HB

166

DELIVER TO: LIOCDLD

ORIGINAL
SENT: 04/22/89 TIME: 10:14
FROM: LIOCMAB
SUBJECT: (H)L&C;HB166;4-22
PRINT DATE: 04/22/89 TIME: 10:14

*** ANCHORAGE PARTICIPANT LIST ***

TO: ALL TELECONFERENCE SITES
FROM: MARYANN--> ANCHORAGE
SUBJECT: HB166, CIVIL LIABILITY
DATE: APRIL 22, 1989
TELECONFERENCE NO. 89-04-047

TO TESTIFY:

CHARLES MCKEE

TO OBSERVE:

BOB NESTEL
GENE ROGUSZKA

EOM ..... DJ

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DELIVER TO: LIOCGLE

ORIGINAL
SENT:          04/20/89  TIME: 16:17
FROM:          LIOCINE
SUBJECT:       (H)L&C;HB166;4-20;ANC,PL#1
PRINT DATE:    04/20/89  TIME: 16:19
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*** ANCHORAGE PARTICIPANT LIST ***

TO: ALL TELECONFERENCE SITES
FROM: INEZ ---> ANCHORAGE

DATE: APRIL 20, 1989
TC #: 89-04-048
SPONSOR: HOUSE LABOR AND COMMERCE
SUBJECT: HB 166 - CIVIL LIABILITY

TO TESTIFY:

1.) CHARLES MCKEE
2.)

TO OBSERVE:

1.) GAIL GATTON
2.)

EMAIL ADDRESS IS: LIOCINE
BACKUP NUMBER IS: 561-1199

EOM ..... JV

DELIVER TO: LIOCGLE

ORIGINAL
SENT: 04/20/89 TIME: 16:22
FROM: LTCCSOL
SUBJECT: H L&C;PL#1-HB166;4-20
PRINT DATE: 04/20/89 TIME: 16:22

T/C NO: 89-04-040

DATE: 4-20
SPONSOR: HOUSE LABOR & COMMERCE
SUBJECT: HB166 CIVIL LIABILITY
MODERATOR: ALYSON
SITE: SOLDOTNA

PARTICIPANT LIST

TESTIFIED

	NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1.				
2.				
3.				
4.				
5.				

OBSERVED

	NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1.	DENNIS MURRAY	ADMINISTRATOR HERITAGE PLACE 232 ROCKWELL		
2.		SOLDOTNA, 99669	262-2545	
3.				
4.				
5.				

TESTIFIED:
UNABLE:
OBSERVED:
TOTAL:

START TIME: END TIME:

***

HOUSE COMMITTEE REPORT

(7)
Date Referred: February 10, 1989 FURTHER REFERRALS: JUDICIARY

Date of Committee Action: 5/8/89

The LABOR & COMMERCE Committee considered: HB 166

HOUSE BILL NO. 166 [CIVIL LIABILITY]
"An Act relating to civil actions; amending Alaska Rules of Civil Procedure 68 and 82; and providing for an effective date."

RECOMMENDS:

[V] replacing with CS HB 166 (L+C) [ ] the same title [✓] a new title
[ ] the attached amendment(s)
[ ] do pass
[ ] do not pass
[V] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):
[ ] fiscal impact
[ ] zero fiscal note
[ ] zero with analysis

APPROVES PREVIOUS:
[ ] fiscal note(s) published:
_____
[ ] zero fiscal notes(s) published:
_____

SIGNING DO PASS:

SIGNING OTHER THAN DO PASS:
(Do Not Pass, No Recommendation, Amend)
AT THIS TIME NO REC.
NR - needs amending
- NO REC
needs amendment
/ NO REC
/ NO REC
- NO REC
- DO NOT PASS this VERSION

agree original Committee Report this way

Chairman's signature

SPECIAL MEETING
OF
THE ALASKA MENTAL HEALTH PROGRAM DIRECTORS' ASSOCIATION
February 19, 1988

RESOLUTION 4-88

CS-SB 67

Whereas, there is pending before the legislature CS-SB 67, a bill which mandates inclusion of mental health coverage in policies of insurance providing coverage for physical health,

AND

Whereas it is apparent to this Association that there is a critical need for welfare of citizens of Alaska for said coverage,

NOW therefore be it RESOLVED

That this organization supports and urges passage of said CS-SB 67.

ADOPTED: February 19, 1988

Pamela J. Delys-Baglien, Ph.D.
Chair, Alaska Mental Health Program
Directors' Association

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

STEVE COWPER, GOVERNOR

REPLY TO:

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☒ *P.O. BOX K—STATE CAPITOL*
JUNEAU, ALASKA 99811-0300
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April 26, 1989

The Honorable Dave Donley
Chair
House Labor & Commerce Committee
House of Representatives
P. O. Box V
Juneau, AK 99811

Dear Representative Donley:

Thank you for your request of April 5, 1989 concerning issues raised by the EXXON VALDEZ oil spill and the impact HB 166 would have on them.

Because the State of Alaska will be involved in litigation concerning the oil spill we are unable to respond to your request. We apologize for the inconvenience.

Sincerely,

DOUGLAS B. BAILY
ATTORNEY GENERAL

By: Ronald W. Lorensen
Deputy Attorney General

RWL:EJK:prm

03-C5LH

NATIONAL INSURANCE
CONSUMER ORGANIZATION

Statement of

J. PETER HUNTER, PRESIDENT
NATIONAL INSURANCE CONSUMER ORGANIZATION

Before: The Joint Hearing
of the
House Labor and Commerce Committee
and the
House Judiciary Committee
of the
Alaska State Legislature

April 25, 1989

Mr. Chairman and members of the Committee, it is a great pleasure to be back in Alaska.

I have a question: Why are you still considering so-called "tort reform" when everywhere else the issue is now insurance reform and "tort reform" is a dead issue? There is a good reason for the change. Consider these facts:

*20 States, including Alaska, have sued insurers alleging collusion to create the liability insurance crisis of the mid-1980's --- the predicate for "tort reform."

*California citizens adopted Option 103, wisely recognizing the need to tame the monumental (and uncontrolled) insurance industry.

*We now know that tort reform doesn't lower insurance rates but insurance reform does!

*Key insurance reform proposals have gained widespread support (for example, the effort to repeat the anti-trust exception insurer enjoy in the McCarran-Fergusen Act is supported by both ABA's (Bar and Banker), small businesses, the American Nurses' Association, the National Association

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

of Attorneys General), AARP, all consumer groups, environmental groups, civil rights groups, the FTC and the Ford, Carter and Reagan Justice Departments).

I. FROM A CONSUMER VIEWPOINT, WHAT'S WRONG WITH TORT REFORM?

A. "Tort Reform" doesn't lower prices

Given this history, any adoption of Tort Reform without mandatory lower insurance rates is surely buying 'a pig in a poke.'

1. The Aetna and St. Paul Filings. Aetna Casualty and Surety Co. and St. Paul Fire and Marine Co. have undertaken closed claim studies purposing to demonstrate that the savings resulting form five major tort reforms enacted in Florida -- eliminating the collateral source rule, capping non-economic damages, restricting joint and several liability, limiting punitive damages, and requiring periodic payment of future economic damages -- would be negligible. See attachments 1A and 1B.

2. The State Farm letter. State far has corroborated the Aetna and St. Paul results. In a letter to the Kansas Insurance Department State Farm concludes, on the basis of "a sampling of commercial liability claims," that the following tort reforms would bring about the following savings:
   a. eliminating the collateral source rule -- "about 1%";
   b. non-economic cap -- "will not exceed 1%";
   c. restricting joint and several liability -- "in our sample of liability claims, no claim was found that would have been affected by the joint and several restriction";
   d. limiting punitive damages -- "in our sample, no punitive damage awards were found";
   e. alternative payment of future economic losses - savings "would be negligible."

State Farm also emphasized that "it will probably be several

years before any effect from tort reform legislation can be expected to influence our experience." See Attachment 2.

3. The Florida Insurance Department data. 277 rate filings purporting to calculate the effect of the Florida tort reforms are on file with the Florida Insurance Department. 175, or 63%, showed no effect from the Florida tort changes, and the average reduction in all 277 filings was 1.2%. See Attachment 3. By way of contrast, insurance companies increased premiums in Florida by 62% in 1985, according to NAIC data, and by a similar amount in 1986.

4. The Great American West letter. In Washington state, which enacted perhaps the most comprehensive tort reform package in the nation in 1986, Great American West, Inc. calculated that the new law would, if anything, raise insurance rates. Great American West concluded:

   "It does not appear that the 'tort reform' law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the 'tort reform law." See Attachment 4.

5. The ISO Chief Executive Circular. Perhaps most disturbing, the Insurance Services Office has announced that it is issuing "advisory" rates that show no reduction resulting from tort reform, and has emphasized to its member companies that "any beneficial effects of tort reform cannot be quantified with any degree of accuracy" (emphasis ISO's). See Attachment 5. Yet when in 1975 New York enacted tort reform that would expand liability by replacing contributory negligence with comparative negligence, with comparative negligence, and would through raise insurance costs, ISO immediately raised its advisory rates by 5%,

and provided full actuarial justification for the increase. See Attachment 6. It is not readily apparent why ISO can tell us how much rates should rise when tort law expands, but can't tell us how much rates should fall when tort law is limited.

Whether it is good public policy to reduce insurance rates by limiting compensation to seriously injured people is a question on which reasonable minds can differ. But it is clearly not good policy to limit compensation to injury victims and get nothing in return.

B. "Tort Reform" lowers consumer rights and gives them nothing in return.

"Tort reform" takes away from the victim of negligence. It grants nothing in return for this reduction in rights. There should be a quid-pro-quo if Alaska's citizens are to be denied their rights.

C. "Tort Reform" is not based on careful analysis of need.

There have been few careful studies of how victims are treated under the current liability system to determine if there is a problem that needs fixing.

For Texas, where a closed claim study was undertaken, it showed no need for changes in the legal system

To try to find something without understanding what, if anything, is wrong with it, makes no sense.

D."Tort Reform" lowers the deterrance effect of the legal system.

How could copying the liability of Exxon's oil transport strike you? Or Ford in building Pintos? Or A.F. Robbins in building Dalcom Shields?

America's consumers need the protection of the legal system to deter inappropriate behavior; to stop "crime in the suites."

E. The need for flexibility

People are not chattle. They are not fenders bumped or houses burned. When a drunk driver runs over a bread-winner, or a little girl, or a underwater reef, the penalty must fit the circumstances, both in terms of the victim and the wrongdoers act.

II. WHY DO CONSUMERS WANT INSURANCE REFORM?

A. Insurers are grossly inefficient

"Republican or Democrat, liberal or conservative, there is one thing we can agree on --- waste is bad, inefficiency robs us all."

Andrew Tobias
The Invisible Bankers

"Tobias says we are inefficient and he's right. We spend too much on distribution, overhead and just plain waste."

John Cox, President
Insurance Agency of North America

One of the best service auto liability insurers, USAA, delivers the product at a total overhead cost of twenty cents on the premium dollar. The average insurer requires over thirty-five cents. Prices could fall by 19% if the average insurer becomes as efficient as USAA.

B. Insurers are not well regulated.

Alaska's insurance regulation has historically been, to put it in its most favorable light, non-existant. Often bragging about the highest profits in the nation in its annual report, the Department has not historically protected consumers in this state.

When last I appeared here, I challenged then Director George by saying I doubted that the Department had ever

disapproved a rate. He responded by pointing out that he had too disapproved a rate -- an automobile rate for State Farm -- a decrease!! He said he was afraid State Farm would attract too much business if their rates went down.

How's that for consumer protection?

I don't mean to pick on Alaska, particularly State regulation generally is awful. I am encouraged by the neew Director Roller. The U.S. General Accounting Office found "a lack of arms-length relationship between the regulators and the regulated" and that consumers were, generally, not protected by the state insurance departments of the nation.

C. Insurers are not fully competitive

In most states, insurers are structured comparatively. In auto insurance, for instance, 29 states have low concentration (Herfindahl-Hirschman Index below 1000), 21 are moderately concentrated (HHI between 1000 and 2000) and one, Alaska is heavily concentrated (HHI greater than 1000).

So, you have a problem with relying on competition, even in the best of competitive worlds.

But insurance is hardly "the best of competitive worlds," viz:

*it is largely exempt from anti-trust laws (Alaska exempts it from state anti-trust law and the McCarran-Fergusen Act exempts it from federal anti-trust law).

*it is the last bastion of fair trade laws (the Alaska anti-rebate law makes it unlawful for agents to offer discounts).

*there are prohibitions on group sales

*insurance price and service information is hard to understand, if you can find it at all.

Combining these comparative impediments with weak regulation guarantees two things:

- inefficiency and/or
- excessive profits

D. Alaska's profits are excessive

We know insurers are inefficient so profits can be hidden. But profits are too high in Alaska. According to the National Association of Insurance commissioners, Alaska's property/casualty insurance profits are among the highest in the country.

Here are the overall profits for the last decade:

	Premium Earned	Operating Profit	Total Return on Equity Ø	Premium Earned*	Operating Profit	Total Return on Equity
1978	$285 Million	6.3%	17%	$80 Billion	5.9'1	16'1.
1979	258	9.1	23	89	4.7	14
1980	257	6.8	19	95	4.6	15
1981	264	3.5	13	97	3.3	13
1982	332	18.0	43	103	0.7	8
1983	412	4.8	17	111	-0.2	7
1984	443	3.1	14	121	-3.2	1
1985	537	-1.9	4	140	-4.1	-
1986	642	3.4	15	176	2.0	13
1987	636	7.1	23	197	3.1	15
Total	$4,066 Million	5.4%	18%	$1,209 Billion	1.4%	10'1.

*Source: National Association of Insurance Commissioners, Profitability by line, by state, ten most recent editions.

Ø Estimated by assuming equity to premium rates of 2:1; investment income on equity of 9% latest year decreasing by 0.5'1. by year.

And this national 10% return understates the real economics vitality of their industry. during the same 10 years, the property/casualty industry's common stock have risen by 308'1. vs. 163'1. for the NYSE Composite Index (Source: Bests' Insurance Management Regents, January 1988.

Profitability in 1987 in Alaska for Medical Malpractice was over 50'1. return on equity and for other liability was over 40%r e-turn. But this was a high profit compared to other recent years. Medical malpractice profits in Alaska mirror the national aver-ages over a ten-year review. When the General Accounting Office discounted reserve method of measuring profits is used, the return is about 30% over 10 years. The other liability return in Alaska was lower than the national average of GAO, 26% It was about 12% a good, not excessive return (if you ignore expense inefficiencies).

In 1987, Alaska's leading writers did well, viz:

Leading Medical Malpractice Writers:

		Loss Rates*
1.	Medical Indem. Alaska	50.8%
2.	Medicine/N.S. Exch.	34.0
3.	CNA	66.5
4.	Health Care Indem.	56.6
5.	Amer. International	53.0

A profitable loss ratio would be about 90%. This shows remarka-ble profits in 1987.

*Source: Best's Executive Data Service

Alaska's Leading Other Liability Writers

		Incurred/Earned Less Ratio
1.	American International	62.9%
2.	Alaska National Insurance	33.8
3.	Crum & Forster	64.8
4.	Nationwide	50.3
5.	CNA	50.6

A loss ratio of the order of 85% should be profitable. Again, 1987 was a remarkably good year for insurers in Alaska.

1988 was better, nationally. I do not have 1988 Alaska data as yet.

III. THE SPECIFIC PROBLEM - MEDICAL MALPRACTICE FOR DOCTORS DELIVERING BABIES IN RURAL AREAS

A. A real problem

No one should minimize the serious nature of unaffordability of malpractice insurance in rural areas for doctors delivering babies. Alaska is not alone in having this problem.

B. The Medical Malpractice "Crisis" in Alaska is NOT Due to an Expensive Aggregate System Cost.

If you look at the total costs of the Medical Malpractice system in Alaska it is an inexpensive system. For example, the latest data from the National Association of Insurance Commissioners (NAIC) shows total premiums in Alaska of $13.6 million during 1987. That's $28.00 per person (The statistical Abstract of the United States shows 481 Thousand people in Alaska in 1984).

For perspective, the average American spends $133f per year on tobacco products.

Another way to look at system cost is vis-a-vis total medical costs in the state. According to the Alaska Department of Health, Alaska spent $2,763 per capita health care costs by 1.0% ($28.00 divided by $2,763). I dare say that if you had no system to compensate the victims of malpractice and someone offered to do it for you for a percentage this small, you'd probably grab it.

C. Allocation is the Problem.

The problem is cost allocation, not total system costs. There are only about 550 doctors in Alaska (Statistical Abstract, 1986). This drives the cost very high, to about $25,000 per doctor on average, some of which may

be positive (because of deterrence effects), but some of which is likely inappropriate.

If you think of the medical profession as a pyramid, with the relatively many G.P.'s at the bottom and the relatively few specialists at the top, I think the problem becomes easier to visualize.

If I wake up in the morning with a bad back and go to my G.P., the likelihood of a major malpractice suit arising is negligible. But if my back is a serious medical problem, I will be referred up the specialty ladder until I get to the neurosurgeon.

At the top of the pyramid, where the number of insureds is least, the risk is greatest. Bad outcomes become more likely. The chance of lawsuit rises, and the cases are much more complex.

I believe it violates insurance spread-of-risk principles to force so much through such a narrow base. (Even though neurosurgeons net income, after med mal premiums, is excellent according to medical economics).

For one thing, why should the defense costs for the complex suits neurosurgeons win be forced to be spread through only the neurosurgeons? Why shouldn't the referring physician and the hospital granting privileges bear some of the cost of successful suits (as incentives for safer referrals/privilege granting)?

The overall system cost is reasonable in your state. Your focus should be on the allocation process, in my estimation.

IV. REINSURANCE PROBLEMS

A. Lloyds of London, the dominant reinsurance company with approximately 25% of the world-wide market, has been wracked by scandals in recent years.

For example:

o Between 1973 and 1982, two Lloyd's underwriters, Peter Cameron-Webb and Peter Dixon, siphoned off for their own use $55 million belonging to 1,500 Lloyd's members. Investigators say they used the money for yachts, corporate aircraft, a French orange juice company and a pornographic movie entitled "Let's Do It." see Chicago Tribune, Oct. 20, 1985, at 5; Business Week, Aug. 5, at 57.

o Many of the 1,500 swindled by Cameron-Webb and Dixon are suing Lloyds (although Parliament immunized Lloyds from lawsuits in 1982, the 1.500 are claiming that the immunity doesn't apply to events occurring before 1982). Lloyds, on the other hand, is claiming that the 1.500 owe Lloyds another $180 million. 100 members face bankruptcy and 200 have been suspended for failing to meet Lloyds' solvency test. See Chicago Tribune, Oct. 20, 1985; Business Week, Aug. 5, 1985.

o Lloyds has grown too fast. In the last decade the number of Lloyds' members has more than tripled to 26,050. Chicago Tribune, Oct. 20, 1985. Since 1981 alone, Lloyds has added 7,000 new members, including "newly rich doctors, lawyers, accountants and rock musicians . . . lured by the hope of annual returns to members that topped 100% some years." Business Week,. Aug. 5, 1985. Its total premium writing capacity rose from $3.4 billion to $9.4 billion. Id.

B. In 1982, Lloyds was granted immunity from lawsuits by the British Parliament. Business Week, Aug. 5, 1985, at 58.

C. Lloyds has threatened, coerced and intimidated both insurers and insureds -- such as states -- in order to keep insurance rates high, as the following statements indicate:

o You may recall this statement:

> "If you change your tort laws in Alaska, you will have a market here when the rest of the United States will not. Lloyds is pulling out of the United States as a reinsurer -- they have already pulled out of Connecticut, New York and New Jersey
>
> -- and they're continuing to pull out of more states."
>
> Statement of Jeff Johnson, Partner, LeBoeuf, Lamb, Lieby and McCrae (U.S. counsel for Lloyds), at the Casualty Insurance Colloquium, Anchorage, Alaska, Sept. 17, 1985.

Alaska is not alone:

o ". . . in order to keep [Lloyds] participation on cover we had to accede to some strong suggestions from the reinsurers to beef up the rate charged to the OB's."

> Statement of John Spinella, President, Medical Mutual Liability Insurance Society of Maryland, before the Governor's Task Force on Medical Malpractice, Oct. 22, 1985.

o "[reinsurance brokerage head Thomas A.] Green said that beginning in 1986, Lloyd's syndicate would 'simply not write reinsurance for the American casualty industry.'"

> Journal of commerce, June 18, 1985.

o "Mr. Wakefield conceded that Lloyds cannot dictate to American regulators on Policy approval, but he wryly

said that if the new form is not approved, Lloyds will not reinsure American liability underwriters."

Journal of Commerce, July 26, 1985, citing C.T. Bowing & Co. Chief Executive Gerald Wakefield, presenting Lloyds' views to 17 insurance commissioners.

- "A Lloyd's of London delegate who flew over expressly for the [insurance commissioner's] meeting added that unless the U.S. industry was permitted to adopt the new form, the lloyds reinsurance market would discontinue backing American underwriters forthwith."

Journal of Commerce, July 27, 1985.

D. Neither the U.S. government, the states, or the British Parliament regulate Lloyds.

E. The British pound, which was worth $2.80 in the mid-1960's has been worth less than half that for most of the last two years and fell to $1.05 in February 1985. Thus, whereas Lloyds would need to pay only 10,000 pounds to satisfy a $28,000 claim in 1963, today it must pay 20,000 pounds to satisfy the same claim and in February 1985 -- when the pressure first started to build for tort reform -- it had to pay 26,600 pounds.

V. SOLUTIONS

A. How to Solve the Insurance Crisis -- What Alaska Should Do

1. Repeal Alaska's Anti-trust Exemption
2. Repeal statutes that prohibit businesses and consumers from joining together to buy insurance in groups. Today, in most states, group health and life insurance is available, but group liability insurance is illegal. If laws prohibiting such group insurance were repealed, the price of liability insurance would fall.

3. Prohibit rate increased from taking effect until such increases are approved by the insurance commission. Today, in most states, increases automatically take effect unless disapproved within a certain number of days; because the burden is on the insurance commission to disapprove a rate, and because insurance commissions do not have the staff to analyze even a fraction of rate filings, most increases automatically take effect. Shifting the burden of proof to the insurance company to demonstrate that a rate increase is justified would limit such increases.

4. Allow greater consumer representation before regulatory bodies. Typically, only regulators and insurance companies participate in rate cases. to increase citizen participation in the ratemaking process, states should authorize Citizens' Insurance Boards, groups of insurance consumers who would intervene on their own behalf. In the alternative, states could establish Offices of Public Advocates to intervene in rate cases, as new Jersey and some other states have. In New Jersey when the Public Advocate intervenes in a rate case the cost of that intervention is billed back to the insurance company seeking the rate increase, thus discouraging insurers from seeking exorbitant increases.

5. Require that insurance rates be based on experience. Because insurance companies today often lump all insureds in a category together, regardless of how often any individual insured has been sued, good risks currently subsidize bad risks. Experience rating would go along way toward bringing down premiums for medical malpractice insurance, in which experience rating is now virtually non-existent.

6. Enact tough conflict-of-interest statutes to close the "revolving door." As the U.S. General Accounting Office has found, 50% of state regulators come from and return to the industry; the relationship between the industry and the regulators is not an arms-length relationship.

7. Require that insurance companies disclose their loss data on a line-by-line basis. Such disclosure would enable regulators to better discern whether rates are excessive, inadequate or unfairly discriminatory.

8. Establish state reinsurance programs.

9. Beef up the Insurance Department both authoritatively and with resources.

10. Repeal the state anti-rebate law.

11. Publish buyers guides with price and service information.

B. Medical Malpractice

Render the above:

1. Lessen the number of classes.

2. Let hospitals bear part of the cost for adverse procedures in the hospital. Consider channeling doctors malpractice costs through hospitals.

3. Consider a specific subsidy in rural areas for physicians consider additn a malpractice charge on all health insurance premium as a subsidy dollar base.

4. Attract more physicians to Alaska to normalize the patient/doctor ratio.

VI. WHY CONSUMERS OPPOSE HOUSE BILL NO. 166

Generally:

1. We lose rights.
2. We get nothing in return (such as a victim's reparations regime).
3. It treats us like a fender, not a person.
4. It won't work to lower rates and make insurance more available.
5. It lowers deterrance.
6. There is no study showing need for change.

It specifically has these problems, among others.:

1. Lets faulty product manufacturers or bad surgeons off the hook if six years go by before the product blows up or the sponge works its way into someone's heart.

2. Fixes the possibly real problem of collateral source in exactly the opposite (and wrong) way. While no one should collect twice for the same injury, the wrong doer should pay, not our policies. Our rate should go down, not drunk drivers.

   mandate subrogation and order lower health insurance rates.

3. Creates inter-family problems by limiting a baby's right to sue to two years ending special treatment for minors.

4. It limits our freedom to choose the sort of settlement we want, lump sum or structured.

5. It creates a disincentive for insurers to pay (as if they needed any more) by charging them below market interest if they delay.

6. It caps non-economic damages in wrongful death cases at a pitiful $50,000.

VI. CONCLUSION

Alaska needs reform that works -- Alaska needs insurance reform. Like other smaller population states, large multi-national insurers can hold you hostage. You may well need consider working for interstate compacts with larger states to avoid the kind of under pressure Lloyds and others have brought to bear here. And other states are moving. Almost every state has insurance reform bills before the legislature. Little New Mexico voted to repeal that state's anti-trust exemption, but the governor vetoed it under intense pressure from the insurers. Arizona has many reform bills before it. South Carolina is moving a bill. Maryland returned to prior approval. The Texas Senate late last week voted to repeal that state's anti-trust exemption. The Chairs of the U.S. Senate and House Judiciary Committees have introduced bills to end McCarran's broad anti-trust immunity.

Now is the time for insurance reform. I pledge NICO's assistance to you in achieving such real reform.

Thank you. I would be happy to answer your questions when that is appropriate.

Schwarze

LAW

F: 101(e)

HOUSING / LAND / PROPERTY - BUILDING LAWS

The scope and legality of statutes of repose

Most courts uphold laws cutting off actions against designers and contractors, but split on the issue of their application to products

By Milton F. Lunch

For more than 25 years the design profession, jointly with contractors, has acted to secure state laws which effectively cut off rights of action by plaintiffs for alleged negligence after a reasonable period of time following completion of a project.

These efforts have been largely successful through enactment of what were originally called "statutes of limitation," but now are more properly designated as "statutes of repose." Only two state legislatures (Arizona and Iowa) have failed to pass any kind of legislation along this line.

With few exceptions, these laws cutting off a right of action against A/Es and contractors after the established period of time have been attacked on constitutional grounds. The score stands at 30 states finding them constitutional and 10 holding them unconstitutional. In the remaining 10 states there has been no definitive decision.

The basic legal issue on which the courts have ruled one way or the other on the constitutional question is in reality more of a social or policy issue. Courts which have come down against such statutes argue that they are contrary to the "open court" provisions in the state constitution to bar an action for injury before the injury has occured. Thus, where there was a defect in design or construction which was not manifest until years after substantial completion of the project, and beyond the statutory cutoff period, it would be an injustice to dismiss the suit for damages before the injured party had a chance to prove negligence.

The contrary, and majority, view of courts which have passed on the issue is that it may be equally unfair to the designer or contractor to face a negligence claim indefinitely. At some reasonable point in time, a person should not have to face a never-ending possibility of a suit based on work done many years earlier.

Factors favoring a limitation

The courts finding in favor of the constitutionality of statutes of repose also note the problem of proof of fault years after the project is completed. Documents have disappeared and witnesses, if still available, have faulty memories of the facts. Favorable decisions often note that, unlike products, the design and construction of projects are not subject to testing. Finally, the majority view is that the issue is properly one for legislative policy determination, rather than judicial fiat.

What is a reasonable cutoff period following substantial completion? This varies considerably among the state laws, ranging from a low of four years to a high of 15 years, with an average of seven or eight years. Some attempts are being made to lower the cutoff to five years, but there is a danger that the courts may consider this unduly short.

Now that the basic concept is well established in the majority of states, a series of court decisions have dealt with the question of interpretation of the specific language. Still a current question is whether the statute of repose applies to products incorporated into a structure. The courts are split, depending on the particular facts of the case, and it may be some time before a consensus emerges on the issue.

In a recent Pennsylvania case, for instance, a federal court applying Pennsylvania law in an action against the manufacturer of an oven that had been installed in an industrial building held that the statute did not apply because the oven was not "an improvement to real property." This is language common to all the state statutes of repose.

