to view a risk with an eye that even the Warren Dept. is a step ahead of," he said. "You've got to view a risk with an eye that even the Warren Dept. is a step ahead of."

places across the board," said Levy. Insurers are redefining what they will and will not cover. Some new legal codes included in liability limits change involves the notion of time.

Most policies cover claims on an occurrence basis, a manufacturer and today for a loss that happened in 1952 would be covered by whatever held the policy that year.

Insurers say this leaves them vulnerable to the past, pointing to asbestos suits that have been filed two to five decades after a policy was written.

The industry wants regulators to approve "claims-made" policies that hold insurers liable for claims filed only during the time a policy is in force.

This change allows insurers to look to the past and present, instead of the uncertain future, to set rates. Under the present system, a suit by a shipyard worker awarded in asbestos in the 1960s would fall on the shoulders of the company that wrote the insurance 30 years ago, when there was no knowledge of the potential problems with asbestos.

head of the National Insurance Consumer Organization. "There's a predictability for the companies, but much less predictability for the consumer."

Consumer advocates like Hunter and Ralph Nader say state regulators must be wary that insurers may be overstating today's problems to leverage an advantage in the future.

"State regulators must do some investigation and for one must tell people the truth," said Nader. "A general rule is setting high risk groups can get insurance."

He recommended federal backing for some high risk insurance pools. Ironically, some of the concerns are rebuffed by the insurance industry.

James Holland, head of The Travelers Companies' Casualty Property Division, feels government must work with the industry to establish such insurance pools.

"Companies individually can't respond to this problem," said Holland. "It has to be some collective action and under main basis that will not expose us to financial self-destruction."

with the North Carolina League of Municipalities, does not see any need for members to pool his organization's establishing. "But it may be better than no insurance at all," he said.

While some look for alternatives to commercial insurers, state officials are hearing calls from consumers for closer scrutiny of the insurance industry.

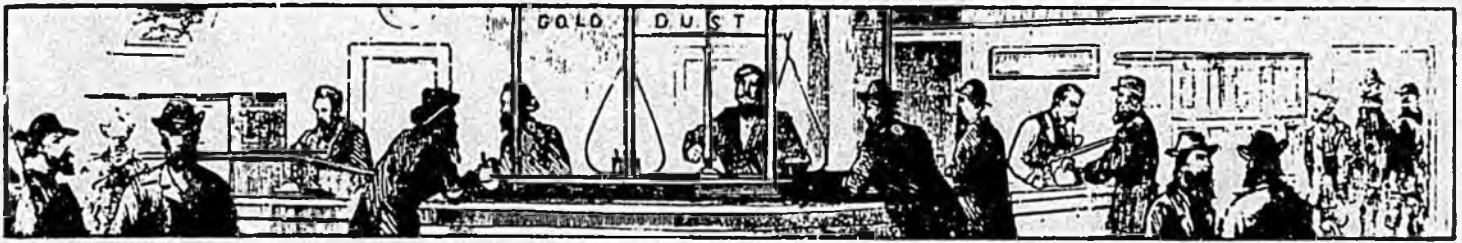
Hunter, of the National Insurance Consumer Organization, said regulation of the industry was poor.

state level since the end of World War II. In many states, Hunter said, the insurance departments, often numbered and acquired by the insurance industry, often riskier stamp rate increases and changes in coverage.

"The states are clearly underpaid and without the experience to enforce the law," he said. "I'd want to talk to an officer with the National Association of Insurance Commissioners, agree the quality of regulation varied from state to state. To deal with that, he said, he said his goal was setting up a computer network that will allow states to compare rates and create more uniform regulations.

But he cautioned that lighter regulation to the industry might require state reinsurers to be deemed liquid. "It is difficult to say in a business that you should get more for tomorrow," he said. "But if it is in the interest of the public, the regulation to make sure the business is there to take care of it is a long-term goal. But it's not an all-out effort."

A Bi-Monthly Report on Government Finance Issues in the States



THE FISCAL LETTER

An Information Service of the National Conference of State Legislatures — Earl S. Mackey, Executive Director

Editors : Corina Eckl
Leann Stelzer

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Contents:

Liability Insurance: Wrestling with a Thorny Issue.	1
A Spy in our Midst.	4
Tobacco Taxes: Emerging From the Back Burner?	5
Another Look at Tax Amnesty Programs.	8
State and Local Tax Levels in 1984.	10
Recent Transportation Finance Studies	12
PENSION REPORT:	
Women and Public Pensions: Are All Aspects Equal?	13

LIABILITY INSURANCE: WRESTLING WITH A THORNY ISSUE

In the past year, states, local governments, and private businesses have found it increasingly difficult to obtain or afford liability insurance. Cities, states, physicians, and hospitals, among others, have seen dramatic increases in their liability insurance rates. North Dakota estimates that liability coverage for its Department of Human Resources will increase 219 percent, from \$453,346 to \$1,446,133 during the 1985-87 biennium, as compared to the previous biennium. Specialists in some parts of the country are seeing their medical malpractice premiums climb to more than \$50,000 annually.

Small businesses, long distance truckers, directors and officers of corporations, owners of gasoline stations, grain elevator operators, and colleges and universities are examples of others facing huge increases in liability insurance premiums. Child care centers are finding it dif-

ficult to buy insurance in light of an increase in sexual abuse claims. And many waste dump operators cannot find a company to insure them--a serious problem, as insurance is usually a license requirement.

Roots of the Problem

Several factors in combination have led to today's "crisis" in liability insurance affordability and availability. While there is some difference of opinion on the extent to which each contributes to the problem, the following are the most frequently cited factors:

- A drop in the return on investments made by insurance companies. In the late 1970s, when interest rates were high, insurers eagerly wrote policies and invested the premiums. The competition for business

(Continued on page 2)

LIABILITY INSURANCE (Continued)

drove down the price of insurance, but the claims continued. As the return on investment dropped with the rate of inflation, losses in the insurance industry have mounted. In the past two years, companies lost more than in the previous 25 years.

- Excessive damage awards. A small percentage of cases account for the bulk of dollar payouts. Whereas settlements for more than \$1 million were rare just five years ago, such high settlements are somewhat more common today. For example, a swimmer who became paralyzed after diving in the surf at a town beach won a \$6 million judgment against the city of Newport Beach, California, earlier this year. Large awards for pain and suffering often result in high settlements. Some also argue that the collateral source rule results in excessive awards. This rule forbids the introduction of evidence that the plaintiff is already receiving compensation from other sources. Thus, a patient may receive compensation from more than one source for a single element of loss, such as medical expenses.
- Increased uncertainty about the number and size of future claims and awards. In recent years, insurers have seen more and more plaintiffs successfully sue either for events which took place many years ago, whose harmful effects are only now coming to light (e.g., leaking toxic waste sites), or for which claims were once virtually unheard of (e.g., sexual abuse claims against operators of child care centers). As insurers find it increasingly difficult to accurately predict the nature of their clients' liability, they are more and more reluctant to assume such risks.
- High administrative costs. Estimates are that only 28-40 cents of each medical malpractice premium dollar ultimately goes to injured parties. Administration, claims evaluation, and litigation costs, including plaintiff attorneys' contingent fees and defense attorneys' hourly fees, absorb more than one-half of each medical malpractice insurance premium dollar. Similar figures apply for much of the liability insurance market.

Several additional factors have exacerbated the liability insurance problem for state and local governments:

- The doctrine of joint and several liability. This doctrine allows a plaintiff to sue any or all of the possible defendants for the full amount of his damage. Although a plaintiff cannot collect more than his legally determined damages, he may collect it from the defendant with the most resources or the "deepest pocket," irrespective of that defendant's degree of fault. This rule

often works against governments because they are always considered deep pocket defendants. For example, a city which is found to be 10 percent at fault in an accident may have to pay all or most of the damages if the other defendants have no resources.

- Loss of sovereign immunity. Under the doctrine of sovereign immunity, which is derived from an ancient English common law, citizens cannot sue their own government. This doctrine has been eroded substantially over the years as a result of federal and state legislative and judicial actions.

Potential Solutions

Proposed strategies for dealing with the liability insurance problem fall into three categories: 1) those that involve tort law revisions; 2) those that require administrative reforms; and 3) those that may be taken independently by the states. Table 1 summarizes categories of insurance liability bills likely to be introduced in upcoming legislative sessions.

Under the heading of tort law revisions, the following proposals are frequently mentioned:

- Amend the joint and several liability rule to limit the liability of deep pocket defendants where their percentage of fault is relatively minor.
- Change the collateral source rule to allow evidence to be introduced that the plaintiff has received compensation from other sources.
- Establish pretrial panels to encourage early settlement and weed out frivolous claims.
- Place limits on the amounts recoverable; these limits may be placed on the total amount of an award or only on the amounts recoverable for non-economic losses, such as pain and suffering, disfigurement, impairment of quality of life, or punitive damages.
- Permit courts to allow structured damages--damages paid in installments throughout the plaintiff's period of disability, up to a lifetime--in lieu of lump sum awards.
- Regulate the contingent fee arrangements of plaintiff's attorneys.

Administrative reforms may include the following:

- Require insurance companies and self-insurers to submit basic information on their liability experience to give states a better understanding of the frequency and severity of claims and the adequacy of premiums, as well as provide feedback on the effect of enacted legislation.

(Text continued on page 4)

TABLE 1

BILLS DEALING WITH LIABILITY INSURANCE LIKELY TO BE
INTRODUCED IN UPCOMING LEGISLATIVE SESSIONS*
November 1985

STATE	TORT LAW REVISION							INSURANCE REGULATION		NOTES
	Joint/Several Liability	Collateral Source	Prejudgment Interest	Caps on Damages	Structured Awards	Frivolous Suits	Sovereign Immunity	Insolvency - Guaranty Fund	Administrative Action to Promote Access	
Alabama										May consider insurance code revision.
Alaska										
Arizona	•	•		•	•				•	Created special commission on property/casualty insurance.
Arkansas										
California	•	•	•	•	•	•	•		•	
Colorado	•	•	•	•	•	•	•		•	
Connecticut										
Delaware										Abolished collateral source rule for MedMal claims (1985).
Florida										State has authority for joint underwriting.
Georgia**										
Hawaii				•		•			•	Insurance code scheduled for revision in 1987.
Idaho**										
Illinois**									•	May propose citizen advocate for insurance board.
Indiana										
Iowa	•	•	•	•	•	•	•			
Kansas										Capped punitive damages in MedMal claims (1985).
Kentucky							•			Awaiting court test of cap on damage awards.
Louisiana										
Maine				•						Created MedMal and liability insurance task forces.
Maryland										
Massachusetts				•						
Michigan	•	•	•			•				
Minnesota									•	
Mississippi										
Missouri										
Montana				•						
Nebraska**									•	Insurance insolvency statute enacted (1985).
Nevada										
New Hampshire										
New Jersey**									•	Moratorium on insurance cancellations in place.
New Mexico										
New York										
North Carolina**	•								•	
North Dakota										
Ohio							•		•	Order prohibiting mid-term insurance cancellations.
Oklahoma										
Oregon	•									
Pennsylvania									•	May prohibit mid-term cancellation or rate increase.
Rhode Island										Currently reviewing insurance investment rules.
South Carolina	•		•	•					•	
South Dakota	•	•	•	•						
Tennessee										
Texas**										
Utah										Major rewrite of insurance code (1985).
Vermont										
Virginia		•	•				•			Insurance code may be recodified.
Washington	•	•	•	•	•				•	
West Virginia		•	•	•						
Wisconsin				•						
Wyoming**										Bill may give increased authority to Insurance Commissioner.

* Based on a survey of state legislatures conducted by the National Conference of State Legislatures, November 1985.

**Study of possible tort law revisions in progress.

Definitions:

Insolvency/Guaranty Funds: actions taken to protect claimants from insolvency failure of insurance companies.
MedMal: medical malpractice.

Prejudgment Interest: assessment of interest as of the date of the filing of the claim.

Structured Awards: allows defendant to pay a claim over a period of time.

LIABILITY INSURANCE (Conclusion)

- Prohibit midterm cancellations of policies unless the risk has demonstrably increased and direct companies to give policyholders more notice of intent to cancel.
- Allow insurance companies to write policies on a "claims made" rather than on an "occurrence" basis. Occurrence-based insurance holds the insurance company responsible for claims resulting from treatment rendered during the coverage period, regardless of when the claim was filed. Claims-made based insurance holds insurers responsible for claims filed only during the coverage year.

Independent actions that states may take to control their liability insurance costs include:

- Reassert, wholly or partially, sovereign/government immunity and extend this immunity to local governments.
- Improve risk management in order to reduce the likelihood of claims.
- Self-insure instead of buying liability insurance from third parties.

An Example from Medical Malpractice Insurance

A crisis in the availability of malpractice insurance inspired reform legislation in almost every state ten years ago. Many of the strategies outlined above were enacted at that time to deal with the crisis. These reforms were meant to encourage settlements before trial, to limit recoveries, to improve quality of care, and to alter the legal process.

State legislation was effective in solving malpractice availability problems, but the effect of tort reforms on claims and recoveries is far less clear.

Economist Frank Sloan of Vanderbilt University, who analyzed the reforms' impact on malpractice premiums, concluded that "the empirical results of this study give no indication that individual state legislative actions, or actions taken collectively, have had their intended effects on premiums."

Dr. Patricia Danzon of Duke University analyzed malpractice claims closed by almost all insurers in the mid- to late 1970s. Her conclusions were:

- Limits on the dollar amount of awards, including caps and provisions for periodic rather than lump sum payments, appeared to cut average settlements by 25 percent, to raise the proportion of cases dropped from 43 to 48 percent, and to reduce slightly the share of cases going to verdict.
- Relaxation of the ban on introducing evidence of collateral sources of compensation available to the plaintiff appeared to reduce settlements, although the statistical significance of this finding was low.

- Limits on attorneys' contingent fees cut average settlements by nine percent, somewhat raised the number of cases dropped without payment, and slightly reduced the percentage of cases going to verdict.

As legislatures tackle the thorny issue of controlling liability insurance costs during the upcoming legislative sessions, they need to carefully weigh the expected benefits of actions which may reduce the ability of defendants to sue, cap awards, limit attorneys' fees, or involve expensive or cumbersome administrative actions.

NCSL Contact: Barbara Yondorf, Denver.

Editors' Note: This is the first in a two-part series on the liability insurance problem. The second article, which will appear in the January/February 1986 edition of The Fiscal Letter, will take a closer look at the effectiveness of different strategies in controlling liability insurance costs.

A SPY IN OUR MIDST

Who was the most famous legislative fiscal staff member in the country in 1985? He was written up in the Wall Street Journal, the major news weeklies, wire service stories, and even had his name mentioned in Chinese newspapers. Many of his colleagues may not have realized that an apparently meek, mild-mannered economist who attended several NCSL meetings in 1984 was a notorious agent for the Russian KGB.

The person who received all of this attention was a 33-year-old revenue estimator for the Legislative Fiscal Office of New Mexico, Edwa 1 Howard. Late last summer, just as the FBI was about to arrest him, he managed to escape. He is now reported to be in Moscow.

It seems that Howard had been trained by the CIA to serve as a contact with one of our most valuable Russian undercover agents. When testing showed that Howard was taking drugs, the CIA fired him, but it reportedly helped him to obtain a position with the New Mexico Legislature. Press reports suggest that the CIA treatment of Howard led him to divulge secrets about their operations to the KGB.

During his two years with the Legislative Fiscal Office, Howard appeared to be just another employee. In retrospect his colleagues noted some strange behavior, such as a preference for using a public pay telephone in the capitol rather than his office phone. He sometimes disappeared for extended periods while attending meetings out of town, including the 1984 NCSL Annual Meeting in Boston.

Some people may think that legislative fiscal staffers tend to be dull, but the Ed Howard story suggests otherwise. The Fiscal Letter plans to report more human interest stories in the future as they come to our attention. Anyone with additional details about Ed Howard is urged to contact The Fiscal Letter and the Federal Bureau of Investigation, not necessarily in that order.

THE KIPLINGER WASHINGTON LETTER

Circulated weekly to business clients since 1923—Vol. 63, No. 9

THE KIPLINGER WASHINGTON EDITORS

1729 H St., N.W., Washington, D.C. 20006 Tel: 202-887-6400

Cable Address: Kiplinger Washington D C

Dear Client:

Washington, Feb. 28, 1986.

At last, a little GOOD news on business liability insurance:

Some relief is in sight. Not MUCH for the time being, but some, enough to indicate that the worst may be over...a shifting of the winds. The day of wholesale lawsuits over all kinds of "wrongs" may be ending.

We've been looking into the situation in a number of key states where the legislatures are already working up a wide range of remedies. Note that most of the activity is in the states. Congress isn't expected to vote anything, in spite of hearings and publicity in recent months.

New liability laws are coming in many places to curb the mania to file lawsuits...provoked by the huge awards dished out for injuries.

These are most active: N.H., Conn., W.Va., Mich., Ill., Colo. and Calif. But changes in current laws are now expected in 29 states. And legislatures in a few others will probably jump on the bandwagon.

Here are changes that top the list so far:

Joint liability. Repeal or easing of laws that require payment of all damages by someone who's only partly at fault...if other parties who are primarily to blame can't pay. Some 13 states working on this.

Limits on lawyers' fees. About 12 states are going to regulate contingency fees that sometimes eat up 40% of the awards or settlements. Legal fees are already regulated in one form or another by 22 states.

Limits on vague damages such as pain & suffering, anxiety, etc. Legislatures want to cap what can be paid for hard-to-measure injuries.

Same for punitive damages...require greater proof of fraud, malice, willful and wanton action. These are subject to abuse today.

Compensation from outside sources. Some 10 states are studying ways to reduce awards when an injured person is also getting something from another source such as job-injury pay. Make awards more realistic.

Tighter laws on negligence. Stricter definition...to curb suits.

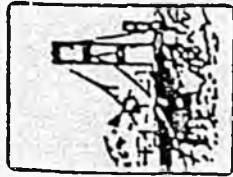
Relief for bars & restaurants. A ceiling on damages against them to help such places buy insurance...now often unavailable at ANY cost.

Instalment payment of damages...rather than a required lump sum.

Plus other wrinkles to ease the current situation. Many states are likely to copy those around them, thus eventually fleshing out laws that will go a long way toward curbing abuses. But this will take time.

Meanwhile, this advice from several states...to those businesses having trouble on insurance: It isn't wise to "go bare"...run the risk of injury and damages with no insurance. Call your state commissioner. Frequently he can steer you to a firm that will supply liability coverage at a rate you can afford...or suggest some alternative to "going bare."

Premiums are high, and probably are headed higher before long. But relief IS ahead. And that's encouraging. We'll watch it for you.



The Tacoma News Tribune

The Pacific Northwest's Leading Independent Newspaper—Established 1883

Nov. 13, 1985

Insurance firms blamed for rate crisis

By RICK SEIFERT
The News Tribune

OLYMPIA — Insurance companies are largely to blame for rising liability insurance rates and widespread insurance policy cancellations, according to a state legislative report issued today.

"In far too many cases, people are being victimized by a giant industry facing a crisis of its own making," concluded the bipartisan Joint Study Committee on Insurance Availability and Affordability. The five-member group was chaired by State Insurance Commissioner Dick Marquardt.

The report comes in the heels of a

committee hearing late last month at which insurance company executives complained about mounting legal costs, multi-million dollar court judgments and unpredictable coverage risks.

In its report, the committee, which made several recommendations for legislation, called the problems within the insurance industry a crisis, one which was expected to last through 1986.

But the committee laid the bulk of the blame at the feet of the insurance companies.

At six public meetings held around the state this fall, the committee heard from hundreds of people, scores of whom "told of being hit by sharply increased insur-

ance costs or of not having insurance available at any price," reported the committee.

Among those justifying were child-care providers, doctors, nurses, restaurant owners, truckers, local public officials, installers of wood stoves and tow-truck operators.

Some are caught in a "catch-22" situation: of being required by law to carry insurance but unable to buy it at any price, the committee reported.

And committee members learned that governments, which must stay in business regardless of insurance availability, "are forced to function with dangerously low amounts of protection or with no protec-

tion at all," the members said they discovered.

The root of the problem, the committee concluded, originated with insurance companies engaging in "cash-flow underwriting" in which they lowered rates to win premium dollars, which in turn were invested at the high interest rates of the early '80s.

"Sound underwriting and investment practices ... were either ignored or glossed over in favor of a quick return," concluded the committee. Insurance executives said they were forced to cut rates in order to remain competitive.

The report also cited the rising number and cost of court cases as contributing to

the problem. One large company told the committee that in 1974, six doctors per 100 were being sued annually. By this year, the ratio had grown to 16 per 100.

The same company reported that legal costs for defending doctors has risen from \$12 per \$100 in claims in 1950 to \$51 per \$100 this year.

The committee made several recommendations for legislation, including:

- Expanding high-risk insurance pools to include liability insurance.
- Requiring companies to give 120 days' notice to agents and brokers prior

Continued on Page A-1

Insurance
Continued from Page One

to canceling agency contracts.
• Funding the insurance commissioner's office in a way that would tie the amount of funding to the demands placed on the office. Presently the commissioner's office is underfunded, forcing it to rely too heavily on information provided by the companies, the committee concluded.
• Requiring insurance companies to sell commercial policyholders why policies are canceled or not renewed.
The committee also decided that some reform of the state's tort law "appears to be needed" but the group concluded the complex question needs further study. A tort is wrongful act or damage which can be the subject of a civil court suit. A proposed change in the law might place a lid on the amount for which plaintiffs can sue for pain and suffering.

A REPORT TO THE LEGISLATURE *of Washington*
FROM THE
JOINT STUDY COMMITTEE
ON
INSURANCE AVAILABILITY AND AFFORDABILITY

November 13, 1985

Dick Marquardt
Insurance Commissioner, Committee Chairman

Senator Ray Moore
Chairman, Senate Financial Institutions Committee

Representative Gene Lux
Chairman, House Financial Institutions and Insurance Committee

Senator Alex Deccio
Ranking Minority Member, Senate Financial Institutions Committee

Representative Shirley Winsley
Ranking Minority Member, House Financial Institutions and
Insurance Committee

REPORT ON INSURANCE

AVAILABILITY AND AFFORDABILITY

November 13, 1985

<u>SECTION</u>	<u>TITLE</u>	<u>PAGE</u>
I.	INTRODUCTION	
II.	THE INSURANCE CRISIS - AN OVERVIEW	1
	HOW DID IT HAPPEN	2
	THE CAPACITY CRUNCH	3
	GROWTH OF COURT CLAIMS	3
	THE NEED FOR COVERAGE	4
	RESOURCES OF THE REGULATOR'S OFFICE	4
III.	RECOMMENDATIONS (YELLOW)	5
IV.	APPENDICES (BLUE)	
	A. Cash Flow Underwriting	8
	B. Capacity Crunch	10
	C. Resources of the Regulator's Office	12
	D. Draft Legislation on Agency Cancellations	13
	E. Funding of the Insurance Regulatory System	15
	F. Cancellation & Nonrenewal Statutes with Proposed Amendments	17

INTRODUCTION

Six public meetings were held by the Joint Study Committee on Insurance Availability and Affordability to gather information on the current "insurance crisis" affecting Washington and the rest of the country. In the interests of readability, this report of the committee has been kept short. For readers wanting more detail, the appendices address various aspects of the problem in some depth. Copies of draft legislation, case histories and other reference materials are being prepared by the Insurance Commissioner's Office.

Five of the six meetings - held August 1 in Wenatchee, August 9 in Yakima, August 14 in Bellingham, August 21 in Spokane and September 11 in Seattle - were scheduled well in advance, to hear from people wanting to comment on any insurance problems. Testimony was sought specifically on day care liability, restaurant and liquor liability, insurance for long-haul trucking, insurance for local governments and insurance for non-profit agencies.

The sixth meeting, held October 21, was set after the insurance industry failed to offer substantive testimony at the first five sessions. Officials of 12 companies were invited to appear and give their views on the insurance crisis as well as on specific cases involving their firms. Eleven of the 12 companies invited sent representatives to the meeting. This report summarizes the committee's conclusions and recommendations.