Contrary to the conclusion in the Pennsylvania case, the Texas Court of Appeals has held that the statute did apply to the manufacturer of a wall heater that allegedly caused carbon monoxide poisoning. The heater, the court said, was an "improvement to real property," and not just a fixture because it was actually built into the wall.

Therein may lie the distinction to guide the courts in subsequent cases: Was the product an integral part of the building, thereby being an "improvement to real property"? Or was the product installed in such a way that it was readily movable, thereby being a fixture? A dissenting justice in the Pennsylvania case said the answer "should turn upon whether their component parts were specifically designed for this purpose or were shelf items intended for many purposes . . . ."

The Supreme Judicial Court of Massachusetts recently held that the statute of repose did not protect the supplier of a circuit breaker which had been incorporated into the structure on a permanent basis, but applied only to those who " . . . render particularized services for the design and construction of particular improvements to particular pieces of real property."

As is always the case, each decision turns on its own facts. But the most likely test should be whether the product in question becomes a permanent part of the structure, thereby losing its character as a separate product, just as the bricks and steel in a building are absorbed into and become an integral part of the building. However, as usual, the courts will have the last word. △

Milton F. Lunch is former general counsel of the National Society of Professional Engineers, and presently serves as a consultant on architectural and engineering legal matters. No statement in this article should be acted upon until your attorney assures you that it applies to your situation.

HOUSING, LAND, PROPERTY
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BUILDING LAWS

EXHIBIT "A"

State	Statute of Repose	Constitutional/ Unconstitutional	Citation
Alabama		Unconstitutional	Jackson v. Mannessman Corp., 435 So.2d 725 (1983).
Alaska	$09.10.055	Undecided	
Arizona	None		
Arkansas	§37-239	Constitutional	Carter v. Hartenstein 455 S.W.2d 918 (1970)
California	§337.1, 337.15	Constitutional	Barnhouse v. City of Pinole, App., 183 Cal.Rptr.881 (Ct.App 1982)
Colorado	§13-80-127	Constitutional	Criswell v. M.J. Brock & Sons, Inc. 681 P.2d 495 (1984)
Connecticut	§52-584a	Constitutional	Patricia O. Ecker v. Town of West Hartford 205 A.2d 219 (1987)
Delaware	§8127	Constitutional	Cheswold Vol. Fire Co. v. Lambertson Const., 489 A.2d 413 (1984)
Dist of Columbia	§12-310	Constitutional	Westerman v. Firemans Fund Ins Co.,499 A.2d 116 (Ct.App. 1985)
Florida	§95.11	Constitutional	American Liberty Ins Co. v. West & Conyers 491 So.2d 573 (Ct.App 1986)

HOUSING, LAND, PROPERTY
BUILDING LAWS

State	Statute of Repose	Constitutional/ Unconstitutional	Citation
Georgia	§3-1006	Constitutional	Mullis v. Southern Co Services, Inc., 296 SE.2d 579 (1982)
Hawaii	§657-8	Undecided*	Shibuya v. Architects Hawaii Ltd., 647 P.2d 276 (1982)
Idaho	§5-241	Constitutional	Twin Falls Clinic & Hospital Bldg v. Hamill, 644 P.2d 341 (1982)
Illinois	§22.3	Constitutional	Mateyka v. Melia, 456 N.E.2d 353 (Ill.App. 1983)
Indiana	§34-4-20-1	Constitutional	Beecher v. White, 447 N.E.2d 622 (Ind.App.1983)
Iowa	None		
Kansas	None		
Kentucky	§413.135	Constitutional	Carney v. Moody, 646 S.W.2d 40 (1982)
Louisiana	§9:2772	Constitutional	Burmaster v. Gravity 366 So.2d 1381 (1978)
Maine	§752-A	Undecided	
Maryland	§5-108	Constitutional	Whiting-Turner Contracting Co. v. Coupard, 499 A.2d 178 (Ct.App. 1985)

H/OUSING, LAND BUILDING LAWS

State	Statute of Repose	Constitutional/ Unconstitutional	Citation
Massachusetts	$2B	Constitutional	Klein v. Catalano, 437 N.E.2d 514 (S.Jud.Ct. 1982)
Michigan	$27A.5839	Constitutional	O'Brien v. Hazelet & Erdal, 299 N.W.2d 336 (1980)
Minnesota	$541.051	Constitutional	Calder v. City of Crystal, 318 N.W.2d 838 (1982)
Mississippi	$15-1-41	Constitutional	Anderson v. Fred Wagner, Etc., 402 So.2d 320 (1981)
Missouri	$516.097	Undecided	
Montana	$93-2619	Constitutional	Reeves v. Ille Electric Company, 551 P.2d 647 (1976)
Nebraska	$25-222,223	Constitutional	Williams v. Kingery Const Co, 404 N.W.2d 32 (1987)
Nevada	$1	Unconstitutional	State Farm Fire and Cas v. All Elec., In 660 P.2d 995 (1983)
New Hampshire	None	Unconstitutional	Henderson Clay Products v. Edgar Wood, Etc., 451 A.2d 174 (1982)
New Jersey	$2A:14-1.1	Constitutional	Rosenberg v. Town of North Bergen, 293 A.2d 662 (1972)

HOUSING, LAND, PROPERTY
BUILDING LAWS

State	Statute of Repose	Constitutional/ Unconstitutional	Citation
New Mexico	§37-1-27	Constitutional	Howell v. Burk, 568 P.2d 214 (Ct.App. (1977)
New York	None		
North Carolina	§1-46	Constitutional	Lamb v. Wedgewood South Corp., 302 S.E.2d 868 (1983)
North Dakota	§28-01-44	Undecided	
Ohio	§2305.131	Constitutional	Elizabeth Gamble Deaconess Home v. Turner Const., 470 N.E.2d 950 (Ct.App. 1984)
Oregon	§12.135	Constitutional	Joseph v. Burns, 491 P.2d 203 (1971)
Pennsylvania	§5536	Constitutional	Freezer Storage, Inc. v. Armstrong Cork Co. 382 A.2d 715 (1978)
Rhode Island	§9-1-29	Constitutional	Walsh v. Gowing, 494 A.2d 543 (1985)
South Carolina		Unconstitutional	Broome v. Truluck, 241 S.E.2d 739 (1978)
South Dakota		Unconstitutional	Daugaard v. Baltic Co-Op. Bldg. Supply Ass'n., 349 N.W.2d 419 (1984)

BUILDING LAWS

State	Statute of Repose	Constitutional/ Unconstitutional	Citation
Tennessee	§28-314	Constitutional	Harmon v. Angus R. Jessup Associates, Inc., 619 S.W.2d 522 (1981)
Texas	§5536a	Constitutional	McCulloch v. Fox & Jacobs, Inc., 696 S.W.2d 918 (Ct.App. 1985)
Utah	§78-12-25.5	Constitutional	Good v. Christensen 527 P.2d 223 (1974)
Vermont	§511	Undecided	
Virginia	§8.01-250	Constitutional	Smith v. Allen Bradley Co., 371 F.Supp. 698 (1974)
Washington	§4.16.310	Constitutional	Jones v. Weyerhaeuser Co., 741 P.2d 75 (Ct. App. 1987)
West Virginia	None		
Wisconsin	§893.155	Constitutional	United States Fire Ins Co v. E.D. Wesley Co., 301 N.W.2d 271 (1980)
Wyoming	§1-3-111	Undecided*	Phillips v. ABC Bldrs' 611 P.2d 821 (1980)

* Previous statute declared unconstitutional. New statute has been adopted by the Legislature, but not ruled upon by the Court.

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STATUTES OF REPOSE FOR DESIGN PROFESSIONALS

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Held Constitutional

ARKANSAS	Carter v. Hartenstein, 455 S.W. 2d 918 (Ark. 1970); app. dismissed for want of substantial federal question, 401 U.S. 901 (1971)
CALIFORNIA	Regents of the University of California v. Hartford Accident & Indemnity Co., 131 Cal. Rptr. 112 (Cal. App. 1976)
COLORADO	Yarbro v. Hilton Hotels Corp., 655 P. 2d 822 (Colo. 1982)
DELAWARE	Cheswold Volunteer Fire Co. v. Lambert & Sons Constr. Co., 462 A 2d 416 (Del. 1983)
D. C.	Britt v. Schindler Elevator Corp., 637 F. Supp. 734 (D.D.C. 1986)
FLORIDA	American Liberty Insurance Company v. West & Conyers, Architects and Engineers, 491 So. 2d 573 (Fla. App. 1986)
GEORGIA	Mullis, et al. v. Southern Services Co.,296 So. 2d 579 (Ga. 1982)
IDAHO	Twin Falls Clinic & Hospital Bldg. Corp. v. Hammill, 644 P. 2d 347 (Ida. 1982)
LOUISIANA	Burmaster v. Gravity Drainage District No. 2, 366 So. 2d 1381 (La. 1978)
MARYLAND	Whiting-Turner Contracting Co. v. Coupard, 499 A. 2d 178 (Md. 1985)
MASSACHUSETTS	Klein v. Catalano, 437 N.E. 2d 514 (Mass. 1982)
MICHIGAN	O'Brien v. Hazelet & Erdal, 299 N.W. 2d 336 (Mich. 1980)
MINNESOTA	Calder v. City of Crystal, 318 N.W. 2d 838 (Minn. 1982)
MISSISSIPPI	Anderson v. Fred Wagner & Roy Anderson, Jr., 402 So. 2d 320 (Miss. 1982)
MONTANA	Reeves v. Ille Electric Co., 551 P. 2d 647 (Mont. 1976)
NEW JERSEY	Rosenberg V. Town of North Bergen, 293 A. 2d 662 (N.J. 1972)
NEW MEXICO	Terry v. New Mexico State Highway Commission, 645 P. 2d 1375 (N.M. 1982)
NORTH CAROLINA	Lamb v. Wedgewood, 286 S.E. 2d 876 (N.C. App. 1982)
OHIO	Hartford Fire Ins. Co. v. Lawrence, Dykes, Goodenberger, Bower & Clancy, 740 F. 2d 1362 (6th Cir. 1984)
OREGON	Joseph v. Burns, 491 P. 2d 203 (Ore. 1971)
PENNSYLVANIA	Freezer Storage Inc. v. Armstrong Cork Co., 382 A. 2d 715 (Pa. 1978)
TENNESSEE	Harmon V. Angus R. Jessup Associates, Inc., 619 S.W. 2d 522 (Tenn. 1981)
TEXAS	Hill v. Forrest & Cotton, Inc., 555 S.W. 2d 145 (Tex. Civ. App. 1977)
UTAH	Good v. Christensen, 527 P. 2d 223 (Utah 1974)
VIRGINIA	Smith v. Allen-Bradley Co., 371 F. Supp. 698 (W.D. Va. 1974)
WASHINGTON	Yakima Fruit & Cold Storage Co. v. Central Heating & Plumbing Co., 503 P. 2d 108 (Wash. 1972)

STATUTES OF REPOSE FOR DESIGN PROFESSIONALS

Unconstitutional

HAWAII	Fujioka v. Kam, 514 P. 2d 568 (Hawaii 1973)
ILLINOIS	Skinner v. Anderson, 231 N.E. 2d 588 (Ill. 1967) *
KENTUCKY	Tabler v. Wallace, 704 S.W. 2d 179 (Ky. 1986)
NEVADA	State Farm Fire & Casualty Co. v. All Electric, Inc., 660 P. 2d 995 (Nev. 1983)
NEW HAMPSHIRE	Henderson Clay Products, Inc. v. Edgar Wood & Associates, Inc., 451 A. 2d 174 (N.H. 1982)
OKLAHOMA	Loyal Order of Moose Lodge 1785 v. Cavaness, 563 P. 2d 143 (Okla. 1977)
SOUTH CAROLINA	Broome v. Truluck, 241 S.E. 2d 739 (S.C. 1978)
SOUTH DAKOTA	Daugaard v. Baltic Cooperative Bldg. Supply Assn., 349 N.W. 2d 419 (S.D. 1984)
WISCONSIN	Kallas Millwork Corp. v. Square D. Co., 225 N.W. 2d 454 (Wis. 1974)

* But see, Skinner v. Hellmuth, Obata & Kassabaum, Inc., Oct. 17, 1986, upholding separate classification of A/Es for purpose of two-year cut-off period not related to substantial completion issue (copy enclosed).

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Guidelines for Improving Practice
architects and engineers professional liability

Volume XVIII, No. 8
(Replaces Volume IX, No. 6)

STATUTES OF LIMITATION AND REPOSE

Almost thirty years have passed since the enactment in 1961 of the first special statute of limitation for lawsuits against architects, engineers and others who design and build construction projects. During this period, much interest has been focused on the legislative programs that led to the enactment of such statutes and their interpretation by the courts once enacted.

This issue of *Guidelines for Improving Practice* updates Volume IX, Number 6; it will review some of that history and provide an update on the current status of statutes of limitation and repose for architects and engineers. It should be recognized, however, that new court decisions interpreting these statutes are being handed down with increasing frequency and some of the following information could quickly become out of date. Therefore, if the need arises, an attorney should be consulted to determine the precise status of the statutes of limitation or repose in any given jurisdiction.

The earlier Guideline reports on this subject have been identified as statutes of limitation, whereas in more recent years the courts have generally identified these statutes as statutes of repose. The essential difference between the two is that a statute of limitation refers to a limited period of time during which a plaintiff must file an action after the cause of action accrues; that is from the time the injury or damage was first discovered or reasonably should have been discovered. This limited period of time is usually in the two to three year range. A statute of repose, on the other hand, bars an action for injury or damage after a stated period of time following substantial completion of the project. Thus, injury or damage flowing from a constructed facility more than the number of years stated in the law (on the average between seven and eight years) is barred and the question of the alleged negligence of the design professional is not subject to legal procedures.

Statutes of repose have been challenged on constitutional grounds in almost every state which has enacted such a law. Most of these challenges have failed, but as shown in the following tabulation, some courts have rejected the statute of repose in cases where the injury or damage occurred after the statute had run out, and the plaintiff was denied the opportunity to present evidence of alleged negligence. Those courts which have rejected the constitutional challenges have noted that in striking a balance between the interests of potential plaintiffs and the interests of potential defendants who have a right to be free from suit after the passage of a reasonable period of time, the plaintiff is still free to pursue a claim against the owner or tenant in possession of the building; therefore the plaintiff is not left without a remedy.

In addition to the constitutional issue, the courts in many cases have had occasion to interpret the statutes in terms of those protected by it, the precise language as to scope of coverage by types of projects, and, in some cases, differences between patent (obvious) and latent (hidden) alleged defects. The following tabulation is summarized from a detailed review of the reference to the state codes and the pertinent court decisions. This comprehensive information is available to those architects and engineers, as well as to their attorneys, who may need such detail.

STATE BY STATE STATUS OF STATUTES OF LIMITATION AND REPOSE

Alabama—Seven year statute enacted in 1975 ruled unconstitutional in 1983.

Alaska—Six year statute enacted in 1967 held unconstitutional in 1988.

Arizona—No special statute has been enacted.

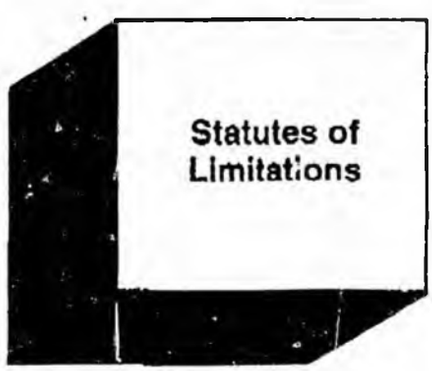
Arkansas—Five year (contract) and four year (tort) statute enacted in 1967 upheld in 1970, and U.S. Supreme Court dismissed further challenge because no federal question was involved.

California—Four year (patent defects) and ten year (latent defects) statutes enacted in 1967 and 1971 upheld in 1976 and 1982.

Connecticut—Seven year statute enacted in 1969 upheld in 1988.

Delaware—Six year statute enacted in 1970 upheld in 1984.

District of Columbia—Ten year statute



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enacted in 1972 upheld in 1986.

Florida—Fifteen year statute for patent defects and four years for latent defects enacted in 1980 upheld in 1986.

Georgia—Eight year statute enacted in 1968 upheld in 1982.

Hawaii—Ten year statute enacted in 1983. No cases to date on validity of the statute; previous statutes held unconstitutional in 1973 and 1982.

Idaho—Six year statute enacted in 1965 upheld in 1982.

Illinois—Two year statute of limitations for architects and engineers enacted in 1983 upheld in 1986; four year statute of repose held unconstitutional in 1967.

Indiana—Ten year statute enacted in 1967 upheld in 1983.

Iowa—No special statute enacted.

Kansas—Two year (patent defects) and ten year (latent defects) enacted in 1963. No reported cases, but held by trial court to bar malpractice action against an architect in 1977.

Kentucky—Five year statute enacted in 1966 held unconstitutional in 1985.

Louisiana—Ten year statute enacted in 1964 upheld in 1978.

Maine—Ten year statute enacted in 1975. No reported cases.

Maryland—Ten year statute enacted in 1979 upheld in 1985.

Massachusetts—Six year statute enacted in 1968 upheld in 1982.

Michigan—Six year statute enacted in 1967 upheld in 1980.

Minnesota—Ten year statute enacted in 1980 upheld in 1982.

Mississippi—Ten year statute enacted in 1966 upheld in 1982.

Missouri—The year statute enacted in 1976. No reported cases.

Montana—Ten year statute enacted in 1971 upheld in 1976.

Nebraska—Ten year statute enacted in 1972 upheld in 1987.

Nevada—Twelve year statute enacted in 1985 following 1965 statute being held unconstitutional in 1983. No reported cases on 1985 statute.

New Hampshire—Six year statute enacted in 1965 held unconstitutional in 1982.

New Jersey—Ten year statute enacted in 1967 upheld in 1972.

New Mexico—Ten year statute enacted in 1967 upheld in 1977.

New York—No separate statute for design professionals, but general malpractice law applied to cut off actions against design professionals on contract claims after six years following issuance of certificate of completion, and three years for claims based on negligence. Personal injury action by person with no prior relationship to design professional not covered by three year limit for negligence claim.

North Carolina—Six year statute enacted in 1963 upheld in 1983.

North Dakota—Ten year statute enacted in 1967 upheld in 1988.

Ohio—Ten year statute for negligence enacted in 1963 upheld in 1984; contract actions governed by fifteen year statute of limitations.

Oklahoma—Ten year statute enacted in 1978 held unconstitutional in 1987; appeal pending before state supreme court.

Oregon—Ten year statute enacted in 1971 upheld in 1971.

Pennsylvania—Twelve year statute enacted in 1965 upheld in 1978.

Puerto Rico—Ten year statute under ancient Spanish "plazo decenal" concept (imposing presumption of liability by design professionals if damage occurs within ten years of substantial completion, but absolute immunity after ten years) upheld in 1988.

Rhode Island—Ten year statute enacted in 1975 upheld in 1985.

South Carolina—Thirteen year statute enacted in 1986 after ten year statute enacted in 1970 was held unconstitutional in 1978. No reported cases under 1986 statute.

South Dakota—Ten year statute enacted in 1966 held unconstitutional in 1984.

Tennessee—Four year statute enacted in 1965 upheld in 1981.

Texas—Ten year statute enacted in 1975 upheld in 1987.

Utah—Seven year statute enacted in 1967 upheld in 1974.

Vermont—Eight year statute under general tort law enacted in 1959 applied to dismiss action against design professional in 1976.

Virginia—Five year statute enacted in 1964 upheld in 1974.

Washington—Six year statute enacted in 1967 upheld in 1972.

West Virginia—Ten year statute enacted in 1983. No reported cases.

Wisconsin—Six year statute enacted in 1979 following 1976 statute being held unconstitutional in 1975. No reported cases under 1979 statute.

Wyoming—Ten year statute enacted in 1973 held unconstitutional in 1980.

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Assessing the Effects of Tort Reforms

Stephen J. Carroll
With Nicholas Pace

1987

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The Institute for Civil Justice, established within The RAND Corporation in 1979, performs independent, objective policy analysis and research on the American civil justice system. The Institute's principal purpose is to help make the civil justice system more efficient and more equitable by supplying policymakers with the results of empirically based, analytic research.

RAND is a private, nonprofit institution, incorporated in 1948, which engages in nonpartisan research and analysis on problems of national security and the public welfare.

The Institute examines the policies that shape the civil justice system, the behavior of the people who participate in it, the operation of its institutions, and its effects on the nation's social and economic systems. Its work describes and assesses the current civil justice system; analyzes how this system has changed over time and may change in the future; evaluates recent and pending reforms in it; and carries out experiments and demonstrations. The Institute builds on a long tradition of RAND research characterized by an interdisciplinary, empirical approach to public policy issues and rigorous standards of quality, objectivity, and independence.

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I. INTRODUCTION

Liability insurance availability and affordability problems became widespread in the early 1980s. These problems touched off extensive debate over the need for changes to the body of laws governing compensation for personal injury or property damage—the tort system. By 1986, most state legislatures were considering modifications to their tort systems. In at least 41 states, the debate over what has come to be known as tort reform led to changes in the law.[1]

The debates, and resulting changes in the law, have given rise to widespread concern about how we should go about measuring the effects of tort reforms. These concerns have been accompanied by confusing, and sometimes conflicting, claims for what it is we want or need to know in order to assess the effects of changes in a state's tort system, how we might go about developing that knowledge, and what data we need to perform the required research.

This report offers a framework for assessing the effects of tort reforms. It provides a coherent structure for systematically thinking about how research can contribute to the policy debate over tort reform. Specifically, the report has three purposes:

- To alert policymakers to the issues that need to be considered when assessing tort reform.
- To suggest the kinds of research that would illuminate the major policy issues.
- To offer some guidance to data collection efforts by identifying the generic kinds of data needed.

This report does not provide step-by-step instructions for assessing the effects of reforms. Nor does it provide a list of specific research projects to be performed. Research designs will be needed to translate the general guidance provided here into specific research projects.

We do not suggest that all the studies discussed here are worth undertaking. Research and data collection efforts can be extremely costly; it is possible that the value of the information obtained in any particular study will be less than the cost of obtaining the information. Both public officials and private interests concerned with tort reform

[1]Some proponents of reform argue that relatively few states have undertaken significant reform and that many of the so-called reform states made changes to their tort systems so minor as to be negligible. The Appendix summarizes the tort reforms enacted in 1986.

issues will have to evaluate the likely benefits of each project, relative to its costs, to decide if the effort is worthwhile.

LIMITATIONS OF THE TORT REFORM DEBATE

While the nature of the debate varies from place to place, depending upon a variety of local factors and circumstances, certain limitations characterize the debate almost everywhere.

The debate focuses almost exclusively on the questions of whether, and if so, how much, the tort system affects the increasing cost and declining availability of liability insurance. Reform proponents argue that liability insurance is increasingly costly and sometimes unavailable because the tort system is increasingly expensive. In their view, the only way to control insurance costs is to modify the tort system to make it less expensive.[2] Their opponents counter that malfunctions in the operation and regulation of the insurance system are the cause of the problems, and reform would disadvantage injured claimants while having little effect on insurance premiums or availability.[3] Other issues affecting the tort system and questions of how reform might affect it are raised from time to time, and seriously considered on occasion. But, by and large, concern over insurance costs overshadows other considerations.

In fact, however, effects on insurance costs and availability are no more than byproducts of the tort system's operations. The system serves fundamental social purposes: It provides basic forms of protection, encouraging or discouraging certain kinds of behavior; it establishes the rules for compensating those who have suffered losses through the actions of others; and it offers the context for resolving civil disputes arising out of injuries or property damage. Significant changes, for better or worse, to the system's ability to deter unduly risky behavior, to fairly compensate injured parties, or to encourage rapid and decisive dispute resolution are arguably as important as changes in insurance rates and, in any event, cannot be disregarded in any evaluation of reform.

Second, the debates tend to focus on the performance of some individual segment of the tort system, disregarding its relationship with the entire system. But a change in any one part of such a complex system can reverberate throughout the system. We cannot understand

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[2]See, for example, "The Need for Legislative Reform of the Tort System: A Report on the Liability Crisis from Affected Organizations," Sidley & Austin, May 1986.

[3]See, for example, Thomas G. Goddard, "Testimony before the Liability Insurance Commission of the Iowa Legislature," Tucson, AZ, September 2, 1986.

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observations of any one part without considering how it affects and is affected by what is going on elsewhere in the system.

Reform proponents, for example, argue that the growing use of the legal system contributes to increasing costs.[4] Their opponents respond with a barrage of statistics indicating that the number of lawsuits is growing slowly, if at all. Throughout this debate, all sides tend to focus on the number of lawsuits, paying little attention to the behavior of parties in negotiating claims prior to the filing of a suit.[5] But any change in the general patterns of those pre-suit negotiations can have dramatic impact on the relationship between the frequency of lawsuits and the costs of the system.[6] Again, the interpretation of data on events in one part of the system (e.g., court filings) depends on events in other parts of the system (e.g., the resolution of claims before suits are filed).

Third, the debates are severely constrained by data limitations. Proponents of reform would insist that some particular change in the tort system is needed to bring about certain improvements, but they generally lack the data to estimate the amount of improvement if the change were made. Opponents, adamantly predicting that the change would result in disastrous consequences, are equally unable to provide estimates of the magnitude of the disaster.

Many public and private institutions collect data relevant to the tort and insurance systems. However, their data collection systems focus on information needed to inform and manage their own affairs; they rarely capture the kinds of data needed to address the debate issues. The extensive data collected by state insurance regulators, for example, are relevant to rate-making and solvency concerns[7] and do not include

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[4]See, for example, Robert D. Kilpatrick, "Solving the Lawsuit Crisis," address to the Rotary Club of Chicago, June 17, 1986. The "litigation explosion" thesis as initially put forth by commentators concerned with the long-term viability of the courts is reviewed in Marc Galanter, "Reading the Landscape of Disputes: What We Know and Don't Know (and Think We Know) About Our Allegedly Contentious and Litigious Society," *UCLA Law Review*, Vol. 31, No. 1, October 1983, pp. 4–71.

[5]See, for example, "Are Caseloads Really Increasing?, Yes . . . Thomas B. Marvell, Not Necessarily . . . Stephen Daniels," *The Judges Journal*, Summer 1986, p. 35.

[6]If defendants generally become less forthcoming in dealing with claimants, perhaps to discourage growth in claims or to ease cash flow pressures, there could be an increase in the frequency of lawsuits even though claims are neither more prevalent nor larger than in the past. Conversely, if defendants frequently make more attractive settlement offers, perhaps because the legal system seems increasingly sympathetic to the plaintiff, an increasing fraction of claims could be disposed before they reach suit; therefore, the rate at which suits are filed could be unchanged even if people are, in fact, increasingly likely to perceive themselves as having been injured and to seek compensation.

[7]Commissioner Fletcher Bell (Kansas), chair of the National Association of Insurance Commissioners' Legal Liability Insurance Task Force, NAIC News Release, Kansas City, MO, June 12, 1986.

the information needed to determine how any particular change to the tort law might affect the number and sizes of claims, the amounts paid to claimants, or any of the other concerns that lie at the heart of the reform debate. Similarly, few courts collect data in sufficient detail to identify particular types of civil cases. The caseload information they have generally lumps tort and other types of civil cases together and cannot be used to examine tort reform issues.[8]

Finally, the debate gives rise to widespread demands, particularly by various public authorities, for additional data. For the most part, these demands come from persons primarily concerned with their own state's tort or insurance system and focus on data for their state. Demands for data on tort and insurance affairs in one state are seldom coordinated with demands in other states. There is little recognition that comparing the outcomes of claims across states is critical to assessing the effects of tort reform. However, data for an individual state may prove to be of some value.

Moreover, the demands for data have not emerged from systematic research plans. Once collected, the data may prove to be useless to address the concerns of policymakers. Even worse, if the data collected omit elements essential to a critical analysis, the entire database will be unable to support the analyses policymakers require.

ASSESSING THE EFFECTS OF REFORMS

The tort reform debate is likely to continue. Proponents of reform express dissatisfaction with the extent of reform in many states, suggesting that the changes are inadequate. It is likely they will seek additional changes in subsequent legislative sessions. At the same time, opponents of reform are going to seek rollbacks of what they consider to be the more onerous changes in tort law.

Aside from the ongoing political debate on the need for tort reform, a dispassionate view of the system suggests another critical issue: In our ignorance of how these reforms will affect the system, we have almost certainly made some mistakes. Even when the reforms were adopted with general agreement, other parts of the system may be affected with undesirable consequences; and where the effects of reform were anticipated, their magnitude may be either greater or less than intended. The debate over how to fine-tune the system could prove to be as heated as the debate over whether reform was needed in the first place.