REPORT OF THE SPECIAL COMMITTEE ON INSURANCE AVAILABILITY
AND AFFORDABILITY

The Insurance Crisis - An Overview

The fact that a crisis does exist in the insurance market is apparent to anyone willing to even briefly examine the problem. The number of people directly affected by the rising cost of insurance or the lack of availability of certain types of coverage seems to grow every day.

While it is difficult to determine just how serious the problem will become and how long it will last, most industry observers feel it will continue at least through 1986. How severe its effects will be on our society, on our economy, will depend a great deal on what actions are taken, by legislation or regulation, to ease it.

The inability to obtain adequate, affordable insurance coverage deeply concerns many people. It is an emotional issue, one often colored by subjective viewpoints and misinformation. Insurance underwriting may involve speculation as well as science, and many factors in the current crisis are not easily measured or verified.

The greatest problems of cost and availability exist in the commercial insurance lines, which refers to property and casualty coverage provided to business, professional people and governments. The commercial lines are distinct from the personal lines such as auto or homeowner's insurance, which are property and casualty coverages provided to private individuals.

The Insurance Code states that the business of insurance is "affected by the public interest, requiring that all persons be actuated by good faith..." The public interest is not being served by the commercial insurance underwriters. It is clear that the property and casualty companies are not meeting the needs of business and government. In fact, the ability of business and government to function normally is being

severely curtailed, and in some cases their very existences are threatened. Many businesses and branches of local government are going without insurance coverage or are facing 200 to 300 percent increases in premiums for coverages with dangerously low liability limits.

How Did It Happen?

Property and casualty insurance goes through cycles, with competition during profitable times driving prices low and a tight market forcing prices high. The cycle often depends on outside factors, such as interest rates on investments or an unanticipated rise in the number or size of claims. The highs and lows are more extreme in the commercial insurance lines than in personal lines such as auto or homeowner's insurance.

During the past few years, insurance companies engaged in "cash flow underwriting" (see App. A), competing for every premium dollar. Lower premiums were used to get cash quickly and invest it at the high interest rates then available. Sound underwriting and investment practices, which are the bedrock on which the insurance industry was built, were either ignored or glossed over in favor of a quick return.

Price wars violate the Insurance Code (RCW 48.30.240), but policing the commercial underwriters to see that proper rates and forms are used is the job of the Examining Bureau. The Bureau, established by the Legislature (RCW 48.19.410) as a self-policing arm of the insurance companies, has been limited to property insurance. While rates must be filed with the commissioner's office before they are used, the "watchdog" role was assigned to the companies, acting through the Examining Bureau. From time to time, the commissioner's office has requested funding for field rate investigators so the commissioner could do his own rate examinations, but these requests have always been denied. The committee believes the commissioner's office should be authorized, and staffed with rate investigators, to be sure filed rates are actually being used.

During the height of the price war, so many filings came in that would have permitted even lower premiums than previously allowed, that the commissioner's rate analysts had to adopt a standard form letter of denial. For practical purposes, however, there is no policing mechanism to assure that only approved rates and forms are actually being used in the field.

The Capacity Crunch

The consumers are now paying the price for the insurers' drive for investment dollars. Today's comparatively low interest rates and new restrictions imposed by the "reinsurers," the international companies that in a sense "insure" the insurance companies, have forced a halt to cash flow underwriting. The commercial insurers now find their ability, or "capacity" to provide coverage, severely limited. The "capacity crunch" and the key role played by the reinsurers is described in Appendix B.

Growth of Court Claims

Compounding the current crisis is the long-term growth in the number and size of lawsuits companies must fight. One big insurance firm with long experience in liability coverage told the committee that in 1974, six doctors per 100 were being sued annually, but by 1985, the ratio was 16 per 100. Defense costs for that company rose from \$12 per \$100 in claims paid in 1950 to \$58 per \$100 in claims paid in 1985. Evidence given the committee pointed to court actions and legislation which increased the number of lawsuits and cases in which a defendant could be held liable. Significant growth in the size of jury awards during recent years was also shown.

The Need for Coverage

While the insurance market has been hit by such cyclical financial turmoil before, never has the "low point" been so low. The current crisis is the worst in the memory of those now in the insurance business. Unfortunately, the insurers seem determined to solve the problem, which they created, by sudden and drastic action that places often intolerable burdens on business and government.

For some businesses, insurance is an absolute necessity -- required by statute or regulation as with truckers, contractors and escrow companies. They are in a "Catch 22." The law requires insurance, but for some, insurance is not available at any price.

For most others, it is a practical necessity. Without insurance, or with inadequate protection against catastrophic loss, many businesses must severely cut back operations or simply close their doors. Governments, on the other hand, cannot "go out of business" but are forced to function with dangerously low amounts of protection or with no protection at all.

Resources of the Regulator's Office

While the insurance industry was going through the turmoil of cash flow underwriting from 1981 through 1985, more than one-fifth of the Insurance Commissioner's staff was cut. During the same period the number of authorized insurers increased by 132. More companies meant more premiums, more agents and brokers, more policy filings, more rate filings--a huge increase in paperwork. This required the commissioner to put proportionately more people onto the "paper pushing" end of the system (See App. C).

RECOMMENDATIONS

The committee unanimously adopted the following recommendations to enable the insurance commissioner to exercise more effective regulatory control of the insurance industry, to provide a means for guaranteeing insurance availability, and to prevent abusive marketing practices by insurers.

1. The Legislature should make sure insurance is available to those needing it by reauthorizing and expanding the FAIR plan. The FAIR plan, also known as the Washington Essential Property Insurance Inspection and Placement Program, would be expanded to provide liability insurance. The general idea behind the FAIR plan for fire insurance and the assigned risk pool for high-risk drivers auto insurance, both of which have been functioning for many years, is assuring that coverage is available for all.
2. The Legislature should adopt a new law requiring companies to give 120 days notice to agents and brokers prior to cancelling agency appointments. This would prevent insurers from arbitrarily and indiscriminately cancelling contracts with agents and brokers, thereby eliminating coverage for large blocks of policyholders. This new law would give agents and brokers more latitude in getting cancelled policyholders new insurance (See App. D).
3. The Legislature should adopt a new method of funding the Insurance Commissioner's Office that would tie the amount of funding to the level of activity in the insurance industry. This would provide more stability for the regulatory staff, assuring staff cuts would not occur at the same time more industry control is needed. Funding should allow the hiring of six field rate investigators and two new rate analysts that are needed to enable better monitoring. With only three rate analysts and no field rate investigators, the commissioner now must rely on information supplied by the companies. Funding should also allow restoring six positions in the commissioner's consumer protection office lost during the budget cuts and provide supporting staff for the new personnel (See Appendices C and E).

4. The Legislature should require insurance companies to notify commercial policyholders of the reasons why their policies were cancelled or not renewed. Current law requires insurers to do this for policyholders in the personal insurance lines, and the law should be extended to cover all commercial policies.

 5. The Legislature should amend existing law to improve the ability of insurance companies to comply with statutes on cancellation and nonrenewal of insurance contracts. This would involve limited changes to a bill adopted during the 1985 legislative session that required insurers to give policyholders more notice of cancellation or nonrenewal (See App. F).
-

In addition to the recommendations to the Legislature, the committee unanimously recommends or endorses the insurance commissioner's actions in the following areas:

1. The committee recommends that the commissioner return to "Prior Approval" on commercial rate filings. The committee recognizes that while the commissioner has the authority to do so, more staff is needed to implement it. This action would assure that the commercial insurance rates are fair and thoroughly "checked out" before they are used.

2. The committee endorses the current regulatory action by the commissioner to narrow from 40 percent to 25 percent the "judgmental" factor allowed companies in adjusting commercial insurance rates above and below the filed rate.

3. The committee endorses the commissioner's recent adoption of a regulation prohibiting insurance companies from cancelling, failing to renew or denying homeowner policies for the sole reason that day care facilities are being provided in the home.

- more -

In addition to the foregoing recommendations and endorsements, the committee is taking the following direct action.

The committee has begun setting up a Legal Action Task Force to review and collect data relevant to Washington's experience in tort law, and to recommend any changes needed to improve the availability and affordability of liability insurance. Based on testimony received by the committee, some reform of Washington's tort law appears to be needed. The committee, however, has neither the legal expertise to judge tort reform proposals, nor enough facts pertinent to Washington's experience to make informed recommendations of appropriate legislative action.

APPENDIX A

Cash Flow Underwriting .

Cash flow underwriting had its roots in the runaway inflation that peaked in the late 1970s and early 1980s. Federal deficits, the oil embargo, "guns and butter" financing of the Vietnam War -- whatever the reasons for inflation, they can also be assigned blame as the root causes of the current dilemma. The excessive inflation led to excessive interest rates, which in turn led to the excesses of cash flow underwriting which resulted in the excessive measures being taken now by insurers against policyholders.

In the latter half of the 1970s, inflation pushed interest rates to unprecedented heights. Insurers began moving away from their traditionally conservative investment philosophy in favor of the short-term high yields that became available during those years. This practice picked up momentum and, by 1980, the insurance industry was engaging in a mad scramble to obtain premium income for the primary purpose of reinvesting it at the high interest rates. Sound underwriting considerations were glossed over or ignored in the rush to increase the cash flow.

The day of reckoning arrived when interest rates moved down to today's levels. About the same time, the disregard for sound underwriting started affecting the surpluses of insurance companies. An insurer's surplus is roughly equivalent to the net worth of a conventional business. It is the money available to pay claims if premiums are inadequate.

In the Spring of 1984, the reinsurers that had survived the rate cutting frenzy let it be known that, as their treaties (contracts with insurance companies) came up for renewal, sanity would have to return to the markets. By the Spring of 1985, most of the treaties that had not been cancelled had been renewed with strict requirements that the primary insurers increase their premiums -- particularly in the liability lines. The commercial underwriters had no choice but to comply. Appendix B, which follows, describes how the unregulated reinsurance market exercises ultimate control over commercial insurance underwriters.

APPENDIX B

The Capacity Crunch and the Reinsurers

The "capacity crunch" is industry jargon referring to the insurance companies' inability to write as many policies, measured by the amount of "premium" or money taken in each year from policyholders, as they did a few years ago. There are three reasons why the companies do not have the capacity to handle new policyholders or even some of their old policyholders.

The first is that the companies' surplus (money available to pay claims that exceed the total of premiums taken in) has diminished as interest rates have fallen and claim frequency increased.

Second, there are recognized industry guidelines limiting the amount of premium property and casualty insurers can write. The amount of premium, which translates into number of policies written, has a fixed relationship to the amount of surplus. Insurance companies can generally write up to three times as much premium as they have surplus. Historically, most insurers have written more policies -- more premium -- than three times their surplus, but have maintained their good ratings by passing the excess premium (policies or "risks") on to a reinsurance company. When the reinsurance carriers pulled out of the market, that practice was severely restricted or ended.

The third reason for the capacity crunch is that higher premiums on individual policies meant fewer policies could be supported by a relatively fixed or shrinking capacity. Some companies were forced to cancel policies to stay within their capacity level.

To illustrate, assume an insurer had \$100 million of surplus and thus could write \$300 million of premium based on its own resources. Such a company might have written as much as \$400 million by passing excess premium (and risk) on to a reinsurer. The cash flow underwriting binge has not only depleted the \$100 million surplus and thus the amount the company could write on its own resources, it has also caused the reinsurer to withdraw from the market. Thus, the insurance company is limited in its writings by its own resources. If, in this example, its surplus had been reduced from \$100 million to \$90 million, the company is now limited to \$270 million of premium, instead of the \$400 million it was writing when its surplus was \$100 million and it had reinsurance treaties extending its writings to as much as \$400 million. Capacity has been reduced by \$130 million -- from \$400 million to \$270 million.

A company with its capacity limited is like a merchant who can sell more goods than he has on the shelf. The supply is constricted but the demand continues to grow. An insurance company in this situation will contrive to raise premiums, be very selective in its underwriting, cancel contracts with its producing agents, and generally conduct itself like any supplier in a seller's market.

BILL SHEFFIELD, GOVERNOR

**DEPARTMENT OF COMMERCE &
ECONOMIC DEVELOPMENT**

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OFFICE OF THE COMMISSIONER

December 17, 1985

Honorable Bill Sheffield
Governor
Juneau, AK 99811

Dear Governor Sheffield:

As chairman of your Task Force on Insurance Availability and Pricing, it is my pleasure to submit the report of the task force. I believe we have fulfilled our clearly delineated responsibility. The report summarizes the testimony and documentation presented to the task force without making specific recommendations.

The issue of insurance availability and pricing is expansive. The task force accumulated a huge amount of documentation on the subject. The documents appended to the report are only a fraction of the available data. We included in the report only the minimal documentation necessary to adequately explain the issues.

The task force believes that insurance issues will continue to be at the forefront for at least another year. We also believe that an ongoing review of insurance issues would be beneficial.

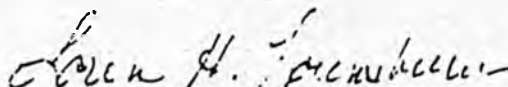
Throughout the work of the task force, the issue of tort reform was suggested as one of several probable causes of the insurance crisis.

It is apparent that tort reform will be a major issue in the next Legislature and will receive prominent attention. You may, therefore, wish to consider appointing a task force or advisory group to further study this specific issue.

The task force is pleased to report to you that State agencies universally expressed their desire to work with licensees, vendors and contractors to resolve insurance problems stemming from State mandated insurance requirements. We believe this reflects positively on your Administration.

Thank you for giving us this opportunity to assist.

Sincerely,


Loren H. Lounsbury
Commissioner

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TASK FORCE ON INSURANCE AVAILABILITY AND PRICING

REPORT TO GOVERNOR BILL SHEFFIELD

STATE OF ALASKA
OFFICE OF THE GOVERNOR
DECEMBER, 1985

9/26/85

GOVERNOR'S TASK FORCE ON INSURANCE
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INSURANCE TASK FORCE REPORT

EXHIBITS

- I. Written Testimony
- II. New Jersey Liability Survey
- III. State Regulation and the NAIC
- IV. NAIC Accounting Procedures
- V. Typical Annual Statement
- VI. Reports of Insurance Services Office
- VII. Surplus Lines Insurance
- VIII. Civil Justices Response
- IX. Position of the Citizens Coalition for Tort Reform
- X. Opposition to Tort Reform
- XI. Typical Insurance Rate Filing
- XII. Alaska News Articles
- XIII. National News Articles
- XIV. Report of the Governor's Medical Malpractice Insurance Commission
- XV. Bodily Injury Reparations Advisory Committee

SCOPE

The Task Force has been charged with determining the scope and seriousness of problems of insurance availability and pricing.

Prior to appointment of the Task Force, it was recognized that a crisis existed in insurance. No one had compiled sufficient information on the various groups affected or the extent of the problem to delineate clearly what the real crisis is. Although many solutions were being proposed (from all sides), the basis for rational examination of the entire problem had not been collected.

The intent of this Task Force Report is to delineate clearly the problem, examine the reasons for the problem, define the persons or groups affected by the problem, capsule pertinent testimony, and to present the documents and evidence collected by the Task Force.

It is not within the scope of the Task Force to make recommendations or to endorse recommendations made by others.

SUMMARY

The Task Force has found that the problems associated with insurance availability and cost are not unique to Alaska. They impact directly or indirectly every citizen in the entire country.

Many underlying causes contribute to the numerous separate problems which have been referred to as the insurance crisis. We have verified to our satisfaction that the majority of major insurers definitely have lost substantial amounts of policyholder surplus during the past year. This impairs their ability to offer as much insurance to consumers, because of diminished financial capacity. Many insurers have been put into liquidation or rehabilitation by State regulators due to severely impaired financial condition.

Insurers acted foolishly in overcompeting for business in prior years in order to reap investment income. When investment yield fell at the same time that insurers were experiencing higher than anticipated claims awards, premiums were forced to adjust dramatically upward and underwriting criteria tightened.

The Insurance Report for 1985 prepared by the Division of Insurance compiles premium and loss figures for admitted insurers for calendar year 1984. It indicates that the experience of insurers in Alaska was uneven. Some insurers had profitable years while others were not so fortunate.

However, overall insurers had better pure loss ratios (claims vs. premiums) in Alaska than the national average. Although comparisons of premium and losses do not account for the expenses of operation, these are similar comparisons to other types of comparisons included in the appendix for national experience. Despite a better than average performance, the small volume of business and high cost of operation still makes Alaska a less than attractive place to insure risks. A significant factor to consider when reviewing the report is that the accumulation of coverages for premium and loss comparisons, tends to hide bad losses by a particular subcoverage by combining them with profitable subcoverages to show an average loss or gain. Thus, day care experience is comingled with many other lines making it impossible to examine it separately.

It appears that insurers are selecting out subgroups of coverages to improve profitability, to mesh with reinsurance coverage, or to concentrate their efforts in areas they feel more competent to underwrite.

The Task Force finds that in Alaska most coverages are available at some price either from the regulated or unregulated insurance market, for those insureds that have good claims experience and are high quality risks. However, excess policy limits are sometimes unavailable, and insurers who have been largely unprofitable have limited capacity to issue insurance policies even at adequate rates.

FINDINGS

- A. THE TASK FORCE CONCLUDES THAT EVERY ALASKAN IS DIRECTLY OR INDIRECTLY AFFECTED BY THE HIGHER COST OF INSURANCE WHICH IS BEING DEMANDED IN TODAY'S MARKETPLACE.
- B. THE TASK FORCE FOUND THAT THE BEST RISKS OF MOST CLASSES OF BUSINESS WERE INSURABLE AT LEAST FOR PRIMARY LIMITS IN VIRTUALLY ALL CASES IF THE INSURED WAS WILLING TO PAY THE HIGH COST. MUCH, BUT NOT ALL, OF THIS INSURANCE WAS OFFERED IN THE UNREGULATED SURPLUS LINES MARKET.
- C. WE FURTHER FOUND THAT HIGHER POLICY LIMITS WERE NOT READILY AVAILABLE IN MANY CASES.
- D. THE TASK FORCE FINDS THAT TORT REFORM WAS RAISED AS A SIGNIFICANT ISSUE BY MANY WITNESSES. TORT REFORM IS A BROAD CONCEPT WHICH HAS MANY SPECIFIC PARTS EACH OF WHICH REQUIRE EXHAUSTIVE STUDY AND IS FAR BEYOND THE SCOPE OF THE TASK FORCE TO COMMENT KNOWLEDGEABLY ABOUT. THE TASK FORCE ACKNOWLEDGES TWO PREVIOUS REPORTS, THE REPORT OF THE GOVERNOR'S MEDICAL MALPRACTICE INSURANCE COMMISSION (1975) AND THE BODILY INJURY REPARATIONS ADVISORY COMMITTEE (1979) BOTH OF WHICH ARE INCLUDED IN THE APPENDIX. THESE REPORTS BOTH CONTAIN COMMENTS ON TORT REFORMS.

✓ E. THE TASK FORCE FINDS THAT THE INSURANCE CRISIS IS NATIONAL OR INTERNATIONAL IN SCOPE. THE PROBLEMS EXPERIENCED IN ALASKA ARE NO DIFFERENT THAN EXPERIENCED IN OTHER STATES.

THE TASK FORCE FINDS THAT MANY THINGS ARE CURRENTLY BEING DONE TO EASE THE INSURANCE CRISIS. THE FOLLOWING ARE AREAS WHERE THE STATE IS ACTIVELY WORKING TO RESOLVE THE PROBLEMS.

1. THE DIVISION OF RISK MANAGEMENT HAS BEEN WORKING WITH STATE AGENCIES ON REVISION OF STATE CONTRACT INSURANCE REQUIREMENTS.

✓ 2. THE DIVISION OF INSURANCE HAS ESTABLISHED A MARKET ACCESS PROGRAM TO ASSIST INDIVIDUALS IN LOCATING INSURANCE COVERAGE.

3. THE DIVISION OF INSURANCE HAS ESTABLISHED THE CADIS (COORDINATION OF ALASKA DAY CARE INSURANCE SEARCH) PROGRAM TO IDENTIFY POTENTIAL MARKETS AND SHARE INFORMATION WITH BOTH INSURANCE PRODUCERS AND DAY CARE OPERATORS.

THE TASK FORCE RECOMMENDS THAT THE DOCUMENTS COLLECTED DURING THE TASK FORCE RESEARCH BE READ BY ANYONE WHO INTENDS TO PROPOSE A SOLUTION TO THE COMPLEX PROBLEM WE ADDRESS AS THE INSURANCE CRISIS.

HOW INSURANCE IS REGULATED

INSURANCE IS A HIGHLY REGULATED INDUSTRY IN WHICH THE INDIVIDUAL STATES, NOT THE FEDERAL GOVERNMENT, HAVE COMPLETE JURISDICTION. IN ORDER TO REGULATE INSURANCE MORE UNIFORMLY AMONG THE STATES AND TO AVOID SERIOUS DUPLICATION OF EFFORTS, THE STATE REGULATORS CREATED THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS.

THROUGH THE NAIC, ACCOUNTING AND FINANCIAL REPORTING BY INSURERS HAS BEEN STANDARDIZED AMONG THE STATES. EVERY ADMITTED INSURER DOING BUSINESS IN ALASKA MUST FILE THE STANDARD NAIC FINANCIAL REPORTING STATEMENT WITH THE DIRECTOR OF INSURANCE. THE ANNUAL STATEMENT IS COMPREHENSIVE AND IS SPECIFICALLY DESIGNED TO REFLECT THE INFORMATION REQUIRED TO DETERMINE THE FINANCIAL HEALTH OF THE INSURER. THE DIRECTOR HAS THE AUTHORITY TO CONDUCT EXAMINATIONS OF INSURERS IN ORDER TO VERIFY THE TRUTHFULNESS OF THE FINANCIAL STATEMENTS. EACH COMPANY IS PERIODICALLY EXAMINED TO DETERMINE ITS SOLVENCY, BY NAIC EXAMINER TEAMS, MADE UP OF EXAMINERS FROM VARIOUS STATE INSURANCE DEPARTMENTS. ALASKA CONDUCTS SOME OF ITS EXAMINATIONS THROUGH NAIC EXAMINATION TEAMS.

THE NAIC ENTERS INFORMATION FROM INSURER FINANCIAL STATEMENTS INTO ITS COMPUTER WHICH IS DESIGNED TO COMPUTE SIGNIFICANT RATIOS AND COMPARISONS. COMPANIES WHOSE RATIOS ARE FOUND OUTSIDE THE NORMAL PARAMETERS ARE TARGETED FOR IMMEDIATE EXAMINATION. IN 1985, OVER 200 INSURERS FAILED SEVEN OR MORE OF THE ELEVEN RATIO TESTS.

THE NEED FOR IMMEDIATE EXAMINATION OF THESE COMPANIES HAS SEVERELY TAXED THE ABILITIES OF THE STATES' EXAMINER TEAMS TO CONDUCT TIMELY EXAMINATIONS OF THE MOST SERIOUSLY TROUBLED COMPANIES.

* ALASKA ALSO DEPENDS HEAVILY ON SURPLUS LINES INSURERS WHO OPERATE IN A TOTALLY UNREGULATED SYSTEM. ALASKA STATUTES REQUIRE INSURANCE PRODUCERS TO ATTEMPT TO PLACE INSURANCE IN ADMITTED OR REGULATED INSURERS FIRST. IF COVERAGE IS UNAVAILABLE IN THE ADMITTED MARKETS, THEY MAY PLACE COVERAGE THROUGH A SURPLUS LINES BROKER IN THE UNREGULATED MARKET. ALASKA RELIES HEAVILY ON THE SURPLUS LINES MARKET FOR MARINE, AVIATION, PROFESSIONAL LIABILITY, EXCESS LIMITS AND OTHER NONSTANDARD CLASSIFICATIONS. NO RATE OR POLICY FORM RESTRAINTS APPLY TO SURPLUS LINES INSURERS.