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[8]See National Center for State Courts, *State Court Caseload Statistics: Annual Report 1984*, Williamsburg, VA, 1986, for a discussion of the data maintained by state court systems.

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Future debates over tort reform will lead to demands for evaluations of the past reforms. States contemplating tort law changes will want to learn from the experiences of others.

Public officials and private parties have made it clear that they expect results to follow reform. States that enacted reforms will be pressured to examine the results of those reforms. ("Have we gotten what we thought we were going to get when we went along with reform in the first place?")[9]

Further complicating the situation, the demands for evaluation and data are sometimes maneuvers among political adversaries rather than serious requests for policy-relevant information. This contributes to the problem of identifying the research that would illuminate the policy debate and the data needed to conduct that research.

Thus, the debate continues, with many demands for information but little regard for the data and research needed to provide it. At the same time, new or enhanced data systems are in demand, and some are being put into place without much regard for the kinds of research they might support or the ways in which that research is linked to policy concerns. Conflicting demands have led to a system of data collection and research requirements that can fairly be described as chaotic.

More fundamentally, there is no coherent framework for evaluation. To our knowledge, no one has tried to make clear what we need to know: how information on one subject relates to information on another, what kinds of approaches are appropriate for trying to get which kinds of information, and so forth.

CLAIMANTS AND DEFENDANTS

We use the word "claimant" to refer to the person, organization, or institution pursuing a claim whether or not they have filed suit. Similarly, we use the word "defendant" in reference to the person, organization, or institution against whom a claim is brought, again without regard to the filing of a lawsuit. In general, we do not distinguish between the defendant and, if there is one, the insurer. In discussing the effects of reform on settlement negotiations, for example, we would refer to the "defendant's offer" rather than to the "offer made by the defendant or insurer."

[9]See, for example, William D. Hager "The Commissioner Comments," in *Iowa Insurance Quarterly*, Vol. II, Fall 1986.

OVERVIEW OF THIS REPORT

Section II begins with an overview of the connections between tort reform and the societal outcomes of policy interest. The overview suggests four basic kinds of policy questions in assessing the effects of tort reform. Subsequent sections focus on each of these questions in turn, discussing the kinds of research needed to illuminate the question, the strategies that might be used to do the work, and the kinds of data needed to conduct the research. Section VII presents our suggestions for what can be done now.

Analyses of the effects of tort reforms ultimately involve comparisons of states that have enacted the reforms of interest to states that have not. The Appendix lists the reforms that were enacted in each state in 1986.

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II. WHAT DO WE NEED TO KNOW?

Much of the reform debate focuses on the relationship between the tort system and the costs and availability of insurance. Most demands for tort reform evaluations and the data needed to conduct them concentrate on information presumed relevant to the connection, if any, between the tort and insurance systems. But analyses concerned exclusively with this relationship would be grossly inadequate and could be misleading. This section discusses the information policymakers need to assess the effects of reforms.

AN OVERVIEW OF THE TORT SYSTEM

The objectives of the tort system are numerous and conflicting, and not all are explicit. The balance among them is subject to continual change as social perceptions and preferences change. Nevertheless, the objectives can be defined in terms of the system's effects on three major areas of social concern:

- The economic and social well-being of the society at large.
- The injuries and grievances suffered by individuals and groups within the society.
- The prompt, efficient, and just resolution of disputes.

The tort system can affect these areas indirectly through legal rules. The rules influence the behavior of people and institutions and, to the extent that they modify behavior, influence our economic and social well-being, the injuries we suffer, and the outcomes of resulting disputes. Figure 1 depicts one view of the connections among legal rules and the social purposes served by the tort system.

Productive behavior refers to the everyday activities of businesses, organizations, and individuals producing the goods and services we all enjoy: for example, the activities of manufacturers producing goods, the actions of health professionals providing medical services, the behavior of drivers providing private or public transportation, and the activities of insurers providing insurance. But as Fig. 1 indicates, productive behavior sometimes results in injuries or grievances, which, if not informally resolved by the parties, become disputes.

Disputes are resolved through interactions among people—claimants and defendants, their legal representatives, judges, jurors, mediators,

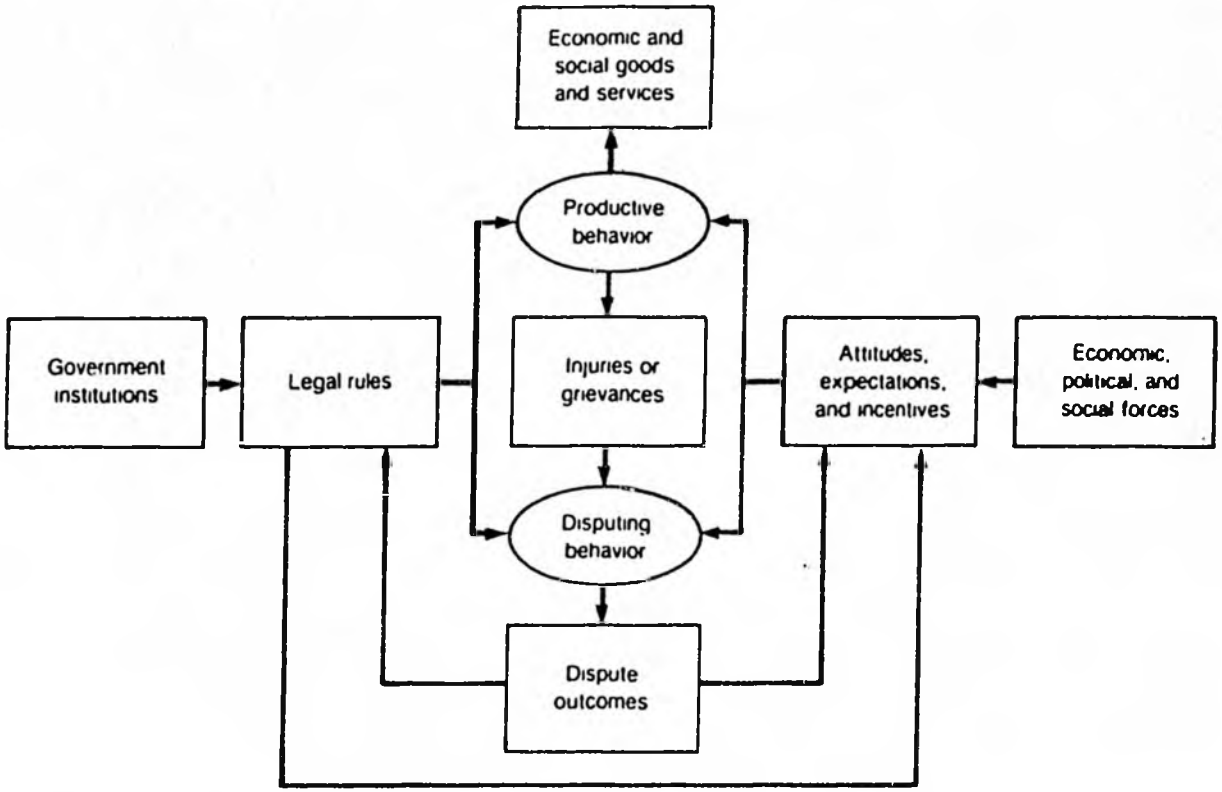

Fig. 1—A conceptual view of the tort system

arbitrators and so forth. The behavior of those involved in dispute resolution are affected by legal rules; but they are also affected by the parties' attitudes, expectations, and incentives, which, in turn, are shaped by numerous economic, political, and social forces.

Parties' disputing behaviors determine the outcomes of disputes. Dispute outcomes, in turn, influence attitudes, expectations, and incentives of individuals and institutions. Finally, productive behavior is affected by both legal rules and individuals' and institutions' attitudes, expectations, and incentives.

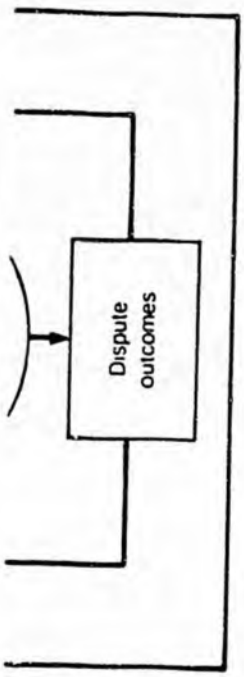

Fig. 1—A conceptual view of the tort system

Consider the relationship between tort reform and insurance costs. Assume some change in legal rules. For that change to have any effect, it must stimulate a change in someone's disputing behavior. If those involved in resolving disputes are unaware of the change in the law, or simply choose to disregard the change, dispute outcomes will remain the same. Unless there is some change in dispute outcomes, the losses insurers expect to incur are unaffected and insurers have no incentive to modify underwriting practices or premiums.

Suppose, on the other hand, that the change in the law induces some change in the disputing behavior of those resolving claims. A cap on awards for pain and suffering, for example, might lead defendants confronted with substantial claims to offer less in settlement than they would if the potential trial award were unlimited. Similarly, plaintiff attorneys might scale down their demands in cases where potential verdicts are constrained by the cap. The changes in disputing behavior may, in turn, result in different dispute outcomes. Large claims, for example, might settle for less when awards for pain and suffering are capped than if there been no cap. Underwriters and others forecasting the outcomes of future disputes may observe that some types of disputes are now being resolved at lower cost than used to be the case and revise their expectations of future costs accordingly. To the extent that premiums reflect expected future costs, they will then decrease.

Thus, dispute outcomes are the signals sent by the system to those engaged in productive activities (e.g., insurers). To bring about changes in those activities (e.g., lower insurance premiums), dispute outcomes must be changed. But, outcomes will change only when dispute resolution behavior is modified.

BASIC POLICY QUESTIONS

The view of the system offered above suggests four basic policy questions needed to assess the effects of reforms.

How Soon Can We Expect to See the Effects of Reforms?

Reforms will not affect dispute outcomes until dispute resolution behavior changes. Behavioral changes will not occur overnight; some reforms may never affect anyone's behavior. Time must pass before a new law takes full or even measurable effect because it takes time for participants in the disputing process to adjust their behavior.

The implementation of laws has received surprisingly little study. Therefore, we need to study the ways laws are implemented, the amount of time necessary for behavioral changes, if any, to occur, and the ways disputes are resolved during these transition periods as behavior responds to changes in the law.

Have Reforms Affected the Outcomes of Disputes?

The effects of reform on the costs of the system are clearly a major policy concern. But a number of other outcomes are also worthy of study. Filing patterns can be affected by changes in the law: Reform can affect litigants' perceptions of the rate of return to litigation, and thus, the incentive to litigate. Reform can also affect whether litigants perceive the law in a jurisdiction as sympathetic to their position and thus, their interest in pursuing the dispute there rather than some other forum.

Reforms that affect either the costs of litigation or litigants' perceptions of the rate of return can affect disposition patterns. More or fewer cases might be settled rather than pursued to trial; cases might be encouraged to settle earlier or later.

Reforms can directly affect litigation costs. Additionally, changes in either disposition patterns or in filing patterns or both are likely to affect the public and private costs of litigation.

We need analyses of the effects of reform on costs, including the amounts paid injured parties in compensation and the transactions costs incurred. To place those results in their proper context, we need analyses of the effects of reforms on filing and disposition patterns.

Who Won? Who Lost? How Much?

If reform affects the outcomes of any dispute, someone must pay, and someone else be paid more or less than would have been paid without reform. The winners in reform are those who pay less, or are paid more; the losers are those who pay more, or are paid less.

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Regardless of the concerns that motivated any particular reform, effects on the equity of the system cannot be neglected. Who won? Who lost? How much? Who paid the price of reform?

Did Reform Affect Economic Outcomes or Injuries?

Finally, while the debate has focused on the costs of the system, the indemnification of injured parties is only one of the tort system's purposes. The system also shapes our basic obligations to each other and influences the structure and policies of our social and economic institutions. Modifications to the tort system, whether or not they have cost or equity effects, may affect producers' and service providers' decisions regarding the kinds, characteristics, and prices of the goods and services they make available to society. Changes in these decisions can result in changes in the constellation of goods and services consumed by society and, consequently, in society's well-being.

At the same time, changes in the kinds and characteristics of available goods and services can generate changes in the frequency and severity of the injuries incurred by the use of goods or services.

More generally, tort reforms can affect pressures on manufacturers and service providers to keep goods and services associated with liability claims off the market or to make them safer. Whether society gains or loses when products or services are withdrawn from markets or are modified depends on value judgments regarding the usefulness of the product or service, the costs of modification, the costs of injuries, and related issues. Whatever those judgments might be, policymakers need to assess the effects of reforms on the deterrence function of the system.

III. HOW SOON CAN WE EXPECT TO SEE THE EFFECTS OF REFORM?

IMPLEMENTATION PROBLEMS

Validity and Interpretation

Changes in the law are rarely implemented immediately, and, in fact, may never be fully implemented. Whether, and to what extent, a law of uncertain validity affects the outcomes of disputes is an open question. It is possible that a reform will not be fully effective so long as its status is uncertain.

California's medical malpractice tort reform package, enacted in 1975, is an example of implementation delay due to sequential constitutional challenges to each of its provisions. It took more than a decade of litigation to finally determine the legitimacy of the law. The degree to which the outcomes of medical malpractice cases resolved during the transitional period were affected by the reform package is unknown. If the law did not become fully effective until the mid-1980s, analyses of its effects based on earlier data may be misleading.

The implementation of a reform can also be delayed by questions of interpretation and application. Consider, for example, a cap on damages for pain and suffering. The wording of the statute may not be clear as to whether the cap applies to the award assessed against each defendant in a multiple-defendant case or to the aggregate award provided to the plaintiff. It may not be clear whether the cap applies to cases in the system at the time the law was passed or only to cases filed after its effective date. Independent of the intentions of those who framed the law, there may be disputes as to the legitimacy of those intentions.

Operational Procedures

Even when the meaning of a reform is clear, its effect remains problematic until it is put into operation. A law becomes more than words on paper when it causes someone to do something. It must specify who must do what, what measures are to be used to discover whether they have done it, and what should be done if they haven't.

Consider, again, the example of a cap on awards. Assuming constitutional and interpretative issues have been resolved, the cap must still

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be enforced. One possibility is to instruct the jury not to award more than the specified amount for pain and suffering. Appropriate jury instructions, possibly requiring itemization of the components of the award, must be developed.

What if the judge believes that the jury has disregarded the cap, returning an award that includes an excessive amount for pain and suffering? Rules are needed to establish the judge's responsibility and the factors he must consider.

Alternatively, enforcement of the cap might be left to the judge, leaving the jury free to return any award it deems appropriate. Here, too, rules establishing the judge's responsibility and authority in enforcing the cap are needed.

California's medical malpractice reform package illustrates the problem of operational procedures. The package includes a limitation on contingent fees in the form of a fee schedule. In California, however, contingent fees are not reported. There is no reason to suppose that plaintiff attorneys are charging fees other than those specified by the reform,[1] but there is no way to systematically examine how that provision of the law operates nor is there a way to systematically enforce the law.

Recognizing the Effects of the Law

The vast majority of civil cases are resolved in settlement negotiations. Because parties are free to settle a dispute on any mutually acceptable terms, settlement negotiations are affected by changes in the law that alter parties' bargaining positions and strategies. These strategies, in turn, reflect expectations of the likely outcome of the claim if pursued to verdict and the costs of litigation.

But expectations of verdicts and litigation costs may not change the instant a reform is enacted. Attorneys, claims adjusters, and others involved in the negotiating process may require time to learn what difference a change will make. Will the first verdict returned under the new legal regime change expectations? Or will it take two verdicts, or ten verdicts, or ten years of verdicts before the settlement negotiation process is changed? The effects of reform will be realized only after people become aware of the change in bargaining strength brought about by the change in the law.

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[1]The California State Bar Association is investigating an allegation that an attorney collected an excessive fee in a medical malpractice suit. See John Kendall, "Trial Lawyer Chief's Fee Dispute Will Go to Bar," *Los Angeles Times*, October 7, 1987, p. 21.

RESEARCH REQUIREMENTS

To learn more about the nature and effect of implementation problems, three kinds of analyses are needed to focus on the timing of reform activities, the behavior of participants in disputes pending complete implementation of a reform, and the differential effects of alternative implementation strategies.

The Timing of Reform Activities

Conducting studies before fundamental questions are resolved may misconstrue the effects the law will have once it is fully in place. Policymakers and researchers need to know the timing of activities that influence the implementation process. When were constitutional challenges resolved? When were questions regarding the interpretation of key terms and phrases finally answered? More generally, when did the law become certain? The answers to these questions govern both the timing of future research and the interpretation of research results.

Behavior Pending Implementation

Policymakers and researchers need to know how parties involved in dispute resolution—judges, jurors, attorneys, claims adjusters, and so forth—behave during the implementation process when the status of a reform is uncertain. Do they conduct themselves as though the reform had not been enacted, as though its validity or interpretation was unquestioned, or somewhere in between? How long does it take to learn the practical consequences of a new law? How do people behave when the status of a new law is certain but its practical consequences are still unknown because cases to which it applies have not yet gone to trial? The answers to these questions determine how much we can rely on analyses of reforms conducted before reforms are fully implemented; they also provide guidance on interpreting analysis results to anticipate the likely effects of the reforms once fully implemented.

Alternative Implementation Strategies

Depending on the nature of the reform, there may be several ways of going about implementation, each with its own implications for the speed and magnitude of the reform's effects. Policymakers need to know the differential effects of alternative implementation strategies.

For example, a reform requiring compensation from collateral sources to be offset could be implemented by instructing the jury to adjust for such sources in arriving at its award. Alternatively, the jury

might award whatever it deems appropriate, and the judge would deduct collateral source compensation. The method used may affect both the speed of implementation and the effects of the reform itself. Developing jury instructions may take more or less time than developing rules for judges. Having juries account for collateral source payments may result in awards that differ from adjustments made by judges.

STRATEGIES FOR STUDYING IMPLEMENTATION

General Approach

Case studies of the behavior of people involved in dispute resolution are an appropriate strategy for studying tort reform implementation. We need to examine their actions when the law is uncertain, and after the law is certain but its effects are still unknown. In either case, research needs to probe the expectations and perceptions of the parties and their reasons for acting as they did.

We can initiate studies now to examine how people today are negotiating in the new environments created by the reforms enacted last year. Consider for example, California's Proposition 51, modifying the doctrine of joint and several liability. Researchers can investigate the settlement policies of presumably affected institutions, such as government agencies, to identify how they are responding to the change in the law. By studying other states that have similarly modified their tort systems, researchers can identify the common themes that run through different implementation experiences.

Retrospective studies of implementation are also possible. During the mid-1970s, a number of states modified their laws relevant to medical malpractice. Researchers can examine the experiences of those involved in medical malpractice disputes to develop an understanding of how people behaved during the transition period.

An Example: Implementing California's Judicial Arbitration Program

In 1978, the California State Legislature enacted mandatory judicial arbitration to alleviate increasing civil caseloads, stabilize court costs, and reduce time to disposition and other burdens on litigants. An analysis of implementation by the local courts demonstrates both the

methods of implementation analysis and the kinds of results that can be obtained.[2]

The analysis was primarily based on interviews with court officials and practicing attorneys in courts representing different-sized jurisdictions and different sections of the state. In each court, the researchers interviewed the judge responsible for directing the arbitration program, the court executive officer or the deputy or both, the arbitration administrator, and attorneys who were familiar with the program.

The study found that local courts made very different implementation decisions in adopting a series of rules or policies to establish their program's operating procedures. In doing so, some of the courts consciously deviated from statutory provisions and Judicial Council rules. And where local discretion was permitted, local courts opted for different approaches. For example, although Judicial Council rules set forth a detailed timetable for the sequence of steps in the arbitration process, some courts deviated from those rules: Some adopted special practices to accelerate the process; others deliberately pursued a "no-monitoring" policy once an arbitrator was assigned to a case.

It may be that each court's implementation decisions resulted in the arbitration program best suited to its needs, given the resources available to it and the demands on it. Nonetheless, these decisions profoundly affected the degree to which each court's program achieved the stated goals. Failing to take account of local courts' implementation decisions would result in very misleading conclusions. For example, some courts required that all litigants whose cases were assigned to arbitration appear at a settlement conference prior to arbitration. In these courts, the arbitration program actually increased pressures on court resources, not because arbitration programs necessarily burden courts, but rather because these courts chose to expend judicial resources to ease burdens on the arbitration program.[3]

Data Requirements

The most basic data requirement is information on the timing of implementation activities: when reforms were enacted, what their

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[2]Deborah R. Hensler, Albert J. Lipson, and Elizabeth S. Rolph, *Judicial Arbitration in California: The First Year*, The RAND Corporation, R-2733-ICJ, 1981.

[3]These courts offer an intriguing example of the ways in which means and ends can become inverted in the implementation process: They were expending approximately 30 minutes of judicial time per case to avoid overburdening a program that was meant to relieve pressure on the judicial system.

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effective dates were, and when constitutional challenges to them were resolved.[4]

To study the implementation process, we need data on the experiences, activities, and perceptions of attorneys and claims managers. Researchers need to interview and observe people involved in dispute resolution to understand what they are doing and why; their objectives and goals; and how changes in the law have affected their objectives, perceptions, and disputing strategies.

Consider, again, the study of California's judicial arbitration program. The researchers interviewed executive, legislative, and judicial personnel involved in the design of the program. They interviewed local court officials who decided how the program would be implemented at the local level or were responsible for its subsequent operation, or both. They interviewed attorneys who served as arbitrators and attorneys whose cases had gone before arbitrators. The interviews included representatives of all those involved, except litigants, in the resolution of disputes applicable to the program.

In addition to interviewing representatives of different perspectives, the researchers purposely selected study sites that span the range of the jurisdictions involved in the program. This allowed them to examine whether the formal rules and statutory provisions were being implemented in a uniform manner and, if not, how differences in implementation decisions were linked to differences among the sites. They could thus identify the factors affecting implementation and the features of the law that, if changed, might induce the originally desired behavior.

Studies of the implementation of reforms can be conducted while the implementation process is under way. In fact, implementation studies would probably yield more accurate results if undertaken while those involved are still engaged in the process. Studies deferred to some future date will suffer the problems of recall and rationalization that often plague retrospective studies.

Initiating studies now of how those involved in dispute resolution are behaving and how their behavior changes in response to reform could inform the current policy debate. Policymakers are pressed to make judgments on the need for further reforms, or on the need to undo past reforms, on the basis of what seem to be the effects of reforms, whether or not the reforms have had sufficient time to influence behavior. Implementation studies can suggest how much we can base policy on what is happening in the tort system now. For example, implementation studies may find that important players in the system

[4]The Appendix is a step toward the creation of this database.

have not yet adapted to the reforms, and we cannot base policy on the assumption that their current behavior will continue.

Implementation studies will also guide the timing of studies of the effects of reforms. We need to know the degree to which reforms have been implemented before we can decide when to study their effects.

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IV. HAVE REFORMS AFFECTED THE OUTCOMES OF DISPUTES?

The policy debate centers on the effects of reform on "costs," meaning defendants' and insurers' aggregate outlays—the sum of indemnity payments to injured parties and legal defense costs. But there are several other types of dispute outcomes that could be affected by reform. While these are less directly related to insurance costs—they are nonetheless important and need to be considered.

DISPUTE OUTCOMES

Aggregate Outlays

The basic question is: How have defendants' and insurers' aggregate outlays been affected by reform? In considering how research can help answer this question, it is important to recognize that aggregate outlays include several different components. Outlays comprise indemnity plus defense costs. Indemnity, in turn, is the product of the frequency of claims, the percentage of claims closed with payment, and the average size of paid claims.

Reforms can impinge on different components of outlays in different ways, affecting one but not another, or affecting two or more components in the same or in different directions. To fully appreciate effects of reforms, we need to identify effects on outlays and on components of outlays. We want to know whether changes in aggregate outlays came about because of changes in the amount of indemnity paid or because of changes in defense costs or both. To the extent that indemnity was affected by reform, we also want to know whether those effects resulted from changes in claim frequency, or in the fraction of claims closed with payment, or in the size of payments, or in a combination of the three.

Patricia Danzon's study of the effects of medical malpractice reforms on the frequency and magnitude of claims illustrates the importance of analyzing separately the components of outlays.[1] She found that the introduction of arbitration of medical malpractice cases increased outlays. Does this imply that arbitration resulted in larger

[1]Patricia M. Danzon, *New Evidence on the Frequency and Severity of Medical Malpractice Claims*, The RAND Corporation, R-3410-ICJ, 1986.

indemnity payments? No: She also found that arbitration contributed to increased claim frequency. (Presumably arbitration offered a less expensive means for resolving disputes, encouraging parties to make claims otherwise too small to warrant pursuing when only the more expensive, traditional means were available.) Because the frequency of smaller claims grew, the size of the average paid claim declined. But because there were more claims overall, total outlays increased.

Disposition Patterns

Changes in the law can affect the point at which a dispute is resolved (before suit was filed, filing, just before trial, etc.). Litigants' decisions about whether to make an offer, how much, or whether to accept an offer made by the other side partially depend on their expectations of the financial consequences of pursuing the matter. Legal changes that affect either the expected recovery or the costs of litigation can influence negotiating strategies on both sides. And if either side's negotiating strategy changes, the dispute may settle earlier (or later) in the process.

Reforms that reduce either the odds that the plaintiff will prevail at trial or the likely size of the award will reduce both sides' expectations of the expected recovery. A settlement offer that would have appeared inadequate to the claimant prior to the reform may be acceptable after the reform. On the other hand, the defendant might be more willing to risk trial after the reform and, consequently, be less forthcoming in settlement negotiations. The net effect on disposition patterns will depend on how much claimants' expectations change relative to the changes in defendants' expectations.[2]

Reforms that affect the uncertainty of dispute outcomes can also affect disposition patterns. Reforms that reduce the uncertainty of dispute outcomes will encourage settlement and reduce the need for protracted litigation. Caps on awards, for example, can reduce the difference between plaintiff's and defendant's expectations as to the value of a case and lead to more rapid resolution. Conversely, reforms

[2]Suppose a reform generally reduces claimants' expectations more than defendants' expectations. While defendants may now make lower settlement offers (because they are a little *more optimistic* about their chances at trial should the offer be declined), claimants will be relatively more willing to accept defendants' offers (because they are, comparatively, a lot *more pessimistic* about their trial prospects). Both the fraction of claims resolved before a suit was filed and the fraction of suits resolved before trial will likely increase. Conversely, if defendants generally believe the reform had a comparatively large effect on trial prospects while claimants see the effect as being much smaller, defendants may substantially reduce their settlement offers while claimants' settlement demands decline only a little. If so, fewer claims will be resolved before suit and fewer lawsuits settled before trial than without reform.

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that increase the uncertainty of dispute outcomes can widen the gap between claimants' and defendants' expectations, reducing the prospects for settlement and, where settlement is still feasible, increasing the amount of time and effort to reach settlement.

Changes in disposition patterns are important in themselves; the time to disposition is obviously of interest to the parties. Disposition patterns are also a key factor in interpreting changes in the frequency of lawsuits and signal the effects of reforms on parties' negotiating strategies. Disposition patterns can be a significant factor in the costs of litigation: Reforms that lead to disposition at an earlier stage in the process can reduce the amounts of public and private resources expended to resolve the dispute.

Filing Patterns

In many cases, claimants have some flexibility as to when and where a suit is filed. Attorneys might rush to the courthouse prior to the effective date of a reform they consider unfavorable to their position, or they might delay filing until after the effective date of one they deem favorable to their position.[3]

Similarly, tort reforms can affect the desirability of pursuing a claim in one jurisdiction compared to another (e.g., in federal rather than state court or in one state rather than another).

These choices are of concern on their own merits: Does it serve society's interest to shift the location of disputes from this jurisdiction to that? Does the creation of incentives to file lawsuits early or late generate unnecessary litigation?

Moreover, these choices affect the interpretation of information on the effects of reform. A surge in litigation following on the heels of reform could result from significantly enhanced plaintiffs' expectations of recovery, inducing claims by parties who, before reform, found the rate of return to litigation so low that they did not bother pursuing their claim. Alternatively, the surge could result from a rush to the courthouse as claimants who deemed the reform prejudicial to their position sought to pursue their claim before the reform took effect. These are very different interpretations of the same observation; to sort out the real effects, policymakers need information on how reform affected filing patterns. Similarly, policymakers need to distinguish a

[3]An extreme example of the reform effects on the timing of litigation is the commentator who argues that Florida plaintiffs should delay filing suit for three years in the hope that a reform law favorable to the defense with a three-year sunset provision would not affect their case. George L. Priest, "Tort Reform Legislation . . . Is Only Smart," *The Wall Street Journal*, February 11, 1987, p. 26.

change in a jurisdiction's litigation rate due to a change in the law from a *shift* in litigation from one jurisdiction to another.