ALL ADMITTED INSURERS DOING BUSINESS IN ALASKA ARE REQUIRED TO SUBMIT INSURANCE RATES AND POLICY FORMS TO THE DIRECTOR OF INSURANCE FOR APPROVAL PRIOR TO USE. ONLY A FEW EXCEPTIONS TO THESE FILING REQUIREMENTS EXIST. STAFF LIMITATIONS PRECLUDE THE DIVISION FROM CLOSELY SCRUTINIZING EVERY RATE AND FORM FILING PRESENTED; HOWEVER, THE DIVISION DOES A CURSORY REVIEW OF EACH FILING TO SELECT A LIMITED NUMBER FOR DETAILED EXAMINATION. RATES ARE REVIEWED TO DETERMINE THAT THEY ARE ADEQUATE BUT NOT EXCESSIVE BASED ON PROBABILITIES OF FUTURE EXPECTED LOSSES ACCORDING TO THE BEST ACTUARIAL INFORMATION AND ASSUMPTIONS AVAILABLE.

PUBLIC TESTIMONY

The Task Force heard testimony from a broad spectrum of Alaska's entrepreneurs. Represented in their group were day care facilities, architects, engineers, aircraft operators, commercial vehicle operators, bar owners, * fuel oil distributors, commercial fishermen, school districts, municipalities, security services, nonprofits, Native corporations, school bus contractors, and State agencies. It is safe to speculate that, with the possible exception of private passenger automobile insurance and homeowners insurance, all property and liability insurance has been affected to some degree by the current insurance market situation.

Anyone who needs to purchase property and liability insurance will be affected by higher insurance cost this year. Additionally, the Task Force learned that some businesses faced higher rate increases than others. Liability insurance rates increased more than property rates and some types of liability coverages increased more than others.

THE TASK FORCE CONCLUDES THAT EVERY ALASKAN IS DIRECTLY OR INDIRECTLY AFFECTED BY THE HIGHER COST OF INSURANCE WHICH IS BEING DEMANDED IN TODAY'S MARKETPLACE.

✓ Several witnesses testified that they were unable to obtain any insurance coverage whatsoever. Further examination by Task Force staff reveals that several different reasons for the "I can't get insurance" statements.

✓ Some have been offered insurance at a price which is deemed to be so high as to preclude purchase. Others have been told by one or more agents that it isn't available. Task Force staff has successfully found markets for the majority of these people after canvassing the marketplace. Coverage was not always inexpensive but was available in most cases if enough time and effort were expended. In the few cases where insurance was not found, the particular risk was not insurable even though others in its same class of risk were insurable. Examples were individual claims history, condition of a particular fishing boat and inability or unwillingness to institute loss control measures. In only a very few cases was no coverage found for a class of risk. * Pollution coverage and sexual abuse coverage for day care operations were not offered at any price.

✓ Division of Insurance staff were successful in finding limited markets at some price for wooden fishing vessels, fuel distributors, day care operators, fireworks display ~~operations~~, liquor liability and others when the particular policyholder did not have poor loss history or an unseaworthy vessel.

✓ A related problem was nonavailability of required excess limits coverages. Although liquor liability is available for primary limits of \$300,000 per occurrence, higher limits were not always found. The same is true in other classes of insurance such as fuel delivery, day care, and professional liability. ✓ If entrepreneurs require high policy limits, they may not always be able to procure them.

One reason given for lack of higher limits was the inability to generate enough premium in the excess layers where losses are less frequent but more severe. Another reason was primary insurers lacked the internal capacity to retain the exposure and were unable to find reinsurers to share the risk.

THE TASK FORCE FOUND THAT THE BEST RISKS OF MOST CLASSES OF BUSINESS WERE INSURABLE AT LEAST FOR PRIMARY LIMITS IN VIRTUALLY ALL CASES IF THE INSURED WAS WILLING TO PAY THE HIGH COST. MUCH, BUT NOT ALL, OF THIS INSURANCE WAS OFFERED IN THE UNREGULATED SURPLUS LINES MARKET.

✓ WE FURTHER FOUND THAT HIGHER POLICY LIMITS WERE NOT READILY AVAILABLE IN MANY CASES.

Many persons testified about what they felt was the underlying cause of the insurance crisis and their own personal crisis if insurance coverage was unavailable. Summary of the testimony of the vast majority of the witnesses leaves the Task Force with the impression that the witnesses were frustrated with the liability imposed upon them by the courts or by their insurers settling cases in which they did not feel they were liable.

Although witnesses expressed willingness to accept responsibility for what they interpret as their own negligence, almost everyone expressed resentment of the actual or potential negligence and related high awards assessed against them by the legal system. In short, they believe the theories of negligence and compensation imposed by the civil justice

system are out of synch with their own. The proposals of the Citizens Coalition for Tort Reform included in the appendix summarize the various specific suggestions made by the pro tort reform witnesses.

Two witnesses gave testimony in opposition to tort reform. The disparity in numbers of persons for and against tort reform relates to the nebulous make up of persons who would benefit from the no tort reform option. These are in most cases persons who have not yet been injured but who will in the future seek recovery through the civil justice system. Since they are presently unidentified, they did not testify. Clearly aligned with this group of future benefactors of the present system are the attorneys who have represented injured parties in the past and who presumably will be asked to obtain recovery for persons injured in the future. In essence, they testified on behalf of their future clients.

Paul Cossman's letter to the Task Force summarizes the testimony in opposition to tort reform and is included in the appendix.

THE TASK FORCE FINDS THAT TORT REFORM WAS RAISED AS A SIGNIFICANT ISSUE BY MANY WITNESSES. TORT REFORM IS A BROAD CONCEPT WHICH HAS MANY SPECIFIC PARTS EACH OF WHICH REQUIRE EXHAUSTIVE STUDY. IT IS FAR BEYOND THE SCOPE OF THE TASK FORCE TO COMMENT ON TORT REFORM AT THIS TIME. THE TASK FORCE ACKNOWLEDGES TWO PREVIOUS REPORTS, THE REPORT OF THE GOVERNOR'S MEDICAL MALPRACTICE INSURANCE COMMISSION (1975) AND THE BODILY INJURY REPARATIONS ADVISORY COMMITTEE (1979) BOTH OF WHICH ARE INCLUDED IN THE APPENDIX. THESE REPORTS BOTH CONTAIN COMMENTS ON TORT REFORMS.

DOT INSURANCE REQUIREMENTS

During one of the Task Force meetings, Department of Transportation requirements for contractor bonding and insurance were discussed. Although the department has the ability to waive bonding requirements, they seldom, if ever, do so. Apparently, the decision has been made that contractors who are unable to obtain bonding do not necessarily have the financial capability of financing the job and successfully performing the contract performance. If DOT waives the bond requirement, the State could end up with no recourse in the case of contractor default. DOT did express some interest in bidding certain contracts for architects and engineers with and without professional liability insurance in order to better define the insurance cost of the job. Cost benefit comparisons could be made for the specific job to determine the merit of insurance. They also are considering waiving professional liability insurance on contracts where in-house expertise is available to monitor and approve the contract work for quality.

Although DOT could eliminate insurance and bonding problems for contractors dealing with the State by simply not requiring insurance, they must also consider the increased liability and exposure to the State which is assumed by the process.

LOSS CONTROL

Although the Task Force heard from numerous individuals and groups on the availability and price of insurance and some commented on the high cost of resolving loss through the legal system, little testimony centered on elimination of or reduction in loss frequency. Any resolution of the crisis involving transfer of risk to insurers would be incomplete without fully exploring cost containment through loss prevention.

Loss control is an individual, industry and government function. One concern expressed to the Task Force in written testimony was that any resolution of the crisis must include continued and possibly increased State effort in policing labor standards, law enforcement, and license qualifications. Insureds also have an obligation to control their own loss expense through prevention.

Documents submitted to the Task Force and testimony support the national and international scope of the insurance crisis. A report prepared by the State of New Jersey summarizes the problems reported by the majority of states. Other documents support the contention that European insurance markets have withdrawn or are about to withdraw from the U.S. market due to severe losses. Only a small portion of their book of business is concentrated in the U.S. but the majority of their losses have been sustained here.

✓ THE TASK FORCE FINDS THAT THE INSURANCE CRISIS IS NATIONAL OR INTERNATIONAL IN SCOPE. THE PROBLEMS EXPERIENCED IN ALASKA ARE NO DIFFERENT THAN EXPERIENCED IN OTHER STATES.

The general consensus of the information sources surveyed by the Task Force was that nationally insurers began competing aggressively for premium dollars for investment purposes in 1979. High interest rates could provide profit to the extent that some underwriting loss could be offset. New insurers were formed to take advantage of high profits generated by small underwriting losses and high investment yield. As competition increased the law of supply and demand caused rates to drop further. As the competitive spiral decreased premium rates, inflation slowed and interest rates fell. Insurers found that they could not increase premiums in order to make up for lost interest income. To do so meant almost instant loss of new business to lower priced competitors.

At the same time that rates were at a seriously inadequate level, insurers began to experience increased losses.

Had rates remained at the 1979 level they would not have generated profits in many lines of insurance. Increased social pressure and liberal interpretation of policy language by the courts caused coverage for claims which insurers had intended to exclude. It caused average awards to increase and promoted the rare but often quoted multi-million dollar awards for seemingly minor or questionable negligence.

Reinsurers were the first to put the brakes on the cycle. Reinsurers typically receive a percentage of the premium and take a percentage of the risk of the primary insurer. Figures show that reinsurers were hardest hit in the loss ratio column. When they gave primary insurers the ultimatum across the board of more premium or no reinsurance, premiums increased.

✓ Year-end 1984 insurance company results showed severe losses. More importantly the losses decreased policyholder's surplus, the ultimate measure of an insurers ability to write new insurance policies. With the substantial decrease in surplus, insurers were unable to write as much insurance in 1985 as they had in the previous year. Other insurers closed their doors because of insolvency or to pursue other more profitable ventures.

✓ As a result of the insurers' folly in pursuit of investment profits and their unwillingness to increase rates in the face of aggressive competition during the past few years, we are experiencing two distinct problems today: (1) insurance industry capacity falls short of the national demand for insurance, and (2) insurance rates which have been depressed for six years are taking a quantum leap in 1985 in order to be adequate for current year losses. Profit, if any, will go to rebuilding surplus which has the effect of increasing insurance capacity.

HOW ALASKA FITS INTO THE NATIONAL SITUATION

Despite its geographic size, Alaska accounts for an almost insignificant portion of insurance premium in the U.S. marketplace. Even in the period of excess capacity and cut rate premiums, the Division of Insurance ✓ devoted substantial efforts toward attracting insurers to do business in Alaska. High costs relative to the small volume, lack of local servicing and the perception of Alaska in the lower 48 are constant obstacles to attracting new markets. Alaska is the last state market many insurers enter and the first to feel the company's consolidation of business efforts. Generally, insurers fared better in Alaska, on a pure loss ratio basis, than the national average.

The Division of Insurance believes its long-term efforts to encourage insurers to operate profitably has lessened the present insurance crisis to a large degree. Since Alaska business is largely insignificant to many insurers, any move to pressure them into areas they perceive to be unprofitable or potentially volatile may cause them to shift their underwriting to another part of the country. To the extent Alaska cultivates insurers and encourages their participation, capacity may be attracted here from other states. At least for the present time total insurance capacity does not exist in sufficient amount to satisfy the national need. The particular efforts and conditions in each state, therefore, affect the amount of insurance capacity dedicated by insurers to that state.

INSURANCE INDUSTRY RESPONSES

Insurers interviewed by the Task Force staff made recommendations that they considered would improve the availability of insurance in Alaska. The highest priority was related to reforms in the civil justice system that would give stability and predictability to liability claim settlements and judgments. Joint and several liability, caps on awards for wrongful death and pain and suffering, disclosure of collateral source recoveries and prejudgment interest, were high on the insurers' list. The industry was severely impacted by the recent announcement by the chairman of Lloyds of London that Lloyds would not insure casualty risks in the U.S. after this year because of their frustration with the U.S. legal system. Insurers have responded by asking for tort reform and by switching to a "claims made" form of liability policy. "Claims made" policies respond to losses reported during the policy period only as opposed to covering claims which occur during the policy period but are reported years later. The full impact of the new form will only be known after policies have been in effect for several years. ✓

Insurers did not hesitate to point out the seriousness of their efforts to turn massive losses into profit in the short-term. Further losses would put insurers out of business. Participation in guarantee association programs for insolvent insurer bailout would exacerbate the problems for currently marginal insurers.

Insurers stated that they would devote their limited capacity to the best risks and coverages. Any line they felt had potential for unexpected claims or catastrophic loss would be avoided or priced to guarantee profitability. Being forced to unwillingly write coverage for classes of insured that have an unpredictable risk and/or the potential for catastrophic loss or to subsidize the rate, would be cause for the insurer to reevaluate their overall profit potential in that state and to readjust overall company strategy. Insurers are also holding back until they determine the cost and availability of their reinsurance and the exclusions it contains for certain types of risks.

DIVISION OF RISK MANAGEMENT RESPONSE

State insurance programs have also been adversely affected by the present insurance market situation. Public entities, including states and municipalities of all sizes, have been singled out by the insurance industry as difficult risks due to type and variety of exposures and deteriorating claims experience. Risk Management is well aware of the current market problems, and they have empathy for others caught in the same problem.

They see risk management or "management of risk" as a program requiring three elements of attention: (1) insurance, including various levels of self-insurance; (2) claims control to fairly and quickly adjust or adjudicate claims against the State; and (3) loss prevention or loss control programs designed to reduce the number and severity of claims. As we are

forced to higher levels of self-insurance, loss prevention programs become paramount in control of costs. Risk Management is now providing agencies with useful claims reports and analysis on a quarterly basis. This should help locate and identify problem areas that can be corrected. Another important segment of loss control involves State contract insurance requirements. These are necessary to prevent the State from having to pay or defend claims caused by negligent acts of independent contractors unless the State by its own negligent acts is also responsible.

The Division of Risk Management is in complete agreement with Task Force recommendations concerning reassessment and possible revision of State contract insurance requirements.

Risk Management has been working with State agencies on revisions of insurance requirements for a number of months. They have addressed these issues both on an individual contract basis, and, where applicable, on a specific program basis. They are also in the process of revising several elements of Appendix B ("boiler plate" insurance requirements for many agency contracts) to help alleviate the problem where these insurance requirements are in general use.

Due to the great variety of State contracts, it is very difficult to adopt one program or even a series of programs that fit the needs of all contract agreements. They, therefore, look upon "boiler plate" requirements as "guides" and Risk Management will work with any of the State agencies to consider revisions when necessary.

Risk Management services should be looked upon as a resource available to all State agencies or contractors. They are willing and anxious to meet with agency contract officers or other personnel at any time to explain the State program and to understand or assist with agency insurance problems.

They believe it is in the agencies' best interests to remain involved in insurance decisions or deviations because the agencies attest better to the type of work involved, inherent exposures, possible statutory requirements, and the importance of the program or contract "to the best interests of the State."

To reiterate, they cannot emphasize too strongly that "boiler plate" insurance requirements are considered by Risk Management as "guides." While in many cases these requirements have been set for good and sufficient reasons, there are also many types of contracts depending on supervision, type of work, and other reasons that, as a practical matter, call for modification of such requirements. When these cases are called to Risk Management's attention, they have been recommending accordingly.

The present insurance crisis will probably remain with us for another two or three years, especially in the areas of professional or hazardous liability and property exposures. Recognizing this market situation, Risk

Management will continue to respond to the difficulties the private sector has in meeting State insurance requirements. So far, in most instances they have been able to agree on alternatives acceptable to both parties.

MARKET ACCESS PROGRAM

After the first Task Force meeting, many individuals have called the Division of Insurance for assistance in finding insurance coverage.

The division undertook on an experimental basis a market availability program to these displaced persons. In the majority of cases, diligent market search turned up coverage for these people. Although very time consuming and insufficient on a per policy basis, this experiment proved that few reasonable risks are unable to be insured by someone at some price. The division is working on several ideas which may increase the efficiency of this program in order to make it relatively cost effective.

CADIS

(Coordination of Alaska Day Care Insurance Search)

EVOLUTION AND CONCEPT

During February and March 1985, the division became aware of a growing problem for day care operators attempting to purchase or renew day care liability insurance. Numerous articles have been written on the subject in a variety of publications.

Since the time that the division became aware of the problem, we have attempted to identify potential markets and share the information with both insurance producers (insurance agents and brokers) and day care operators. We have also advised operators how to approach the market.

We understood from the beginning that this challenge could not be met with empty rhetoric. It has to be met with a program of active cooperation by all involved parties. We have used this opportunity to create and test a pilot program wherein we attempt to identify markets, identify their needs, and bring the buyer, intermediary and seller together. This approach is also useful in attracting new markets. It has, in fact, already attracted a market that was not generally available prior to the development of CADIS.

Division personnel have spent many hours talking to individual operators, speaking before groups, meeting with other State agencies and discussing the situation with insurers. From this has come an understanding of the problem and the seeds of how the challenge might be approached.

It became clear in talking with operators that, at the very least, underwriters must be suffering from a severe information deficiency. It was also discovered that much information was available from the permitting and licensing agencies. CADIS attempts to get the information flowing to

those needing it to make decisions. It also helps the operator to understand the insurers concerns and needs, and shows how the information gap can be bridged.

MECHANICS OF CADIS

The approach developed in cooperation with the Department of Health and Social Services and the Department of Education starts with the day care operator. Each licensed day care operator has been informed by the appropriate regulatory agency of the existence and availability of CADIS. The operators have been advised how they might participate in CADIS.

If a licensed operator wishes to participate in CADIS, the operator has been told that his or her insurance producer should be supplied with the following documents:

If the licensed day care operator is regulated by the Department of Health and Social Services, a copy of the evaluation report completed by the licensing worker of the Department of Health and Social Services.

If the licensed day care operator is regulated by the Department of Education, a copy of the application for pre-elementary certification, the pre-elementary certificate, and the written on-site review inspection evaluation of the preschool facility, if available (some preschools do not have this report).

In addition, the following must be included in all cases:

A copy of the fire and sanitation inspection report.

Pictures of the facility showing pertinent underwriting features:

1. The front of the facility with fence and fire hydrant, if available
2. General exterior layout
3. Inside of the building showing general layout
4. Kitchen area
5. Playground equipment
6. Any barriers or features designed to prevent children from reaching items that are hazardous to their health or safety
7. Stairs, if any

After the insurance producer receives this packet, the producer can contact this office and request identification of those companies currently accepting the particular kind of insurance under CADIS. The producer can then submit the packet to the companies with the appropriate application. We are asking the producers to advise us of the results as a means to monitor the success of the program.

There is no guarantee that coverage will be granted by the insurer, but such a package will be more attractive than that generally provided before this program was designed. We have already received favorable comments

from one insurer concerning the quality of submissions. It should be clearly understood that this is a purely voluntary program. It is not an assigned risk plan and should not be characterized as one. At this stage, we believe that the program can be endangered by misconception, so we are treading very cautiously. We believe that the program is working, even at this early stage.

EFFECT ON PARTIES

The effect of this effort of the various parties is, in itself, of value.

The licensed day care providers can receive assistance in locating coverage needed to maintain, license and operate their business. Initially, the program will put them in touch with admitted companies through their agent or broker. This has the advantage of having the protection afforded by the Alaska Guaranty Association Act. These will be companies subject to rate and form review, which should reduce the potential for outlandish pricing.

insurance producer has the advantage of being provided the most desirable of situations, an informed buyer with a complete submission package and the markets to approach with that package. This should result in substantial reductions of the time required to put together the materials needed when approaching an underwriter. The producer also has the attraction of using an admitted market with its known protections. That represents one less exposure to the producers surplus lines brokers bond.

The insurance company will receive submissions that will be unusual in quality resulting in less effort in putting together the information needed to underwrite properly this class of business. This approach will make the resulting portfolio of risk more attractive to the insurers/reinsurers. Hopefully this should stabilize the market somewhat. It will give them insureds that have a better understanding of the risk the insurer is taking and one who is willing to reduce the hazards that could result in loss. This will certainly be attractive to an insurer willing to look at this line of insurance.

WHAT NEXT

At this time, the program is limited to licensed day care operations. To some degree it can help preschools regulated by the Department of Education. We are exploring expansion of the program to operators not subject to licensure. We are also looking to the surplus lines market for a broader base of coverage availability. The program will undoubtedly be subject to fine tuning for some time.

LEGISLATION

Legislation has been submitted which will require insurers to give longer notice of cancellation to insureds and return unearned premium prior to the effective date of cancellation. This will allow additional time to find replacement coverage and provide funds to the insured to apply to the new policy.

ALTERNATIVES FOR INSURANCE

✓ Within staff time and personnel limitations, the Division of Insurance has provided assistance to entities seeking alternatives to commercial insurance such as self-insurance, formation of captive insurers or pools and risk avoidance through loss control.

The Task Force believes that continuation of these ongoing responses is appropriate.

LICENSE AND CONTRACT REQUIREMENTS

✓ We encourage all State agencies to review insurance criteria they impose on others as license requirements or contract requirements, to determine that they are reasonable and appropriate.

Liability awards have increased at a much greater rate than the cost of living or inflation rate and at a greater rate than anticipated by insurers. The civil justice system has gradually expanded theories of liability so that more acts or failure to act are found to be negligent conduct. As insurers are asked to accept this transfer of negligence from individuals, they must anticipate the probable future expansion of legal theories in order to properly charge for the insurance product.

Insurers are also responding to expansion of legal theories with new policies and language which limit coverage for some exposures, in some cases limiting the time in which claims may be covered, and limiting the cost of defense and attorney fees. In effect, they are refusing to accept the transfer of certain types of risk that they feel are unpredictable or unreasonable at this time.

Individuals find that they are less able to transfer the cost of their own negligence to insurers. The punishment afforded by punitive damages is more likely to be assumed by the negligent person than by an insurer in the future.

✓ Insurers having hit their financial low in 1985 have adjusted their practices and anticipate some profits in the future. This has caused insurance stocks to increase in value over prior year lows. As insurers build up their surplus through profitable underwriting, insurance capacity will increase.

THE TASK FORCE RECOMMENDS THAT THE DOCUMENTS COLLECTED DURING THE TASK
FORCE RESEARCH BE READ BY ANYONE WHO INTENDS TO PROPOSE A SOLUTION TO THE
COMPLEX PROBLEM WE ADDRESS AS THE INSURANCE CRISIS.

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Tort Reform:

**A Comprehensive Solution
To The Crisis in
Civil Justice and Insurance**

733 1-7-2018

**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 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.*

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 Visitors Association
Alaska Broadcasters Association	Anchorage Board of Realtors
Alaska Chapter, American Institute of Architects (AIA)	Anchorage Restaurant and Beverage Association (ARBA)
Alaska Dental Society	Cabaret Hotel and Restaurant Retailers (CHAR)
Alaska General Contractors	Childbirth Educators
Alaska Chapter, American Optometric Association	Daycare Operators Association
Alaska Movers Association	Fairbanks North Star Borough
Alaska Oil Marketers Association	Financial Managers
Alaska Rental Association	Hotel and Motel Association
Alaska Section, Fairbanks Branch, American Society of Civil Engineers	Insurance Brokers and Agents Association
Alaska Society of Professional Engineers	Nurse Midwives Association
Alaska State Health Association (Hospitals)	Pension Consultants
Alaska State Medical Association	Professional Physical Therapists Association
Alaska Support Industry Alliance	Risk Management Association
Alaska Truckers Association	Southern Alaska Association of Life Underwriters

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison.."

1991 10 19

TO: ALL LEGISLATORS

FROM: CITIZENS' COALITION FOR TORT REFORM

SUBJECT: ENCLOSED DATA FOR YOUR USE AND REVIEW

Thanks,

Al Tamagni, Sr.
Chairman

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The Citizens Coalition for Tort Reform, Inc.

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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.

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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
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News Media Contact:
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(907) 276-4600

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 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.*

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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.*

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.*

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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.

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 institutionally 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-

continued on page 50

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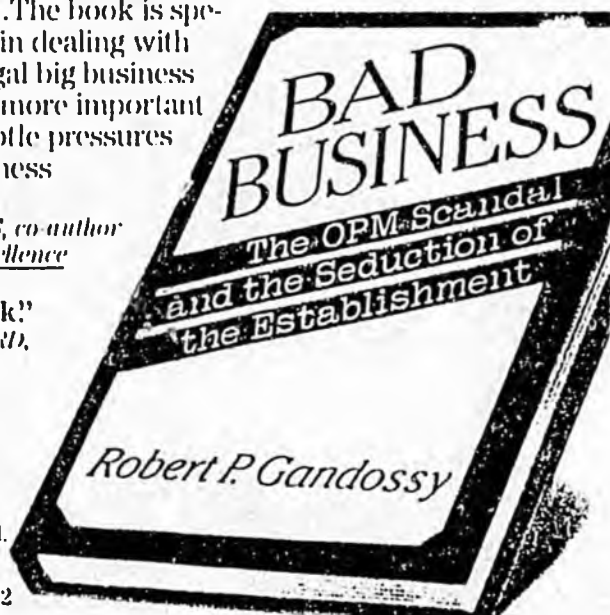
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ing polio from it—as if this would lead any rational person to expose his children to the far greater risk of catching polio from *not* taking it.

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.

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison.."

Hon. Fred Zharoff
Chairman
Senate Labor and Commerce 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

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 Committee
February 24, 24 and 26, 1986

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CITIZENS COALITION FOR TORT REFORM, inc.

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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	<u>+ 2.1</u>
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:

<u>Profit (Loss) in P/C Industry</u>		
<u>(\$ Billions)</u>		
	<u>1985</u>	
Underwriting Loss	\$(25.2)	<u>Underwriting loss here was supplemented by income from investments (interest and dividends) to produce an operating loss.</u>
Investment Income	19.7	
Net Operating Loss	(5.5)	
Realized Capital Gains*	5.3	However, <u>capital gains</u> primarily from the sale of stocks offset this loss, plus
Tax Credits and Other* Income	1.9	<u>tax credits and other minor income items</u>
		so that
Net After-Tax Income*	1.7	<u>net after-tax income was positive.</u>

*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.

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 \$848 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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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.

3/19/85: 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.



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.

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.



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.

However, the obvious cyclical factors in the industry tended to obscure a basic phenomenon 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 system? 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:

<u>Column 1</u>	<u>Premiums paid</u>
<u>Column 2</u>	<u>Losses paid</u>
<u>Column 3</u>	<u>Investment income</u>

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 15% 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 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:

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2. An erosion of traditional common law disincentives to sue.
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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.

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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

THE LANGUAGE OF INSURANCE

The language of the insurance profession can be confusing, obscure and frustrating. Here is a glossary of common insurance terms. As you learn them, you'll be better able to understand the basics of insurance.

A

accident An unforeseen act or result which may cause bodily injury or property damage. In some policies, it is identified as occurring at a specific time and place. In others, it includes continuous or repeated exposure to the same conditions. Refer to the appropriate policy for exact definition. Also see occurrence.

act of God An event caused by the forces of nature, without human intervention and which could not have been prevented by reasonable care; for example, flood, earthquake, hurricane.

actual cash value The present day value of property measured in cash, determined by subtracting depreciation brought about by physical wear, tear and obsolescence from the replacement cost.

additional insured A person, other than the named insured for whom the policy is written, who is protected against loss by the terms of the policy.

additional premium The additional amount of money charged the policyholder which is over and above the original premium charged. This may occur because of endorsement for increase in limits of liability, rate increase or other increase in the exposure of risk.

additions and alterations The fire policy usually extends permission to build additions or make changes or alterations to the dwelling without violating the policy and coverage is extended to include such additions and alterations.

adjacent Lying near to, but not in actual contact with. Nearby. Property near the property insured. Such adjacent property may increase the hazard of loss.

adjuster An individual representing the insurance company in discussions leading to agreement on the amount of a loss and the company's liability.

adjustment The process of determining the cause and amount of a loss; the amount of indemnity the insured may recover.

agent, independent An independent business person who represents insurance companies under contract in a sales and service capacity and is paid on a commission basis.

all risk insurance Coverage for all perils except those specifically excluded in the policy. By contrast, a named peril policy specifically names each peril for which the policy insures.

allied lines Various coverages offered by fire insurers, all of which are closely associated with fire insurance. Examples are extended coverage, and even also malicious mischief and sprinkler leakage.

amount of insurance The maximum dollar amount payable by the insurer under the conditions of the policy. In effect, amount of insurance is synonymous with limit of liability.

appraisal Determination of the value of property, or of the extent of damage, usually by impartial experts. The fire insurance policy provides for appraisal where the company and the insured cannot agree upon the amount of loss.

appurtenant structure Other structural property on and belonging to the insured dwelling including fences, walkways, pools and private garages.

assigned risk A means by which persons unable to purchase automobile insurance through the voluntary market are able to obtain insurance. If eligible, these drivers will be assigned to a licensed company in their state through the Assigned Risk Plan. Also referred to as Auto Plan.

assignment The transfer of the legal right or interest in a policy to another party, generally in connection with the sale of property. It is valid only with the consent of the insurer.

attractive nuisance A dangerous place or device attractive to children. The owner of an attractive nuisance has the legal duty to make particular precautions for children, e.g., swimming pools, animals, construction project.

Auto Plan See assigned risk.

automobile A land motor vehicle. Also see private passenger automobile

automobile non-ownership liability Insurance against loss due to claims for damages arising out of the use of motor vehicles not owned by or hired by the insured but used in the conduct of the insured's business.

B

BI Bodily injury

bailee One who has possession of property belonging to another, for a specific purpose.

bailment Delivery of personal property for a particular purpose with the intent that the property will be returned to the person who originally delivered it.

bailor A person who entrusts goods to another.

basic limits coverage The lowest limits of liability ordinarily written; basic limits are those for which manual rates and minimum premiums are computed.

binder A temporary contract of insurance made with an insured pending delivery of the policy.

bodily injury The impairment of a person's faculties, including pain, suffering, disability and death for which negligence is the proximate cause.

bordereau A memorandum containing detailed information used in passing reinsurance from one company to another under a reinsurance agreement. See reinsurance.

broker An insurance broker ordinarily is a solicitor of insurance who does not represent insurance companies in a capacity as agent but places orders for coverage with companies designated by the insured or with companies of the broker's own choosing.

builders' risk insurance Insurance against loss to buildings in the course of construction. With the value of construction changing during the building process, a fixed amount policy would not properly cover the risk. May be written on a reporting form or on a completed value form.

bureau A national, regional or state organization, supported by participating insurance companies, which may develop standard forms of coverage and policies; develop, publish and file rates to be used by insurers in making premium charges or act as a statistical agency. Bureau frequently is used interchangeably with ISO or WS&RB.

burglary As differentiated from robbery, burglary is the act or intent to take property belonging to another with visible evidence of breaking into or breaking out of locked premises.

C

CIC Certified Insurance Counselors

CPCU Chartered Property and Casualty Underwriter

CSL Combined single limit

cancellation The termination of a policy before its normal expiration date. Cancellation may be requested by the insured at any time. Some restrictions apply to cancellation requested by the insurer in some policies.

captive An insurance company established to insure a specific company or group of companies. The captive is usually owned by the company it insures.

carrier Any organization that "carries" insurance. A carrier may be a company, corporation, association or facility.

casualty insurance A type of insurance primarily concerned with losses caused by injuries to persons and the legal liability imposed upon the insured for such injury or damage.

catastrophe A sudden and severe calamity or disaster. An event which causes a loss of extraordinarily large amount.

certificate of insurance A statement of coverage taking the place of the policy as evidence of insurance and stating the coverages of the policy in general terms.

Chartered Property and Casualty Underwriter (CPCU) A designation conferred by the American Institute of Property and Liability Underwriters to one who has attained certain standards of education and proficiency on property and casualty insurance and has passed a series of examinations.

claim A demand by an individual or organization to recover under an insurance policy for loss which may come within the policy. A demand by an individual against an insured for damages caused by an event. In the latter case, such claims are referred to the insurance company for handling on behalf of the insured.

claimant One who makes a claim.

class rates Fire rates that apply to a group of similar risks. They are obtained from a manual by matching the characteristics of the insured property with the appropriate class described in the manual.

classification The underwriting or rating group into which a particular risk is placed. Pertains to type of business, location and other factors. Classifying persons, property, or operations as a basis for tabulating statistical experience and determining premium rates.

client The customer. The company or person who buys the insurance. See insured.

clause A section of a policy contract, or of endorsements attached to it, dealing with a particular subject in the contract, as the insuring clause or the coinsurance clause.

coinsurance A provision in an insurance policy requiring the insured to contribute a fair and just share of the total premium out of which losses are to be paid. The inclusion of this provision, whether mandatory or optional, usually gives the insured lower rates than would otherwise apply.

coinsurance clause Provision in a fire insurance policy whereby the property owner is to carry insurance up to an amount determined in accordance with the provisions of the policy. This usually is a stated percentage of the value of the property, in return for which the insured pays a lower premium. Failure to maintain limits at the specified percentage causes a reduction in the amount payable to the insured in the event of loss.

coinsurer One who shares the loss sustained under an insurance policy. Usually applied to an owner of property who fails to carry enough insurance to comply with the coinsurance provision and who therefore suffers part of the loss.

collision Insurance against loss to property caused by striking or being struck by a stationary or moving object; includes loss caused by upset.

commission A percentage of the premium paid to an agent or broker in return for business procured.

commissioner of insurance The official charged with enforcement of laws pertaining to insurance in the state.

common law liability The responsibility for injuries or damage imposed upon a party because of his or her actions, by that part of the law based upon custom and usage as established by the courts.

comprehensive Insurance covering the insured's own auto for damages other than collision or upset. It is distinguished from insurance against specific hazards, such as fire and theft.

conditions Provisions of an insurance policy which along with the insuring agreement, coverage forms and exclusions complete the contract. The part which states the obligations of the insurance company and the insured, in such areas as claims, premium payment and cancellation. Also called provisions.

condominium A condominium unit owner owns only the air space inside the unfinished walls, floor and ceiling of the unit. The building and land beneath are owned by the owner's association and unit-owners; have an individual share in the common property.

consequential loss The loss not directly caused by the damage to the property but which arises from the result of such damage. A fire may damage refrigeration equipment and the nonoperation of the refrigerator cause spoilage. Such spoilage is a consequential loss of the fire.

construction class Classification of fire risks, according to type of construction to enable fire insurance rates to be established equitably.

cooperative Multiple family projects owned by a nonprofit corporation. A group owns the building and land; no one individually owns the unit he or she occupies.

countersignature A signature of a licensed domiciled agent required by state law to validate an insurance policy.

coverage The extent of the insurance afforded under an insurance contract. Coverage is frequently used interchangeably with the word protection.

D

daily report An abbreviated copy of pertinent policy information. Identical copies are usually prepared so that insurance companies, agents and brokers may each have one.

declarations The part of the insurance contract which contains information regarding the insurance risk, such as naming the insured, property covered, policy period, limits of liability and premium.

deductible A policy provision under which the insured, in the event of loss, agrees to bear a specified portion of the loss. The company is liable only for the excess.

depreciation Loss in value of property brought about by physical wear, tear and obsolescence. The difference between the replacement cost new and present actual cash value.

deviation Use of a premium rate other than the standard rate filed with a state insurance department.

direct loss A loss which is the immediate consequence of the peril insured against.

direct writer An insurer that uses its own employees to sell insurance.

dividend A refund of part of the premium paid at the beginning of the year that still remains after the company has set aside the necessary reserve and made deductions for claims and expenses.

dwelling The basic structure of a residence which includes walls, floors, roof, attached structures, building equipment, fixtures and outdoor equipment used for the service of the residence.

E

EC Extended coverage

earned premium That portion of the premium which represents coverage already provided. Each day that an insurance policy is in force is a day of earned premium.

effective date The date on which an insurance policy goes into effect and from which time protection is furnished.

endorsement An alteration to an insurance policy by attaching a form bearing the provision or the terms necessary to make the change.

excess insurance A policy which (1) provides limits of liability over and above those of specified underlying primary policies, but which relies on the insuring agreements and conditions of such underlying policies as to definitions of coverage; or (2) provides limits of liability in excess of a self-insured retention for agreed upon exposures.

exclusions The part of the insurance contract which limits, restricts or eliminates coverage under the policy.

expiration date The date upon which an insurance policy will cease to provide coverage unless previously cancelled.

exposure Refers chiefly to the state of being subject to loss from a hazard.

extended coverage A clause or an endorsement of a fire policy which provides additional coverage for other perils, such as wind, hail, explosion, etc.

F

Fair Plan A program, created by law, to make fire and other forms of property insurance available to persons who have difficulty obtaining coverage from insurance companies.

financial responsibility law A statute requiring motorists to furnish, either before or after an accident, evidence of ability to pay damages.

fire Fire must be combustion sufficient to produce a spark, flame or glow, but not an explosion, and must be hostile, as opposed to friendly, i.e., not in the place where it was intended to be. It must be accidental and must be the proximate cause of the damage.

fire protection grading A national system, developed by a predecessor of ISO, which rates cities and towns according to public fire protection and other criteria. The grading scale is 1 (best) to 10 (no effective fire protection). No city is presently graded class 1. See protection class.

floater policy An inland marine policy under the terms of which protection follows movable property, covering it wherever it may be.

full coverage Any form of insurance that provides payment without deduction on all covered hazard losses.

G

glass insurance Insurance to cover the costs of replacing damaged glass, such as door and windows.

H

hazard A specific situation that introduces, or increases, the probability of occurrence of a loss arising from a peril, or that may influence the extent of a loss. Examples of hazards include slippery floors, congested traffic and unguarded premises.

hazard, moral Characteristics of the insured that increase the probability of loss, i.e., dishonesty.

hazard, physical A physical or structural condition of the insured property that makes it more likely a loss will occur.

I

IIA Insurance Institute of America

IM Inland marine

ISO Insurance Services Office. See bureau.

improvements and betterments Additions or changes made by a lessee or renter at his or her own expense which enhance the value of the occupied building. These become part of the realty (and are not legally subject to removal) and require special insurance consideration.

indemnity The insurance concept that enables the insured to be reimbursed for a loss, without either gaining or losing financially, i.e., restored to the condition that existed before the loss.

independent agent See agent, independent.

indirect loss See consequential loss.

inherent vice A condition in property which causes deterioration or damage; for example, the painting of damp wood or spoilage of vegetables.

inland marine insurance Covers property against various hazards or losses while it is being transported from place to place or wherever the property may be located.

insurable interest Any interest in a subject, or any legal relation to it, of such a nature that a certain happening (such as fire) might cause monetary loss requiring insurance.

insurance The business of insuring persons or property. Coverage by contract whereby one party undertakes to indemnify another against loss by a special contingency or peril.

insurance commissioner See commissioner of insurance.

insured A person covered by an insurance policy.

insurer The insurance carrier, or insurance company.

insuring agreement That part of an insurance policy which provides the agreement of the insurance company to protect the insured against loss or damage. This agreement is the basis of the insurance contract.

L

legal liability An obligation enforceable by law most often considered in a monetary sense. Broadly, any legally enforceable obligation.

liability This is a broad term denoting any legally enforceable obligation. An obligation, usually financial.

liability insurance Coverage whereby the carrier agrees to pay damages and to defend against suit, on behalf of the policyholder, for any claim that may occur. It includes coverage for both bodily injury and property damage, where appropriate. Liability coverage is often referred to as third-party insurance.

limit of liability The maximum dollar amount which an insurance company agrees to pay in the event of loss.

loading In inland marine, an amount added to the base rate or premium to cover additional perils.

loss A financial setback or monetary deprivation. A claim or claim payment. The basis for a claim for indemnity or damages under the terms of an insurance policy.

M

McCarran Act See Public Law 15.

manual A book published by an insurer or bureau giving rates, classifications and underwriting rules for some phase of insurance.

manual rates A method for determining the cost of an insurance policy using predetermined rates, usually obtained from a rate book or manual.

medical payments A form of insurance coverage, usually included in automobile and liability policies, under which the insurance company agrees to pay medical, surgical, hospital, ambulance and funeral expenses resulting from an accident covered by the policy, regardless of negligence.

minimum premium The smallest amount that a carrier charges for providing coverage for a given period.

model year To identify the year a car or truck was manufactured. October 1 is considered the start of a new model year.

monoline A policy written to cover a single line of insurance, such as fire alone.

mortgage Legal document obtained as security for money loaned on property. It may apply to either real property or personal property, including autos.

mortgagee The party loaning money toward the purchase of property. Examples would be a bank or lending institution.

mortgagor Borrower who conveys his or her property as security for a loan.

Multiple line policy A policy which is a combination of fire and casualty in a single insurance contract, such as the homeowners policy.

N

named insured That person, partnership or organization for whom an insurance contract is written, and who is specifically designated as being "insured" in the contract.

named peril Named peril policies specify what specific perils are covered or insured against. All risk policies do not specifically name the perils.

negligence Failure to do what a reasonably prudent person would do under the circumstances of a particular case, or doing what a prudent person would not have done.

no fault insurance Provides for payment to persons who sustain bodily injury in a motor vehicle accident, on a first-party basis regardless of negligence. May also include property damage.

O

occupancy Refers to the activity or property of the insured, i.e., what the building is used for or the nature of its contents.

occurrence Any event or happening that may occur gradually over a period of time, or all at once, and which may cause bodily injury or property damage. The exact definition varies by kind of policy. Also see accident.

P

PD - Property damage

PIP Personal injury protection

PUD Planned unit development

peril A cause of damage or loss. Examples include fire, automobile accident, theft, windstorm and explosion. Exposure to the risk of being destroyed or lost.

personal injury coverage An extension of liability coverage to provide for libel, slander, false arrest, invasion of privacy and the like.

personal injury protection This refers to first-party, no fault coverage for damages due to automobile accident.

physical damage coverage Comprehensive and collision coverage for the insured's own automobile.

planned unit development The major difference between a townhouse and a PUD is that the unit-owner in a PUD also owns the land beneath the unit. The common grounds are owned by a nonprofit corporation. See townhouse.

policy A written contract of insurance between an insurance company and the policyholder.

policyholder One who possesses an insurance contract. Often a synonym for insured.

policy period The period during which a policy contract affords insurance.

premises Particular location or portion thereof as stated in the policy.

premium The amount of money paid by the policyholder for insurance coverage.

private passenger automobile A four wheel motor vehicle, other than a truck type.

pro rata In proportion.

property damage Injury to or destruction of property, including (in liability) the loss of use of such property.

property insurance Insurance that provides coverage for direct loss or damage to property such as a home or building. Frequently used interchangeably with fire and allied lines insurance.

protection Used interchangeably with the word "coverage" to denote the insurance provided under the terms of the policy.

protection class A code designating the degree of a property's protection by an adequate fire fighting organization which has sufficient equipment, water supply and alarm transmittal facilities to permit it to extinguish an ordinary fire in the property. See fire protection grading

Public Law 15 A federal statute passed in 1945 declaring that the continued regulation and taxation by the several states of the business of insurance is in the public interest. Its effect is to exempt the business of insurance from federal antitrust laws to the extent that there is state regulation.

R

rate The cost of insurance per unit of exposure used in rating for the determination of premium.

rating The determination of premium to be charged for coverage on a risk based upon risk characteristics and actuarial calculations on the chance of loss.

rating bureau See bureau.

reinsurance The cession by an insurance company (the reinsured) of a stated proportion or amount of risk and the assumption of such cession by another carrier (the reinsurer) in consideration of a premium paid by the reinsured to the reinsurer. The proportion of the risk not ceded is referred to as the retention or net line. Reinsurance is effected under a contract called a reinsurance agreement or treaty.

renewal Continuation of an insurance contract beyond the original date of expiration, by endorsement, certificate or new contract.

replacement cost Replacement cost insurance extends property damage policies to cover the actual cost of repairs or replacement without deduction for depreciation.

rider A form containing special provisions that are not contained in the policy contract and which are added or attached to the policy. See endorsement.

risk The possibility of loss or injury. The chance of loss or the perils of an insurance contract; the degree of probability of such loss.

risk That entity to which coverage attaches. It may be defined by line of business and may take the form of a vehicle, building, physical or geographical location, named person or any object.

S

schedule An enumeration of various properties covered by a policy.

self-insurance A decision made by a company to assume the risk for its own specific loss.

Self-insured retention An amount of liability for a given risk or exposure which is assumed or retained by the insured.

subrogation The legal process by which an insurance company seeks from a third party recovery of an amount paid out by the insurance company to a claimant under the policy.

T

term The period of time for which an insurance policy is issued.

territory Specific areas in cities and counties on which rates are based.

theft Any act of stealing or any unlawful taking.

third-party insurance Protection for the insured against liability arising out of bodily injury to others or damage to their property. Insurance against loss due to liability to third parties. Used synonymously with liability insurance.

tort A civil wrong committed by one person, against another person, for which the law provides compensation.

townhouse Single family dwelling or a multiplex. The occupant of each unit owns either all or a portion of the building structure, including the unit's walls. Owners also have an undivided share in all common grounds, but they do not own the land beneath their unit.

U

umbrella policy An all-encompassing policy providing increased or broader coverage above the basic liability policy.

underinsurance A condition in which not enough insurance is carried to cover the insurable value and especially to satisfy a coinsurance clause.

underinsured motorist coverage Automobile bodily injury protection for loss caused by a motorist without insurance or with inadequate limits of liability or a hit-and-run driver.

Underlying The amount of insurance or reinsurance on a risk which attaches before the next higher excess layer of insurance or reinsurance attaches.

Underwriting The process of selecting policyholders that meet the company's standards of acceptability.

Uninsured Not having insurance on a specific exposure.

Unoccupied Contains furnishings pertaining to operations or activities customary to occupancy of the building, but no one is there at the time.

V

V&M Vandalism and malicious mischief

Vacant Not lived in and void of furnishings.

Valued policy A policy which provides that a special amount shall be paid in event of a total loss of the property. Most fine arts and some other inland marine policies have this provision. In fire insurance in some states there are valued policy laws which require that fire insurance on buildings be treated as valued policies.

vandalism and malicious mischief The willful injury or destruction of property, e.g., throwing stones through the window of a home and damaging home furnishings would be vandalism.

W

WS&RB Washington Surveying and Rating Bureau. See bureau.

warranty The statement of the insured, the truth of which becomes a condition of the validity of the policy. Statement or stipulation in the policy as to the existence of a fact or a condition of the insurance, which, if untrue, will void the policy.

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March 11, 1986

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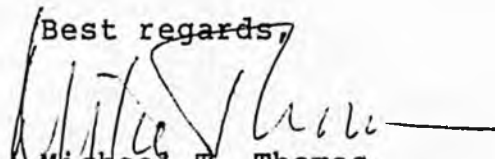
MAR 13 1986

Dear Senator Zharoff:

Enclosed are three documents which may be of some use to you and to the members of your committee as you try to sort out the various proposals for legislation pertaining to insurance and the civil justice system:

1. A "white paper" produced by trade associations in California, relating to their experience.
2. A paper on the financial condition of the insurance industry by the Insurance Services Office.
3. A copy of a statement by Charles Fritzel, an officer of the National Alliance of Independent Insurers before a committee of the U.S. Senate.

Please let us know if there is further information we can provide.

Best regards,

Michael T. Thomas
Counsel for the American
Insurance Association

MTT/kas

Enclosures

January 1986

THE LIABILITY SYSTEM IN CRISIS

The attached resource file is presented to you in the hopes that it will help to explain the current crisis in California's liability system and identify some meaningful measures that will ameliorate the crisis in the short term and solve the underlying problems that created it in the long term.

These papers were prepared in a joint effort by the Alliance of American Insurers, the American Insurance Association, the Association of California Insurance Companies and the National Association of Independent Insurers, who represent 869 insurance companies writing more than half of the property-casualty insurance premiums in California.

It is our hope that you will keep this information on hand throughout the coming months as insurance issues are sure to be among the most newsworthy items during that time.

The causes of the current crisis and the solutions proposed are complex, so a complete review of the situation requires a rather voluminous explanation. Accordingly, we have arranged this material by subject matter and indexed it for easy reference.

We will update the financial data in this report as complete quarterly data become available.