Transactions Costs

The transactions costs of litigation are the sum of plaintiffs' costs, defense costs, and public costs. They are the "overhead" costs of the system in the sense that the services purchased are not desired for themselves. Rather, they are means to ends: the deterrence of injurious behavior, the compensation of injured parties, and the resolution of disputes. To the extent that reform increases (decreases) transactions costs, society must expend more (fewer) resources to achieve those ends.

Reform can affect the transactions costs of litigation in a number of ways. On the plaintiffs' side, any reform that reduces the plaintiff's recovery will reduce the amount (but not the share) paid the plaintiff attorney on a contingent fee basis. Limits on contingent fees can reduce both the amount of plaintiff's costs and the share of recovery paid in legal fees. To the extent that defendants are represented on an hourly fee basis, any reform that reduces (increases) the amount of litigation activity will reduce (increase) defendants' costs. Because the public costs of litigation are related to the stage at which a case is disposed, any reform that affects disposition patterns can affect public costs.

STRATEGIES FOR STUDYING THE OUTCOMES OF DISPUTES

General Approach

In studying the effects of reforms on dispute outcomes, policymakers can concentrate on aggregate outcomes and need not be concerned with individual claims. The question at hand is not how John Doe's claim was affected by reform, but rather, how reform influenced all claims.

Because all the claims resolved in a state at about the same time were resolved in the same legal environment, differences among their outcomes cannot cast light on how reform affected the outcomes of claims. This suggests a research approach based on comparing aggregate outcomes across states to see if a dispute outcome—say, aggregate outlays—systematically differs from one legal environment to another. Alternatively, we could compare aggregate outcomes in a state in years

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before and after reform. An even more powerful approach would be to combine both approaches in an analysis across states over time.[4]

Because outcomes can be affected by a variety of factors other than the legal environment, other factors need to be taken into account. Suppose, for example, that the population of State 1 tends to be more sympathetic toward the plaintiffs' perspective than the population of State 2. If these states had identical systems of tort law, we would expect the average size of paid claims (magnitude) in State 1 to exceed the average size of paid claims in State 2. If State 1 enacted a reform that tended to reduce magnitude, the average size of paid claims thereafter would be less than if the reform had not been introduced. But the magnitude of paid claims in State 1 might still exceed the magnitude in the State 2, despite this reform, if the effect of the population differences was greater than the effect of the reform. And even if the reform had an effect sufficient to outweigh the effect of the population differences, the effect of the reform would be greater than the observed difference in magnitude between the two states.

Multivariate statistical analyses are an effective method for controlling the effects of other factors in comparing the aggregate outcomes of claims across states, over time, or both. Figure 2 suggests the nature of the statistical analysis. Suppose the solid lines indicate the claim frequency in each of six hypothetical states over the 1974–1984 period. Neglect the dashed lines for the present. Assume the following:

- States A, B, C, and D are highly urbanized while states E and F are generally rural;
- States A, B, D, and E had adopted pro-plaintiff common law doctrines prior to 1974, while States C and F had not adopted these doctrines by 1984;
- States A and D adopted mandatory collateral source offset in 1975, effective as of 1976; and
- States B, C, E, and F made no changes to their tort rules over the 1974–1984 period.

The data presented in Fig. 2 show that claim frequency is generally higher in States A through D than in States E and F, suggesting that highly urbanized states have greater claim frequencies than do less urbanized states. The slopes of the lines for States B and E and, before enactment of collateral source offset in 1976, in States A and D are generally steeper than are the slopes of the lines for States C and F. This pattern suggests that the growth rate of claim frequency is

[4]Research on the effects of any particular type of reform is limited by the opportunities to observe that type of reform. The Appendix lists the reforms enacted in 1986.

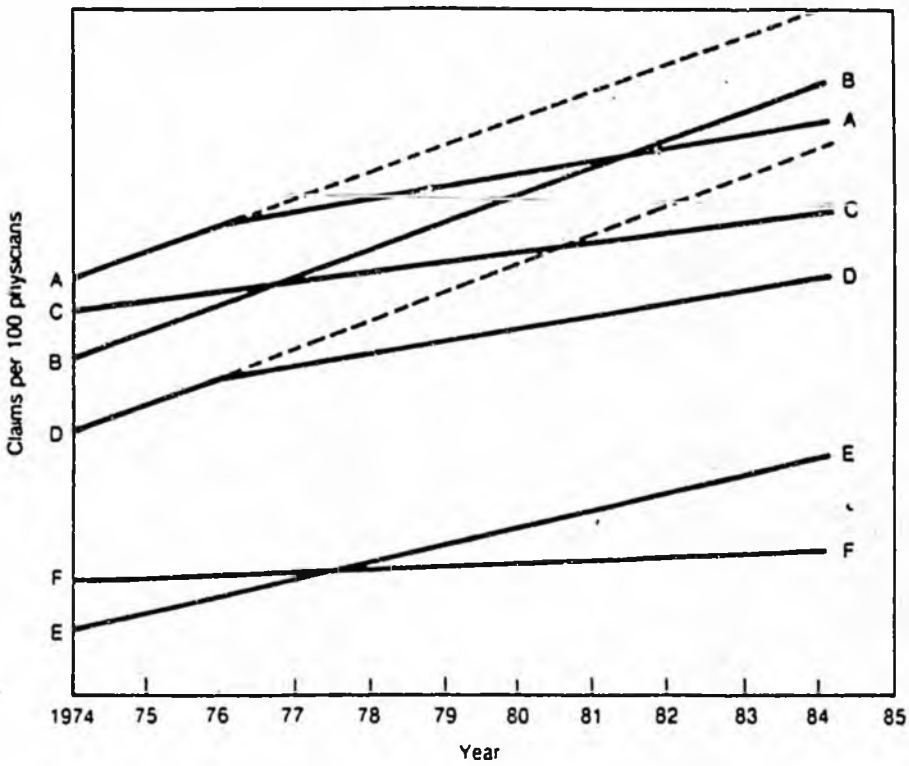
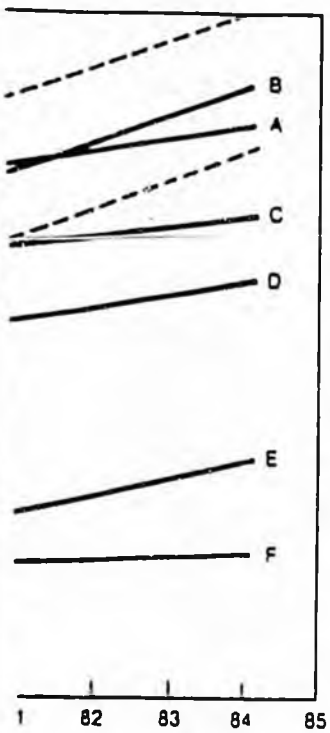


Fig. 2—Hypothetical comparisons of aggregate outcomes of claims

generally greater in states that had adopted pro-plaintiff common law doctrines. Finally, the slopes of the lines for States A and D are less steep after 1976 than before. The adoption of mandatory collateral source offset slowed the growth in claim frequency in the two states that enacted that reform.

Note that the lines for the states that did not enact reforms—States B, C, E, and F—are straight over the entire period. Because there are no "kinks" in those lines, we conclude that the growth rate of claim frequency was constant over the entire period in all four states. The dashed lines indicate what claim frequencies would have been in States A and D if each state's claim frequency had grown over the 1976–1984 period at the same rate as the 1974–1975 period. The vertical distance between the dashed line and the solid line for State A and for State D shows the effect of reform on claim frequency in each state.



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This stylized example neglects the complexities encountered in analyzing real data. Growth rates, for example, are rarely constant and so do not result in straight lines like those shown in Fig. 2. Year-to-year fluctuations in growth rates generate zig-zag lines over time that are far more difficult to interpret. The analyst, on the other hand, is not dependent on visual inspection of graphs but can employ powerful statistical methods to search out the patterns and relationships in the data.

An Example: Assessing the Effects of Reforms on the Frequency and Magnitude of Medical Malpractice Claims

Patricia Danzon used multivariate statistical methods to assess the effects of tort reforms on the frequency and average size of medical malpractice claims closed in 1970 and 1975–1978.[5] She subsequently updated her results using data on claim frequency and size for 1974–1984.[6] The units of observation were not individual claims, but individual states in each year. Each study attempted to explain claim frequency per 100 physicians and the average size of paid claims, by state and year.

The first study examined the effects of legal rules present in a state, such as the number of pro-plaintiff common law doctrines the state had adopted by 1970, and whether the state had adopted a cap on total awards or on pain and suffering awards. To control for other influential factors, the analysis controlled for aspects of each state's medical environment and demographic composition such as the percentage of the population over age 65, the percentage of physicians belonging to a state or local medical society, and the number of lawyers per 100,000 population. The second study employed basically the same kinds of variables.

Danzon was able to estimate the effects of caps on awards (a 19 percent reduction in the average size of paid claims according to the initial study, a 23 percent reduction according to the follow-up study). Similarly, she showed that statutes permitting or mandating the offset of collateral benefits reduced both the frequency of claims (by 14 percent) and the average size of paid claims (by 11–18 percent) relative to comparable states without collateral source offset. Among the other factors

[5]Patricia M. Danzon, *The Frequency and Severity of Medical Malpractice Claims*, The RAND Corporation, R-2870-ICJ/HCFA, 1982. Danzon uses the word "severity" in reference to the average size of paid claims.

[6]Patricia M. Danzon, *New Evidence on the Frequency and Severity of Medical Malpractice Claims*, The RAND Corporation, R-3410-ICJ, 1986.

affecting claims, Danzon found urbanization a highly significant factor that explains much of the observed difference among states in claim frequency and magnitude. Per capita income, the unemployment rate, and the number of attorneys per capita had no statistically significant effect after controlling for urbanization.

Data Requirements

The research approach suggested above requires information, by state and year, on the outcomes of disputes, the legal environments, and the other factors that might have affected outcomes. The outcomes of interest include the following: claim frequency; the percentage of claims closed with payment; the average size of paid claims; disposition patterns or the fraction of claims closed before suit, after suit but before trial, and after trial; filing patterns; plaintiffs' and defendants' costs of litigation; and public costs of litigation. Note that data on individual claims are not required to address these issues; statewide aggregate measures of dispute outcomes will suffice.

Construction of the legal variables poses few conceptual problems. However, the number of variables that can be included depends on the number of states that have adopted the laws of interest. If only one state enacts some reform, there is no way to distinguish that reform's effects from those of any other factor unique to that state. Even if several states enact the same type of reform, but opt for different variants of the reform (*e.g.*, a cap on awards for pain and suffering at $500,000 in one state, at $250,000 in another state), it may be impossible to estimate the differential effect of each variant. In such cases, it is necessary to define a legal variable for the type of reform and use the same variable for every state that adopted a reform of that type, regardless of differences among the variants. This approach essentially estimates the average effect for each type of change in the law.

The identification of the "other factors" that might influence dispute outcomes can be difficult. Theory, the experiences of practitioners, and the results of previous research are the major guides to identifying factors that need to be controlled to separate out the effects of legal variables. For example, Danzon observes that hospital admission rates for the elderly are roughly twice as high as those for persons under 65 and that a previous study had found a higher rate of negligent injury per admission for the elderly. Her theory suggests that claims will be more frequent when injuries are more frequent. This combination of theory, observation, and the results of research led her to control for the fraction of a state's population over 65. However, there is no simple formula or certain guide to the selection process and no list of all

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the "right" factors to include in the analysis; different analyses require that different factors be controlled. "Other" factors expected to influence one dispute outcome will not necessarily be the same as "other" factors expected to influence another dispute outcome.

The measurement of "other factors" can also present difficulties. For example, Danzon argues that the number of malpractice incidents in any period depends on the frequency, types, and quality of medical treatment among other factors, but these data are not readily available. Accordingly, she used "proxy" variables such as the number of non-federal physicians in patient care per 100,000 population and the percentage of physicians belonging to a state or local medical society.

The interpretation of the results for other factors can be problematic. For example, Danzon's first study found that urbanization had a significant effect on claim frequency. Why? We can speculate, but the fact is that we do not know.

To provide variance in the legal environment (which differs from state to state but not within states), the analyses must include states with and without reform. And because of the need to control for other factors, a number of states must be included. This, in turn, requires the collection of data for most, if not all, states. Data for a single state or even a small number of states is not sufficient to accurately assess the effects of reform. In addition, data for each state are needed for a number of years before and after reform. Studying the years before reform means researchers can control better for whatever trends existed beforehand.

Finally, to make meaningful statements about the effects of reform, policymakers must be able to apply specific research results to disputes in general. That means data must pertain to the universe of claims or to a representative sample of claims.

V. WHO WON? WHO LOST? HOW MUCH?

Regardless of the concerns that motivated any particular reform, effects on the equity of the system cannot be neglected. Who won? Who lost? How much? Who paid the price of reform?

THE EFFECTS OF REFORM ON INDIVIDUAL CLAIMS

Recovery

Any change in the outcomes of claims resulting from reform raises questions regarding the adequacy and equity of compensation. To address these questions policymakers need to know how patterns of recovery among various types of claimants and against various types of defendants are affected by reform. More specifically, policymakers need information on how changes in the law affect the probability of recovery, the amount successful claimants recover, and claimants' net recoveries, by type of claimant and type of defendant.

Consistency/Predictability

We have few value-free standards as to what anyone ought to be awarded for an injury, but we do have some basic standards of equity: Similarly situated people ought to be treated alike; dissimilarly situated people ought to be treated differently in ways consistent with the dissimilarity. Translated into the concerns of the tort system, similarly injured people ought to recover about the same amount and more seriously injured people ought to recover more than less seriously injured people.

Consistency, a fundamental equity issue, is intimately related to another issue of some concern in this area: predictability. The legal system is more consistent as the amount recovered is more closely related to the seriousness of a claimant's injuries; that is, when the variance of outcomes, given the characteristics of claims, is smaller. A reduction in the variance of recovery, other things equal, increases the predictability of outcomes. Insurers have argued that a growing lack of predictability is a major contributing factor to the availability and affordability problem. They maintain that they are unable to offer insurance when the likely outcomes of future claims are so unpredictable that they cannot "price" their product. Reforms that increase the

predictability of outcomes reduce the difficulty of determining the appropriate premium for insurance.

Disposition Patterns, Filing Patterns, and Transactions Costs

The issues of the effects of reform on aggregate disposition patterns, filing patterns, and transactions costs also arise with respect to individual claims. For example, both claimants and defendants have an interest in the effects of reform on disposition patterns. Both care when the defendant must pay, and the claimant must be paid, whatever compensation is agreed to or awarded by the court. And the stage of disposition and, possibly, the time to disposition might affect the parties' legal costs. But there is no reason to believe that reform will affect all claims in exactly the same way; equity considerations thus make the question of which kinds of claims are affected in what ways an important policy concern.

STRATEGIES FOR STUDYING THE OUTCOMES OF INDIVIDUAL CLAIMS

General Approach

Statistical analyses of the relationship between legal rules and the outcomes of individual claims, controlling for the claims' characteristics and for other influential factors, are needed. The approach is similar to that taken to analyze reform effects on aggregate claims. Here, however, the focus is how reforms have affected the outcomes of particular kinds of claims: How did reform affect small claims? Or large claims? Or claims against some type of defendant? Or claims brought by some type of claimant? And so forth.

Here, too, differences among the outcomes of disputes resolved in a single state at about the same time cannot result from differences in legal environments and, so, cannot cast light on the issue of how reform affected the outcomes of claims. The analysis must, therefore, compare the outcomes of individual claims across states, over time, or preferably both.[1]

The analysis must take account of claims' characteristics: the severity of the claimant's injury, the medical costs and lost income, whether the claimant was disabled and, if so, how much and for how long. The

[1]The Appendix lists the reforms enacted in 1986, implying the states in which analyses of various types of reforms can be conducted.

characteristics of the parties to the dispute might also affect the claim's outcomes. For example, juries might return larger awards to plaintiffs when the defendant is an institution than when the defendant is an individual. Institutional defendants might offer more in their settlement than individual defendants, other things equal, because the potential consequences of failing to settle are relatively greater for them. The net effect of these patterns is consistently greater recovery by claimants against institutional defendants compared to individual defendants.

Again, characteristics of the social and economic environment within which a claim is pursued can affect its outcomes. These factors must be considered.

An Example: Assessing the Effects of Parties' and Claims' Characteristics on Jury Verdicts

Audrey Chin and Mark Peterson examined how parties' and claims' characteristics affect jury verdicts, using data for all civil jury trials reaching verdict in cases for money damages in Cook County (Chicago), Illinois, between 1960 and 1979.[2] Because the data pertain to a single legal environment, they do not address the effects of the law on the outcomes of trials.

Chin and Peterson examine four sets of factors affecting jury awards: (1) case type (e.g., automobile accident, malpractice, intentional tort); (2) the type of plaintiff—individual, corporation, government and, if the plaintiff was an individual, his or her characteristics, (3) the defendant's type and characteristics; and (4) the type, number, and severity of the plaintiff's injuries and losses.

Parties' characteristics explained some of the differences in awards. For example, after accounting for the type of lawsuit and the plaintiffs' injuries and losses, black plaintiffs received, on average, 25 percent less than whites with the same injury, and corporate defendants paid more than individual defendants, with the premium increasing from 23 percent in the 1960s to 40 percent in the 1970s.

If similar data were available for several other jurisdictions that had enacted reforms, the analysis could be replicated for each jurisdiction and the results compared to determine whether the results were systematically related to the presence or absence of particular laws. We could see, for example, if the premium paid by institutional defendants is affected by the presence of caps on awards.

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[2]Audrey Chin and Mark A. Peterson, *Deep Pockets, Empty Pockets: Who Wins in Cook County Jury Trials*, The RAND Corporation, R-3249-ICJ, 1985.

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An Example: Assessing the Effects of Reforms on the Outcomes of Medical Malpractice Claims

Patricia Danzon and Lee Lillard used a cross-sectional, time-series approach to estimate the effects of reforms on the outcomes of individual medical malpractice claims.[3] Their objective was to estimate the total effect of reform; they did not attempt to understand who won or lost as a result of reform. Nonetheless, their study used data on individual claims and, thus, provides an example of the approach suggested above.

Danzon and Lillard drew on individual claims' data from two surveys of insurance companies' claim files closed in 1974 and 1976. Both surveys were broadly representative of claims against physicians and hospitals. They also used data from other sources on the legal environment of a state (e.g., whether the state had limited contingent fees or modified the collateral source rule) to examine two claim outcomes: the stage of disposition and the amount of payment, if any. The researchers introduced variables to control for the severity of the injury, the claimant's characteristics and economic loss, the defendants' characteristics, and the ease of proving negligence.

Danzon and Lillard used multivariate statistical techniques to estimate the effects of tort reforms. For example, they found that imposing limits on contingent fees reduced settlement amounts (by 9 percent), the proportion of cases dropped (by 5 percent), and the share of cases going to trial (from 6.1 percent to 4.6 percent).

If Danzon and Lillard had performed a separate analysis of, say, severe injury claims, the results would have shown how those claimants were affected by reform. Similarly, they could have performed separate studies of the effects of reform on claimants with a specific income or separate analyses of claims brought against physicians. The data and general approach used in their study could have been used to study reform's winners and losers.

Data Requirements

To analyze the effects of reform on the outcomes of individual claims, researchers will need detailed data on individual claims of the sort generally obtained through "closed-claim" studies. The data must identify the outcomes and other characteristics of individual claims.

[3]Patricia M. Danzon and Lee A. Lillard, *The Resolution of Medical Malpractice Claims: Modeling the Bargaining Process*, The RAND Corporation, R-2792-ICJ, 1982, and Patricia M. Danzon and Lee A. Lillard, *The Resolution of Medical Malpractice Claims: Research Results and Policy Implications*, The RAND Corporation, R-2793-ICJ, 1982.

Researchers will also require indicators of the legal rules that applied to each claim. While the data for this type of study are reasonably straightforward, they tend to be very expensive and difficult to obtain.

Studies of the effects of reform on the outcomes of individual claims can be conducted with data on particular types of claims. The data need not describe the universe of claims or even a representative sample of all claims. For example, if policymakers are concerned with the impact of reform on severely injured claimants, research requires samples of severe-injury claims in states with and without reforms, for years before and after reforms. These data would suffice for an analysis that indicates whether reform has resulted in severely injured people receiving X percent more or Y percent less, recovering Z percent more frequently or Q percent less frequently, and so on. If we do not know how the number of severe-injury claims compares to the number of less-severe injury claims, we cannot then inflate the findings to a statewide aggregate; but that is not the primary concern of this type of study.

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VI. DID REFORM AFFECT ECONOMIC BEHAVIOR?

Producers of goods and providers of services run the risk that someone will claim to have been injured by their goods or services. The costs of defending against such claims and compensating claimants, either directly (self-insurance) or through insurance, presumably enter into decisions as to the types and prices of products and services that will be offered. Reforms that affect the frequency and severity of claims can change these decisions and, consequently, the kinds and prices of the goods and services available to society. These changes, in turn, could result in changes in the frequency and severity of injuries.

ECONOMIC OUTCOMES

The Availability of Goods and Services

Producers and service providers must decide what products or services they will offer, on what terms, and in which markets. They may choose not to enter, or to withdraw from, markets in which the potential liability costs added to the other costs of doing business exceed the perceived benefits of entering, or remaining in, the market. Asbestos is an example of a product once used widely but now withdrawn because of mounting liability costs. Potential liability costs are claimed to threaten the availability of both existing and promising new vaccines,[1] severely constrain birth-control options in the United States,[2] have virtually ended the production of light piston-engined aircraft,[3] and have caused manufacturers of child car safety seats to refuse to place new products on the market.[4]

Insurance is the most apparent example of a service withdrawn from some of its markets in response to concerns over liability-related costs.

Reforms that reduce potential liability costs, reduce pressures on producers of "risky" goods and services to cease production. Reform

[1]Edmund W. Kitch, "Vaccines and Product Liability: A Case of Contagious Litigation," *Regulation*, May/June 1985, pp. 11-18.

[2]Michele Galen, "Birth-Control Options Limited by Litigation," *The National Law Journal*, October 20, 1986.

[3]Jack Cox, "The Christen Hurky," *Sport Aviation*, August 16, 1986.

[4]Malcolm Baldrige, "Product Liability Woes Hurting U.S. Industries," *Journal of Commerce*, April 28, 1987.

may result in the continued availability of a product or service that otherwise would have been withdrawn from the market.

Whether or not it is in the social interest to "save" a product from being withdrawn depends on the value of the product relative to its risks. It has been argued that the value of vaccines to society so greatly exceeds their risks that the current system for compensating for vaccine-related injury needs to be changed to reduce deterrent effects.[5] Similarly, much of the current tort reform debate is concerned for the social consequences of insurance withdrawals. On the other hand, despite the many disputes over who was responsible for what in the asbestos arena, there seems to be general agreement that our society is better off for asbestos being withdrawn from some of its past applications.

Whether or not society is better off when a product or service is withdrawn from a market depends on a combination of facts and value judgments. The factual questions, in principle amenable to research, address the product's uses and dangers: Who uses the product for what purposes? What substitutes are available? What would those who use the product do if it were not available? What injuries are likely to occur from its use or the use of substitutes if the product is not available?

The Costs and Characteristics of Goods and Services

Producers and service providers may respond to increases in their liability (or liability insurance) costs by increasing the prices of their products and services, passing a part of the increase on to their customers. Some will continue to purchase the product while others find the product no longer attractive. Consumers thus bear part of the costs of the liability system. Reforms that reduce, or limit increases in, producers' and service providers' liability costs can reduce the costs borne by consumers.

The price of liability insurance is a prominent example of a service whose price reflects the costs of the liability system. In fact, the primary argument put forth in support of tort reform is that reducing the costs of the tort system will result in lower insurance prices.

Producers and service providers may attempt to reduce their liability exposure and, hence, liability costs by modifying their products and services. Modifications might involve changes that reduce the risk of a product-related injury or the severity of injuries that may occur. Or

[5]Committee on Public-Private Sector Relations in Vaccine Innovation, Institute of Medicine, National Academy of Sciences, "Vaccine Supply and Innovation," National Academy Press, Washington, D.C., 1985.

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they might involve changes primarily designed to enhance their defense in the event of a liability claim, such as doctors ordering unnecessary tests as a hedge against malpractice claims.[6]

Modifications that affect the safety of a product or service may also affect its ease of use or its suitability for certain tasks. Safety devices on power tools reduce both the risk of injury and the ease with which they can be used. Modifications can also change the cost of producing the product or providing the service. Some consumers may consider the modifications unnecessary or unwarranted; increased costs resulting from what consumers consider to be unnecessary changes are losses.

If reform reduces producers' and service providers' liability exposure, they will be less inclined to engage in liability-driven modifications to their products. Whether or not this is socially desirable depends upon the same kinds of evaluations that arise in considering the availability of products and services. How much does the modification reduce the danger of the product? Does it limit the usefulness of the product? What does the modification cost and who pays the bill?

Development of Innovative Products and Services

Research and development is inherently risky because there is no assurance that something of value will result. Potential liability must be included in the cost side of the equation for a new product or service to justify the R&D effort. For example, researchers are slowing efforts to test and market computers with artificial intelligence because they fear potential lawsuits.[7] Reforms that reduce the potential liability costs of products or services might stimulate research efforts and the rate of technical innovation.

Macroeconomic Outcomes

If tort reforms bring products to market that otherwise would have been withheld, or change the characteristics or prices of the products, the economy as a whole is influenced. Some say that the high costs of our liability system have impaired U.S. competitiveness.[8] Reducing those costs would improve U.S. firms' ability to compete with foreign firms, increasing their sales both here and abroad. If these claims are

[6]Roger A. Reynolds et al., "The Cost of Medical Professional Liability," *Journal of the American Medical Association*, Vol. 257, January 1987, pp. 2776-2781.

[7]William J. Broad, "Does the Fear of Litigation Dampen the Drive to Innovate?" *The New York Times*, May 12, 1987, p. 17.

[8]Malcolm Baldrige, "Product Liability Woes Hurting US Industries," 1976.

valid, tort reforms that reduce liability costs could result in improvements in the U.S. trade balance, increased employment, and a higher rate of overall economic growth.

THE FREQUENCY AND SEVERITY OF INJURIES

Liability concerns can lead producers and service providers to withdraw "risky" products and services from the market or to modify them to reduce their risks. Reforms that reduce liability concerns may ease these pressures, resulting in more, and more serious, injuries.

STRATEGIES FOR STUDYING ECONOMIC OUTCOMES AND THE FREQUENCY AND SEVERITY OF INJURIES

General Approach

In principle, the statistical approaches described in previous sections could be used to analyze the effects of reform on economic outcomes and the frequency and severity of injuries. In practice, however, these approaches are frequently, though not invariably, infeasible.

The statistical approach can be used to study the reform effects on the availability, characteristics, and prices of products or services sold only on local markets. Suppose that we wanted to study the effects of reform on the frequency of a medical test. We might assume that most doctors are sensitive to their state's legal environment, but not to other states' legal environments. If so, doctors in states that undertook reforms might be under less pressure to "build a file" in anticipation of a possible claim and, therefore, less frequently administer tests they consider unnecessary. Assuming sufficient data on test frequency and other variables could be obtained, we could see whether there was a systematic relationship between the enactment of a reform and the rate at which some tests were given.

However, products and services are frequently sold on national markets. If producers do not develop and distribute different versions of their products in states with different liability standards, the availability, characteristics, and prices of products will not vary across states with different tort laws. If some states introduce reforms, producers will either modify their products or they will not. If they do, the changes will affect the products sold in all states. Thus, the effects of reform cannot be estimated by relating economic outcomes in different states to their legal environments.

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An Example: Assessing the Effects of Reforms on Medical Malpractice Insurance Premiums

Frank Sloan used the multivariate statistical approach to assess the effects of tort reforms on medical malpractice insurance premiums.[9] The analysis was based on premium data for a standardized policy paid annually by physicians in three fields in each state between 1974 and 1978.

Sloan characterized a state's legal environment by variables such as whether there was a cap on recovery. To control for other factors that might influence premiums, he used real per capita income and the numbers of surgical operations, lawyers, and patient-care physicians, respectively, per capita. These variables were selected on the basis of theory (the number of surgeries per capita, because injury is more likely when a surgical procedure is performed) and the results of previous research (per capita income, because an earlier study found it related to malpractice premiums).

The empirical results gave no indication that the reforms considered had any significant effect on premiums. Sloan suggests that insurers probably base premiums on expected outlays which, in turn, reflect the frequency and severity of claims. Because state-specific data on claim frequency and severity are not available for 1974 and thereafter, he could not control for these important factors. This result demonstrates the importance of adequately controlling for influential factors other than legal rules.

An Example: Assessing the Effects of Product Liability Standards on Product Safety

George Eads and Peter Reuter wanted to analyze the effects of product liability laws and other factors on the safety of consumer products.[10] Because there was no reason to believe that firms respond in different ways to the differences among states in their product liability laws, they could not statistically relate measures of product safety to legal environments. In any event, there were no comprehensive data on the frequency of injuries arising from defective products. Even if there were, their interpretation would be problematic. The mix of products and users changes over time in ways that affect the injury

[9]Frank A. Sloan, "State Responses to the Malpractice Insurance 'Crisis' of the 1970s: An Empirical Assessment," *Journal of Health Politics, Policy and Law*, Vol. 9, No. 4, Winter 1985, pp. 629-646.

[10]George Eads and Peter Reuter, *Designing Safer Products: Corporate Responses to Product Liability Law and Regulation*, The RAND Corporation, R-3022-ICJ, 1983.

rate, even when firms act with equal care at all times. Hence, the efficacy of changes aimed at increasing product safety could not be judged by analyzing accident data. These problems are typical difficulties encountered in assessing the effects of reforms on economic behavior.

Because statistical approaches were not feasible and direct measurement of outcomes (product safety) was impossible, Eads and Reuter conducted a series of case studies of how firms organized their efforts to ensure that the design of products was not unsafe. They interviewed officials of nine large manufacturing firms, one large retailer, and several other organizations with an interest in product safety.

Of all the various external social and economic pressures, product liability had the greatest influence on product design decisions. But because the linkage between good design and a firm's liability exposure remains tenuous, product liability sends an extremely vague signal: It tells the firm that it must be careful or it will be sued, but it does not say how to be careful or how careful to be. Eads and Reuter felt that the connection between the law and product design is weak and even major changes in the law would have little effect on consumer product safety except when significant changes occurred in the overall costs of product claims.

Data Requirements

Data requirements are uncertain because, at this point, we cannot identify clear research strategies; but the requirements will surely be highly specialized. We cannot simply invent a single data collection system to conduct research on all of these issues; rather, we will have to tailor data collection systems on a case-by-case basis.

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VII. WHERE DO WE GO FROM HERE?

The available data are generally not sufficient to assess the effects of tort reforms. We do not systematically collect information on the behavior of participants in the system, on the outcomes of claims—either aggregate or individual—on economic outcomes, or on injuries. Nor do we systematically collect information on the factors that influence behavior or outcomes. Improved data systems are needed to assess the effects of tort reforms.

While the need for better data is clear, data collection efforts are expensive in terms of the direct costs of collecting the data and the indirect costs of diverting the attention and energies of those from whom the data are collected. Data collection efforts are warranted only when their benefits, measured by the value of the research they make possible, outweigh their costs. Both the benefits and costs of a data collection effort depend on which data are collected, in what amounts, from whom, and how. The next step toward assessing the effects of tort reform is to develop detailed designs for data collection efforts. These designs can then be evaluated to determine whether their benefits outweigh their costs.

We sketch out the conceptual issues that must be addressed in designing the data collection efforts needed for research on tort reform; the design of data collection systems is beyond the scope of this report.[1]

WHAT DATA SHOULD BE COLLECTED?

A data collection effort that is not focused on specific questions may overlook elements essential to the analysis. At the extreme, a database missing critical data elements can turn out to be largely worthless in terms of its ability to support the analyses policymakers require. At the same time, data collection undertaken without regard to the eventual use of the data may waste resources on efforts that eventually prove useless.

Analyses of the implementation of tort reforms will require data on the behaviors, expectations, and perceptions of participants in the

[1]The design of a data collection effort also involves a number of operational issues—developing a sampling frame, designing and testing instruments and procedures, and so forth—that cannot be addressed until detailed research specifications have been developed.

resolution of claims. Precisely what information will be needed from which participants depends on the reforms being studied.

The data needed to assess the effects of reforms on dispute outcomes include:

- the aggregate outcomes of disputes, by state and year,
- relevant characteristics of each state's legal environment, by year, and
- the other factors that influence the outcomes of disputes, by state and year.

We discussed several specific aggregate outcomes of policy concern: claim frequency, the percentage of claims closed with payment, the average size of paid claims, disposition patterns, filing patterns, plaintiffs' and defendants' costs of litigation, and public costs of litigation. Data collection and analysis efforts can focus on one, a few, or all of them, depending on policymakers' concerns relative to the costs of collecting and analyzing the data.

Detailed data on the characteristics of individual claims are needed to assess reform's winners and losers, or, alternatively, the effects of reform on various kinds of claims. Specifically, we need data on:

- the outcomes and characteristics of individual claims, for claims resolved in reform versus nonreform states or differences in states before and after reform, or both;
- relevant characteristics of each state's legal environment; and
- other factors that can affect the claims' outcomes.

Several outcomes of individual claims are relevant to the policy debate: the probability of recovery, the amount of recovery, net recovery, the consistency/predictability of outcomes, disposition patterns, filing patterns, and transactions costs. Here, too, data collection and analysis efforts can focus on one, a few, or all of them, depending on policymakers' concerns relative to the costs of collecting and analyzing the data.

Analysis of economic outcomes and injuries will require information on the availability, characteristics, and costs of goods and services of particular policy interest and on the frequency and severity of injuries.

Theory, the experiences of practitioners, and the results of previous research will help identify the other factors that need to be controlled to separate out the effects of the legal variables. There is no simple formula for the selection process and no list of all the "right" factors to include in the analysis. For that matter, different analyses require control of different factors. The factors expected to influence one dispute

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IN WHAT AMOUNTS?

The degree to which research can provide useful information is limited by the quantity and quality of the available data. More elaborate data collection systems can provide more accurate, more detailed data that enhance the accuracy of research and its relevance to policymakers' needs. But the cost of data collection efforts increases with their scope. Those involved in the design process must weigh the costs of an expanded effort against the benefits of more accurate results.

Analysis of reform requires data on outcomes and the factors that affect them, by state and year. Analysis of who won or lost from reform requires data on the outcomes and other characteristics of individual claims. The numbers of states and years or the number of claims for which data are required depend on the tradeoff between the costs of collecting and analyzing data and the need for accuracy in the results. At a minimum, research will need data for several states that have implemented each type of reform of interest. As the number of states and years or claims for which data are collected increase, analysis can more accurately estimate reform effects, but at greater cost.

Similarly, policy debates sometimes focus on particular types of claims and hinge on the issue of how reform affects those types of claims. For example, the problems child care centers or municipalities encounter in obtaining insurance are the focus of particular concern in the tort reform debate. Participants in the debate might find assessments of the effects of reform on those institutions particularly relevant; estimates of the effects of reform on all institutions or on the availability of insurance in general would be inadequate.

If existing data systems happen to maintain data in a form that permits identification of particular claims, it may be possible to collect the data needed to perform separate analyses of the effects of reform on them. If not, new data systems will have to be developed and put into operation before separate analyses can be conducted. The development and implementation of new data systems can dramatically increase the costs of the data collection effort. Here, too, design efforts must address the tradeoffs between the increased value of data collection systems that obtain a high level of detail and their higher price tags.

The availability of "baseline data" is an important factor in the design of data collection efforts: To estimate the effects of any reform,

it is necessary to compare "what is" after reform with "what would have been" had the reform not occurred. Data on the value of some outcome after reform are not sufficient in themselves to assess the effects of reform. At a minimum, data on the values of an outcome prior to reform will be needed to compare to that outcome's postreform values.[2]

Baseline data sufficient to estimate how outcomes would have changed over time without reform will be needed to accurately assess the effects of reforms. These data will generally include information on the outcomes of interest and on the other relevant variables before reform. Data collection efforts that capture detailed data "from now on" are not going to provide data from the past; baseline data on past performance will have to be collected.

The need for appropriate baseline data, in turn, implies that the feasibility and costs of collecting retrospective information must be considered in deciding on the level of detail.

FROM WHOM?

The insurance industry is the obvious source of data on the aggregate outcomes of claims. Aside from claims against self-insured individuals and organizations, the insurance industry is the one place where all claims eventually appear. The kinds of information insurance companies record for management purposes include much of the data needed to assess the aggregate performance of the tort system; a variety of reporting systems that capture data from insurers exists. In principle, data on the outcomes of closed claims (e.g., indemnity paid, mode of and time to disposition, and the jurisdiction in which the claim was brought or a lawsuit filed) could be routinely compiled to generate an ongoing database that would suffice for studies of aggregate outcomes.

The insurance industry may seem like an obvious source of data on the outcomes and characteristics of individual claims. However, the information it collects may not include some of the data needed to assess the effects of reforms on various kinds of claims or claimants. For that matter, some relevant information may not even be known to

[2]However, most of the issues of the current policy debate have dynamic patterns of their own: They are changing over time and would have changed from the prereform year even without reform. Research cannot simply attribute all differences between the value of an outcome this year and some earlier year to reform. Rather, research must somehow account for the dynamics of the process—estimating where the system would have been this year in the absence of reform—and compare that estimate to where the system is given the presence of reform.

insurers. Insurance companies, for example, may not routinely obtain information on claimants' wealth; their data, therefore, would not suffice for a study of the effects of reform on relatively poor claimants.

Claimants and defendants tend to be "one-time" participants in the system and the involvement of any particular claimant or defendant is generally unanticipated. We have no means of predicting in advance who will be claimants or defendants, and there are no centralized systems to which claimants or defendants must report. But if the policy debate raises questions regarding the effects of reforms on particular types of parties or claims, and if insurance companies do not routinely obtain the information needed to distinguish them, then special surveys of claimants or defendants or both will be needed.

In principle, all the information required to assess the effects of reforms on aggregate outcomes and on the outcomes of individual claims (winners and losers) could be obtained from lawyers. However, there are no data systems that routinely collect information from lawyers; obtaining such data would require the creation of entirely new systems and the development of monitoring techniques to ensure that the proper data are provided in a timely manner for all cases. Because of the large number of lawyers from whom information would be needed, these systems would be extremely cumbersome and expensive. Attorney-client privilege issues might also limit the data that could be obtained through attorneys. Nonetheless, there may be particular policy questions that hinge on data available only from attorneys. Special surveys of attorneys might be needed to obtain these data.[3]

The courts routinely collect significant amounts of information. But they generally collect data for their own administrative needs, and the data tend not to be useful for assessing the effects of tort reforms. It may be possible for the courts to provide more useful information on an ongoing basis. In particular, data on the aggregate numbers of cases filed and disposed and on the means of and time to disposition, by case type, could be very helpful.

The courts obtain information on such matters as the type of suit and the alleged injuries indirectly in a variety of documents—complaints, answers, motions, and so forth—designed for purposes other than data collection. Using court personnel to review these documents and extract information would undoubtedly strain court resources; but it may be possible to devise forms that plaintiffs and defendants, or their representatives, could fill out and submit to the court.

[3]Because claims can be resolved before a lawyer is involved, the litigants known to the bar are self-selected samples of all litigants. And because the basis for self-selection is likely to be related to outcomes of interest, the sample would be inappropriate for many kinds of analyses.

Although the insurance industry seems an appropriate source for much of the requisite data, several problems must be addressed. Insurance companies may not have access to important information such as collateral source payments. Differences occur among companies in the kinds of information they obtain for a claim, the definitions of various characteristics of a claim, and the coding systems they use. Data on claims against self-insureds would have to be collected separately. "Double counting" is a problem in claims against two or more defendants because, except by chance, the defendants will have different insurers and there would be duplicate reports of the same claim.

The Insurance Services Office (ISO), a nonprofit corporation that makes available advisory rating and other services to the insurance industry, is now collecting information on at least 12,000 individual claims in 27 states that have modified their tort systems.[4] These will include a sample of large claims (over $25,000) arising out of policy year 1983 and closed after July 1, 1985, or still open, a sample of all claims closed during the month of May 1987, and a sample of all governmental claims from policy year 1983. These data will provide a first step toward the development of a database sufficient to assess the effects of reform.

Because almost all the claims in the database will have closed soon after reforms were enacted, their outcomes may not reflect the full impact of reform.[5] However, these data should suffice to establish a baseline with which the outcomes of future claims can be compared.

In collecting these data, ISO will presumably have worked through the problems of obtaining compatible information from different insurance companies. Their procedures should provide guidelines to such issues as consistent definitions of data elements.

NEXT STEPS

The next step in assessing the effects of reform is to design and evaluate data collection systems that could be used in the future to capture data on the performance of the tort system. We suggest

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[4]Insurance Services Office, *Insurance Data: A Close Look*, 1987.

[5]ISO intends to have experienced claims managers estimate the values of each claim in its new legal environment. This approach is the only way to obtain an early estimate of the impact of reform. Nonetheless, because the claims managers will have had relatively little experience with the new legal environments, their estimates may not fully reflect the impact of tort reforms. Pending analyses of the implementation process, there is no way to determine the degree to which they, or anyone else, are able to anticipate the eventual effect of reform on claims' outcomes.

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consideration of three types of new data collection systems. One comprises systematic efforts to obtain data from insurers and self-insured defendants on the aggregate outcomes of liability claims. Ideally, these efforts would result in systems for collecting these data on an ongoing basis to support continuing analyses and monitoring of the overall effects of reform. The second type of system would involve the design of special surveys of claimants, the bar, and insurers to obtain the detailed individual claim information needed to identify reform's winners and losers. Finally, we need to explore the feasibility of systems for collecting information on the other factors that influence participants in the tort system and must, therefore, be included in analyses, and on economic outcomes and injuries.

Once feasible designs are constructed, they need to be evaluated to determine whether the research they will support is sufficiently important to warrant the costs of the data collection and analysis efforts.

Appendix

STATE TORT REFORM ENACTMENTS, 1986

Table A.1 summarizes the principal tort reforms enacted during 1986. The remainder of this appendix describes the provisions of those reforms.

A. COMPARATIVE/CONTRIBUTORY NEGLIGENCE (CN)

CONNECTICUT	HB 6134—Damages will be diminished by the plaintiff's percentage of fault.
ILLINOIS	SB 1200—Plaintiffs who are more than 50 percent at fault are barred from recovery, and the jury would be instructed as to 15 possible barring effects. The law applies to negligence actions and product liability actions brought under a strict liability theory.

B. JOINT AND SEVERAL LIABILITY (JSL)

1. All Tort Suits

ALASKA	SB 377—The application of joint and several liability is now limited for low fault defendents (less than 50 percent at fault) as they cannot be held jointly liable for more than two times the apportioned percentage of damages.
CALIFORNIA	Prop 51—Joint and several liability has been abolished for all noneconomic damages.
COLORADO	SB 70—Outright abolition of joint and several liability has been approved.
CONNECTICUT	HB 6134—A measure abolishing joint and several liability has been enacted; each defendant is liable only for their attributed share of damages; Orphan Share Clause: Defendants are liable for that portion of an uncollectible sum that is proportionate to their share of the entire judgment but may not be forced to pay the entire uncollectible amount.

Table A.1

STATE TORT REFORM ENACTMENTS, 1986

STATE	CN	JSL	DAM	PUNI	AFMS	CSR	PPJ	INTX	DRAM	GOV	MMPL	MISC
Alabama										2		
Alaska		1	1	1		1	1	1			2	1
Arizona					1				2			1
California		1										
Colorado		1	3	1		1			2	2	2	3
Connecticut	1	1			1	1	1		2	2	2	
Delaware											2	
Florida		1	1	1		1	1					
Georgia					1					2		
Hawaii		1	1	1	3	1	2			2	2	1
Idaho					1				2			
Indiana					1	1		1	2		2	2
Illinois	1	1		1	1	1				2	2	
Iowa				3	1		1		2	2	2	3
Kansas			2		3		2				2	2
Louisiana									2			2
Maine					2		2		2	2	2	
Maryland			1				1				2	
Massachusetts			2		2	2					2	
Michigan		1	2		1	3	1	1	2	2	2	1
Minnesota			1	1	1	1		1				
Mississippi										2		
Missouri			2							2	2	
Montana			2							2		
Nebraska					1			1				
New Hampshire		3	3	1	1				2	2	2	1

[illegible]				2		2		2	2	2	
Maryland		1				1				2	
Massachusetts		2		2	2					2	
Michigan	1	2		1	3	1	1	2	2	2	1
Minnesota		1	1	1	1		1				
Mississippi									2		
Missouri		2							2	2	
Montana		2							2		
Nebraska				1			1				
New Hampshire	3	3	1	3				2	2	2	1

Table A.1—continued

STATE	CN	JSL	DAM	PUNI	AFMS	CSR	PPJ	INTX	DRAM	GOV	MMPL	MISC
New Mexico			2		2				2			
New York		1			1	1	1				2	1
New Jersey												2
Ohio											2	2
Oklahoma				1	1			1				
Rhode Island					2	2					2	
South Carolina			2							2		
South Dakota		2	2	1			1			2	2	
Tennessee									2	2	2	2
Utah		1	2				2		2		2	
Virginia			2	2				2		2		
Washington		1	1		1		1			2	2	1
West Virginia		3	2		2					2	2	
Wisconsin			2		3						2	
Wyoming		1			1				2	2	2	2

NOTE: 1 = Applicable to most tort suits; 2 = applicable only to particular case types or parties; 3 = applicable to most tort suits and specifically to particular case types or parties.

ABBREVIATIONS:

CN = Comparative/Contributory Negligence
JSL = Joint and Several Liability
DAM = Limits on Damage Awards
PUNI = Punitive Damages
AFMS = Attorney's Fees/ Miscellaneous Sanctions
CSR = Collateral Source Rule Changes
PPJ = Periodic Payment of Judgments
INTX = Interest and Taxes on Judgments
DRAM = Dram Shop Liability Reform Legislation
GOV = Government Liability
MMPL = Medical Malpractice and Professional & Director's/ Officer's Liability
MISC = Miscellaneous Provisions

FLORIDA	SB 465—Joint and several liability has been severely restricted in cases involving over $25,000 in damages: No joint and several liability for noneconomic damages in negligence actions and likewise for economic damages for those defendants less at fault than the plaintiff. Itemization of damage awards is also required. No modification of the rule for: (a) action seeking economic damages for pollution incidents (b) intentional torts (c) actions governed by a specific statute providing for joint and several liability
HAWAII	SB S1(SS)—Joint and several has been eliminated for low fault defendants (less than 25 percent); this limit on joint and several does not apply to (1) economic damages, (2) automobile accident cases, (3) product liability cases, (4) property damage cases, or (5) environmental pollution cases.
ILLINOIS	SB 1200—Joint and several liability has been eliminated in negligence and strict liability product liability actions for low fault defendants (less than 25 percent). This does not apply to (1) medical malpractice cases, (2) environmental liability cases, and (3) medical expenses specifically awarded as damages in any action.
MICHIGAN	HB 5154—Joint and several liability is now limited, except in (1) product liability actions, (2) actions involving a blame-free plaintiff. Defendants are only severally liable for damages, but Michigan has the Orphan Share Clause, (i.e., any uncollectible shares of a judgment can be proportionately reallocated between solvent codefendants). Joint and several liability is now abolished for municipalities.

NEW HAMPSHIRE	HB 513—Apportionment of damages between codefendants is now allowed.
NEW YORK	SB 9391—Joint and several liability is now eliminated for noneconomic damages for low fault defendants (50 percent or less at fault). The limitation does not apply for: (a) contract cases (b) indemnification by public employee claims (c) administrative proceedings (d) workers' compensation claims (e) intentional torts on actions alleging reckless disregard for rights of others (f) motor vehicles or motorcycle accident cases (g) actions involving absolute liability resulting from construction (h) toxic tort cases (i) product liability actions where the manufacturer could not be joined (j) and certain other actions The law also requires the itemization of verdicts for personal injury, property damages, and wrongful death.
UTAH	SB 64—Outright abolition of joint and several liability has been approved.
WASHINGTON	SB 4630--Except as follows, joint and several liability has been abolished. The exceptions include: (a) where defendants act in concert or a servant acts for a master (b) where a plaintiff is entirely fault-free (c) where toxic substances or solid waste disposal is involved (d) tortious interference with contract or business relations (e) where specified types of fungible products are involved
WEST VIRGINIA	HB 149—Joint and several liability has been abolished for defendants less than 25 percent at fault.

WYOMING	SB 17—The doctrine of joint and several liability is abolished; a party may request or a court may require apportionment of damages, and a defendant's liability is then limited to that share apportioned to him, her, or it.

2. Particular Suits or Parties

NEW HAMPSHIRE	HB 513—Just and several liability only applies to municipality when they are over 50 percent at fault.
SOUTH DAKOTA	SB 216—Joint and several liability is now modified in respect to actions against local governments.
WEST VIRGINIA	SB 714, HB 149X—Joint and several liability has been eliminated in medical malpractice actions for low fault defendants (less than 25 percent negligent).

C. LIMITS ON DAMAGE AWARDS (DAM)

1. All Tort Suits

ALASKA	SB 377—A cap on noneconomic damages of $500,000 is now provided. However, the cap does not apply to damages resulting from severe physical impairment or disfigurement. Also provided for the itemization of damages between economic and noneconomic losses.
COLORADO	SB 67—$250,000 cap on noneconomic damages, unless a court finds clear and convincing evidence that the damages exceed the cap raising the ceiling to $500,000. Eliminates awards for derivative noneconomic loss except when the court finds "clear and convincing evidence."
FLORIDA	SB 465—A cap of $450,000 on noneconomic damages in all personal injury, wrongful death, and property damage actions.
HAWAII	SB S1(SS)—A $375,000 cap has been provided on damages awarded for pain and suffering (but not other types of noneconomic losses such as loss of consortium or emotional distress) in certain tort actions. Additionally, awards for mental anguish

	are unavailable in actions seeking recovery for property damage only; provides standard for determination of loss or impairment of earning capacity.
MARYLAND	SB 558—A cap of $350,000 on all noneconomic damage.
MINNESOTA	SB 2078—A cap has been enacted on "intangible losses," (embarrassment, emotional distress, and loss of consortium) exclusive of pain and suffering and disfigurement; the cap is set at $400,000.
NEW HAMPSHIRE	HB 513—A cap on noneconomic damages has been set at $875,000.
WASHINGTON	SB 4630—All noneconomic damages are capped based upon a measure of economic damages and the Washington average annual wage; a portion of this amount (.43) is used as a base figure and is adjusted to reflect life expectancy of a plaintiff (estimated to be somewhere between $177,000 and $493,000).

2. Particular Suits or Parties

COLORADO	SB 86—A $50,000 cap on damages in dram shop actions has been passed.
KANSAS	HB 2661—Noneconomic damages have been capped at $250,000 and all damages at $1,000,000 in medical malpractice actions; the cap on noneconomic damages will be annually adjusted to reflect the consumer price index. Mandatory itemization of noneconomic damage awards has been instated in such cases. "Pinhole" provision to allow courts to award supplementary medical benefits up to $3 million also instated.
MASSACHUSETTS	HB 5700—Unless special circumstances are demonstrated indicating a plaintiff will not be justly compensated, noneconomic damages in medical malpractice actions are now capped at $500,000.
MICHIGAN	HB 5154—A cap of $225,000 on noneconomic damages in medical malpractice actions that

	will be adjusted to reflect the C.P.I. has been enacted. (This cap does not apply in wrongful death actions, actions involving reproductive system injuries, and actions for loss of a vital bodily function.)
MISSOURI	SB 663—Noneconomic loss in medical malpractice actions has been capped at $350,000; the cap amount is the limit that may be awarded against each individual health care provider.
MONTANA	SB 22XX—The liability of the state and its political subdivisions has been capped at $750,000 per claimant and $1,500,000 per incident.
NEW HAMPSHIRE	HB 513—The liability of governmental subdivisions is now limited to a cap on all civil damages that has been set at $150,000/$500,000.
NEW MEXICO	NM HB 244—A $50,000/person, $100,000/incident, cap on personal injury/death damages in dram shop actions has been passed, $20,000 for property damage.
SOUTH CAROLINA	HB 2266—Limits liability of state and its subdivisions to $250,000/incident and $500,000/occurrence.
SOUTH DAKOTA	SB 282—The existing cap on noneconomic damages in medical malpractice actions has been changed to a cap of $1,000,000 covering all damages. Additionally, the cap was broadened to include actions against all health care providers.
UTAH	SB 111—Noneconomic damages in medical malpractice actions are capped at $250,000, but specifically included are damages for pain and suffering and inconvenience; punitive damages are specifically excluded.
UTAH	SB 182—A cap on damages in dram shop actions has been enacted; liability is limited to $100,000/$300,000.
VIRGINIA	HB 624—A cap of $25,000 or the amount of insurance coverage carried is provided in actions against transportation districts.

WEST VIRGINIA	SB 714, HB 149X—A $1,000,000 cap on noneconomic damages has been enacted on medical malpractice damages.
WEST VIRGINIA	SB 3—Noneconomic damages are limited to $500,000 when involving political subdivisions.
WISCONSIN	AB 4—Damages in medical malpractice actions have been capped at $1,000,000.

D. PUNITIVE DAMAGES (PUNI)

1. All Tort Suits

ALASKA	SB 377—Clear and convincing evidence is required before punitive damages can be awarded.
COLORADO	HB 1197—Punitive awards may not exceed the amount of compensatory damage award; one-third of a punitive damage award goes to the State General Fund; proof of malice, fraud, or willful and wanton conduct is required; court has ability to reduce punitive awards if deterrent effect is accomplished, or to increase them up to three times the amount of actual damages if misbehavior continues during trial.
FLORIDA	SB 465—Punitives cannot exceed three times the compensatory damage award unless clear and convincing evidence is shown; 60 percent of any punitive damage award goes to the Public Medical Assistance Trust Fund or the State's General Fund.
HAWAII	SB S1(SS)—Punitive damages are now uninsurable unless an inclusion is specifically provided by an insurer.
ILLINOIS	SB 1200—Plaintiffs would no longer be able to plead for punitive damages in their original complaint; subsequent motion to amend is granted only following a hearing where the plaintiff stands a chance to win the punitive award at trial. Defendant must be shown to have acted in a willful and wanton manner. Court has discretion to distribute punitive award among the plaintiff, his or her attorney, and the State's Department of Rehabilitation Services; applies to negligence actions and product liability actions based on a strict liability theory.

IOWA	SB 2265—Willful and wanton disregard for the rights and safety of another must be proven prior to an award of punitive damages. 75 percent or more of a punitive award must be paid to the State's Civil Reparations Trust Fund, except where the action resulted from a tort specifically directed at the particular plaintiff; no discovery of a defendant's wealth is permitted prior to establishment of a prima facie case.
MINNESOTA	SB 2078, HF 1950—Pleas for punitive damages are no longer permitted in their complaint; a prima facie showing of defendant's liability is required before an amendment of pleadings.
NEW HAMPSHIRE	HB 513—Punitive damage awards are now prohibited.
OKLAHOMA	SB 488—Punitive damage awards have been capped; no punitive award may exceed the amount of actual damages awarded; the level of proof required raised also.
SOUTH DAKOTA	SB 280—Punitive damages must be proved by clear and convincing evidence of willful, wanton, or malicious conduct on the part of the defendants.

2. Particular Suits or Parties

IOWA	SB 2265—Limits liability of municipal officers and employees for punitive damages.
VIRGINIA	HB 624—Punitive damage awards are prohibited in actions against transportation districts.

E. ATTORNEY'S FEES/MISCELLANEOUS SANCTIONS (AFMS)

1. All Tort Suits

ARIZONA	HB 2377—Establishes penalties for unjustified actions.
CONNECTICUT	HB 6134—A contingent fee scale limiting attorney's fees is now required (1/3 of 1st $300K, 1/4 of next $300K, 20 percent of next $300k, 15 percent of next $300K, and 10 percent of rest). Also creates sanctions (which could include defense costs) for frivolous behavior for filing in absence of probable cause.