INDEX

The Liability System in Crisis

- TAB 1 - An Insurance Industry View
- TAB 2 - Pollution Liability Insurance
- TAB 3 - Professional Liability Insurance
- TAB 4 - Government Liability Insurance
- TAB 5 - Day Care Liability Insurance
- TAB 6 - Motor Carrier Liability Insurance
- TAB 7 - Directors and Officers Liability Insurance
- TAB 8 - Financial Condition of The Insurance Industry - Update
Prepared by Insurance Services Office
- TAB 9 - Glossary

THE LIABILITY SYSTEM IN CRISIS

An Insurance Industry View

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January 1986

INTRODUCTION

For the first four years of this decade, most buyers of commercial and professional liability insurance enjoyed stable or decreasing insurance premiums. Then, in early 1985, premiums turned upward, often precipitously, and some buyers found it difficult to obtain adequate coverage at prices they regarded as affordable. The liability crisis has been extensively covered by the media, and there have been proposals from many quarters as to what to do about it, ranging from voluntary efforts by insurers and agents to fundamental tort reform.

The insurance industry believes that it is critically important that efforts to solve availability and affordability issues be grounded in a sound understanding of the private insurance mechanism and the impact that the liability system* has on it. Accordingly, this paper describes the reasons for the recent escalation in commercial and professional insurance premiums and sets forth actions, some voluntary and some requiring regulatory or legislative approval, that can lead towards an easing of problems of availability and affordability. The paper also cautions that ill-conceived measures, such as a return to administered pricing or the adoption of involuntary market mechanisms, may impede the return of the insurance industry to financial health and thus operate to the detriment of consumers in the longer run.

*As used in this paper, "the liability system" means the whole panoply of substantive and procedural rules by which losses are transferred from one party to another. It also includes the mechanisms through which disputes are resolved in court or otherwise, including judicial decisions with respect to insurance contracts.

This paper is addressed to California legislators, regulators, the news media and the public.

Together, the Alliance of American Insurers, the American Insurance Association, the Association of California Insurance Companies and the National Association of Independent Insurers ("the trades") represent 869 insurance companies that write more than half of all property and casualty insurance premiums in California.

FINANCIAL RESULTS

1984 was the worst year ever for the U.S. property-casualty insurance business, and it is estimated that 1985 results will be even worse.

The 1984 results were the culmination of an unbroken string of underwriting losses that began in 1979. Underwriting losses grew at an average annual rate of \$3 billion through 1983 and then jumped by \$8 billion in 1984. Total underwriting losses for the 1979-1985 period will approach \$80 billion.

Until 1983, growing investment income, fueled by high interest rates, was able to offset underwriting losses. But in 1984, a 10.6% increase in investment income (\$1.7 billion) was not able to overcome a substantial increase of \$8 billion in underwriting losses, and the industry sustained the largest net operating loss in its history. In 1984, pre-tax operating income (the combination of investment income and underwriting results) plunged to a negative \$3.8 billion.

In 1984, there were underwriting losses of \$16.8 billion in commercial and professional lines. These losses were 79% of all underwriting losses in 1984, whereas premiums for commercial and professional lines were only 51.3% of total industry premiums. In contrast, personal and commercial lines have historically had closely parallel loss ratios.

General liability (combined ratio:* 152) and medical malpractice (combined ratio: 170) were especially hard hit. The combined ratios mean that actual expenditures and incurred obligations exceeded earned premium income by 52% and 70%, respectively, in these lines. Total underwriting losses in 1984 were \$3.2 billion for general liability and \$1.2 billion for medical malpractice. These underwriting losses of \$4.4 billion for general liability and medical malpractice were 21% of all underwriting losses in 1984, whereas premiums for these lines were only 7% of total industry premiums. Under the most optimistic assumptions, investment income available in the market today falls far short of making up underwriting losses of this magnitude.

In 1983 and 1984, reinsurers were hit even harder by losses than the direct market. Historically, reinsurers' combined ratios closely paralleled those of the industry as a whole. In 1983, however, reinsurers had a six point higher combined ratio than the direct market (118 as opposed to 112), and in 1984, the reinsurers' combined ratio was ten points higher (128 as opposed to 118).

*The combined ratio is the ratio of incurred losses, loss adjustment expenses and policy holder dividends to earned premiums plus the ratio of underwriting expenses to written premiums. For example, a combined ratio of 150 means that insurers paid out \$1.50 in losses and expenses for every \$1 they received in premiums.

Although the overall combined ratio for the industry declined from 118 in 1984 to 116 for the first six months of 1985, and the combined ratio for commercial lines declined from 128 to 122 for the same period, the industry nonetheless sustained a net operating loss of \$2.3 billion for the first six months of 1985. The net operating loss for the first nine months of 1985 was \$3.7 billion. If this trend continues, the industry may well experience a greater net operating loss in 1985 than in 1984.

THE CONSEQUENCES

These escalating financial losses had the following consequences:

- the partial or total withdrawal of major reinsurers in the United States, Britain and Western Europe from difficult U.S. liability lines (for example, environmental pollution and asbestos containment contractors' liability).

- a plunge in the industry's annual rate of return on net worth to 1.7% in 1984. The rate of return on net worth was actually negative for 50 of the top 100 insurer groups. While the industry's annual rate of return recovered to 5% for the first six months of 1985, it is still almost ten percentage points below the average rate of return for the Fortune 500 companies.

- a significant increase in the number of companies found to be financially impaired. In 1984, regulators found 20 companies to be insolvent. In 1985, an additional 22 became insolvent. In addition, companies representing more than 20% of industry premiums have failed at least four "early warning" tests established by the National Association of Insurance Commissioners.

In sum, severe recent losses have produced less capacity to write insurance and an increased number of companies that are insolvent or facing major financial difficulties.

The financial condition of the U.S. property/casualty industry in 1984 necessitated large and widespread premium increases in liability lines and reduced the availability of coverage for commercial and professional buyers. Underwriters also became more cautious in deciding what terms to offer to which buyers. In liability lines, by the spring of 1985, liability insurance was not available at any price to some buyers in some lines of insurance, either through the admitted market or the surplus lines market. In addition, reinsurers began withdrawing from the market. Lloyd's of London expressed dismay with continuing losses in the North American market and seriously restricted the flow of reinsurance to U.S. insurers. Without reinsurance, primary insurers had no choice but to restrict their premium writings drastically, causing availability problems in nearly every commercial line. Buyers for whom availability has been particularly a problem in 1985 include: day care center operators, municipalities, nurse-midwives, toxic waste facility operators and truckers.

By and large, liability lines -- and especially those where shortages of capacity developed -- present the greatest risk of losses, just at the time when the commercial insurance industry desperately needs predictable, manageable business in order to create stability and reasonable profits as a basis for expanding its capacity.

In the 1980-84 period, as events turned out, insurance companies seriously underpriced their products. The warning signs were there as the

frequency and severity of losses increased. But it took net losses in 1984 to bring home to the industry the absolute necessity of substantial price increases and selectivity in underwriting. In part, underpricing was due to the vigorous competition among insurers during that period for premium income to employ at high yields in financial markets. But the decisive factor in underpricing was the inability of underwriters to predict with any degree of accuracy the losses they would eventually be required to pay. The expansionist, almost capricious nature of the liability system and the costs this would eventually entail were seriously underestimated by insurers.

EXPANSION OF THE CIVIL LIABILITY SYSTEM

As recently as twenty years ago, the tort law was a tightly configured system of rules under which losses were transferred from fault-free plaintiffs to clearly identified, negligent defendants. Causation was strictly construed, and latent injury claims were a thing of the future. The organizing principles of the liability system were the fairness of shifting losses where clear negligence could be shown and the general deterrence of others that was thought to result. Compensation of victims was important, but it was to be accomplished under a standard of fairness to all parties.

Today, things are far different. Negligence has been eroded or done away with as a standard, and assumption of the risk and contributory negligence have all but disappeared. Causation requirements have been overcome by judicial or statutory presumptions, and mass torts (usually with a long gestation or latency period) are now commonplace.

Californian's have become far more litigious in the last few

years. For example, the number of personal injury lawsuits arising out of auto accidents increased 38 percent in the period 1970-1984. The number of other personal injury lawsuits increased 190 percent over the same period. Overall, the incidence of litigation per 100,000 California residents has increased 54 percent since 1970.

Individuals and groups differ as to the desirability of these developments. But their impact on the property-casualty industry is clear. Costs are way up and over time must be adequately reflected in premiums. More fundamentally, the industry has great difficulty in predicting its losses and making adequate provision for them. The unpredictability and costliness of the liability system, as it has evolved, bear a direct relationship to the current problems with availability and affordability.

A detailed discussion of all of the changes in the tort system in recent years that have affected insurance availability and costs is beyond the scope this paper. A few examples, however, will illustrate the scope and complexity of the problem:

- The doctrine of joint and several liability has been combined with the rule of comparative negligence to create a situation where a party who was only minimally responsible for an accident may have to pay for all the damages arising out of the accident. (American Motorcycle Assn. v. Superior Court 20 Cal 3rd 578 1978)
- An "entitlement" psychology has become deeply rooted in American society. This encourages adversarial proceedings and a feeling that every "wrong", no matter how defined, should be put right by somebody.
- The Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA) imposes a regimen of nearly absolute liability for the costs of toxic waste clean-up. Through judicial interpretation, CERCLA applies retroactively to conduct occurring before its enactment in 1980.

Moreover, one or more defendants, among many potentially responsible, may be held solely or disproportionately accountable for damages through rigorous application of the doctrine of joint and several liability. (See paper on pollution liability-Tab 2).

- There has been an erosion of traditional fairness doctrines that found liability based on what the defendant knew or should have known when he acted or failed to act (Becker v. IRM Corp. 38 Cal. 3rd 454 1985). In Becker, the California Supreme Court held that a landlord could be held strictly liable in tort for latent defects in the premises, even when the landlord did not create or know about the defect, but acquired the property with the defect already in existence. As Justice Lucas said in his dissenting opinion in this case, "any landlord, even one renting the family home for a year, will now be the insurer for defects in any wire, screw, latch, cabinet door, pipe or other article on and in his premises at the time they are let despite the fact that he neither installed the item nor had any knowledge or reason to know of the defect."
- There has been a gradual shift from traditional requirements that responsibility must be proved against particular, identifiable defendants to theories of enterprise liability (Sindell v. Abbott Laboratories, 26 Cal.3rd 588 1980). This case established "market share" liability for producers of fungible goods.
- Insurance contracts have increasingly been ignored, even when the language is clear. The most egregious recent example is Jackson Township v. Hartford Accident & Indemnity, 186 N.J. Super.156 (1983), in which the pollution exclusion in a standard general liability policy was read against clear policy language and intent to include coverage for the gradual seepage of pollutants from the insured's land.
- Relative to indemnity to claimants, the costs of resolving disputes have risen astronomically. Illustrative of this is the growth in loss adjustment expenses, of which 90% are legal fees. As a percentage of damages, allocated loss adjustment expenses have risen from less than 15% in the late 1950s to almost 40% in 1984. A special ISO study indicates that costs may well approach 50% of the ultimate settlement value for claims reported in the last three years. A study by the Institute for Civil Justice finds that only 37 cents of every \$1 expended in litigating asbestos claims reaches claimants.

INDUSTRY PROPOSALS

In light of the expansion of the liability system, the insurance industry firmly believes that there will be no permanent and satisfactory solution to problems of insurance availability and affordability in commercial lines until changes are made in the liability system.

Here is a brief list of such reforms:

- passage of the "deep pocket" initiative on the June, 1986 ballot.
- extension of the reforms contained in the Medical Injury Compensation Reform Act (MICRA) to all personal injury and wrongful death actions.
- limitations on and reasonable standards for the awarding of punitive damages.
- state of the art reforms that will assure that liability is based on the standards in effect at the time a product is produced or the time the service in question took place.

These changes, which will be explained later in greater detail, will help to restore predictability to the process of assessing liability risks and will permit a more expeditious and economical resolution of disputes.

Until such lasting, structural changes in the liability system can be made, the insurance industry recognizes that it has a responsibility to respond to the needs of insurance buyers, both in decision-making by individual companies and discussions on public policy issues with legislators and regulators.

In order to address insurance availability and affordability problems in the short term and longer range, the Alliance of American Insurers, the American Insurance Association, the Association of California Insurance Companies and the National Association of Independent Insurers offer the following proposals. The trades are willing to work toward solutions based on these proposals with legislators, regulators and the public.

1. Reasonable Limitations on the Cancellation or Non-Renewal of Commercial Insurance Policies

The industry acknowledges the need for reasonable limitations that cover individual and block policy cancellations; notice of changes in policy terms; and notice of non-renewal. The industry believes that a reasonable balance should be struck between the buyer's need for stability and time to react if changes are necessary, and the insurer's need for a degree of flexibility to respond to changes in the individual risk or impairments in the financial status of the insurer or its reinsurers.

2. Voluntary Market Mechanisms

Many in the industry have been and are working actively with regulators and producers to broaden the availability of coverage in such difficult lines as day care liability. Evidence of this is the "Cal-Care" market assistance plan that the industry set up last year to handle problem risks in the day care area. Provided that regulators and

legislators understand that a market assistance plan is not a panacea, and that there are lines in which the volatility and dimensions of the underlying exposure make voluntary efforts difficult if not impossible to undertake, the industry is ready to continue its work with regulators, under their leadership, to maximize the opportunities to write difficult lines in the private market.

An additional virtue of voluntary efforts is that they can rather quickly document the extent and characteristics of the problem, so that further steps, if any are needed, can be considered in light of the facts.

Voluntary plans also enable insurers to review the loss control procedures of difficult-to-insure commercial buyers and make helpful suggestions. By minimizing hazards through a loss control plan, the buyer may be able to provide a potential insurer with the assurance necessary to provide desired coverage.

3. Insurance Availability Clearinghouse

The insurance industry will work with the National Association of Insurance Commissioners (NAIC) to develop and implement a clearinghouse to exchange information on the various voluntary market mechanisms and to encourage positive market response in difficult lines. This process has begun.

4. New Commercial General Liability Policy

With the uncertainties involved in trying to anticipate

future losses accurately in an ever-changing legal environment, actuarial pricing has become all but impossible for some risks. Expansive interpretations affecting any area of tort liability are likely to find application in other areas as well, making even the so-called profitable risks of a few years ago potentially uninsurable.

The Insurance Services Office has recently introduced a new Commercial General Liability Policy (CGL), including a claims made form. By itself, the CGL will not and cannot solve all of the current insurance availability or affordability problems, but its use by the industry would be a positive step in restoring a degree of underwriting confidence in the general liability marketplace. Predictability is an essential ingredient in the insurance business, and without predictability some risks will no longer be assumed.

The new CGL policy, with policy aggregate limits, encourages both the insurer and the insured to evaluate the risk objectively. The parties can then determine adequate limits and a definite coverage amount. Moreover, the introduction of a claims made version of the CGL allows for precision in determining the coverage period, avoids the stacking of limits and policies that now occurs and avoids costly litigation over policy application. Finally, the provision for "tail coverage" at the termination of a claims-made policy allows the insurer and policy holder to treat coverage for "Incurred But Not Reported" (IBNR) losses and its price separately, providing it only when it is needed rather than in every policy, defining the insurer's financial commitment, and pricing the coverage based on a reasonable loss expectation.

5. New Capacity

Many insurance companies are adding capital, both to assure that present business is adequately funded and to enable the writing of new business. This, coupled with adequate pricing, will do much to overcome availability problems. The industry recognizes, however, that there are limits on the amount of new capital that can be generated from insurance sources, at least until there is substantive reform of the liability system. The industry, therefore, supports efforts by businesses and others to add capacity to the marketplace through appropriate self insurance.

There are, in addition, exposures that are simply too difficult for the private market to write under current rules because of the impossibility of measuring or even defining the exposure represented by businesses. Risks posed by toxic substances, such as asbestos and chemical wastes, are generally viewed by insurers as falling into that category. Unless such exposures can be clearly defined and limited by reform of the liability system, it may be that risks such as those posed by toxic waste facilities will have to be funded, in whole or in part, by public funds. Otherwise, an unacceptable choice must be made between requiring businesses to bear financially unacceptable risks themselves and imposing an involuntary and potentially catastrophic burden on the insurance industry. Clean-up costs for known toxic waste facilities have been estimated at \$22 billion to \$100 billion by federal government

sources. Imposing even a substantial fraction of these costs on the insurance industry under the Jackson Township theory would leave little if any capacity left for all other risks consumers and businesses expect the industry to assume.

CIVIL JUSTICE REFORMS

Unless reforms are enacted to reduce the number and size of personal injury lawsuits, and unless balance is restored to the rules by which those lawsuits are decided, consumers and their insurers can, at best, expect only temporary relief from the problems plaguing the commercial insurance marketplace.

The costs of the system place great financial burdens on claimants, defendants, business and the professions, and, ultimately, consumers and taxpayers. Rapid changes in legal rules through court decisions create unpredictability that fosters litigation and discourages out-of-court settlements. As a result, insurance underwriters cannot accurately price insurance coverage. Businesses hesitate to invest in innovative products. Professionals practice their crafts defensively for fear of litigation -- often performing unnecessary tasks and procedures for which consumers must pay. The cumulative results of the system's problems are slower economic growth, higher prices for consumers, higher taxes, higher premiums, greater costs for self-insured businesses, fewer jobs and slower technological change for society.

As major "consumers" of the civil justice system, insurance companies have accepted the responsibility to offer fair and sensible solutions that restore balance to the system while protecting the rights of those who are injured as a result of the negligence of others.

The following program of reforms will be actively pursued by the trades and other interests during the coming months:

1. Joint and Several Liability.

The rule of joint and several liability allows an injured person to recover the entire judgment from any defendant regardless of the defendant's degree of fault. If the defendant who is primarily at fault has no assets or insurance, the "deep pocket" defendant must pay the total amount of the award even though the deep pocket may be minimally responsible for the accident.

After four unsuccessful attempts to modify the deep pocket doctrine in the California Legislature, a coalition of business, professional and insurance groups has joined with cities and counties to qualify an initiative on the June 1986 ballot. This initiative, the Fair Responsibility Act of 1986, retains the rule of joint and several liability for economic damages such as medical bills and lost wages, but applies the rule of several liability to non-economic damages such as pain and suffering and emotional distress. This compromise approach guarantees that injured people will be fully compensated for their out-of-pocket expenses such as medical bills and lost wages, both present and future. However, it provides relief to "deep pockets" in that they would only be required to pay their proportionate share of intangible damages such as pain and suffering and emotional distress. The passage of this initiative is viewed as a crucial first step in restoring a measure of equity to our liability system.

2. Extension of MICRA Reforms to All Personal Injury and Wrongful Death Actions.

Ten years ago, in response to a crisis in medical malpractice liability, the California Legislature enacted sweeping reforms in statutes regarding health care professionals. The legislation was entitled the Medical Injury Compensation Reform Act (MICRA).

Last year, after 10 years of litigation, the California and U.S. Supreme Courts upheld major provisions of this Act. Since the day the Governor signed the Act in 1975, skeptics predicted that it would be ineffective. The only real test of such a measure is hard data. Here it is:

	<u>Nationwide</u>	<u>California</u>
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%

These figures present evidence of the kind of savings that can be realized if significant tort reforms are enacted. The MICRA reforms apply only to tort actions against health care professionals, however, and they should be broadened to apply to all personal injury and wrongful death actions, so that savings can be realized across-the-board.

The tort reforms contained in MICRA are:

-- Periodic payments of awards in excess of \$50,000. Periodic payments of large awards assures the injured person will receive the health care as needed for the rest of that person's life. Plaintiff's

attorneys like the lump sum benefits because they often can get larger fees. Family members like the lump sum benefits because it gives them the opportunity to enjoy the benefits sooner. However, periodic payments are designed to provide the cost of care for the rest of the injured person's life. They assure that the money will be there for the purpose the jury intended. It is true that if the injured person's life is short, the payments will be shortened, but in view of the purpose of these particular funds, it should properly be a shortened payment period. Loved ones are not left without anything. The law specifically provides the appropriate payment for support of dependents so family members are assured the security they should have. MICRA only prevents windfalls when there is no longer a need for further care.

-- Collateral sources of benefits received by the claimant may be admitted into evidence. Under this provision, if the injured party has already received reimbursement for medical expenses from a collateral source (such as health insurance) and has paid nothing out of pocket, the jury is told about it. There is no reason why an injured party should be paid for an expense that is not incurred. It is true that many people purchase a medical insurance policy and personally pay for it, but such medical benefits may also be provided as part of employment or some other source for which nothing has been personally paid. If the injured party personally paid for the policy, this fact may be revealed to the jury by the plaintiff. How much is received from collateral sources which offset out of pocket expenses and what personally may have been paid for that benefit can be properly placed before the jury to weigh as part of its judgment on the amount of the award. No one is penalized and the change avoids "double recovery" by the plaintiff. In sum, the jury is entitled to know and consider the whole story.

-- A sliding scale contingency fee system. MICRA provides for a sliding scale attorney fee system, as opposed to the contingency fee system used in other cases where the plaintiff's attorney takes from one-third to one-half of an award or settlement. Under MICRA, a plaintiff's attorney could collect as a fee 40% of the first \$50,000 recovered, 33 1/3 of the next \$50,000 recovered, 25% of the next \$100,000 recovered and 10% of the remainder. This is no burden on the plaintiff's lawyer. This schedule of fees was examined by the courts and approved. Of course, attorneys would like more money, but the sliding scale system is designed to assure the claimant will receive a fair share of his or her recovery. Attorneys are fully reimbursed for all the costs of the trial they may have advanced.

-- A \$250,000 cap on non-economic damages. Non-economic damages are highly subjective and often are determined by the emotional responses of a jury. Without a cap, the extraordinary demands presented by persuasive plaintiffs attorneys can result in huge awards for intangible damages, such as pain and suffering. Because these damages bear no relationship to the cost of living, indexing the cap for inflation, as some have suggested, makes no sense. The validity of MICRA's \$250,000 cap has been upheld by the California and U.S. Supreme Courts. In fact, in the Fein decision, the state Supreme Court stated that:

...serious questions [have been raised] as to the wisdom of awarding damages for pain and suffering in any negligence case, inter alia, the inherent difficulties in placing a monetary value on such losses, the fact that money damages are at best only imperfect compensation for such intangible injuries and that such damages are generally passed onto, and borne by, innocent consumers...(Fein v. Permanente Medical Group)

It is important to remember that the cap applies only to non-economic damages. The injured party still receives compensation for all economic damages such as medical expenses, loss of earnings and other costs incurred both in the past and in the future.

Only now are we able to learn the real value of this ceiling as a means of keeping jury awards within reason. The \$250,000 cap was set to help define the maximum loss and provide a measure of certainty and predictability. This enables insurers to hold down the cost of basic insurance subject to the limit.

In summary, MICRA has demonstrated that there are tangible benefits to substantive tort reform. These benefits should be extended across the board so that professionals and businesses serving other areas of society can share in them.

3. Reform of Punitive Damages.

Punitive damages are awarded in personal injury cases to punish defendants for fraudulent, oppressive or malicious acts. They are awarded in addition to both economic and non-economic damages. In California, there is no limit on either the amounts awarded in punitive damages or the number of times a defendant may be assessed punitive damages.

Punitive damages are said to serve the dual purpose of punishment and deterrence, but these are functions of criminal and not civil law. Defendants in a criminal action are afforded various constitutional and procedural safeguards which are not provided in a civil action. For example, defendants in a civil case are punished by punitive damages even though the plaintiff does not have the burden of

proving his claims beyond a reasonable doubt, but only by a preponderance of the evidence. In addition, a unanimous jury verdict is not required for an award of punitive damages, only a 3/4 jury vote is necessary.

Punitive damages verdicts often are based on subjective and emotional responses of a jury. And unlike criminal law, the act that is punished is not clearly defined as unlawful nor is the punishment to be imposed clearly set out. Unpredictable and excessive damage awards are the result. The jury can punish without limits, and the defendant must face the possibility of punitive damages time and time again for the same mistake, contrary to the constitutional prohibition of double jeopardy in criminal cases.