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GEORGIA	HB 1146 HB 1185—Parties filing frivolous suits to pay defendants fees and cost; dismissals of action for frivolous suits.
HAWAII	SB S1(SS)—Any party may request court review or their attorney's fees; compensation is limited to a "reasonable amount"; attorneys' fees are now available as a sanction for frivolous defenses as well as frivolous actions (not to exceed 25 percent of prayer).
IDAHO	HB 1460—Places limits on attorney contingent fees.
ILLINOIS	SB 1200—Sanctions may be assessed against parties, attorneys, and insurers for frivolous pleadings, defenses, and motions; attorneys' fees would be available as a sanction.
INDIANA	SB 393—Courts may impose attorneys' fees as a sanction against parties who bring frivolous actions or defenses.
IOWA	HB 2265—Authorizes the court to stay actions if past actions by the party have been frivolous. Requires certification of pleadings and motions and provides sanctions for violation.
KANSAS	HB 266—Modification of civil procedures for determination of frivolous suits.
MICHIGAN	HB 5154—Awards of attorneys' fees are now available as sanctions for frivolous suits and defenses.
MINNESOTA	HF 1950—Allows the award of costs in frivolous suits.
NEBRASKA	LB 298—Allows the award of prejudgment interest as a sanction for unreasonable failure to settle (offers of settlement are compared to the judgment to determine reasonableness).
NEW HAMPSHIRE	HB 513—All contingent fee arrangements must be filed with the court and those in actions where the damage award is over $200,000 are subject to court review. Allows the court to assess costs and attorneys' fees from frivolous suits and defenses.

NEW YORK	SB 9351—Attorneys' fees and costs are now available as sanctions for frivolous suits and defenses.
OKLAHOMA	SB 488—Attorneys' fees are now available as sanctions for frivolous suits and defenses up to an aggregate of $10,000.
WASHINGTON	SB 4630—New law provides for the discretionary review of contingent fee contracts by courts; also, attorneys' fees are now available as sanctions for frivolous suits and defenses.
WYOMING	HB 14, HB 15—Courts authorized to determine frivolous suits and make plaintiffs liable for sanctions.

2. Particular Suits or Parties

HAWAII	SS S1—All fees in medical malpractice cases are subject to court approval.
KANSAS	HB 2661—Courts are now able to review attorneys' fee arrangements in medical malpractice cases.
MAINE	SB 958—Establishes an attorneys' contingent fee scale in medical malpractice actions.
MASSACHUSETTS	HB 5700—Establishes fee limits in medical malpractice cases.
NEW MEXICO	SB 1110—Caps fees for workers' compensation cases according to a sliding scale.
RHODE ISLAND	SB 2891—Attorneys' fees and costs are now available as sanctions in frivolous medical malpractice actions.
WEST VIRGINIA	SB 714—Frivolous suit sanctions are provided in medical malpractice actions.
WISCONSIN	AB 4—Attorney's fees have been regulated in malpractice actions.

F. COLLATERAL SOURCE RULE CHANGES (CSR)

1. All Tort Suits

ALASKA	SB 377—Introduction and limited offset are now provided for collateral sources that do not have statutory or contractual rights of subrogation.

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COLORADO	SB 67—Admissibility and offset with broad exclusions or sources with subrogation rights.
CONNECTICUT	HB 6134—Expansion of application of the collateral source rule modifications for malpractice actions to all civil actions; admission and offset are provided, but sources having rights of subrogation are excepted from offset.
FLORIDA	SB 465—The traditional collateral source rule to allow admission of evidence of collateral source benefits; offset is provided, but benefits having a right of subrogation are not offset; those seeking subrogation are required to share the attorneys' fees and costs incurred by the plaintiff.
HAWAII	SB S1(SS)—Court is required to determine the validity of liens and rights of subrogation; such valid liens are to be paid from special damages recovered.
ILLINOIS	SB 1200—The collateral source rule is modified in that only benefits in excess of $25,000 can be offset and no more than 50 percent of a tort judgment can be reduced by offset of duplicative sources, but sources having rights of subrogation cannot be offset.
INDIANA	SB 394—The traditional collateral source rule has been abolished; evidence of collateral sources of payment is now admissible; a court may reduce excessive awards to reflect collateral sources at its discretion as well as reducing subrogation liens under certain circumstances.
MICHIGAN	HB 5154—The traditional collateral source rule has been abolished; the court may consider evidence of collateral benefits; offset of collateral sources is provided, but such offset cannot reduce a plaintiff's damages by more than the amount awarded for economic losses, and the offset is first reduced by the sum of any premiums paid for their benefit by either plaintiff, his or her family or employer. Sources having statutory liens cannot be offset; sources with contractual liens are required to act to assert the lien or lose it.

MINNESOTA	SB 2078, HR 1950—The traditional collateral source rule has been abolished; while evidence of collateral source payments is now admissible, only the court may review such evidence; offset is provided for, but all collateral sources having rights of subrogation are excluded.
NEW YORK	SB 9351—Abolition or traditional collateral source rule; admission of evidence and offset of collateral benefits are now provided; offsets are reduced by last two years premiums and future premiums necessary to secure collateral payments; sources with mandatory liens and workers' compensation, life insurance, and certain social security benefits may not be offset.

2. Particular Suits or Parties

MASSACHUSETTS	HB 5700—Rule on collateral source modified in medical malpractice cases.
MICHIGAN	HB 5154—Admission of collateral sources and offsets by court in medical malpractice cases.
RHODE ISLAND	SB 2891—In malpractice cases, collateral source rule has been modified to provide for introduction of evidence of additional sources of a recovery and an offset of such sources.

G. PERIODIC PAYMENT OF JUDGMENTS (PPJ)

1. All Tort Suits

ALASKA	SB 377—Periodic payment of judgments for future damages is now permitted in certain circumstances.
CONNECTICUT	HB 6134—Mandatory provisions for periodic payment of judgments have been enacted when noneconomic damages exceed $200,000, unless the parties agree otherwise.
FLORIDA	SB 465—Periodic payments are now mandated where a party requests such a plan and where future damages for economic losses exceed $250,000.

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IOWA	SB 2265—Periodic payment of awards is permitted at the court's discretion following petition of a party.
MARYLAND	SB 558—Periodic payments of awards are permitted at the discretion of the court.
MICHIGAN	HB 5154—Periodic payment of judgments for future damages over $250,000 is now mandated.
NEW YORK	SB 9391—Periodic payment of future damages over $250,000 is mandated if a party requests them.
SOUTH DAKOTA	SB 281—Periodic payment of future damages in bodily injury actions is permitted where a good faith claim for such damages of $100,000 or more is shown; provisions for election and objection have been enacted.
WASHINGTON	SB 4630—The court is required to order the payment of judgments by means of a periodic payment plan upon a party's request.

2. Particular Suits or Parties

HAWAII	SB S1(SS)—The state and its subdivisions now have the option of paying judgments against them in excess of $1,000,000 by means of periodic payments.
KANSAS	HB 2661—All medical malpractice settlements are to be paid periodically.
MAINE	SB 958—Mandates periodic payments of future medical malpractice awards in excess of $250,000.
UTAH	SB 155—Periodic payment of damages in medical malpractice actions is now mandated where either party so requests.

H. INTEREST AND TAXES ON JUDGMENTS (INTX)

1. All Tort Suits

ALASKA	SB 377—Establishes prejudgment interest accrual principle.
INDIANA	SB 394—Upon the request of any party, an instruction to jury that it may not consider tax consequences of its verdict is available.

MICHIGAN	HB 5154—Prejudgment interest on awards for future damages is now prohibited; the rate of interest on judgments has been changed to 1 percent above the yield on five-year U.S. Treasury bills.
MINNESOTA	SB 2078—Any award of interest on damages for future loss is prohibited.
NEBRASKA	LB 298—The rate of interest on judgments is now tied to the rate of return on 52-week U.S. Treasury obligations plus 1 percent; the award of prejudgment interest as a sanction for unreasonable failure to settle is now available (offers of settlement made are compared to the judgment to determine reasonableness).
OKLAHOMA	OK SB 488—Prejudgment interest on awards for punitive damages is now prohibited; the rate of interest on judgments has been changed to 4 percent above the U.S. Treasury bill rate.

2. Particular Suits or Parties

VIRGINIA	HB 624—Awards of prejudgment interest damages are prohibited in actions against transportation dist .cts.

I. DRAM SHOP LIABILITY REFORM LEGISLATION (DRAM)

ARIZONA	HB 2170—Liability may be imposed only where the liquor licensee serves an obviously intoxicated person; liability of servers is several only.
COLORADO	SB 86—Dram shop actions are now capped at $150,000; liability for servers is limited to circumstances where a licensee or social host serves a visibly intoxicated person or minor.
CONNECTICUT	HB 6134—Sellers to intoxicated persons are liable up to $20,000/party, $50,000/incident. Rebuttable presumption of such sole liability is established.
IDAHO	SD 1439—Limits dram shop and social host liability.

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INDIANA	SB 85—Dram shop liability is now abolished except where a defendant furnishes alcohol to a visibly intoxicated person or where a plaintiff can show that service was a proximate cause of injury.
IOWA	SB 2265—Liability of servers has been limited to only those licensees who knew or should have known that a person consuming alcohol was already intoxicated; servers other than licensees or permittees may not be held liable for injuries resulting from a person's intoxication; consumption rather than service is legislatively declared the proximate cause of injury.
LOUISIANA	ACT 18—Those who sell, serve, or furnish alcoholic beverages generally not liable.
MAINE	LD 2080—Immunity to servers unless minors can prove negligent service. Does not apply when adult was visibly intoxicated. $250,000 cap exclusive of medical expenses.
MICHIGAN	HB 455—The liability of retail servers of alcohol has been limited to injuries resulting from service to a minor or visibly intoxicated person.
NEW HAMPSHIRE	HB 513—Limitations on dram shop liability have been enacted. Intoxicated drivers need to show gross negligence in future suits; defines "good business practices" for defense purposes.
NEW MEXICO	HB 244—Personal injury/death damages in dram shop actions is capped at $50,000/person, $100,000/incident. $20,000 for property damage. Establishes certain limitations of such liability.
TENNESSEE	HB 1199—Dram shop liability has been abolished except where a defendant serves an intoxicated person or a minor or where injury was caused by such service.
UTAH	SB 182—Liability in dram shop actions is limited to $100,000/$300,000 and is subject to one-year statute of limitations.
WYOMING	HB 13—Dram shop suits now may be brought only in circumstances where a licensee or other person sells or provides alcohol in violation of law.

J. GOVERNMENT LIABILITY (GOV)

ALABAMA	HB 178, SB 369—Grants immunity to certain members and associated 178 parties of various staff boards and commissions.
COLORADO	HB 1185-1187, HB 1196—Various limits on municipal liability including that arising out of water flow; clarifies immunity of public entities and employees.
CONNECTICUT	HB 6134—A measure limiting liability for acts of municipal employees has been enacted.
GEORGIA	HB 1471, HB 1549, HB 1526—Clarifies sovereign immunity of municipal corporations and establishes immunity for government employees and officials.
HAWAII	SB S1(SS)—The state and its subdivisions now have the option of paying judgments against them in excess of $1,000,000 by means of periodic payments.
HAWAII	HB 1993-86—Provides for additional exemptions to the state's tort claim act.
ILLINOIS	SB 1200—Public officials and employees are free from punitive damages claims when they arise from conduct of their official activities; the statute of limitations period in actions brought against public entities is shortened from two years to one year; local government liability is limited in actions arising from provision of traffic control devices and certain police, fire, and emergency services; local government liability is limited where a person is injured as the result of a hazardous recreational activity or on waterways adjacent to public property; local governments would no longer waive immunities by the purchase of insurance.
IOWA	SB 2265—Actual malice or a criminal offense must be proved for liability to be imposed upon officers and employees or municipalities and limits their liability for punitive damages; liability is limited regarding licensing decisions, the granting of permits, inspections, and financial regulatory activities.

MAINE	SB 700—Immunity is now provided to mediators under contract with the state judicial department.
MICHIGAN	HB 5154, HB 5163—Joint as several liability is completely eliminated for municipalities; limits liability of the state and its subdivisions when engaged in the exercise of its governmental functions.
MISSISSIPPI	SB 2166—Sovereign immunity has been totally reinstated.
MISSOURI	SB 647—Reestablishes sovereign immunity with several exceptions.
MONTANA	SB 22XX—The liability of the state and its political subdivisions is capped at $750,000 per claimant and $1,500,000 per incident.
NEW HAMPSHIRE	HB 513—All civil damages against governmental subdivisions are limited to $150,000/$500,000. Joint and several immunity only applies against municipalities when over 50 percent at fault. Acts of a government unit or employee that result in a pollutant incident are conclusively presumed to be reasonable; this presumption applies where the unit acted in accordance with state-of-the-art technology; strict and absolute liability is not available in such actions.
SOUTH CAROLINA	HB 2266—Restores some of the state's sovereign immunity by reestablishing about 20 categories of qualified immunities and limited liability of the state and its subdivisions to $250,000/incident and $500,000/occurrence.
SOUTH DAKOTA	SB 216—Joint and several liability was modified in actions against local governments; sovereign immunity for public entities applies only to the extent of their liability insurance coverage.
TENNESSEE	SB 1701—Except where conduct amounts to willful, wanton, or gross negligence, members of boards of governmental entities are now immune from civil suit.
VIRGINIA	HB 624—A cap of $25,000 or the amount of insurance coverage carried is provided and awards

	of prejudgment interest and punitive damages are prohibited in actions against transportation districts.
WASHINGTON	SB 4630—Immunity has been provided for school board members and directors of hospitals.
WEST VIRGINIA	SB 3—Limits noneconomic damages in suits involving political subdivisions to $500,000, deploys 25 percent rule regarding joint and several liability, lays out standards for liability immunity or political subdivisions employees.
WYOMING	WY 39—Grants officers and board members of governmental entities immunity.

K. MEDICAL MALPRACTICE AND PROFESSIONAL & DIRECTORS/OFFICERS LIABILITY (MMPL)

ALASKA	AK SB 377—Civil liability has been limited for members of boards of not-for-profit organizations, hospitals, school boards, and municipalities.
COLORADO	SB 1201—Limits liability for mental health professionals when they use an accepted standard of care but fail to anticipate a patient's violent behavior.
CONNECTICUT	HB 6134—Plaintiffs in malpractice action are required to file a certificate of merit with their complaints indicating that another provider believes their claims have merit. Also limits liability of directors and officers of nonprofit organizations.
DELAWARE	SB 533—Except for breaches of loyalty, bad faith acts, intentional misconduct, and wrongful transactions from which a director derives personal benefit, shareholders of a corporation may now limit the liability of directors.
HAWAII	SS S1—All attorneys' fees in medical malpractice cases are subject to cost approval; also provides for a statute of limitations of two years after discovery or six years after act (except for minors).

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ILLINOIS	SB 1200—Immunity would be provided for officers and directors of certain not-for-profit corporations.
INDIANA	HB 1284—Directors of not-for-profit corporations have been given immunity for acts and omissions not covered by liability insurance coverage.
IOWA	SB 2265—Expert witnesses in medical and dental malpractice actions must have qualifications directly related to problems or treatments at issue; new requirements for disclosure of expert witnesses in professional liability actions; restricts the discovery and use of medical malpractice peer review and disciplinary proceedings; expands use of voluntary agreements.
KANSAS	HB 2661—Noneconomic damages are capped at $250,000 and all damages at $1,000,000 in medical malpractice actions; the noneconomic damage cap will be annually adjusted to reflect the consumer price index; new expert witness requirements; pretrial settlement conferences are now required; courts are now able to review attorneys' fee arrangements in malpractice actions. Mandatory itemization of noneconomic damage awards and period payment of all settlements; "pinhole" provisions for court award of supplemental medical expenses up to $3 million.
MAINE	SB 958—Mandatory prelitigation screening by mediation panels in malpractice actions; three-year statute of limitations for actions for professional negligence; prohibits wrongful birth and wrongful life actions; mandatory periodic payments of future awards in excess of $250,000; establishes an attorneys' contingent fee scale in malpractice actions.
MARYLAND	SB 600—Personal immunity for directors of charitable organizations if the organization is insured.
MASSACHUSETTS	HB 5700—Noneconomic damages in medical malpractice actions are now capped at $500,000 unless special circumstances are demonstrated indicating a plaintiff will not be justly compen-

	sated. Collateral source rule modified. Attorney fees limited in medical malpractice cases.
MICHIGAN	HB 5154—Noneconomic damages in medical malpractice actions are capped at $225,000 and the cap will be adjusted to reflect the C.P.I. (this cap does not apply in wrongful death actions, intentional torts, foreign objects left inside, actions involving reproductive system injuries, and actions for loss of a vital bodily function and a few other exemptions); stricter standards for expert witnesses, and a prohibition contingent fee on compensation of expert witnesses; option for defendants to file an affidavit of noninvolvement rather than an answer; itemized damages; collateral source rule modifications; a new mediation system for medical malpractice actions; a statute of limitations is now six years regardless of when injury was discovered, and other miscellaneous provisions.
MISSOURI	SB 663—A cap of $350,000 has been enacted on damages for noneconomic loss in medical malpractice actions; the cap amount is the limit that may be awarded against each individual provider. Requires submission of an affidavit that the action is not frivolous.
NEW HAMPSHIRE	HB 513—Directors' and officers' liability is now limited; the burden of proof in medical malpractice actions has been revised.
NEW YORK	SB 9740—Medical malpractice plaintiffs are now required to file a certificate of merit with their pleadings and a new arbitration procedure is available in medical malpractice actions when defendants concede liability; new provisions for monitoring professional competence and investigating misconduct are provided.
	SB 9351—The liability of directors, officers, and trustees of not-for-profit corporations is limited to cases of "gross negligence."
OHIO	SB 366—Immunity has been extended to uncompensated members of boards of directors of charitable organizations.

RHODE ISLAND	SB 2891—Attorneys' fees and costs are now available as sanctions in frivolous malpractice actions; additionally, the collateral source rule has been modified to provide for introduction of evidence of additional sources of a malpractice plaintiff's recovery and an offset of such sources.
SOUTH DAKOTA	SB 282—The previous cap on noneconomic damages in medical malpractice actions has been changed to a cap of $1,000,000 covering all damages; the cap was broadened to include actions against all health care providers.
TENNESSEE	SB 1701—Except for willful, wanton, or gross negligence, directors and members of boards of not-for-profit entities are immune from suit.
UTAH	SB 111—Noneconomic damages in medical malpractice actions are capped at $250,000 (specifically included are damages for pain and suffering and inconvenience; punitive damages are specifically excluded from the cap).
	SB 155—Periodic payment of damages in medical malpractice actions is now mandated upon request of either party.
WASHINGTON	SB 4630—Immunity has been provided for school board members, directors of hospitals, and officers and directors of nonprofit organizations.
WEST VIRGINIA	SB 714—A $1,000,000 cap on noneconomic damages has been enacted on medical malpractice damages; the use of ad danmum clauses is now prohibited in medical malpractice pleadings; a two-year malpractice statute of limitations includes a discovery standard for accrual; all medical malpractice actions must be brought within 10 years of the injury; the period for which minor causes of actions are preserved has been shortened; medical malpractice actions accruing for a minor under 10 years of age must be brought within two years or by the child's twelfth birthday, whichever is later; greater peer review powers have been granted to the Board of Medicine; mandatory pretrial conferences are now required;

frivolous suit sanctions are provided; expert witness standards are specified; joint and several liability has been modified in medical malpractice actions; joint and several liability applies to defendants who are 25 percent or more negligent; several liability applies to defendants who are less than 25 percent negligent.

WISCONSIN — AB 4—Damages in medical malpractice actions have been capped at $1,000,000; attorney's fees have been regulated in malpractice actions; tougher medical disciplinary standards have been enacted.

WYOMING — HB 12, HB 40—Modifies the standard of care used to determine medical malpractice; pretrial screening panels.

HB 39—Grants nonprofit officers and board members of nonprofit entities immunity.

L. MISCELLANEOUS PROVISIONS (MISC)

ALASKA — SB 377—The definition of fault used in the state's comparative fault language has been expanded to include reckless actions, strict liability, and product liability. Bars a party from recovering losses for personal injury or death if it occurs during his or her commission of a felony.

ARIZONA — HB 2377—Raises limits for mandatory arbitration.

COLORADO — SB 69—A measure has been enacted shortening the statute of limitations peri[illegible] the bringing of civil actions from four [illegible] to two years (intentional torts are one year).

SB 76—A Good Samaritan provision has been enacted.

SB 1192—Limits liability for the manufacturing of firearms.

SB 1205—Limits a homeowner's liability when the property is entered illegally.

HAWAII	SB 1(SS)—An arbitration provision has been enacted applicable to actions seeking damages up to $150,000. Punitive damages are now uninsurable unless specifically provided. Also abolishes cause of action for serious emotional distress arising from damage to property or material objects.
INDIANA	HB 1284—Good Samaritan Rule applies to volunteers unless entity assisted has insurance.
IOWA	SB 2265—Plaintiffs found to have prosecuted three or more frivolous actions within five years may be required to post security. Ad damnum clauses have been prohibited in personal injury and wrongful death actions. The liability of non-manufacturers for product liability injuries has been limited. Creates state-of-the-art defense in P.L. suits. No discovery of a defendant's liability permitting prior establishment of a prima facie case.
KANSAS	SB 668—Evidence of product improvements may not be introduced in product liability actions; design feasibility evidence may be used only to impeach a witness who has denied feasibility.
LOUISIANA	ACT 952—Provides for limited civil liability connected with hazardous waste and asbestos abatement and cleanup.
MICHIGAN	HB 5154—A new mediation system for civil actions other than medical malpractice actions is now provided (this system is parallel to, but separate from, the medical malpractice mediation system described in Section II C). HB 5154—Reforms have been enacted in rules determining proper venue.
NEW YORK	A 10664, S 9391A—Statute of limitations extends from three years after exposure to three years after discovering an injury with a one-year revival of claims.
NEW HAMPSHIRE	HB 513—The statute of limitations period for personal injury actions has been shortened from six years to three years.

NEW JERSEY	SB 1678—Provides immunity to volunteer unpaid athletic coaches under certain circumstances.
OHIO	SB 366—Immunity to volunteers of nonprofit or charitable associations (some exemptions).
TENNESSEE	SB 1854—Asbestos removal immunity for local education agency employees.
WASHINGTON	SB 4630—Voluntary intoxication of a plaintiff by means of alcohol or drugs that is responsible for more than 50 percent of an injury is now a complete defense in wrongful death actions; defendants are protected from liability if the injured party was engaged in the commission of a felony.
WYOMING	HB 59—Makes certain entities not liable for injuries at amateur rodeos absent willful neglect.

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STATE OF MINNESOTA
DEPARTMENT OF COMMERCE
ST. PAUL 55101

OFFICE OF THE COMMISSIONER

500 METRO SQUARE BUILDING
ST. PAUL, MN 55101

February 8, 1989

Mr. Paul Roller
Director of Insurance
PO Box D
Juneau, Alaska 99811

FEB 16 1989

Dear Director Roller:

I enclose a copy of a report recently issued by this Department regarding medical malpractice. The report reviews all claims filed with two insurers in Minnesota, North Dakota and South Dakota against physicians from January 1, 1982 until December 31, 1987. These two insurers composed the entire physician malpractice market in Minnesota. The report states as follows:

1. The frequency of physician malpractice claims has not measurably changed over the last six years.

2. The claims have not measurably changed in terms of the average claim payment.

3. Approximately 75% of all claims are closed without payment.

4. Insurers overestimate exposure of pending claims by at least two to three times the amount eventually paid.

5. Claims determined by insurer personnel to be frivolous did not increase.

6. The cost of investigation and defense of claims has not increased.

7. There were only 20 jury verdicts over the six-year period which were entered against a physician.

8. No punitive damages were found to be awarded against a physician.

The report concludes that in specialty markets insurers are able to raise premiums in a non-competitive manner primarily because:

1. Physicians are sold policies which do not insure claims made after the expiration of the policy year. As a result, if a physician attempts to switch insurers, they must purchase a second policy to cover future claims that occurred during the policy year. The second policy, a "tail endorsement," is expensive and creates a negative environment for competitive pricing.

2. Data concerning the frequency of claims or the severity of claims is not available to competitors. As a result, it is difficult for other insurers to price a policy.

3. The number of purchasers of speciality lines of insurance such as medical malpractice is not sufficient to generate substantial numbers of competing vendors. Insurers must insure large numbers of policyholders to spread risk, and that the limited number of policyholders in a niche makes it clear that new competitors would likely not survive market entry.

The report recommends that government agencies periodically examine and collect loss data in niche markets so that competing insurers will have credible data to use in determining whether competitive pricing exists.

The report has been examined by actuaries who verify its credibility. While the insurers acknowledge the accuracy of the raw data, the St. Paul Companies nonetheless has issued a critique of the report charging that it has flawed methodology.

If you have any questions on the report, please give me a call.

Very truly yours,

MICHAEL A. HATCH
Commissioner of Commerce

MAH:nl
Encl.

MEDICAL MALPRACTICE
CLAIM STUDY

1982 - 1987

MICHAEL A. HATCH, COMMISSIONER
MINNESOTA DEPARTMENT OF COMMERCE

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I. INTRODUCTION

Raising the issue of "malpractice" in a room crowded with doctors, lawyers, consumer advocates, and insurance executives results in greater commotion than yelling "fire" in a crowded theater.

Unfortunately, the answers given to the many questions asked are different and conflicting. And everyone has their own statistical study to substantiate their answer. The only sure conclusion is a barrage of accusations and counter accusations that find the public and lawmakers caught in the crossfire. Tort reform? Insurance reform? Physician reform?

This report briefly reviews the history of medical malpractice claims in this country and the various proposals regarding malpractice coverage. The report further analyzes data collected during the Commerce Department's six month study of the two insurers who sell virtually 100 percent of the physician professional liability coverage in the State of Minnesota, the exception being self-insured groups. The two insurers are St. Paul Companies and Minnesota Medical Insurance Exchange (MMIE). During this time, the Department reviewed every individual claim filed with these two insurers over the last six years in the states of Minnesota, South Dakota and North Dakota - over 4,700 files.

It should be noted that, after reviewing this report, both the St. Paul Companies and MMIE asked that the Department clarify that the positions attributed to the insurance industry in this report do not necessarily reflect the individual views of St. Paul Companies or MMIE. Specifically, both companies stated, and the Department acknowledges, that they should not be identified as proponents of "tort reform." Further, MMIE stated that they know of no crisis in physicians and surgeons liability in Minnesota.

It should be emphasized that this report should not be construed as a critique of either insurer. The report is a critique or survey of the medical malpractice insurance market, and these insurers happen to comprise the market in Minnesota.

II. HISTORY

A. Medical Malpractice in the Seventies

Medical malpractice claims first appeared in significant numbers in the 1930's but did not attract much public attention until the late sixties and early seventies. In 1971, President Nixon created a Commission on Medical Malpractice to study the problem of increasing claim frequency. It's report was issued in 1973, about the same time that the medical malpractice insurance market began to experience its first crisis. The commission's findings concluded that the increase in medical malpractice litigation was due to a combination of more affordable and therefore widespread medical care and more complex medical procedures.

During the malpractice crisis of the mid seventies, many insurers raised their rates dramatically. Sky rocketing premiums became commonplace--50 percent, 100 percent, even 300 percent increases occurred in a single year. In addition, several large insurers withdrew from the medical malpractice market entirely, leading to a gap in availability of coverage. As a result, the problem escalated and became one of both affordability and availability.

In response to the crisis, legislatures around the country enacted measures aimed at curbing the effects of the crisis. Since insurers asserted that increased lawsuits caused unforeseen losses, legislation was primarily aimed at limiting the liability of health care providers. The various legislative attempts often included one or more of the following: 1) limits on attorney's contingency fees; 2) limits on non-economic damage awards, i.e. punitive damages; 3) revision of the statute of limitations; 4) creation of pretrial panels to screen cases to establish merit; 5) changes to collateral source rules; and 6) institution of periodic payment of judgments.

B. Joint Underwriting Associations:

In addition to these changes, two other significant changes resulted from the mid seventies crisis. The first was the creation of alternative markets - specifically joint underwriting associations (JUAs) and physician and hospital-sponsored nonprofit insurers or mutuals. A number of states enacted laws giving the insurance commissioner the power to establish a JUA at his or her discretion when warranted by market conditions. JUA's generally are comprised of all companies writing insurance in a particular state or all companies writing property/casualty insurance in a state and are controlled by a group of public and private sector representatives. The purpose of a JUA is to write liability insurance for health care providers who are unable to obtain coverage in the private market. In 1987, 13 medical malpractice JUA's were offering coverage to health care providers, including the Minnesota JUA. The market shares for the active JUA's ranged from 3 percent to 85 percent according to the National Coordinating Committee on Medical Malpractice JUAs.

The committee issued a report in 1987, the 1986 Financial Condition of Medical Malpractice JUAs, which found that five JUAs had insufficient funds to pay all existing claims liabilities. The greatest deficiency, reported in Massachusetts, was estimated to be $365.3 million. The report also found that the JUA market share had not changed significantly overall between 1985 and 1986, although the Florida, New York, and Wisconsin JUAs nearly doubled their respective market shares. It is apparent that those JUAs which incurred large deficits did so because of artificially low rates.

C. Physician Mutuals:

Physician/hospital mutuals, the second form of alternative malpractice market, first appeared in New York, Maryland and California in 1975. The creation of mutuals was based on the

premises: First, that a major influx of new insurers would alleviate the availability crisis and, secondly, that doctor-controlled nonprofit companies could issue affordable coverage to physicians in need. Nationwide in 1987, such mutuals represented more than half the premium volume in the medical malpractice market. In Minnesota, the Minnesota Medical Insurance Exchange (MMIE) began selling coverage in October of 1980. Today, MMIE is the largest insurer of physicians and surgeons in the state.

D. Claims-made Insurance:

The final significant change resulting from the seventies crisis was the change from an occurrence-based policy form to a claims-made form. In medical malpractice cases, there is often a significant time lag between the date an incident occurs and the date the claim is paid. This long "tail" has contributed to the insurers' difficulties in making accurate actuarial evaluations of malpractice loss experience. The claims-made policy form alleviates some of those difficulties by covering only those claims that are reported while the policy is in effect.

Under the traditional occurrence form, the transfer of risk from the health care provider to the insurance carrier took place when the incident occurred. Under the claims-made form, the transfer of risk takes place only when the claim or incident is reported to the insurance carrier. As a result, the health care provider maintains a risk at any given point in time for incidents that are unreported.

It is estimated that 70-80 percent of the medical malpractice market nationwide is now written on a claims-made basis. In Minnesota, St. Paul Companies shifted to the claims-made form in 1975 and MMIE has written coverage on a claims-made basis since the company's inception in 1980.

E. Malpractice Crisis in the Eighties:

The crisis of the eighties is evidence that the response to the crisis of the seventies did not resolve the problems in the malpractice insurance market. Rate increases in recent years have exceeded those experienced in the 1974-75 crisis and, although virtually everyone agrees a problem exists, there is little agreement on just what or who the "problem" is.

Doctors contend the problem is lawyers and their lawsuit-prone clients, a view shared by many insurers. They believe that many patients have unrealistic expectations of their physicians and the medical profession in general.

The trial lawyers place the blame on medical malpractice insurers and physicians saying they've created a "litigation crisis" as a public relations maneuver. They contend that the problems in the insurance marketplace are caused by the industry's inability and/or unwillingness to avoid the investment and "cash flow" cycles that cause the market disequilibrium.

And in the middle lies the public, who simply do not have independent data available from which to make a conclusion

Not surprisingly, since there is little agreement on the source of the problem, there is less agreement on a solution. Representing many physicians, the American Medical Association (AMA) recently proposed a virtual abandonment of the existing tort liability system. The AMA proposal calls for replacing the current court and jury system with an administrative claims facility. Under the plan, medical malpractice complaints would be reviewed by an expert administrative agency to try to reach a settlement between parties and/or make a determination as to the merits of the case. The agency would also have the power to discipline physicians who demonstrate a pattern of substandard conduct. In addition, the AMA plan would redefine the legal basis for determination of medical liability. Currently, medical liability is based on the standard of care a reasonably prudent physician in a given locality would dispense. Under the AMA proposal, the liability would be based on the standard of care a "prudent and competent practitioner in the same or similar circumstances" would provide, thereby eliminating the locality standard.

The insurance industry asserts that "the only truly viable long range solution lies in comprehensive and substantial tort reform." (Medical Malpractice: A Second Opinion. National Association of Independent Insurers (1986) p.15.) Insurers argue that, when enacted on a comprehensive basis, reforms discussed earlier effectively reduce the costs associated with medical malpractice litigation without restricting the right or ability of individuals to recover just compensation for their injuries. They blame ineffectiveness of reforms in many states on lack of a total commitment to comprehensive reform and implementation of reforms in a piecemeal fashion.

Lawyers and consumer advocates are proponents of increased regulation aimed at stabilizing the insurance market. Their proposals include more state regulatory power over rates; federal anti-trust regulation to eliminate price fixing; the creation of more federal insurance pools including reinsurance pools; mandatory reduction of the number of rating classes used to improve the spread of risk; and use of experience rating rather than class rating alone so that physicians with bad claim records would be penalized.

III. THE STUDY

The impetus for this study was not only the magnitude and far reaching impact of the malpractice crisis but the bewildering array of conflicting statistics and reports on the subject. Rather than reviewing statistical Samples presented by hired consultants representating a particular viewpoint, the Department sought to review every claim filed in the State since 1981. It is believed that this study is the only study in the country where independent examiners reviewed each claim filed in a specific line of insurance.

The review included all medical malpractice claims, open and closed, filed against physicians and surgeons in Minnesota, North Dakota, and South Dakota from 1982 to 1987 at Minnesota Medical Insurance Exchange and St. Paul Fire and Marine Insurance Company.

A. St. Paul Companies:

The St. Paul Companies, Inc. was organized in 1853 in St. Paul, Minnesota under the title of St. Paul Fire & Marine Insurance Company. The medical professional liability is underwritten by a wholly-owned subsidiary of The St. Paul Companies incorporated in 1925 under the title "Mercury Insurance Company." The subsidiary changed its name to St. Paul Fire & Marine Insurance Company when the former St. Paul Fire & Marine changed its status to that of a management company in 1967 and took the title "The St. Paul Companies, Inc." The St. Paul is a large diversified financial company specializing in insurance. In 1988 they acquired a large wholesale and retail insurance broker based in the United Kingdom making St. Paul the seventh largest insurance broker in the world. St. Paul Companies currently writes medical malpractice insurance in 43 states. The Medical Services Division is the largest of the company's underwriting units with the malpractice business accounting for 35 percent of the company's premiums in 1987. The St. Paul Companies has written malpractice insurance since the 1930's and presently writes coverage for doctors, hospitals and other health care specialties. In 1987, they had net malpractice premiums nationwide of $722 million which was about 18 percent of the total market, a market share equal to three times that of their nearest competitor.

B. Minnesota Medical Insurance Exchange:

In Minnesota, the Minnesota Medical Insurance Exchange (MMIE) now insures more than 50 percent of the state's physicians. MMIE began business in October of 1980 in Minneapolis as a reciprocal insurance exchange. It is governed by a board composed of twenty-two physicians appointed by the Minnesota Medical Association. Recently, it reorganized as a stock company to raise more funds and sell more coverage and has subsequently changed its name to Midwest Medical Insurance Company. (At the time this report was compiled, the company was operating as MMIE and is referred to as such throughout the report.) MMIE is managed by Minnesota Medical Management, Inc. and currently has over 3,200 policyholders in three states.

The two companies underwrite their malpractice coverage on similar policy forms (see Appendix A) and at similar policy limits. The policy limits range from $100,000 per occurrence/$300,000 aggregate to $10,000,000 per occurrence/$10,000,000 aggregate. The majority of policies are written either at $1,000,000/$3,000,000 (63.3%) or $2,000,000/$4,000,000 (20.4%) limits.

C. Methodology:

Department examiners reviewed a total of 4,747 medical malpractice files from Minnesota, North Dakota and South Dakota: 2251 files

from MMIE and 2496 files from St. Paul Fire and Marine. The study included all incident reports as well as claim files. Incident reports differ from claim reports in that they are made by physicians and do not necessarily result in a claim. Incident files were included because reserves were usually established for these files. It should be noted, however, that MMIE suspended the practice of setting reserves on incident files in 1985 after determining that these reserves "had not proven helpful in evaluating the total liabilities for MMIE ..." The study did not include claims made against hospitals, clinics or other institutions, nor claims against nurses or other health care providers. A four-page survey form was completed for each file.

The first draft of the questionnaire was developed by the Department's property casualty actuary, general counsel and examination supervisor. The malpractice study conducted by the National Association of Insurance Commissioners (NAIC) in 1976 was used as a reference source and St. Paul Companies also provided information with regard to loss coding procedures. Possible survey questions were considered with an eye toward current issues in the medical malpractice insurance market while taking into account which information examiners could reasonably expect to extract from the files based on their prior experience reviewing claims.

The first draft survey was tested by Department Counsel and the examination supervisor in a review of 40 St. Paul claim files pulled at random by the company. Some modifications were made based on the sample review and a copy of the revised questionnaire was then sent to the St. Paul Companies for comment. The St. Paul expressed concern over the issue of confidentiality with respect to the identity of physicians and claimants and other specifics of individual files, particularly open files where the defense of their insured was at risk. Assurances were given by the Department that the identity of any individuals or specific details relating to an individual file would not be released.

The St. Paul Companies also requested that the wording of question #25 be revised. The original wording read: "Based on the insurer's evaluation of this claim and using your own judgment, do you believe a claim was justified under these circumstances?" St. Paul asked that the judgment of the examiner be eliminated so that the question was based entirely on the judgment of the claims adjustor and/or the defense counsel. The Department made the change. In March, prior to beginning the examination of files at MMIE, the survey form was sent to the company and a similar assurance of confidentiality was given. MMIE did not request any changes be made to the questionnaire.

D. Survey Format:

A copy of the survey form is found on pages eight through eleven of this text. Survey questions one through three record basic identifying information for each file. The loss date and report date recorded in four and five allow for computation of the time lag between the incident giving rise to a claim and the report

of the claim to the insurer, an issue which prompted many insurers to switch to a claims-made policy form.

Question six identifies the specific medical procedure or incident which gave rise to the claim. In addition to being an integral piece of the total malpractice picture, a compilation of the loss cause information was thought to be particularly useful for insurers and health care providers in their loss control efforts. The following question identifying the location where the incident took place was included for similar reasons.

Questions eight and nine record personal characteristics of the claimant. The characteristics of age and sex help answer the question, "Who are the claimants?" This information also enables a comparison of claim frequency and severity for different ages and sexes, information which should be useful to insurers in their reserving practices. For example, the same injury may result in a consistently greater or smaller loss depending on the age and sex of the claimant.

Item ten completes the information about the type of loss along with questions six and seven. Here, the actual injury that resulted from the cause identified in question six is described.

Question 11 was included because of assertions that claimants' lawsuits unjustly include everyone remotely connected to a case. Items 12a-c record information about the physician defendant including specialty and the physician's professional relationship to the claimant. The physician's specialty was included to determine which specialties present the greatest risk and whether the rating classes used by insurers appear to be an accurate reflection of actual risk. Question 12c was an attempt to quantify the physician-patient relationship in order to test the theory that the nature of this relationship can be a contributing factor in decreasing or increasing a physician's exposure in a given situation. Although the claim files may not reveal the finer points of this issue, they often told us whether there had been an ongoing doctor-patient relationship and therefore, presumably increased loyalty or concern for the physician's reputation on the part of the patient.

Questions 13 through 16 are essentially recordkeeping items to decrease the potential for duplicate entries when several defendants were involved in the same claim.

In question 17, the policy limits and deductible were recorded. This information was included in order to identify any correlation between the loss amount and the potential compensation available to a claimant through an insurer. The deductible was noted in order to verify that the loss payment recorded reflected the deductible, if any.

For purposes of data analysis, it was necessary to separate closed from open claims and therefore the status of the file was noted in number 18.

Medical Malpractice
Claim Survey

St. Paul Companies

Initial when completed _____
Date: _____

1. File No. 1. _____

2. Policy No. 2. _____

3. State where loss occurred 3. _____

4. Date of Loss 4. _____

5. Date reported to insurer 5. _____

6. Cause of loss 6. _____

_____

_____

7. Location where injury occurred 7. _____

1. Office
2. Clinic
3. Hospital E.R.
4. Hospital-Surgery
5. Hospital-Labor/Delivery/Nursery
6. Hospital-Patient Care Area
7. Hospital-Outpatient Surgery
8. Hospital-Other
9. Surgi-Center

8. Age of injured person 8. _____

1. 0-30 days
2. 30 days - 2 yrs
3. Over 2 yrs - 12 yrs
4. Over 12 yrs - 18 yrs
5. Over 18 yrs - 35 yrs
6. Over 35 yrs - 55 yrs
7. Over 55 yrs - 70 yrs
8. Over 70 yrs

9. Sex of injured person 9. _____

1. male
2. female

10. Briefly describe principal injury giving a rise to the claim. _____

_____

_____

11. Total number of defendants 11. _____

12. Name of defendant for this file.

_____

a. Profession _____ 12a. _____

b. Specialty _____ 12b. _____

c. Relationship to injured party: 12c. _____

1. Family/personal physician
2. No relationship prior to this injury
3. Other _____

13. Named insured on policy covering above defendant.

_____

a. Named insured is an 1. Institution 13a. _____
2. Individual
3. Group

14. List any other defendants in this case covered by the same policy given in #11. 14. _____

Name	Claim File # (if known)
_____	_____
_____	_____
_____	_____

15. List any other defendants also covered by this insurer but under a different policy. 15. _____

_____

_____

16. List other defendants not covered by this insurer. 16. _____

_____

_____

17. Policy limits.

a. _____ occurrence 17a. _____
b. _____ aggregate 17b. _____

18. Status of claim. 18. _____

1. open
2. closed on___/___/___

19. If claim is open, indicate:

a. beginning loss reserve 19a. _____
b. current loss reserve 19b. _____
c. current LAE reserve 19c. _____
d. settlement demand 19d. _____

ANSWER QUESTIONS 20 - 24 ONLY IF CLAIM IS CLOSED.

20. If claim is closed, indicate:

a. beginning loss reserve 20a. _____
b. ending loss reserve 20b. _____

21. Method of disposition 21. _____

1. settled
2. tried
3. arbitration

22. Indicate amount of settlement or verdict broken down as follows:

a. medical expenses 22a. _____
b. future medical expenses 22b. _____
c. pain and suffering 22c. _____
d. lost wages incurred 22d. _____
e. lost wages anticipated 22e. _____
f. punitive damages 22f. _____
g. other 22g. _____
h. total 22h. _____

23. Indicate amount <u>paid to claimant</u>:

a. total amount paid to claimant 23a. _____
b. by this insurer 23b. _____
c. deductible paid by insured over limits 23c. _____
d. amount paid by insurer over limits of policy 23d. _____
e. amount paid by excess coverage insurer 23e. _____
f. amount paid by other defendants/ contributors 23f. _____

24. Amount of allocated loss adjustment expenses:

a.	total LAE	24a. _____
b.	claim investigation	24b. _____
c.	court costs	24c. _____
d.	internal defense counsel	24d. _____
e.	external defense counsel	24e. _____
f.	other	24f. _____

25. Based on the adjuster/defense counsel's evaluation of this claim, does it appear a claim was justified under the circumstances of this injury? 25. _____

1. definitely
2. probably
3. doubtful
4. definitely not
5. uncertain

26. Additional Comments/Observations:

_____

_____

_____

_____

Because different information could be obtained depending on the status of the file, a separate set of questions was developed for open and closed files. Obviously, if a file remains open, information regarding the disposition of the claim and the loss payment are not available. Therefore, in question 19 we recorded loss and loss expense reserves and the settlement demand if one had been made. The reserve amounts are necessary to the calculation of loss ratios. Reserving practices have consistently been an issue in the malpractice debate as lawyers and consumer groups have blamed overly conservative reserves for what they claim are inflated loss ratios published by insurers. In order to address the reserving issue, we recorded both the beginning loss reserve (the reserve set when the file was opened) and the ending reserve (the last reserve recorded prior to the closing of the file.) This was done to trace the progress of the reserve (in a limited way) and also to compare the ending reserves to the actual loss payment to gauge the accuracy of reserving.

Question 21 identified the method of disposition of a closed claim. Much of the media coverage of malpractice issues focuses public attention on jury verdicts and tried cases. Therefore, by separating the claims according to method of disposition, the various expense levels and final outcomes of tried claims as opposed to settled claims could be compared, for example.

Question 22 was directed toward some of the issues in the tort reform controversy. Insurers have pushed for caps on noneconomic damages as part of the solution to the rising costs of malpractice insurance. In order to determine the effect of noneconomic damages on overall loss experience, in question #22 the settlement or verdict was broken down into its various components.

Claimants may receive compensation through more than one source. Question 23 identified the various sources of compensation so that an accurate reading of the losses actually paid by the insurer as opposed to the total compensation awarded a victim could be obtained.

Insurers have pointed to the rising cost of claims management, regardless of whether any loss payment is ever made, as another factor in the rising cost of insurance. Question 24 broke down the allocated loss adjustment expense (LAE) costs according to investigation, court, and legal expenses.

Another argument evoked by insurers when explaining the rising cost of insurance is the large number of frivolous claims and their impact on insurance costs. Question 25 was included to determine the volume of frivolous claims and their cost to insurers.

Finally, space was included for additional comments and observations. Examiners used this section to record observations such as "new file - little information available" or other pieces of information that were not captured in the more quantitative survey questions but which could shed light on the claim.

E. Field Review:

The examiners began their review at St. Paul's Upper Midwest Service Center in Bloomington, Minnesota on January 19, 1988. The number of examiners reviewing files at any one time ranged from one to four. However, three examiners worked for seven weeks of the nine week examination at St. Paul. Department staff were provided a conference room in which to work and a photocopy machine was available for their use. Company employees were cooperative and available to answer examiners' questions. Over 250 of the files given to the examiners were incorrectly identified by the company as being within the survey's parameters. These files were rejected for a number of reasons including files where: The policyholder was not in one of the survey states (for example, frequently, Montana files were found); the claim was made against a health care professional other than a physician; or the claim was made against a clinic or hospital - although examiners did include claims against physicians where the named insured on the policy was a hospital or clinic.

Examiners encountered some difficulties in extracting information from St. Paul's files. Documents within each file were kept in approximate chronological order, however, examiners found a significant number of duplicate documents such as memos, depositions and medical records, which increased their time spent reviewing. In addition, medical records which were detailed and voluminous were often not separated from other file documents making it more difficult to sift through files for the survey information.

Examiners also had difficulty determining the date when the insurer was notified of the claim because frequently several different dates were listed as the report date or notice date in various parts of the file. Since it is the notice date that determines in which year's loss experience a claim is placed, determining the date accurately was an important concern. When examiners raised this issue with the service center staff, they were directed to use the report date listed on the computer printout label found on the cover of each file.

The initial examination at St. Paul was completed on March 23, 1988. Following the completion of the file review at St. Paul, field examiners and the examination supervisor developed data codes for survey questions where an appropriate code system could not be identified prior to the review. The St. Paul data was then entered on a Department computer using a DBASE program. Data entry and coding were performed by the same examiners who reviewed the files for maximum accuracy and consistency. Entry of St. Paul data was completed in approximately two and one-half weeks. Examiners returned to review some additional files retrieved by St. Paul on April 15 for three days.

On April 20, examiners began to review files at MMIE. The same three examiners who reviewed most of St. Paul's files also reviewed MMIE's. Department staff were accommodated in a conference room and had a photocopy machine at their disposal. As with St. Paul,

MMIE's staff was cooperative and available to answer questions. MMIE's files were organized chronologically, however, they did separate the medical records from the other documents within each file. MMIE's files contained fewer duplicate documents than St. Paul's which also decreased examiners' review time. After the first day at MMIE, examiners revised the order of the survey questions to accommodate more efficiently the MMIE file arrangement. The review at MMIE was completed on July 8, 1988 and data was again entered using the same format and procedures as were used for the St. Paul data.

F. Data Reconciliation

Following completion of the data entry process, a variety of data reports were run and staff began checking for data entry errors and organizing data in an appropriate format for use in this report. In late August, examiners noticed a significant discrepancy between the number of claim files listed on loss experience data sheets supplied by St. Paul Companies prior to the file review and the number of files actually reviewed. The Department's first inquiries regarding the discrepancy were met with assurances from St. Paul that the Department had in fact reviewed all their claims against physicians and surgeons. However, after the magnitude of the discrepancy, over 400 files were verified, St. Paul officials informed the Department they believed some files had inadvertently been omitted from the review. Company officials explained that the problem resulted from a communication breakdown between their actuarial department and their claims department as to the "definition of a physician and surgeon claim." For the next four weeks, St. Paul officials sought to determine which files the Department had reviewed and which it had not. During this period, the Department supplied a computer run list of file numbers that had been reviewed. St. Paul then used the list to cross check against their own. Both the Department's list and St. Paul's list were organized by report date. Apparently due to the conflicting information in the files, the two lists did not coincide with regard to report year thereby making files more difficult to cross reference. Consequently, if St. Paul located a file the Department had reviewed but had listed it in a different report year, the Department changed its data base to reflect the date in St. Paul's data base. A total of 197 report dates were changed.

Examiners returned to St. Paul's Upper Midwest Service Center on October 5, 1988 to review the files St. Paul had identified as the remainder of the survey group. Over the course of the next week, examiners reviewed 249 additional St. Paul files. The remaining discrepancy between the original St. Paul figures and the number of files reviewed was explained by the fact that when more than one claimant is involved in a lawsuit, the company counts one claim for each claimant, even when there is only one claim file. In addition, the service center staff was unable to locate the hard files for 50 claims listed in the actuarial division's data base. They did provide the Department with a computer run summary of 45 of the missing files. The Department accepted the 45 claims listed on the computer reports for both the claims center

and the actuarial division even though no claim file was found. This data is included in the study. With regard to the five claims found on the actuarial computer but not the claims center computer, the Department stated it would include such files if they could be found. No such files were found.

G. Company Verification of Data

Following St. Paul Companies' review of this report, they noted that the report differed from their own data in the areas of loss payments and loss expenses on closed files. The Department agreed to review again all individual files where a discrepancy was found. Accordingly, St. Paul Companies and Department personnel reviewed all files where there was a discrepancy of over $100. In files with lesser discrepancies, St. Paul's figures were accepted. Corrections were agreed on between both parties and were then made in the Department's database. These corrections did not result in any notable increase or decrease in the aggregate figures. Approximately the same number and amount of upward and downward dollar figure adjustments resulted from the review.

IV. FINDINGS

A. General

Seventy-eight percent (3689) of the claim files reviewed were closed and twenty-two percent (1058) were open. The following section also refers to a subgroup of closed files identified as "loss files" which includes only those closed claims where a loss payment was made by the insurer. Twenty-seven percent (982) of the closed files were loss files. The remaining seventy-three percent involved no compensation to the claimant by the insurer.

It should be noted that the data in this report is organized according to the year each claim was reported. Accordingly, unless otherwise stated, all references in text and the tables to "year" is a reference to the report (or notice) year of the claim.

The data in the report does not take reinsurance into account in calculating losses. Some of the larger losses in the study were paid in part by reinsurance therefore reducing the amount actually paid by the primary insurer. However, reinsurance also is an expense for insurers and is a factor in setting the target loss ratios discussed below. Reinsurance is a greater relative expense for MMIE than St. Paul Companies because of the company's smaller size and the fact that MMIE has been in business for a shorter length of time.

The loss payments ranged from $0 to $1,296,090. The average loss payment for all closed claims was $14,542 and the median was zero. The average loss payment on loss files only was $54,629 and the median was $15,000.

There were three files (0.1 percent of closed claims) where a company paid one million dollars or more, 15 files (0.4% of closed claims)

where the payment was equal to or greater than $500,000, and 145 claim files (four percent of closed claims) where the loss payment was equal to or greater than $100,000. One of the three payments that met or exceeded $1.0 million was the result of a jury verdict, the other two resulted from negotiated settlements.

B. Loss Ratios

A loss ratio is derived by dividing the sum of the loss payments, loss adjustment expense (LAE), loss reserve, and allocated LAE reserve by earned premium. Allocated LAE represents expenses that insurance companies pay to outside entities such as expert witnesses and attorneys during the course of investigating and litigating a claim. Both MMIE and St. Paul Companies have a targeted loss ratio of 82-85 percent.

It was the Department's intention not to include reporting endorsement premium and losses in this report. Reporting endorsement coverage, commonly known as "tail" coverage, essentially converts a claims made policy to an occurrence policy.

After the report was complete, however, MMIE advised the Department that reporting endorsement premium and loss files had been included in the review at the company. Because reporting endorsements are written on an occurrence basis, MMIE reserves for claims "incurred but not reported" (IBNR reserves) were added to the loss reserve data in the loss ratio calculation. This resulted in an upward adjustment of overall loss ratio by .5 percent.

The overall loss ratio (as determined by the value of the claims on the day the Department reviewed the files) for the six-year period of the study was 71.8 percent. That is, the 4,747 claim files had losses and reserves totalling $182,742,647 which is divided by earned premiums of $254,597,909. Table 1 below gives the loss ratio and its various components for each year of the study. The loss experience for each of the three states individually is found in Appendix B.

It should be noted that reserves are, by definition, estimates. In addition, medical malpractice is a line of insurance that, by its very nature, requires long periods for claim settlement. There is a good probability that claims from the most recent report years, especially 1986 and 1987, will see a number of reserve changes before they are finally paid. As a result, the 1986 and 1987 loss ratios should be viewed as less stable than earlier years. The degree to which reserves are accurate obviously affects fluctuations in loss ratios over time. Reserving accuracy is discussed in section D below.

TABLE 1:
PHYSICIAN MALPRACTICE LOSS EXPERIENCE
COMBINED STATES BY YEAR

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	721	$23,369,849	$16,034,369	$3,833,712	$2,555,000	$ 290,005	$22,713,086	97.2%
1983	776	26,940,428	7,729,884	2,513,698	3,040,501	548,524	13,839,607	51.3
1984	768	32,489,891	12,009,664	3,546,127	8,780,000	1,431,037	25,816,828	79.3
1985	937	43,451,439	10,648,054	3,877,240	19,674,353	2,706,981	37,036,628	85.4
1986	758	57,001,803	5,230,846	2,071,814	27,119,856	5,637,437	40,409,953	70.9
1987	787	71,344,499	1,993,071	761,053	32,655,891	6,916,530	42,926,545	60.2
TOTALS	4,747	$254,597,909	$53,645,888	$16,603,644	$93,825,601	$17,530,514	$182,742,647	71.8%

C. Claim Frequency and Severity

Claim frequency and severity are indicators commonly used in analyzing loss data. Claim frequency is the number of claims made per policyholder. Claim severity is the average size of a claim measured in dollars paid and reserved. Frequency and average severity are important to examine because increases in both have been blamed for the shortage in insurance coverage. If a "litigation explosion" has occurred, it should be reflected in the frequency and severity numbers.

It would appear, however, that the data does not substantiate the litigation explosion assertions. Claim frequency has not changed measurably in the last six years. The 1987 frequency rate is actually less than the 1983 rate. Table 2 illustrates this trend.

TABLE 2: CLAIM FREQUENCY 1982 - 1987

YEAR	NUMBER OF INSUREDS	QUANTITY CLAIMS	CLAIMS PER 100 INSUREDS
1982	6,912	721	10.4
1983	6,605	776	11.7
1984	6,599	768	11.6
1985	6,942	937	13.5
1986	7,072	758	10.7
1987	6,836	787	11.5
TOTAL/AVG.	40,966	4,747	11.6

Claims severity trends also do not evidence a litigation explosion. Both averages and medians may indicate trends in claim severity. The median loss payment for each year was $0. Table 3A compares average loss payments on all closed files and on loss files only. Average payments actually appeared to be decreasing over the period of the study.

It should be noted that the 1986 and 1987 averages do not have substantial credibility due to the large percentage of claims still open.

TABLE 3A: CLAIM SEVERITY 1982 - 1987

YEAR	NUMBER OF CLOSED CLAIMS	PERCENT OF TOTAL CLAIMS	AVERAGE LOSS PAYMENT	PERCENT OF CLOSED CLAIMS WITH LOSSES	NUMBER OF OPEN CLAIMS	AVERAGE OPEN RESERVES	AVERAGE TOTAL
1982	700	97.1%	$22,906	31.0%	21	$121,667	$25,783
1983	741	95.5	10,432	30.6	35	86,871	13,880
1984	685	89.2	17,532	27.6	83	105,783	27,070
1985	783	83.6	13,599	23.6	154	127,756	32,361
1986	516	68.1	10,137	21.3	242	112,066	42,679
1987	264	33.5	7,550	20.5	523	62,440	44,027
TOTAL	3,689	77.7%	$14,542	26.6%	1,058	$ 88,682	$31,066

The "average total" column includes both paid losses and unpaid reserves. Although this column would seem to indicate an upward trend in severity, the discussion below suggests that inflated reserves distort these figures. The more claims that are open, the greater the upward distortion.