Punitive damages become a windfall for the plaintiff and his attorney who often claim that the award actually serves the best interests of society. But the cost of these awards ultimately is passed on to the consumer in the form of higher priced goods and services. Thus, society pays for this windfall.

While the courts are pondering constitutional protections for defendants in personal injury cases, measures should be enacted to eliminate the abuses of punitive damages. This should include caps on punitive damage awards, defining the standard of conduct and proof required to support a punitive damages award and eliminating multiple awards.

4. Product Liability Reforms.

The wide variation among state product liability laws makes it difficult for insurance companies to accurately predict the potential

liability risks of the manufacturers they insure. Uniform product liability legislation on the federal level is necessary because products are often manufactured in one state, distributed in another, and used in a third. Legislation that would help resolve the confusion of conflicting product liability laws (S. 100) is now being considered in Congress. In addition, California should consider proposals to balance the rights of plaintiffs with the rights of defendants. Constructive suggestions include modifying the rule of strict liability, establishing reasonable time limitations within which a suit may be filed, and adoption of a "state of the art" defense. A "state of the art" defense would mean that products manufacturers and professionals would be judged by the standards prevailing at the time the good or service was produced.

5. Reforms Targeted to the Needs of Specific Buyer Groups.

The trades are actively examining each area in which buyers have had difficulty in purchasing adequate coverage to determine whether there are specific legislative, regulatory or private sector proposals -- beyond the general reforms enumerated above -- that might be advanced. With respect to units of government, a package might include partial or total immunity for defined governmental activities and a reasonable cap on awards. For asbestos removal and hazardous waste cleanup contractors, it may be possible to tie liability explicitly to a failure to comply with state standards adopted after extensive technical and political consultations.

ILL-ADVISED CONSTRAINTS
ON THE INSURANCE MARKET

The insurance industry needs a period of time to re-establish reasonable profitability. This in turn will permit the generation of new capacity to handle increasing exposures. The return to profitability and the attraction of new capital have already begun, but as the figures cited earlier in this paper attest, the process has a way to go before the industry can compete effectively with other users of capital.

This healing process could be undercut or even stopped by ill-considered actions by regulators or legislators. There are four such ill-advised actions that, if taken, would significantly impair the ability of the industry to fund the liability system in the future. The common denominator of such measures is that they force a largely market-oriented, competitive industry to write risks that would not necessarily be written voluntarily, usually at inadequate prices. The four such actions are:

1. Financial Responsibility Provisions -- Such laws or regulations require a class or classes of buyers to show that they are financially able to meet tort judgments by the purchase of insurance or (in some instances) self insurance arrangements. While aimed at buyers, such provisions place great pressure on legislators and regulators to require the writing of insurance, whether through residual market mechanisms or otherwise. Where the underlying exposures are large and unpredictable, such as in the environmental area, financial responsibility requirements place a severe burden on buyers that cannot be

legitimately met by insurers.

2. Involuntary Market Mechanisms -- These entities, which typically require all or a portion of the admitted property-casualty insurance industry in a state to absorb deficits of the pooling mechanism, tend to become inadequately funded, "take all comers" residual markets. And if they insure all comers, there are fewer incentives for dangerous businesses to maintain high safety standards. Involuntary mechanisms also mask underlying liability system problems by passing the costs of a malfunctioning system on to insurance buyers, and have generated large deficits that must, for the most part, be borne by the insurance industry. Thus, involuntary mechanisms could, if used extensively, add significantly to the liabilities of the industry at a time when financial results are inadequate.

3. Administered Pricing -- The responsibility for the present problems is not the fault of California's insurance rating law. Nonetheless, proposals are surfacing to make the law much more restrictive, despite the fact that serious availability problems exist in all states regardless of the type of rating law in effect. These proposals, while logical to those who propound them, are based on false assumptions. First, they assume that insurers deliberately underpriced their product, which is not the case. Interest returns on investments were increasing at a rate which justified the conclusion that the rate was adequate to pay losses and produce a profit. Instead, much of the problem should be laid to the fact that insurers are paying losses today based on premiums collected 10, 20, even 30 years ago on risks they did

not intend to assume but are required to assume by legislative and judicial decisions.

Secondly, it is assumed that the California Insurance Department should have foreseen that the price of insurance was inadequate and it should have forced an increase in prices. This presumes a prescience on the part of regulators which cannot exist. No regulator could have foreseen the events of recent years.

Any movement to more restrictive rating laws can result only in restricting the growth of the insurance business and the availability of insurance to the public on competitive terms.

4. Onerous Restrictions on Cancellation and Non-Renewal --

The industry acknowledges that some constraints on freedom of contract may be needed under current conditions. However, a regulation (as adopted in New Jersey) that in effect makes the insurance commissioner the decision-maker on all renewals, cancellations and changes in terms in the state would remove all underwriting discretion from insurers. Such a regulation is likely to discourage additional insurers from doing business in the state and to make currently admitted insurers reluctant to write new business.

CONCLUSION

Historically, California has relied primarily on the private insurance industry to assume and spread risks generated by the liability system. There has been a consensus that a free market system provides the most efficient way to identify, quantify and distribute such risks.

Implicit in this consensus, however, has been the assumption that the insurance mechanism can handle an expanding liability system, at least within broad limits. Due to the escalating and unpredictable expansion of the liability system in recent years, this assumption is no longer automatically true, and the consequence is the current liability crisis. Therefore, as a matter of public policy, the choice is between doing nothing to constrain the liability system (in which case the insurance industry will continue to struggle in attempting to accommodate the expanding system) and working towards a balanced, more predictable system (in which case the insurance industry will be able to operate much more effectively in making coverages available at reasonable prices).

There are a number of early signs that, for many affected buyer groups, the availability crisis is beginning to ease. Underwriters are beginning to look for market niches and opportunities in certain areas. Additional capital is beginning to flow back into the reinsurance markets.

All of this is evidence of a healthy recovery by the insurance industry, even in the face of difficult liability system conditions. For the reasons noted above, the recovery will not be total or permanent unless and until substantive reform is achieved, but these developments point the way to a more liveable situation while reform efforts proceed. The industry is committed to helping in this process by working with legislators, the Insurance Commissioner, and others to make coverage as available as possible.

POLLUTION LIABILITY INSURANCE

BACKGROUND

Until recently, insurance protection against liability for bodily injury or property damage arising out of the handling of hazardous substances was provided under two different policy forms.

The Comprehensive General Liability (CGL) contract provided coverage for damages arising out of an "occurrence" during the policy period that involved the policyholder's business operations. The policy excluded liability for occurrences on property within the "care, custody or control" of the policyholder and, from 1973 onward, excluded all pollution liability except that resulting from "sudden and accidental" occurrences.

Liability insurance policies define the term "occurrence" to mean "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured." The policy limits, i.e. the amount of coverage purchased by the insured, is the maximum amount that will be paid for all damages, regardless of the number of persons involved. For example, an automobile accident in which a driver loses control of his vehicle and damages four other cars constitutes one occurrence rather than four separate occurrences.

The term "sudden and accidental" is used to describe an instantaneous event which occurs by chance, in contrast to an event which occurs over a period of time.

The Environmental Impairment Liability (EIL) form was developed to fill the void created by the CGL's "sudden and accidental" limitation. The EIL policy provided coverage for claims made during the policy year arising out of non-sudden or gradual pollution incidents in the past.

The insurance industry's ability to provide a market for environmental liability insurance depends in part on its ability to predict, with a reasonable degree of accuracy, the exposures which it undertakes to assume, and the extent to which it can rely on the language of its contracts to limit those exposures.

Liability schemes embodied in federal and state environmental protection laws, expansive judicial decisions reinterpreting the plain language of insurance contracts, and increasingly sophisticated technological tools permitting the detection of very small quantities of toxic and hazardous substances have, in recent years, made pollution liability virtually uninsurable. As a result, any individual business or public entity subject to statutory and common law liability for the handling of hazardous wastes or substances is experiencing acute difficulty in finding liability coverage.

PROBLEMS

Nearly absolute liability: CERCLA (federal Superfund), as well as many state derivatives, imposes liability for cleanup costs and damage to natural resources resulting from "releases" of hazardous substances that is absolute except when a potentially responsible party can establish that the release was caused solely by an act of God, an act of war, or by a third party with whom there was no direct or indirect contractual relationship. The im-

pediment to insurability here is the absence of any consideration of a person's conduct in the imposition of liability. The imposition of vicarious liability for others' careless conduct on those who have complied with the law means that an insurer's evaluation of the risk its own policyholder presents has no bearing on the liability that policyholder may be required to assume. A risk that is not predictable is, by definition, uninsurable.

Joint liability: Some courts have interpreted CERCLA to require the liability of defendants to be joint (each defendant liable for all the damages) rather than several (each defendant liable only for his contribution to the cause of the damages). The impediment to insurability here is the impossibility of predicting the extent of a policyholder's exposure to liability resulting from activity in which others are also engaged. An insurer cannot responsibly price the policyholder's exposure in a legal system in which the policyholder may be held liable for harm caused by others, whether or not the policyholder contributed to that harm. Exposure which cannot be priced is, by definition, uninsurable.

Liability without causation: At least one court has held that CERCLA requires no showing by the government that a substance for which the defendant was responsible has been released or threatens to be released from the site at issue. The policyholder is therefore liable, not for the release of a hazardous substance, but rather for the mere presence of the substance at a site from which someone else's substance has been released. Insurance against such a "non-event" is impossible to price.

Retroactive liability: The courts have applied CERCLA provisions ret-

roactively to owners and operators of waste sites, and to generators and transporters of hazardous wastes. Thus, a policyholder becomes liable for behavior which was not negligent at the time it occurred. A risk that does not exist at the time a policy is issued cannot be priced, nor can an insurer collect an additional premium for a contract that has expired.

Insurance coverage decisions: A series of lower and intermediate appellate court decisions has led insurers to conclude that the entire cost of cleaning up hazardous waste sites, estimated between \$22 billion and \$100 billion, will be forced onto expired and existing policies which were never intended to bear this responsibility. The most damaging precedents are those growing out of the contamination of wells serving 97 families by seepage of hazardous wastes from a landfill owned and operated by Jackson Township, New Jersey. The courts in the Jackson Township cases effectively eliminated the pollution exclusion by writing the word "sudden" out of the CGL's policy language; evaded the policy's indemnity limits by ruling that each of the wells constituted a separate "occurrence;" and applied the "bodily injury" coverage terms to plaintiffs who never alleged any actual harm. If the latter case had been upheld, it would have opened the door to an unlimited number of claims for present damages for possible future harm. Equally alarming was a holding in a separate case, subsequently overturned on appeal, requiring an insurer to defend and indemnify its insured against cleanup liability for contamination of the insured's own property. The court simply ignored the CGL exclusion for property under the "care, custody and control" of the insured, and the fact that the contamination had not caused harm to any third party.

Yet to be decided is a suit filed in California in 1983 by Shell Oil

Company. Shell is seeking to recover cleanup costs imposed by the EPA, the U.S. Department of the Army, and the California Department of Health Services from its 270 primary and excess insurers between 1947 and 1983. If the court finds for Shell, insurers will be forced to absorb billions of dollars in current and future claims for which no premium was collected and no claims reserves established.

The long line of adverse court decisions has impelled foreign reinsurers to withdraw entirely from the American pollution liability market and forced primary insurers to exclude coverage for sudden and accidental pollution liability from the new CGL policy.

CALIFORNIA

Some estimates of the cost of cleaning up the nation's abandoned waste sites greatly exceed the entire capacity of the insurance industry to write policies of all types. However staggering the figures may be, they do not include the cost of compensating individuals for bodily injury resulting from exposure to toxic materials.

A report issued in mid-1985 by the California Commission for Economic Development estimated that \$2.7 billion in claims for toxic injuries are pending in the state's courts. The largest suit, \$850 million, was filed on behalf of 5,000 plaintiffs whose wells were polluted by toxic substances leeching into groundwater from the Stringfellow Acid pits in Riverside County. Another action, on behalf of 495 plaintiffs against a Kern County school district, begs \$50 million in purely speculative damages - the increased risk of cancer from drinking fountain water contaminated by DBCP.

ASBESTOS ABATEMENT CONTRACTORS

Since 1982, when the EPA issued the Asbestos-in-Schools Identification and Notification Rule, the public has become acutely aware that the presence of deteriorating asbestos-containing materials poses a potential threat to the health and safety of school children and employees. Although very little is known about the risk of non-occupational exposures to asbestos, it is widely recognized that improperly removed asbestos places building occupants at greater risk of exposure than leaving undamaged materials in place.

Friable asbestos has been identified in hundreds of school buildings throughout California. The estimated cost of removal exceeds \$90 million.

The rush to remove asbestos from schools and other public buildings has created a demand for contractors that far exceeds the supply of those who have any experience with asbestos abatement work. Many unqualified contractors have been attracted to a potentially lucrative new field of business. Only a handful of states including, most recently, California, have attempted to address the problem by issuing uniform training and licensing requirements. Without such standards, insurers have no way to judge the qualifications or risk characteristics of an applicant for insurance.

Any asbestos risk poses special problems. The latency period for asbestos-related illnesses ranges from 15 to 40 years. It is impossible for the underwriter to predict how many of those exposed will become ill, when they will become ill, and what the cost will be to provide medical care and compensation when they do become ill.

With billions of dollars in legal and compensation costs for work-related asbestos disease claimants looming on the horizon, and additional billions in property damage claims already filed, insurers are not in a position to assume any additional asbestos exposures.

An insurance market for abatement contractors might be created if states established removal standards, issued uniform training and licensing standards, and provided certified contractors tort immunity for non-negligent behavior.

SOLUTIONS

Realistic short and long-term solutions to the pollution liability insurance problem must address the underlying insurability issues.

First, federal Superfund must be amended to eliminate retroactive liability and to provide for equitable apportionment of cleanup costs among all potentially responsible parties.

Second, federal and state laws must relieve insurers of any liability for waste cleanup defense and indemnity costs under past policies that did not expressly obligate insurers to provide the coverage.

Third, state common law must become more predictable. The courts must set clear standards of liability based on negligence, as well as standards for those damages that are compensable and which of those damages are covered by the insuring contract.

Fourth, there should be a clear statutory separation of cleanup liability and liability for third-party bodily injury and property damage. Prefunding the inevitable cleanup actions at waste sites authorized under the Resource Conservation and Recovery Act (RCRA) might enable insurers to provide protection against liability for bodily injury and property damage to users, generators, transporters, storers and treaters of hazardous materials. Fees assessed on all persons using a permitted site would provide an assured source of funding for future cleanup actions, act as an incentive to sound disposal practices by conditioning cleanup relief on compliance with RCRA requirements, and provide recovery to persons harmed by an accident.

Finally, California should abandon its flirtation with the notion that more punitive laws will result in prompter cleanup of the state's hazardous wastes sites. Federal Superfund's legal scheme has resulted in the expenditure of \$1.6 billion and the cleanup of only six sites of the more than 800 on the National Priorities List. If we have learned anything during the course of the past five years it is that cleanup of abandoned waste sites is a societal, not a legal, problem. The job can be accomplished expeditiously only by proceeding to do it, and not by pursuing potential deep pockets in the courts, or devoting thirty to forty percent of the funds available for cleanup to legal expenditures.

PROFESSIONAL LIABILITY INSURANCE

California is one of the few major states without a full-blown medical malpractice insurance crisis this year. A major reason for this is the passage 10 years ago of the Medical Injury Compensation Reform Act (MICRA), which instituted several important reforms in our civil justice system with respect to medical malpractice actions.

The major provisions of MICRA are:

1. A limit of \$250,000 is placed on awards for general damages (pain and suffering).
2. Evidence of collateral sources of benefits are authorized to be disclosed to juries.
3. A sliding scale contingency fee system is established, so that a plaintiff's attorney could collect as a fee 40% of the first \$50,000 recovered, 33 1/3% of the next \$50,000 recovered, 25% of the next \$100,000 recovered and 10% of the amount over \$200,000 recovered (normal contingency fees range from 1/3 to 1/2 of the entire amount recovered).
4. Judgments for future damages of over \$50,000 must be paid in periodic installments, rather than a lump sum, if requested by either party.

5. Actions must be brought within three years of the date of injury or one year from the date the plaintiff discovers the injury.

Although in effect for 10 years, the provisions of MICRA were frequently disregarded by judges, apparently due to doubts about the constitutionality of its provisions. However, constitutional challenges were finally disposed of by the U.S. and California Supreme Courts in 1985, and it is expected that California courts will now give full weight to the tort reforms contained in MICRA.

Although there are real problems in the medical malpractice insurance business in California with respect to obstetricians and nurse-midwives, the overall situation is much better here than it is nationally.

For example, according to the California Medical Association, the average size of malpractice awards nationally is \$974,000, while in California it is \$396,000. The average malpractice insurance policy nationally costs 300% more now than in 1975, while in California, the same policy costs just 150% more than in 1975. During the past year, the cost of the average malpractice policy rose 33% nationally, while it went up 15% in California.

The lesson to be learned is that MICRA's reforms have helped in California and these reforms should be broadened to encompass all personal injury lawsuits, not just malpractice claims.

Other types of professional liability insurance that are not covered

by MICRA, such as legal malpractice and architects' and engineers' liability, are experiencing severe problems with both availability and affordability.

Legal malpractice insurance rates are going up 200-400% this year and carriers are withdrawing from the market.

California leads the nation in lawsuits brought against attorneys. Nationally, about one claim is filed for every 17 lawyers in practice and a third of all claims result in a payment to the plaintiff. In California, it is estimated that one claim is filed for every ten lawyers practicing and nearly half of the claims filed result in a payout. For every \$300 legal malpractice payout, it is estimated that \$150 goes to defense lawyers, \$100 to plaintiff's lawyers and \$50 to the plaintiff.

Architects and engineers are being sued as a matter of course nearly every time an injury takes place in a building. If someone slips on a step, the architect can be sued for negligently designing the step so that it did not prevent someone slipping upon it. Even though the architect or engineer being sued may be found to be without fault, the frequency with which these types of actions are brought and the expense of defending them in court has made architects and engineers virtually uninsurable in many instances.

Real estate agents recently found they were having trouble buying liability insurance due to a court case which broke new legal ground by finding that a listing real estate broker was liable for negligence to the buyer of a home for a failure to make a careful and diligent visual inspection of the

property and report any "red flags" which that inspection disclosed.

This new duty on real estate agents and brokers was imposed retroactively in order to be able to award the plaintiff money. The court forced the insurer in this case to pay for an exposure that didn't exist when the policy was purchased and for which no premium had ever been paid. This new duty was subsequently clarified, but not overturned, by the legislature.

These examples illustrate the problems caused by our increasingly litigious society. The desire of people to find a deep pocket to pay for each and every wrong done to them, and the willingness of the courts to help find that deep pocket, have created a situation where many legitimate businesses are considered too risky to insure.

Extending the provisions of MICRA across the board to all personal injury actions would go a long way toward lessening the problems that are being experienced. Beyond that, judges and juries must come to understand that our civil justice system should not be used as a substitute for social welfare. Professionals who have not been negligent in their duties should not be held responsible for injuries that are beyond their control.

GOVERNMENT LIABILITY INSURANCE

BACKGROUND

Court decisions in the last few years have proven that you can fight City Hall - and be handsomely rewarded. The size and frequency of judgments against government entities in the 1980's have increased to the point that many insurance companies are hesitant to provide insurance for municipalities and other government entities.

Historically, cities, counties, states, school districts, transit districts, etc., have enjoyed sovereign immunity from lawsuits that arise from the performance of government functions. When this doctrine was deemed unfair by the courts, state laws were changed to allow citizens to sue for damages from injuries that resulted from the negligent or willful acts of government entities.

In 1978, the California Supreme Court combined the rule of joint and several liability with the rule of comparative negligence to create a situation where the party who is only minimally responsible for an accident may have to pay for all the damages arising out of the accident. This decision encourages lawyers to search for "deep pockets" to blame for accidents in the hope that a jury will find even a slight degree of negligence on the part of the deep pocket. The most common victims of the deep pocket rule are taxpayers who are often sued for no other reason than the simple fact that an accident occurred on a public street.

PROBLEMS

A League of California Cities survey found that 162 cities, one-third of California's total, paid over \$19 million in judgments and out-of-court settlements from deep pocket claims in fiscal year 1983-1984. Two years earlier, the cities had paid about one-fourth of that. Over \$210 million in claims are still pending.

Public entities must also defend themselves against lawsuits that were unheard of a few years ago. Although overturned on appeal, a county supervisor was held personally liable by the trial court for the county's decision to enforce a zoning ordinance. A school district in Alameda has been sued for \$35 million for a high school football player's injuries. Public entities face enormous liability exposure for handling and disposing of toxic waste. The California Supreme Court has just ruled that transit districts are responsible for protecting passengers from the actions of other passengers.

Because of these lawsuits, cities, counties, and other public entities are finding it increasingly difficult to secure adequate and affordable insurance coverage. The League has testified in Sacramento that more than 50 California cities are uninsured or dangerously underinsured, and the list grows as policies expire. Local governments that can find insurance face premiums that are as much as ten times what they were last year. Cutbacks in essential services to pay insurance premiums and court judgments are the result.

SOLUTIONS

Senator John Foran (D-San Francisco) has introduced Senate Bill 75 to more fairly apportion damages in lawsuits while protecting the economic interests of people who are injured in accidents. The bill retains the rule of joint and several liability for economic damages - medical expenses, lost wages, and property damage - thus guaranteeing the plaintiffs will be fully compensated for their loss. However, it provides that non-economic damages - pain and suffering, emotional distress, loss of companionship - will be apportioned according to the degree of fault of the defendants. Thus, if a city is found to be 10 percent responsible for an automobile accident and the person who is 90 percent responsible is uninsured, the city would still be responsible for 100 percent of the plaintiff's lost wages, medical bills, and property damage, but only 10 percent of the award for those intangible damages such as pain and suffering and emotional distress.

Senate Bill 75 represents the fourth attempt to limit the rule of joint and several liability. The Senate has passed Senate Bill 75 and similar legislation by wide margins only to see it stall in the Assembly Judiciary Committee.

Responding to the urgent need for reform, California's business, medical, professional and insurance groups have joined with cities and counties to give California voters the opportunity to limit the waste of the deep pocket rule. The Fair Responsibility Act of 1986, which will appear on the June ballot, will accomplish the same ends as Senate Bill 75. Because of the continuing deadlock in the legislature, the ballot initiative appears to offer the best hope of restoring a measure of fairness to the liability system.

DAY CARE LIABILITY INSURANCE

With an increasing number of single parent families and families with two working parents, the need for day care in California has never been greater. It is estimated that there are more than 100,000 family (in-home) day care providers in California, 33,000 of whom are licensed as required by state law. In addition, there are thousands of child day care centers, which provide care for more than 12 children at a site outside the home.

Effective January 1, 1985, family day care operators (those caring for 1 to 12 children in their own home) were required by state law to carry \$300,000 per occurrence liability insurance for their day care operations, or alternatively, to obtain a signed slip from each parent stating that the parent was aware that the home was without liability insurance.

Many California family day care operators obtained insurance through Mission Insurance Company. In July of 1985, Mission notified its day care policyholders that it would be cancelling or non-renewing this coverage due to severe financial problems, including the loss of reinsurance.

AVAILABILITY PROBLEMS

Normally, this situation would have created simply some inconvenience, as policyholders switched to another insurance company. However, this notification came after a period of increasing awareness concerning widespread cases of child abuse in day care situations, and during a period featuring the most severe underwriting losses ever experienced by the in-

insurance industry. The result was that for a period of time, the day care operators who were being cancelled or non-renewed had no place to purchase alternative coverage in the regular insurance market.

After a few weeks, another insurance company stepped in and voluntarily began writing day care insurance, but by that time, there was a perception that a legislative solution was needed for the day care insurance "crisis." Bills were introduced to establish a "Joint Underwriting Association." The JUA would have forced all insurers to write day care insurance and share premiums and losses on a pro-rata basis, based on their liability insurance premium volume. These bills were opposed by the insurance industry because they would have resulted in a barrier to any insurer wanting to compete voluntarily for day care business. The bills would have established the JUA as the sole underwriter of day care liability risks in certain areas, and thus would have resulted in an uncompetitive environment and higher premiums for policyholders over the long term.

The insurance industry responded to the perceived availability crisis in day care by forming what is called a "market assistance program." This program, dubbed "Cal-Care," is a voluntary effort by insurance companies to help day care operators who are having trouble finding insurance. Participating "Cal-Care" insurers agree to review problem day care risks and to attempt to find coverage for them in the regular insurance marketplace.

AFFORDABILITY

The affordability of day care insurance is another problem frequently mentioned by family day care operators.

There is no question that the cost of day care insurance has risen

steeply within the last year. The reasons include a greater perceived risk as cases of child and sexual abuse come to light, the large losses experienced by some insurers of child care centers, the poor underwriting results experienced by the insurance industry, and the decreasing financial capacity within the insurance industry to underwrite commercial liability insurance.

Court decisions have played a large part in increasing the price of day care insurance and decreasing its availability. Professional day care centers' liability coverage is provided through general liability insurance policies, which exclude coverage for criminal acts, including sexual and physical abuse of children. However, courts have side-stepped the exclusion for criminal acts by allowing plaintiffs to sue for "negligent hiring" or "negligent supervision" when such crimes take place.

Many small family day care operators obtained their insurance through a "business pursuits" endorsement to a homeowners policy. (Business pursuits are normally excluded from homeowners coverage.) Some courts have ruled the homeowners policy, even without the business pursuits endorsement, covers family day care liabilities, despite the fact that business pursuits were excluded from coverage.

The California Supreme Court applied an exception to the business pursuits exclusions for "activities which are ordinarily incident to non-business pursuits." The court noted that "it is difficult to conceive of an activity more ordinarily incident to a non-commercial pursuit than the home care of children," even where the insured is caring for the children for com-

pensation. These kinds of court rulings have led many insurers to conclude they cannot rely on policy exclusions and have increased the reluctance of many insurers to provide any kind of coverage where a day care operation is conducted on the premises.

SOLUTIONS

Availability problems associated with day care operations have been addressed by insurers coming back into the market to provide insurance coverage voluntarily and by the voluntary "Cal-Care" market assistance program.

Problems associated with the affordability of day care insurance have been addressed in legislation passed in 1985 (SB 1064 by Seymour & AB 929 by Allen, et al), which lower the required insurance for family day care operators to \$100,000 per occurrence, \$300,000 maximum annual aggregate. This should help to stabilize insurance rates for family day care operators by lowering the maximum annual risk to the insurer to \$300,000. Under the old requirements, an insurer could be forced to pay \$300,000 for each injury, should a disaster strike. This meant an unlimited potential loss for the insurer, thus increasing the cost and drying up the availability of the coverage.

In addition, AB 929 declares that it is against public policy to insure day care risks under the homeowners policy, unless a separate endorsement has been obtained and an additional premium has been paid. It prohibits the cancellation of a homeowners policy solely for the reason that there is a day care operation on the premises and also prohibits, for a specified period, the non-renewal of a homeowners policy for that reason.

There has also been legislation to increase the enforcement of regulation and laws regarding day care operations.

With the passage of legislation and the response of the voluntary insurance marketplace to the problems associated with day care insurance this year, it is hoped that the day care insurance market will stabilize in 1986.

MOTOR CARRIER LIABILITY INSURANCE

BACKGROUND

The nation's trucking industry and bus transportation companies have encountered serious difficulties obtaining liability insurance required by federal law.

The current situation was brought about in part by the Motor Carrier Act of 1980, which requires liability insurance minimums ranging from \$750,000 for carriers of non-hazardous cargo to \$5 million for haulers of hazardous waste. State-imposed liability limits for intrastate operators have also been raised. Society's concern with environmental pollution and fear of hazardous materials heavily influenced legislators toward including the high-limit insurance requirement in legislation intended primarily to deregulate the trucking industry.

Similar problems were created for bus companies by the Bus Regulatory Reform Act of 1982, which set insurance minimums ranging from \$1.5 million to \$5 million, depending on the passenger capacity of the bus.

PROBLEMS

Along with rising claims costs, adverse judicial decisions extending coverage and overly generous jury awards, the substantial insurance requirements for cargo and passenger motor carriers come at a time when insurers are experiencing severe financial and capacity problems. Because of technical aspects in the federal law for cargo motor carriers, insurers are uncertain of their actual exposure as the limits required vary depending on the cargo. As a result, insurance companies have difficulty in properly pricing the risk involved for an individual insured.

Adding to this, a large-scale influx of high-limit motor carrier, bus, and other commercial auto business is simply more than the residual markets can deal with effectively. If the 12,500 new entrants into the trucking industry since 1980 were required to maintain \$750,000 of insurance, underwriters would have to provide \$9.4 billion in new insurance coverage.

Exacerbating the problems associated with the demands for expanded coverage is a severe constriction in the reinsurance market. Often, when reinsurance is available, it is prohibitively expensive. Greater risk exposure, particularly with operators who are less financially stable and have no safety record, also affects the motor carrier insurance system.

Small trucking firms and independent owner/operators have the most difficulty securing insurance. Generally, the largest trucking companies with good safety histories and claim results are finding a market. Many private carriers, local businesses, and even municipalities fall under federal high limit requirements because they occasionally transport hazardous substances. These conditions could continue to deteriorate because of increased coverage demands and limited market capacity.

SOLUTIONS

Residual market mechanisms cannot be viewed as the solution to these problems. Existing pooling mechanisms partially insulate small and medium insurers from a series of large losses, but overall capacity limitations of the insurance industry will inhibit the mechanisms' effectiveness. In the end, the costs of residual market mechanisms are absorbed by all individual automobile insurance policyholders.

Federal and state legislators and regulators should review high liability limit requirements and consider lowering them selectively. That review should include redefining the types and sizes of motor and passenger carriers required to maintain the higher limits. Exemptions from federal requirements might be considered for carriers having less exposure to loss.

Any further regulation of intrastate carriers' liability limit requirements should take into account probable maximum loss, population density, and geographic and topographic conditions.

More attention should also be given to inspection and safety. Deregulation has resulted in an influx of new carriers, and this competition has placed greater cost pressures on operators. In some cases, safety has been sacrificed because of deregulation. The federal and state governments should review their inspection requirements and procedures.

DIRECTORS AND OFFICERS LIABILITY INSURANCE

BACKGROUND

Purchasers of directors and officers (D&O) liability insurance, particularly financial institutions, report facing larger deductibles, lower limits, more restrictive endorsements, shorter policy durations, and higher premiums. A survey of purchasers conducted during the second quarter of 1985 reported premium increases from 50 to 500 percent and, in a few industries, a true availability problem.

One example of the tightening market is a bank which had its limits reduced from \$15 million to \$10 million, its deductible increased from \$50,000 to \$750,000, and its premium increased 22 times. Financial institutions which had been able to obtain limits in 1984 up to \$200 million are having difficulty now finding limits of \$30 million.

Those industries experiencing particular difficulty are electric (nuclear) utilities, new high tech businesses, wildcat oil and gas companies, research and development enterprises, real estate developers, highly leveraged businesses, petrochemical companies and the steel industry.

Company size does not seem to influence ability to obtain the desired coverage, but capacity constriction has probably hurt larger risks more than smaller risks. Loss experience has been better for smaller not-for-profit policyholders than large profit-making companies.

PROBLEMS

Underlying problems responsible for the capacity shortage include:

- o Significant reduction in reinsurance because of the general condition of domestic and foreign reinsurance markets, combined with reinsurers' perceptions of price inadequacy, the American civil justice system, and the increase in potential liability for directors and officers;
- o Policyholders' well-publicized breaches of traditional relationships with D&O insurers -- Bank of America (\$95 million) and Chase Manhattan (\$175 million) are suing some of their own managers and attempting to collect under their D&O policies;
- o Federal agencies, such as FDIC and FSLIC, that have insured failed banks and savings and loans are attempting to recoup some of their losses by suing former directors and officers;
- o Court decisions hold directors and officers to an increasingly strict standard of conduct by reducing the scope of the business judgment rule so that coverage designed for true mismanagement is becoming a "business judgment errors and omissions policy;"
- o Increase in hostile takeovers and other business practices likely to generate claims (greenmail, poison pills, golden parachutes);
- o A greater concern that directors and officers are not representing the interests of their shareholders may also result from recent corporate battles;
- o The general financial condition of primary insurers;
- o Growth in demand for directors and officers coverage; and,

- o Underpricing in prior years.

In 1984, D&O insurers were paying out three to four times as much in claims as they received in premiums. Average policy limits increased by 45 percent between 1982 and 1984, with a dramatic increase in those purchasing limits over \$50 million. The number of companies seeking D&O insurance increased by eight percent during this period with growth in demand greatest among companies with assets under \$25 million.

The average defense cost for claims in 1984 was \$461,000, up from \$365,000 in 1982. Average total cost of a D&O claim (defense cost plus losses) adjusted for inflation was \$1.62 million in 1984 compared to \$1.34 million in 1982 (up 21%).

Since 1984, there has been a dramatic reduction in capacity. Several major companies have withdrawn from the market and those remaining have significantly curtailed their writings and reduced coverage limits. The few new entrants are offering relatively low limits.

Although the London market popularized D&O coverage, it has not been a major writer recently because underwriters thought U.S. rates were too low. London brokers are reportedly offering primary coverage with limits up to \$20 million. Business is up 100 to 200 percent and much of the business is being placed.

Capacity reduction reflects the current financial condition of primary

carriers and reinsurers. The facultative reinsurance market has all but dried up. It has been estimated that 60 to 75 percent of reinsurers writing facultative reinsurance for D&O risks have withdrawn from the market. To date, primary carriers have been able to obtain treaty coverage. However, it is expected that they will face some difficulties when current treaties expire.

SOLUTIONS

Insurers have responded to broader liability with endorsements excluding certain liability from coverage. There is no standardization, but the new exclusions include:

- o Claims arising from pollution and environmental impairment;
- o Claims brought by government agencies (the so-called "regulatory" exclusion) aimed at FDIC and FSLIC suits; and,
- o The Bank of America-type situations where the policyholder sues its own directors and officers or where one director sues another.

Customers have responded by looking for alternatives to insurance. Twenty-three of the largest banks are studying options such as pooling arrangements and formation of a captive. A group of mid-sized banks is exploring the possibility of forming an offshore association captive. A regional bankers' association has formed its own insurance company, capitalized at \$3 million to provide D&O coverage to its 2,200 members. One organization is forming a new insurer to provide liability coverage for large companies. It reportedly will offer \$50 million coverage in excess of \$50 million.

GLOSSARY

Aggregate Limit - An overall cap on the insurer's liability under a policy.

Allocated Loss Adjustment Expense - All loss expenses which can be assigned to a specific loss. These would include expenses such as legal fees, court costs and medical reports.

Capacity - The total amount of insurance or reinsurance available from a company, or the insurance market in general.

Claims Made Policy - A policy that provides that it will cover only those claims first made during the policy period.

Comparative Negligence - The legal doctrine by which the negligence of the parties is compared, and a recovery is permitted notwithstanding the contributory negligence of the plaintiff.

Earned Premium - That portion of written premium equal to the expired portion of the time for which the insurance was in effect.

Incurred But Not Reported - (IBNR) Those losses which have occurred but have not yet been reported to the insurance company. Insurers establish a reserve to account for IBNR.

Incurred Losses - The total value of all individual losses which occurred during a given time period. Incurred losses include both losses that have been reported to the insurer and losses that have been incurred but not reported.

Insurance Services Office (ISO) - A nonprofit corporation that makes available rating, statistical, actuarial, policy form and related services to property/casualty insurers.

Investment Income - Insurance company income earned from invested premiums and capital. This income is reported to regulators each year in the insurer's annual statement.

Joint and Several Liability - A legal doctrine that allows a plaintiff to recover the total amount of the judgment against any defendant who is found to be negligent, even though other defendants may be negligent to a greater degree.

Loss Adjustment Expense - All loss expenses which can be assigned to a specific loss (allocated loss expense) and expenses which cannot be assigned to a specific loss, such as claim department expenses.

Occurrence Policy - A policy that provides coverage for injuries that have occurred during the policy period.

Policyholder Dividend - A share of surplus allocated to a policyholder.

Premium - The consideration paid for an insurance policy.

Reinsurance - The insurance by one insurer, called the reinsurer, of all or part of the risk of loss of another insurer.

Reserve - An insurer's estimated liability for unpaid claims and expenses.

Surplus - The excess of assets over liabilities.

Tail Coverage - An endorsement to a claims made policy extending coverage for losses incurred but not reported.

Underwriting Results - Money earned or lost by an insurer in its insurance operations, as distinguished from money earned or lost in the investment of assets.

Written Premium - The entire amount of insurance premium collected on contracts issued by the insurer during a period of time.



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FINANCIAL CONDITION OF THE INSURANCE INDUSTRY- AN UPDATE

Earlier this year ISO and NAII jointly published a report on the status of the property/casualty insurance industry entitled "1985 A Critical Year". This analysis compared industry results for 1984 to preceding years and was a call for action during 1985 to return to profitability in insurance operations.

In Part I of the attached, ISO has summarized the findings of that report and we have provided additional analysis through the first 9 months of 1985.

Part II provides an analysis of the factors, internal and external, that have combined to cause current financial conditions.

It is intended that this analysis encourage regulators and the business community to coordinate their talents in addressing proper solutions which will lead to recovery.

SECTION I

I. FINANCIAL CONDITION OF THE INSURANCE INDUSTRY

During the past year, the property/casualty insurance business has come to the forefront as a major public issue. At this stage of the insurance economy and the U.S. civil justice system, the industry finds itself faced with both the need to dramatically raise prices to cover losses, and to face the fact that certain classes of business may be uninsurable.

This situation has generated a feeling of mistrust and cynicism on the part of the consuming public and has prompted regulators and others to search through a variety of possible solutions, frankly some good and some bad.

As part of an overall effort to put the present insurance availability and other marketplace actions and problems into perspective, it is necessary to understand the overall financial condition of the insurance industry. This is done not to condone or provide excuses for specific areas of concern but rather to provide information so that all affected parties will have sufficient information to properly address and understand the problem. Earlier this year ISC and the NAIJ jointly published a report on the status of the property/casualty insurance industry entitled "1985 A Critical Year". This analysis compared industry results for 1984 to preceding years and was a call for action during 1985 to return to profitability in insurance operations. We have summarized

1973-1974. However, while the 1973 ratio was 99 and rose to 105 in 1974, the 1983 combined ratio already stood at the ominous level of 112 before leaping to an unprecedented 118 in 1984 and has only improved to slightly under 116 as of September 1985. The improvement, as compared to the first nine months of 1984, is really due to an improvement in the expense ratio - the loss ratio was actually worse in 1985.

This deterioration in results has been led by the commercial lines. (See Exhibit II.) Historically, personal and commercial lines results have closely paralleled each other. Between 1967 and 1982, the difference between the combined ratios never exceeded 6 points. As recently as 1981, the ratios were only 2 points apart. Then in 1983, the gap grew to 12.5 points. In 1984, it expanded to over 20 points. These high ratios are of even greater concern than they would be otherwise because industry analysts agree that the commercial lines combined ratio is understated due to reserve inadequacy. Since many companies write mostly commercial lines business, the combined ratios for these insurers are much worse than they are for the industry as a whole.

General Liability in particular experienced disastrous results in 1984 with a combined ratio of 152. Results for the first half of 1985 are not appreciably better as General Liability's combined ratio "improved" to only 145. Simply stated, that means that the insurance industry pays out \$145 for every \$100

losses, the industry's pretax operating income - the combination of investment income and underwriting results - plunged to a negative \$3.8 billion in 1984 and a negative \$3.5 billion in the first nine months of 1985. (See Exhibit III.) This figure, pre-tax operating income, is the primary component of insurer income and represents the pre-tax profits from insurance operations. It is this component of income which is responsible for the long term viability of the industry. The huge \$3.8 billion loss in 1984 is the largest ever experienced in this industry. It may, however, be surpassed by the 1985 operating loss, as the first nine months operating loss exceeded \$3.5 billion. Although investment income has been rising gradually over the last several years, it is no longer able to offset the staggering underwriting losses which increased 60% in 1984 alone. Clearly, if the property/casualty insurance industry is to maintain its current capital base, let alone attract new capital to meet the insurance needs of a growing economy, the industry must improve its earnings.

A second measure of insurer profitability is the total rate of return on net worth. This measure includes operating income, realized capital gains, taxes and other miscellaneous income, and is often used to compare the profitability of insurance with other industries.

By this measure also, profits in the insurance business declined in 1984 for the seventh consecutive year. The

companies'. But in fact the rates of return trailed the Fortune 500 average throughout the 1980's.

Yet another ingredient adding to the poor financial condition of the insurance industry at year-end 1984 was the decline in policyholder surplus. Policyholder surplus is the difference between insurer's assets and liabilities and is a measure of an insurer's capacity to provide insurance coverage safely. This is the financial security, the uncommitted funds of an insurer, that stand behind every insurance policy. It is the quantity that provides the necessary cushion to support the shock of major catastrophes, stock market declines and loss reserve inadequacies. As a result of operating losses in 1984, industry surplus fell 3% to \$63.8 billion. In constant dollars, 1984 surplus was 3% below the 1980 level, which indicates that capacity may not be sufficient to meet the insurance needs of an expanding U.S. economy.

The 1984 drop in surplus would have been much worse were it not for the record-breaking influx of new funds into the industry. New funds represent additions to the capital structure of an insurance company. The two major sources of these funds are new stock offerings and contributions from non-insurance parent companies to insurance subsidiaries. Reasons for an addition to capital range from preventing an insolvency to expanding underwriting capacity.

reserve policies. Industry analysts believe that the industry is significantly underreserved, especially in the Commercial Lines. These facts, fueled by latent-injury claims, are driving the business to support ISO's policy-reform efforts and to advocate changes in the U.S. civil-justice system.

The decline in surplus and questions as to adequate loss reserves have raised concerns about the solvency of many insurers. In 1984, at least 22 property/casualty insurance companies were found to be financially impaired. Most of these companies were insolvent. Additionally, several sizable insurers were placed in rehabilitation by regulators with an indication given that liquidation could not be avoided. In total for 1984, companies accounting for more than one fifth of industry premiums failed 4 or more IRIS tests. As of mid-November 1985, 38 companies have become insolvent since the beginning of 1984. That is more insolvencies than in any full two-year period since guaranty funds were formed, and the books aren't yet closed for 1985.

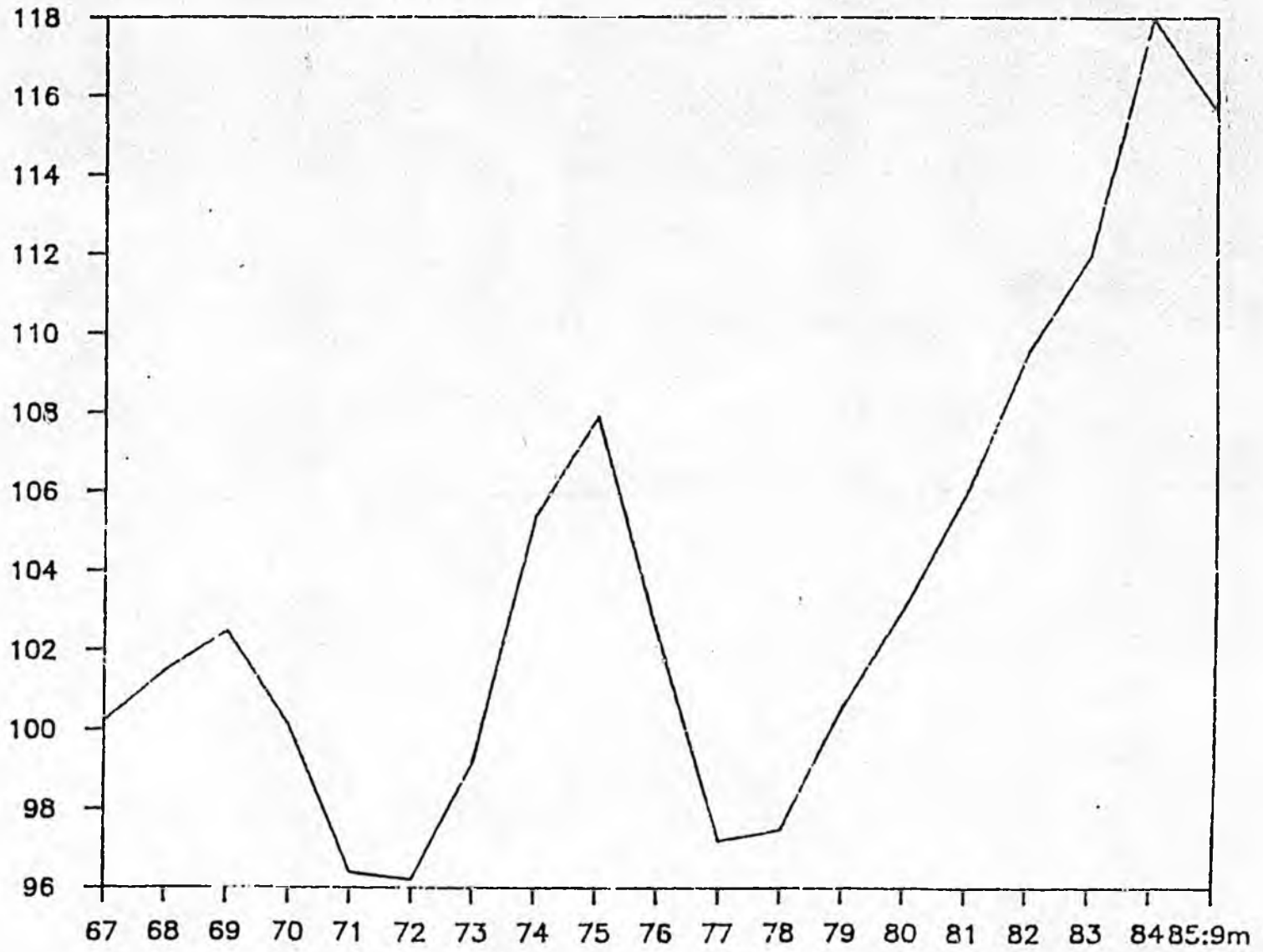
A.M. Best Company annually conducts a specialized financial analysis of most United States insurance companies and expresses its evaluation in the form of a rating. All companies rated "Excellent" are considered to be outstanding and have no material unfavorable variances from A. M. Best's averages. Lower ratings reflect increasingly unfavorable variances from A. M. Best's industry standards. An "Excellent"

has become a victim of fundamental changes in the civil justice system during the past decade. More and more, insurers have encountered court interpretations of prior insurance contracts which expand coverage beyond that which insurers intended. As a result, the availability and cost of insurance for current liability is significantly influenced by: insurers' concern about potential unanticipated past liability; the magnitude of potential liability, both past and future; the seeming inability to use contract language to prudently limit insurers' exposure; and a civil justice system that continues to create new theories of liability and to expand older theories.

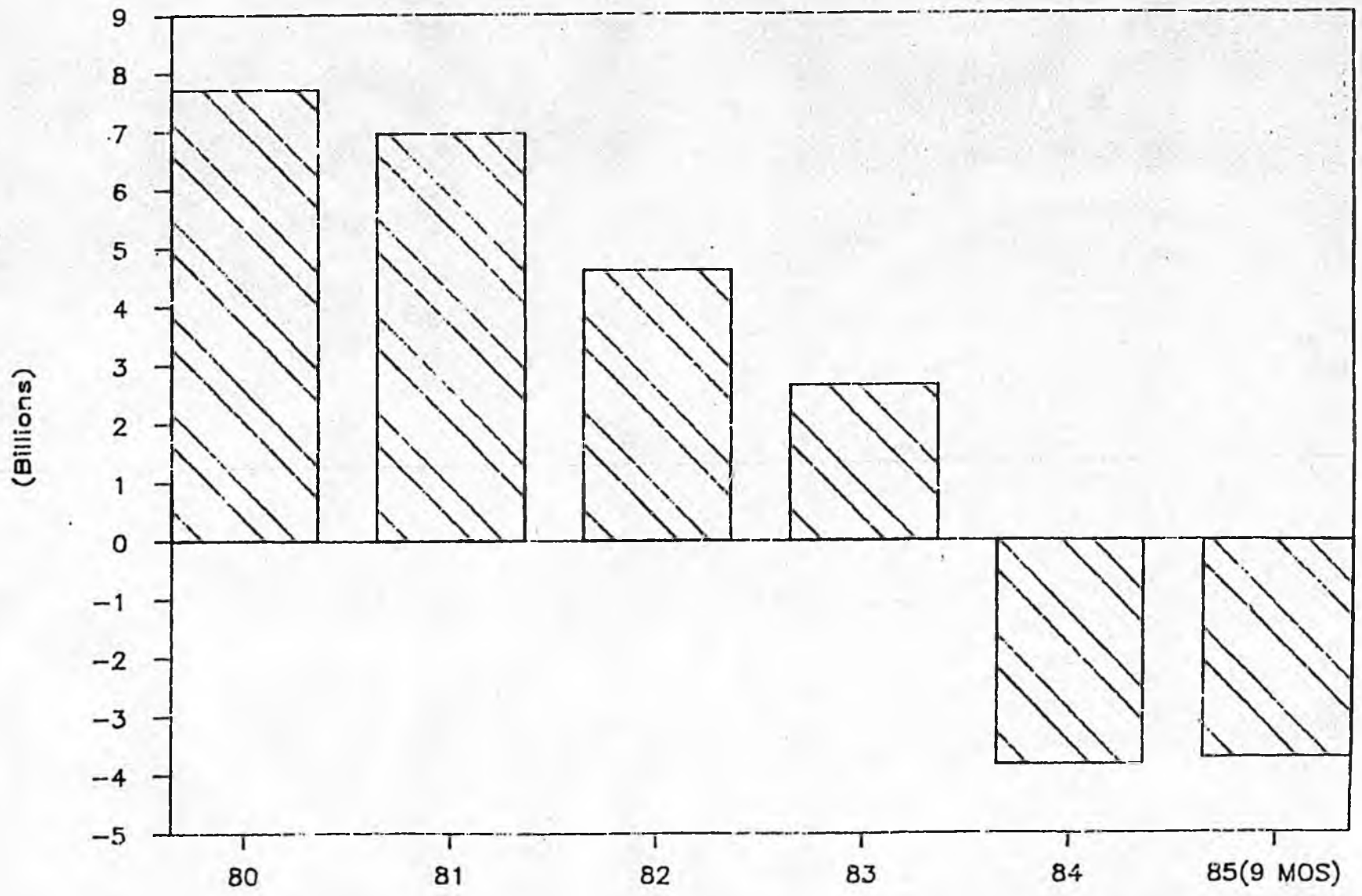
In addition to the growing level of losses suffered by the property/casualty industry, another illustration of the magnitude of the impact of legal costs on loss dollars is the growth in allocated loss adjustment expenses (of which 90% are legal fees). As a percent of damages, allocated loss adjustment expenses have grown from less than 15% in the late 1950's to almost 34% in calendar year 1983. Moreover, a special study of several companies' data indicates that the calendar year statistics may tend to obscure the full extent of recent growth. The study projects total legal expenses approaching one-half of ultimate settlement values for claims reported in the last three years.

Between 1978 and 1983, legal expenses grew 79%, more than twice the growth rate for damages. If these trends continue, \$19

COMBINED RATIOS:ALL LINES

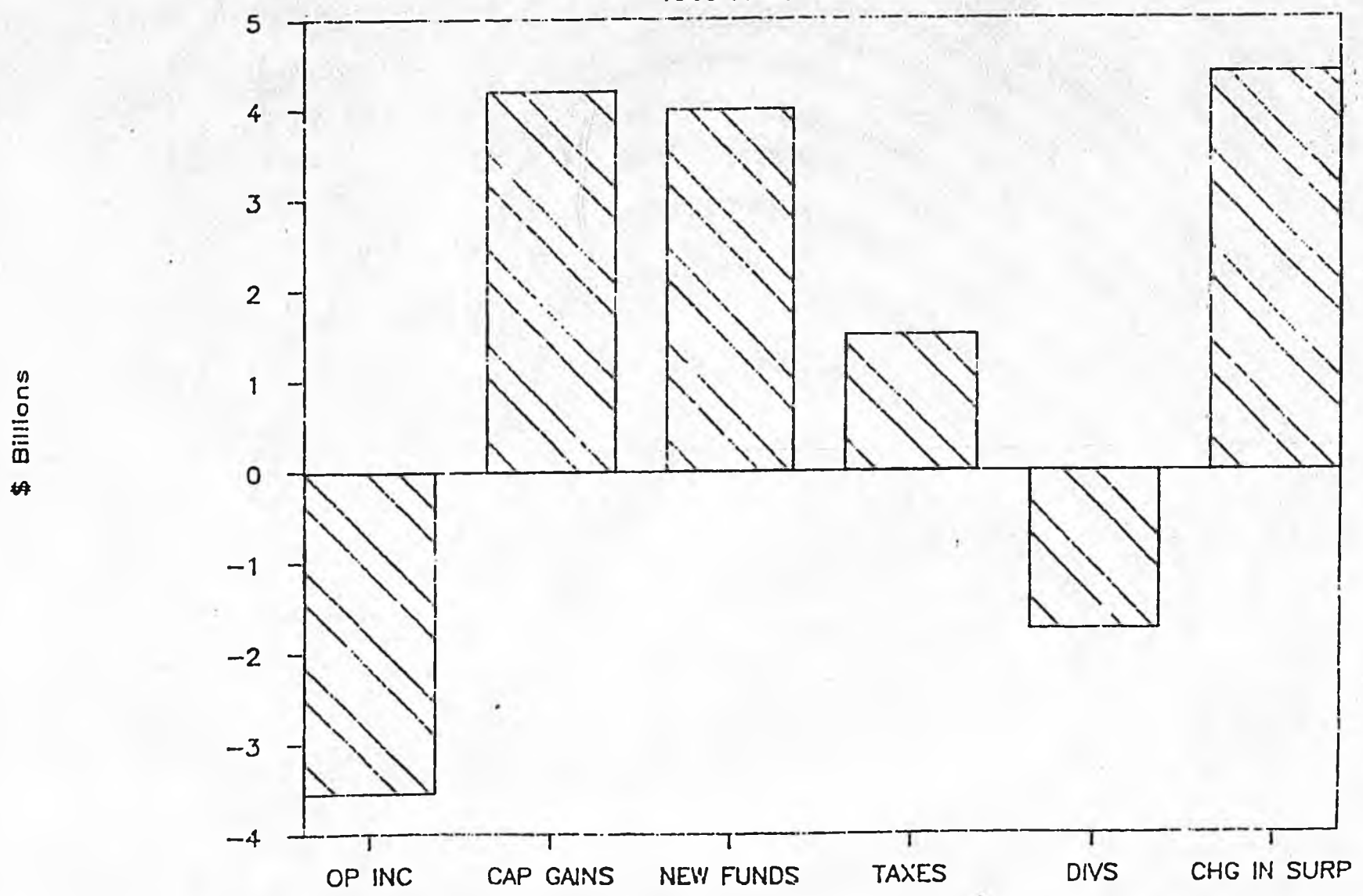


OPERATING INCOME



CHANGE IN SURPLUS AND ITS COMPONENTS

1985 FIRST NINE MONTHS*



* ISO estimates

SECTION II

II. FACTORS INFLUENCING FINANCIAL CONDITION OF THE INDUSTRY

The previous analysis of insurer's financial condition has shown an industry experiencing extremely unprofitable underwriting results, severely impacting the very solvency of many insurers.

This section will sketch the causes and implications of these unprofitable underwriting results. Although a complete answer is complex, two trends are clearly discernible as influencing and causing current conditions: a prolonged period of underpricing and rapidly expanding tort liabilities.

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.

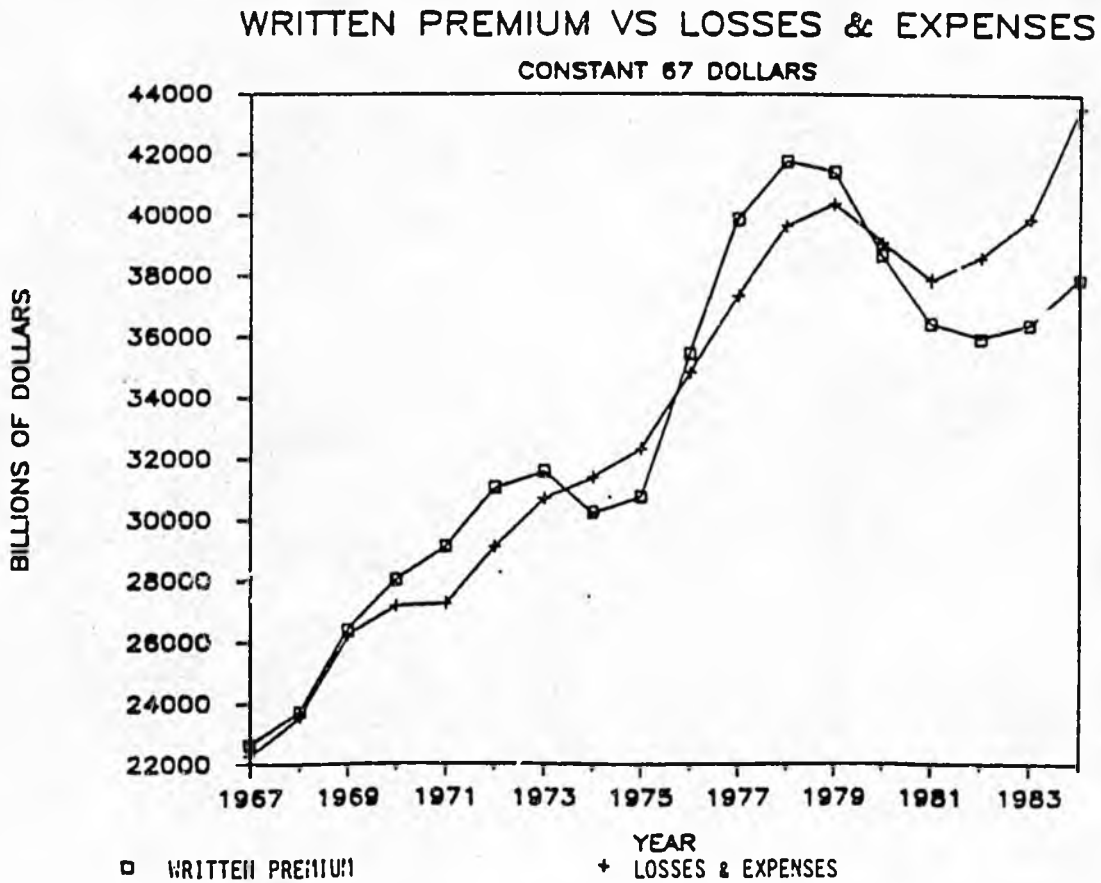
Meanwhile, the second problem -- expanded tort liabilities -- was becoming equally acute. During the first half of this decade, insurers have seen court after court reinterpret policy language and create coverages, retroactively, that were never contemplated or paid for when the policies were written. They also have watched the likelihood of a successful claim become more and more a function of the seriousness of the injury than

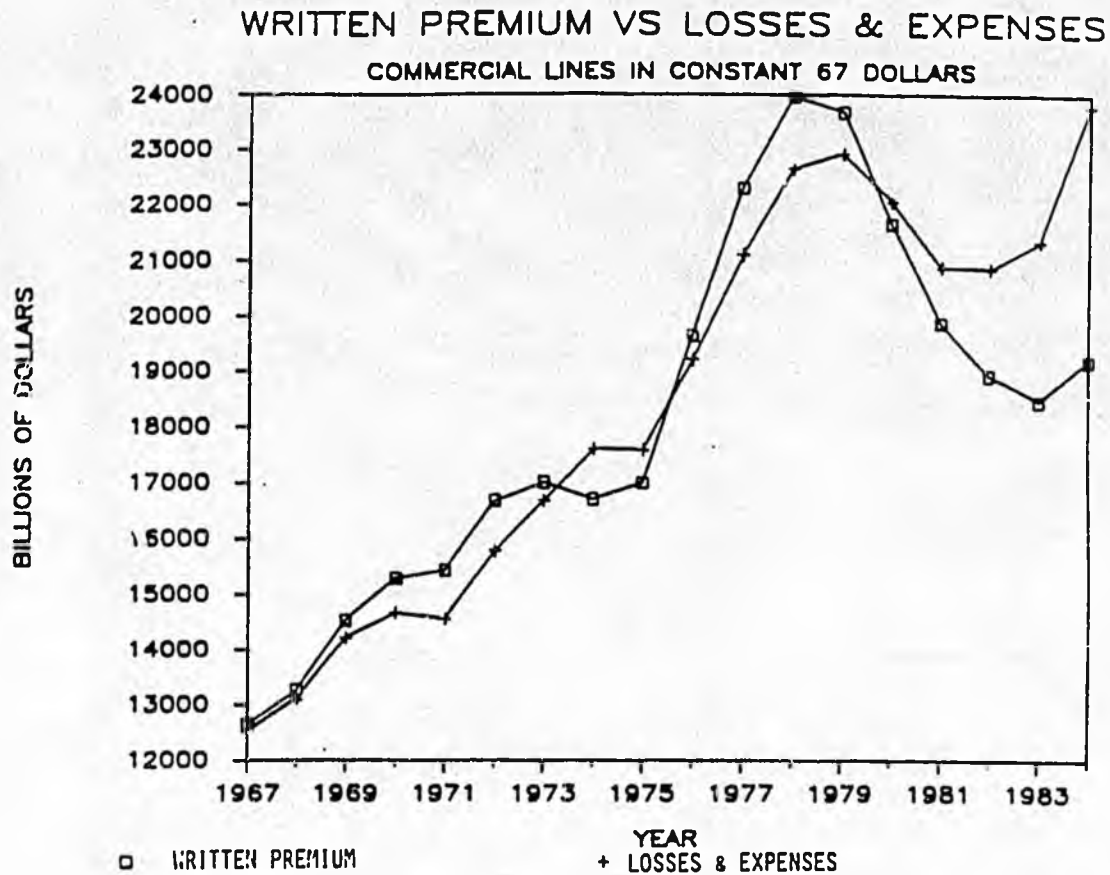
basis (i.e., adjusted for inflation). The comparisons have been performed on an all lines basis, and for commercial lines. The data clearly show that in recent years premium adequacy has deteriorated, significantly in the Commercial Lines.

All Lines

Exhibit 1 reviews total insurance premiums and costs on a constant 1967 dollar basis for the period 1967 to 1984.

EXHIBIT 1





Between 1967 and 1979, written premiums for commercial lines exceeded the sum of incurred losses, expenses, and policyholders' dividends in all but two years. Since 1979, premiums have not kept pace with costs, and the gap widened at an alarming rate.

In constant dollars, 1984 marked the first real increase after five consecutive years of declining written premiums. But 1984 written premiums were almost 20% less than premiums collected in 1978, before the decline in premiums began. At the same time, losses were at an all-time high.

In summary, insurer losses continued to rise, fueled by economic growth and inflation as well as expanding tort liabilities. However, at the same time, an intensely competitive insurance marketplace drove down premiums. Insureds have reaped the benefit of grossly inadequate prices for the past six years, and thus, when questions of affordability are raised, it must be emphasized that, for the average risk, prices at the beginning of 1985 were only returning to prior levels.

Additional premium increases can be anticipated since it is now clear that IBNR estimates in 1984 losses have been underestimated, due in part to judicial trends. In addition, there are several categories of risk which have been more substantially impacted by fundamental legal changes and other factors and thus the rate increases for these risks will be higher than the average.

The Commercial Lines Problem in Context

As outlined above, current availability and affordability problems are the result of the confluence of changes in the underwriting cycle and underlying frequency and severity trends due to expanding tort liabilities. Since 1979, the property/casualty industry has engaged in highly competitive practices which opted for cash flow underwriting, or emphasized marketing and investment operations over underwriting. In this

highly competitive market, other segments of the marketplace - agents, brokers, and commercial risks themselves - also actively participated in driving rates down.

The industry has finally realized that a business cannot indefinitely price its product below cost and expect to survive, and has therefore begun to bring prices in line with costs.

The current upward pressure on prices could be seen as a normal phase of the underwriting cycle. In an ordinary cycle, upward moves in prices would have been a proper response to diminishments in asset values and would have "corrected" the out-of-phase premiums/loss relationship. In other words, corrective price action would lead to respectable profitability quickly and effectively, as occurred both in 1969 and 1975, the low points of the past two cycles.

However, the current cycle differs significantly from previous downturns. This downturn was exacerbated by legislative and judicial trends. These increased loss and expense costs are occurring at the worst possible time in the underwriting cycle. In other words, just as the industry is responding to poor underwriting results through the normal internal dynamics of the underwriting cycle, unprecedented and, in some cases unmeasurable, liabilities have been imposed which have bent the cycle out of shape and placed long term solutions to profitable

insurance underwriting for some classes perhaps beyond the reach and ability of the private insurance industry alone.

Conclusions

The conclusion of this analysis is that price increases and capacity shortages have occurred as the outgrowth of the financial state of the industry. The documented financial problems of the industry have been caused both by downward pressure on prices in the past due to a fiercely competitive marketplace and fundamental changes in tort liability. This latter situation is not amenable to the normal corrective dynamics of the underwriting cycle since the root causes are not internal to the industry.

Finally this situation will affect various markets unevenly, with the more serious dysfunctions occurring in those classes or coverages most impacted by external legal trends.

STATEMENT OF
CHARLES H. FRITZEL
ASSISTANT VICE PRESIDENT FOR GOVERNMENT RELATIONS
NATIONAL ASSOCIATION OF INDEPENDENT INSURERS
BEFORE THE
SUBCOMMITTEE ON BUSINESS, TRADE AND TOURISM
COMMITTEE ON COMMERCE, SCIENCE AND TRANSPORTATION
U.S. SENATE
DECEMBER 3, 1985

My name is Charles H. Fritzel and I am the Assistant Vice President for Government Relations of the National Association of Independent Insurers (NAII).

NAII is a voluntary national trade association of over 500 property and casualty insurers. Our organization provides a truly representative cross section of the property and casualty insurance business in America. Our members range in size from the smallest one-state companies to very large national underwriters, and consist of both stock and non-stock companies. NAII member companies reflect all forms of merchandising -- independent agency, exclusive agency, and direct writers; and they include insurers which serve a general consumer market and those which specialize in serving particular consumer groups such as farmers, teachers, government employees, military personnel and truckers.

We very much appreciate this opportunity to testify on what is termed the "insurance availability and affordability crisis."

Just a few weeks ago NAIH held its 40th annual meeting. Our outgoing Chairman, Brad Mitchell, who is President of Harleysville Insurance Company in Pennsylvania, in his address to our membership spoke at length about the problems we are facing in the insurance industry. One of his statements stuck in my mind: He said that if a company entered the property-casualty business in 1967, in the 18 years from then until today, it experienced only five years of profitable underwriting. 1984 was the worst year we ever experienced.

In the first six months of this year, the industry's net after-tax income was \$1.1 billion, compared to \$562 million in the first half of '84, which, at first viewing, looks like an improvement.

But it is not sufficiently understood that the improvement was based on \$2.35 billion in realized capital gains and approximately a billion in tax credits resulting from the disastrous losses many companies have incurred in recent years.

The underwriting picture isn't getting any better either. In fact, the industry's underwriting loss rose \$1.3 billion over the comparable loss last year. We expect an underwriting loss which will probably exceed \$22 billion in 1985.

The bodycount of financially impaired companies hit a record 27 last year. Unlike the previous high of 20 insolvencies in 1975, which lasted only a year, the 1984 level is expected to continue through '85.

For the first time in history, the industry lost \$2 billion of its surplus last year solely through poor underwriting experience, at a time when the stock market was relatively stable and investment income was growing.

On top of that, it is estimated that the industry is at least ten per cent

In 1984, fifty of the top hundred insurers had returns on net worth that were in the red, a truly shocking performance in view of the fact that only 34 of the Fortune 500 had negative returns.

The usual explanations for the industry's illness include inflation, the recessions of the mid-70s and early 80s, and the bane of cash-flow underwriting.

But none of these is completely convincing. Insurers have weathered inflation and recessions for decades without getting beat up to this extent. And while it is true that some companies, in the commercial lines, nearly perfected Kamikaze pricing, cash-flow underwriting has been part of company operations since the 50s, when the shift from property to long-tail liability coverages amassed large amounts of cash in dormant reserves that could be used for investments.

No, something else, is at work and the numbers show it. This year, after six months of rate increases, a stable securities market and substantial investment gains, we still chalked up a disturbing operating loss of \$2.25 billion.

The reason is unrelenting, deepening losses. The industry has had five underwriting cycles since the 50s. They have gotten shorter on the upside, longer and deeper on the downside. The first three bottomed out at a combined ratio of 103, the fourth at 108, and the latest one at 118.

Something is pulling insurers deeper under water and holding them there. That something is the civil justice system.

We have all heard about the million dollar judgments and I won't bore you with more horror stories.

For the companies who have to pay outrageous claims, the financial shock can be severe. But they are not really the problem for the industry as a whole. As is usually the way with big things, it is the small, little-noticed changes that, over time, produce the big effect. What's happened to the civil justice system is what workers' comp lawyers call cumulative trauma.

In 1982, over 206,000 civil cases were filed in the federal district courts. No one knows how many were filed in the state courts, but in all likelihood, the number was even larger. In Los Angeles alone, the cost for the average civil case is \$20,860. Recently the general counsel of the Travelers estimated that their defense costs went up 79 percent in five years.

Yet, it's not the case that goes to trial and results in a multi-million dollar verdict that should overly concern us. It's the thousands of routine cases that are settled, because the courts' inconsistencies, and their eagerness to find ways to help the claimant hit the jackpot, that have destroyed insurers' faith in the legal process. Who can trust the courts when they change the rules in the middle of the game or rewrite contracts from the bench? What it all adds up to is not only more and larger claims payments, but higher administrative costs as well.

Deplorable conditions like these can be papered over with rate increases and more selective underwriting, but they will not be corrected until the tort system is reformed. We are in the same boat as our insureds - we are all victims of a runaway tort system, but we are the first victims in line. It's only a matter of time before the rest of society joins the infinite list of victims.

At a hearing back in September before the Commerce, Transportation and Tourism Subcommittee of the House Energy and Commerce Committee, NAI Vice President and General Counsel John B. Crosby summed up the short term prospects very well when he said, "In order to continue to provide the insurance protection necessary for a growing economy, the companies must return to a position of solvency and this can only be accomplished through price increases. In the short run this will be traumatic on the budgets of buyers, public and private. To do otherwise raises the prospect of driving a large segment of the industry into insolvency and forcing many buyers of insurance to go bare. As Forbes magazine put it not too long ago, 'a world without insurance' would result."

In order to keep price increases within some degree of reason, Mr. Crosby suggested the loss side of the equation must be dealt with. And it is here that public pressure for civil justice reform must be brought to bear.

In a number of states business coalitions have been formed to review the trends which have developed over the past decade and to recommend legislative remedies such as restrictions on punitive damages, limits on contingency fees, elimination of joint and several liability ... in short, they want what we want: the return of reason and common sense to the civil justice system.

The insurance industry, along with business and labor, have commissioned a study by the Rand Corporation to analyze the present tort system, and we hope to have those recommendations shortly.

The Insurance Services Office is proposing several changes which could have long-range benefits to the buyer. One is to give insurers (and their buyers) the option of using a "claims made" policy. This option will permit insurers to put a more realistic price on the commercial liability product as it eliminates the uncertainty brought about by claims discovered today that are due to occurrences which happened years ago.

The insurance industry is cooperating with state regulators, not conspiring with them, to develop open lines, market assistance plans, joint underwriting associations, and risk pools to name a few of the voluntary and unilateral actions being taken to address the crisis.

These are some of the actions being taken by the insurance industry. But they are short-term actions. The real solution lies with reform in our civil justice system.

Thank you.