After reviewing this report, St. Paul Companies and MMIE objected to the Department's presentation of claim severity in Table 3A arguing that severity must be measured by comparing claims at the same point in their development. Accordingly, Table 3B compares average loss payments for closed claims at the same year of development. For example, a claim reported in 1982 and closed in 1982 would be directly comparable to a claim reported in 1984 and closed in 1984. Both were closed in "year 1" of their development. If claims are becoming more severe, an upward trend would be reflected in these comparisons.

TABLE 3B: CLAIM SEVERITY FOR POLICY YEARS 1982-1987
MEASURED AT EQUAL POINTS OF LOSS DEVELOPMENT

NOTICE YEAR	CLAIMS CLOSED YEAR 1	AVERAGE CLAIMS CLOSED YEAR 2	LOSS CLAIMS CLOSED YEAR 3	PAYMENTS CLAIMS CLOSED YEAR 4	CLAIMS CLOSED YEAR 5
1982	$5,391	$11,567	$21,857	$49,668	$41,963
1983	1,801	4,885	13,665	17,602	36,649
1984	6,690	14,303	10,592	52,712	
1985	8,309	6,987	25,697		
1986	3,040	7,504			
1987	4,604				
TOTAL NUMBER OF CLOSED CLAIMS (by development year)	726	1,527	724	263	109

If average loss payments were becoming increasingly severe, each column of figures in Table 3B should show an upward trend. However,

Table 3B clearly indicates there has been no upward trend in claim severity based on a comparison of loss payments at equal points in loss development.

Attached as Appendix D is a graph of the figures set forth in Table 3B.

D. Accuracy of Loss Reserves

Table 4 compares the reserve established when the file was opened (beginning reserve), the last reserve recorded before the file was closed (ending reserve) and the average loss payment, for all closed files. Although the beginning reserve has, on average, been less than the eventual loss payment, the beginning reserve is significantly closer to the average loss than is the ending reserve. The average loss payment for the six year period is 117 percent of the average beginning reserve but only 36 percent of the average ending reserve. A random sample of 150 claims indicated that the ending reserve is set an average of three months after the beginning reserve is first set. Therefore, at any given time, most of the open reserves are "ending reserves" rather than "beginning reserves."

TABLE 4: LOSS RESERVE ACCURACY CLOSED FILES

YEAR	I AVERAGE BEGINNING RESERVE	II AVERAGE ENDING RESERVE	III AVERAGE LOSS PAYMENT	IV AVERAGE DOLLAR DIFFERENCE (II - III)	V LOSS PAYMENT AS A PERCENT OF THE FINAL RESERVE (III ÷ II)
1982	$16,433	$40,532	$22,906	$17,626	56.5%
1983	10,752	34,922	10,432	24,490	29.9
1984	12,136	47,519	17,532	29,987	36.9
1985	12,418	46,165	13,599	32,566	29.5
1986	10,694	41,755	10,137	31,618	24.3
1987	10,368	23,226	7,550	15,676	32.5
	$12,405	$40,831	$14,542	$26,289	35.6%

It is apparent from the data that the insurers have consistently and significantly over-reserved. Ending reserves have been three times higher than actual loss payments for the last five years. A further comparison of loss payments and open reserves is found in Appendix C.

The insurers have accurately pointed out that over reserving does not necessarily lead to artificially high rates if actuaries reduce the reserve levels appropriately during the rate making process. However, rate filings published by these insurers indicate their actuaries have not compensated adequately for the companies' conservative reserving when developing rates. Both companies apply a loss and loss expense reserve development factor in their ratemaking formula. This factor averaged for the period of the study was .69

for MMIE and .79 for St. Paul Companies. Thus, although MMIE is closer, both companies fall short of an accurate development factor.

E. Allocated Loss Adjustment Expense (LAE)

The allocated LAE for closed claims ranged from 0 to $177,628. The average allocated LAE for all closed claims was $3,244 while the median was $144. For loss files only, the average allocated LAE was $6,573 while the median was $989.

There were seven claims (0.2% of closed claims) where allocated LAE reached or exceeded $100,000.00, 96 claims (2.6% of closed claims) where it was equal or greater than $25,000, and 300 claims (8.1% of closed claims) where the allocated LAE was greater than or equal to $10,000. Table 5A shows the average allocated LAE for closed claims, the average reserve for open claims and the combined average for open and closed files. Insurance companies spent an average of $330 on files where the claim was not pursued by the claimant. A typical example of such a claim is where the physician filed an incident report and no claim was ever filed by the patient.

Insurers argue that the rising costs of defending claims is one cause of the malpractice crisis. Table 5A indicates that the highest defense cost year was 1982, and that costs have actually decreased since that time. Once again, the percentage of claims still open in 1986 and 1987 make a direct comparison with other years less credible. Nevertheless, the figures do not seem to reverse the overall trend of decreasing costs.

TABLE 5A: AVERAGE ALLOCATED LAE

YEAR	NUMBER OF CLAIMS	AVERAGE INCURRED LAE (CLOSED CLAIMS)	NUMBER OF OPEN CLAIMS	AVERAGE LAE RESERVE (OPEN CLAIMS)	AVERAGE LAE INCURRED & RESERVED (CLOSED & OPEN FILES)
1982	721	$5,090	21	$13,810	$5,719
1983	776	2,995	35	16,133	3,967
1984	768	3,781	83	17,241	6,481
1985	937	3,072	154	17,578	7,027
1986	758	1,738	242	23,295	10,170
1987	787	1,111	523	13,225	9,756
TOTAL	4,747	$3,244	1,058	$16,585	$7,194

The same argument the insurers made regarding Table 3A and claim severity trends (see p. 18) could also be made with regard to the LAE severity trends reflected in Table 5A. Accordingly, Table 5B is a comparison of average allocated LAE according to the loss development year.

TABLE 5B: AVERAGE ALLOCATED LAE
BY EQUIVALENT DEVELOPMENT YEAR

POLICY YEAR	CLAIMS CLOSED YEAR 1	CLAIMS CLOSED YEAR 2	CLAIMS CLOSED YEAR 3	CLAIMS CLOSED YEAR 4	CLAIMS CLOSED YEAR 5
1982	$ 522	$1,438	$4,586	$8,902	$13,879
1983	316	625	3,249	6,604	13,934
1984	185	1,350	2,670	17,065	
1985	479	1,200	6,300		
1986	382	1,300			
1987	562				
TOTAL NUMBER OF CLAIMS CLOSED	726	1,527	724	263	109

Once again, if loss adjustment expenses were increasing, each column in Table 5B should show an upward trend. However, this table clearly indicates no discernable upward trend in loss adjustment expenses when comparing claims at equal points in their development.

F. Disposition of Closed Claims

The claims were resolved through numerous methods which are categorized in Table 6. Files where there was no loss payment account for 73.4 percent of all closed files. Over one-third of the files were closed due to a lack of activity or pursuit by the claimants.

TABLE 6: DISPOSITION OF CLOSED FILES

DISPOSITION	TOTAL FILES	PERCENT OF TOTAL	AVERAGE LOSS PAYMENT	AVERAGE LAE	AVERAGE TOTAL COST
No Activity/Not pursued	1,325	35.9%	N/A	$ 330	$ 330
Settled	1,073	29.1	$45,364	5,449	50,813
Dismissed	457	12.4	N/A	2,604	2,604
Dismissed with Prejudice	260	7.1	N/A	3,423	3,423
Statute of Limitations Expired	240	6.5	N/A	478	478
Tried	110	3.0	40,042	27,907	67,949
Summary Judgement	82	2.2	N/A	3,112	3,112
Claim Denied	59	1.6	N/A	306	306
Unknown	52	1.4	10,527	1,780	12,307
Conciliation Court	26	0.7	78	1,094	1,172
Arbitration	5	0.1	3,250	5,001	8,251
TOTAL	3,689	100.0%	$14,542	$ 3,244	$17,786

Three percent (110) of the closed claims were decided by a jury. The defense prevailed in 81 percent (90 of 110) of the tried cases. Claims that were tried cost the insurance companies over five times as much, on average, in allocated LAE than settled claims. However,

the average loss payment was considerably less on the tried claims than those that were settled. Thus, the cost for litigated cases exceeded the cost of negotiated cases by 33.7 percent. There is no evidence that the percentage of claims being tried is increasing. For the years 1982-85 where most files have been closed, the percentage of cases tried has remained remarkably constant: 1982, 6.7 percent; 1983, 3.2 percent; 1984, 2.9 percent; 1985, 2.2 percent.

TABLE 7: COMPARISON OF COSTS
SETTLED VERSUS TRIED CLAIMS

	NUMBER OF CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE	TOTAL COST
CLOSED SETTLED CLAIMS	1073	$45,364	$ 5,449	$50,813
CLOSED TRIED CLAIMS	110	$40,042	$27,907	$67,949

G. Non-economic Damages

Non-economic damages have been a central issue in the malpractice debate. Insurers have asserted, "The huge amounts awarded (by juries) for punitive damages, pain and suffering, and other non-economic loss provide a windfall for the plaintiff while resulting in substantial costs to all other patients in the aggregate." (Medical Malpractice: A Second Opinion. National Association of Independent Insurers (1986) p.10) There were no punitive damages awarded in any of the 110 cases that were tried in the three survey states during the last six years. Further, both companies exclude punitive damages under the terms of their policy. There also were no pain and suffering awards specified in any of the jury verdicts in the study. It should also be noted that the entire issue of non-economic damages is minimized by the fact that there were only 20 cases where any compensation was awarded a plaintiff by a jury verdict due to physician malpractice. Thus, there is no data upon which the insurer can argue that damages for non-economic loss have increased.

H. Physician Specialty

The physicians who were the object of claims have been classified by specialty using the thirty categories listed in Table 8. The table shows the relative market presence of each specialty as a percentage of the total number of insureds and the corresponding percent of total claims and dollar losses for the six years of the study.

TABLE 8: EXPERIENCE COMPARISON
BY PHYSICIAN SPECIALTY

SPECIALTY	PERCENT OF INSUREDS	PERCENT OF CLAIMS	PERCENT OF DOLLAR LOSSES
General/Family Practice	35.6%	22.3%	35.3
Internal Medicine	11.1	6.6	4.6
Pediatrician	5.2	2.4	1.4

Table 8 cont.

SPECIALTY	PERCENT OF INSUREDS	PERCENT OF CLAIMS	PERCENT OF DOLLAR LOSSES
General Surgeon	5.1	10.3	16.6
Obstetrician/Gynecologist	4.9	10.1	8.2
Anesthesiologist	4.0	4.0	1.6
Orthopedic Surgeon	3.8	7.6	7.0
Emergency Medicine	3.5	1.5	1.0
Ophthalmologist	3.4	2.2	1.1
Pathologist	3.0	0.7	0.7
Radiologist	2.9	3.5	2.7
Psychiatrist	2.7	1.6	0.7
Unknown/Other	2.6	15.5	9.5
Neurologist	2.3	2.9	1.6
Urologist	1.7	1.8	1.1
Cardiologist	1.4	1.4	1.6
Dermatologist	1.1	0.5	1.2
Ear/Nose/Throat	1.1	1.5	0.3
Plastic Surgeon	1.0	1.1	0.6
Allergist	0.6	0.3	0.0
Oncologist	0.5	0.4	0.8
Thoracic	0.5	0.6	0.3
Gastroenterologist	0.4	0.3	0.1
Occupational Medicine	0.4	0.2	0.3
Endocrinologist	0.3	0.1	0.0
Pulmonary Specialist	0.3	0.1	0.3
Colon & Rectal	0.2	0.3	1.5
Geriatrics	0.2	0.0	0.0
Rheumotologist	0.2	0.1	0.0
Neonatalogist	0.1	0.1	0.0

General surgeons, orthopedic surgeons, and obstetricians/gynecologists have a claim rate that is approximately double their presence in the marketplace. General/family practice physicians, as well as internal medicine specialists, pathologists, ophthalmologists, psychiatrists, dermatologists, allergists, emergency medicine specialties, and pediatricians all have significantly fewer claims than one would expect based on their relative numbers.

Tables 9-11 below show the average loss payment and average allocated LAE for specialties where there was a minimum of ten closed claims. For comparison purposes, the overall average loss payment for all closed claims was $14,542, and the average allocated LAE was $3,244.

TABLE 9: SPECIALTIES WITH HIGHER THAN AVERAGE PAYMENTS

SPECIALTY	CLOSED CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE
Dermatologist	20	$32,279	$3,273
Oncologist	15	28,049	3,429
General/Family Practice	835	22,706	4,388
General Surgeon	401	22,049	3,580

TABLE 10: SPECIALTIES WITH NEAR AVERAGE PAYMENTS

SPECIALTY	CLOSED CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE
Cardiologist	54	$15,399	$4,892
Pathologist	28	14,185	4,669
Orthopedic Surgeon	283	13,208	2,866
Radiologist	123	11,883	1,981
Ob/Gyn	386	11,364	3,105

TABLE 11: SPECIALTIES WITH BELOW AVERAGE PAYMENTS

SPECIALTY	CLOSED CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE
Emergency Physician	52	$10,081	$1,682
Internal Medicine	244	10,031	2,253
Unknown	520	9,329	3,023
Urologist	64	9,392	3,604
Neurologist	94	9,124	2,604
Pediatrician	88	8,580	1,495
Plastic Surgeon	41	7,405	2,741
Psychiatrist	53	7,383	4,509
Opthalmologist	84	6,966	3,022
Thoracic	27	6,791	2,890
Anesthesiologist	161	5,473	2,043
Ear/Nose/Throat	45	3,275	2,359

The obstetrician/gynecology specialty has been a primary focus in the malpractice debate. The tables indicate that while their frequency rate is higher than average, the average loss payments for obstetricians is $3,000 below the average for all physicians. General surgeons are an example of a specialty with higher than average frequency and severity while emergency physicians are below average in both categories.

It should be noted that, when broken down by specialty, the size of the sample is not large enough to draw any definite conclusions relative to the experience of any one specialty.

I. Location of Injury Occurrence

The location where the injuries occurred were separated into seven areas. The distribution of claims by location are shown in the table below.

TABLE 12: LOCATION OF INJURY OCCURRENCE

LOCATION	PERCENT TOTAL	AVERAGE PAYMENT CLOSED FILES	AVERAGE PAYMENT LOSS FILES
Surgery	34.3%	$13,000	$45,571
Clinic	23.1	12,173	45,327
Patient Care Area	10.5	14,326	58,876
Labor/Delivery/Nurs.	9.4	32,505	117,654
Emergency Room	9.0	20,334	67,985
Office	7.6	9,324	36,674
Hospital-Other	4.6	4,601	31,826
Other/Unknown	1.5	3,543	29,357
TOTAL/AVERAGE	100.0%	$14,542	$54,629

The most expensive injuries are those that occur during labor and delivery. The largest percentage of claims results from events occurring in the operating room, accounting for over one-third of all claims made.

J. Cause of Loss

The causes of the injuries resulting in claims were identified by using the 107 different categories developed and used by St. Paul Companies (see Appendix D). Eighteen of these causes contributed more than one percent of the total claims (open and closed) and they are listed in Table 13 below. The table also gives the average loss payment for closed claims and average payment on loss files only.

TABLE 13: COMPARISON OF LOSS CAUSES

CAUSE OF LOSS	QUANTITY OF CLAIMS	PERCENT OF ALL CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE PAYMENT LOSS FILES
Post Operative Complications	774	16.3%	$11,382	$44,859
Other	657	13.8	5,932	32,406
Birth Related Problems	394	8.3	31,891	142,514
Failure to Diagnose Cancer	250	5.3	21,483	89,202
Surgery, Inadvertent Act	234	4.9	15,802	49,347
Failure to Diagnose FX/Dislocation	198	4.2	4,933	20,381
Improper Treatment FX/Dislocation	172	3.6	11,391	42,565
Drug Side Effect	121	2.5	10,007	41,394
Failure to Diagnose Infection	112	2.4	55,597	166,790
Surgery, Inappropriate Procedure	105	2.2	15,972	53,025
Pregnancy Related Problems	103	2.2	21,923	68,204
Failure to Diagnose Heart Attack	84	1.8	31,949	118,669
Lack of Supervision/Control	74	1.6	3,462	15,981
Incorrect Drug	74	1.6	28,689	67,419
Unnecessary Surgery	67	1.4	5,779	18,422
Post Operative, Death	64	1.3	14,250	51,061
Lack of Informed Consent	60	1.3	13,628	43,439
Surgery, Sponge Left	52	1.1	4,203	6,693
TOTAL/AVERAGE	3,595	75.7%	$14,542	$54,629

The highest average payments were made on claims arising out of birth related injuries and failure to diagnose an infection. These were the only two types of causes where the average payment on loss files only exceeded $100,000. The category "other" is not "unknown", but rather is a cause that is not included on our list. The relatively large size of this category is due to the many claims that result from unusual and unique events which are difficult to categorize.

Table 14 illustrates a more general breakdown of the loss causes through a combination of related types of injuries. These ten categories account for nearly eighty percent of all claims.

TABLE 14: LOSS CAUSE COMPOSITE

CAUSE OF LOSS	PERCENT OF ALL FILES
Surgical Related Problems	29.5%
Other	13.8
Pregnancy/Birth Related	10.7
Fracture/Dislocation Related	7.8
Failure to Diagnose Cancer	5.3
Drug Related	5.3
Failure to Diagnose Infections	2.4
Failure to Diagnose Heart Attack	1.8
Lack of Supervision/Control	1.6
Lack of Informed Consent	1.3
TOTAL	79.3%

K. Characterization of Claimants

The ages of the claimants were grouped according to the breakdowns listed in Table 15. The average loss payment was the highest for the youngest of all claimants. It then declined to a low in the teen years and began rising during the wage earning years reaching a second (lower) crest during the peak wage earning years of 35-55. It then dropped continuously as age increased.

TABLE 15: COMPARISON OF LOSSES BY AGE OF CLAIMANT

	PERCENT ALL CLAIMS	AVERAGE PAYMENT CLOSED FILES	AVERAGE PAYMENT LOSS FILES
Birth - 30 Days	5.8%	$35,273	$133,175
Over 30 Days - 2 Years	3.7	20,188	80,750
Over 2 Years - 12 Years	3.2	12,405	51,528
Over 12 Years - 18 Years	4.0	8,319	26,849
Over 18 Years - 35 Years	30.6	13,505	48,591
Over 35 Years - 55 Years	22.1	19,180	68,283
Over 55 Years - 70 Years	15.1	13,361	51,537
Over 70 Years	6.7	8,385	31,321
Unknown	8.9	4,991	24,125
TOTAL/AVERAGE	100.0%	$14,542	$54,629

Female claimants accounted for 56.3 percent of all the claimants while 42.7 percent of the claimants were male. In 1.0 percent of the files there was too little information to determine the sex of the claimant. The average loss payment for males was $18,107 compared with $12,119 for females, making the average loss payment for males nearly 55 percent more than the average for females.

L. Relationship of Claimant and Physician

In reviewing files, the examiners sought to determine whether the claim was the result of a visit to the claimant's regular physician or the result of a first or second time visit to a physician not seen regularly. In the case of specialists, they determined whether or not the claimant had been seeing this specialist for a problem over a period of time. An example would be a woman who had a family practice physician but who saw an obstetrician during her pregnancies. Both physicians, in this case, would be considered her regular doctor.

Claims made against physicians who were believed to have seen the claimant no more than a couple of times accounted for 62.8 percent of all claims compared with 26.7 percent which were filed against the claimants' regular physicians. In 10.5 percent of the claims this relationship could not be determined. The average loss payment made on behalf of a claimant's regular physician was $18,122 while an average of $13,337 was paid on behalf of physicians who were not seen by the claimant on a regular basis.

While this data may indicate that patients are less likely to file a claim against a physician with whom they have had an on-going relationship, it may also be an indication of the increased risk associated with the work of specialists who frequently would not be categorized as a "regular physician."

M. Frivolous Claims

As stated earlier, question #25 of the survey form was included to determine the volume of frivolous claims. It should be noted that the results of the question as phrased reflect the companies' evaluation of the physician's liability rather than the examiner's evaluation. The files indicate that 8.6 percent of all claims reported definitely involve liability and 16.8 percent probably do, according to the insurers. The files also indicate that liability was doubtful in 28.3 percent of all claims and that physicians liability was virtually ruled out by the company in 10.5 percent of the cases. Liability was uncertain in 34.4 percent of the files reviewed.

If the frivolous claims are defined as those identified by the company as cases of definite absence of liability on the part of the physician, then frivolous claims cost an average total of $112,940 per company annually in loss and loss adjustment expenses. If the definition of a frivolous claim is broadened to include those claims the companies identified as doubtful liability cases, the annual cost per company increases to $615,532.

Comparing these frivolous claim costs to earned premium, the data indicates that such claims cost insurers between .5 percent and 3 percent of earned premium each year, depending on whether the narrower or wider definition of a "frivolous claim" is used. The assertion that frivolous claims are to blame for rapidly rising insurance rates or that an explosion of frivolous suits has occurred is not substantiated by the data.

The data does not indicate any increase in frivolous claims over the last six years. Table 16 shows the percentage of all claims where liability was judged improbable or ruled out by the company.

TABLE 16: FRIVOLOUS CLAIM TRENDS

REPORT YEAR	TOTAL CLAIMS REPORTED	"NO LIABILITY" CLAIMS	"DOUBTFUL LIABILITY" CLAIMS
1982	721	7.8%	30.9%
1983	776	12.1	27.4
1984	768	10.2	29.4
1985	937	12.8	29.5
1986	758	12.1	28.6
1987	787	7.2	23.8
TOTAL/AVG.	4,747	10.5%	28.3%

The data does indicate that there are ways in which the cost of frivolous claims may be controlled. St. Paul Companies spent, on average, nearly twice as much per claim on losses and loss adjustment expenses resulting from frivolous claims than did MMIE. MMIE's average loss payment per claim where their evaluation indicated "no liability" was $72 while St. Paul's was $575, almost eight times MMIE's figure. The average allocated LAE cost on the same group of claims was $1,555 at MMIE and $2,559 at St. Paul. The total cost of the average frivolous claim at MMIE then was $1,627 and the comparable cost at the St. Paul was $3,134. The difference between companies was greater when comparing the "doubtful liability" category where St. Paul's total loss and loss adjustment expense costs were 2.4 times those of MMIE.

N. Company Comparison

A comparison of the experience of the two companies examined is pertinent because of their differing management structures and organizations. Physician-run companies such as MMIE have been criticized nationally by the commercial insurance industry for poor management and the use of artifically low rates.

However, the study data indicates that MMIE's claims management is, in fact, more efficient than St. Paul's. For example, St. Paul Companies spent on average more than twice as much in allocated loss adjustment expenses per claim compared to MMIE. The St. Paul also paid a higher average loss per claim, one and one half times

the average loss payment of MMIE. The companies also differed in the amount of time needed to close a claim. This trend is particularly evident in recent years where, in 1986 and 1987, MMIE has closed approximately 20 percent more of their total claim files in each year than St. Paul has.

Tables 17 and 18 compare allocated LAE, average loss payments and the percentages of total claims that have been closed, by year, for each company.

TABLE 17: MMIE LOSS EXPERIENCE

REPORT YEAR	TOTAL FILES	PERCENT CLOSED	AVERAGE LOSS PAYMENT	AVERAGE LAE
1982	298	99.7%	$15,795	$3,577
1983	347	95.4	7,714	1,952
1984	380	90.5	10,357	1,855
1985	464	87.7	11,481	1,986
1986	355	79.4	14,156	1,289
1987	407	42.5	6,650	383
TOTAL/AVG.	2,251	81.5%	$11,245	$1,955

TABLE 18: ST. PAUL COMPANIES LOSS EXPERIENCE

REPORT YEAR	TOTAL FILES	PERCENT CLOSED	AVERAGE LOSS PAYMENT	AVERAGE LAE
1982	423	95.3%	$28,147	$6,205
1983	429	95.6	12,622	3,838
1984	388	87.9	24,771	5,723
1985	473	79.5	15,892	4,248
1986	403	58.1	5,294	2,279
1987	380	23.9	9,259	2,494
TOTAL/AVG.	2,496	74.3%	$17,802	$4,519

V. FAILURE OF COMPETITIVE RATING IN "NICHE" MARKETS

Medical liability underwriting requires a high degree of expertise that takes time and money to develop. There are a number of reasons why it is not feasible for insurers to move in and out of the medical liability market in the same way they may enter and exit other, less complex liability insurance markets.

First, accurate and comprehensive data is not available to potential insurers. The same type of loss information found in this report is necessary for an insurer contemplating market entry to make an informed decision. The insurance industry has its own data gathering organizations such as the Insurance Services Office (ISO). Neither St. Paul Companies nor MMIE, however, report medical malpractice loss experience to ISO. Thus, the data published by ISO for this line of insurance lacks credibility, at least with respect to Minnesota experience. In addition, neither the state or federal government has obtained the necessary loss data. The result has been a significant information gap and consequently, a competitively weak market.

Second, the number of purchasers in specialty markets such as medical malpractice are not sufficient to generate substantial number of competing vendors. Insurers must insure large numbers of policyholders to spread risks. Just as airlines cannot sustain long term competition in niche markets where there is limited market demand, the limited number of policyholders in the malpractice market makes it clear that new competitors will not likely survive market entry against a well established and financial competitor.

Third, the demand for malpractice insurance is highly inelastic. Unlike other lines of insurance where coverage type, policy limits or coverage needs vary and may provide a basis for non-price competition, competition in the physician malpractice market is based almost solely on price. A potential new insurer cannot create a market niche by offering a unique product. There is little variation in coverage types and policy limits are frequently determined by a physician's employer or by hospitals where a physician has privileges. Physicians are unlikely to buy more coverage than what is required regardless of the price. Perhaps the only non-price competitive base is a "good reputation" particularly with respect to defending and paying claims, something that a new insurer entering the market could not readily acquire.

Thus, the degree of specialization required for successful underwriting of medical malpractice necessitates that a new insurer quickly build a significant volume of business not only to spread risk but to justify the high cost of entering such a specialized market. An insurer like St. Paul Companies that has been in the market for over 50 years has an overwhelming advantage in terms of access to long-term loss data as well as the company's long-standing reputation and underwriting expertise.

MMIE's successful entry into the market is likely a product of the built-in expertise of its physician management and the market draw of its original organizational structure as a mutual-type company. MMIE has succeeded in keeping their rates below St. Paul's and has managed claims in a more cost-effective manner.

It is obvious that insurers are charging considerably higher rates than are necessary to cover losses and expenses and also realize a healthy profit. The ratemakers have not accounted for the historically consistent disparity between actual loss payments and loss reserves. Indeed, the data on file indicates that when all claims are closed, the 1985-87 loss ratios will be substantially lower than than the 80-85 percent range targeted by the carriers. Indeed, when the reserves are properly calculated, the loss ratio will likely be under 50 percent.

VI. CONCLUSIONS

° With the exception of self-insured groups, the St. Paul Companies and Minnesota Medical Insurance Exchange insure nearly 100 percent of Minnesota's physicians. Thus, this report's data represents the only known comprehensive study of physician loss experience for any jurisdiction over the last six years.

° The frequency of claims per year has not materially changed over the past six years.

° The severity of the claims payment has not materially changed over the six year period.

° Fewer than one-half of one percent of all malpractice claimants are awarded damages by a jury. Most important, this figure has remained constant over the period of the study;

° Claims determined by the insurer to be frivolous have not increased over the past six years.

° The likelihood of receiving compensation as a result of filing a malpractice claim is approximately 25 percent. This rate has not materially changed over the period of the study;

° No punitive damages were found to be awarded against a physician.

° The average cost of investigation and defending a claim has changed little in the last six years. Indeed, the amount appears to be decreasing; and

° Despite unchanging claim frequency and declining loss payments and loss expense, on average, physicians paid approximately triple the amount of premiums for malpractice insurance in 1987 than in 1982.

VII. RECOMMENDATIONS

° An independent government agency should periodically conduct claims examinations in specialty lines of insurance.

° The data collected and compiled as a result of these examinations shall be made readily available to the public. This would:

* enable competing insurers to recognize competitively weak markets to enter.

* enable public policy makers to debate insurance and liability issues with credible statistics.

* enable the regulators to address difficulties with pricing and availability of coverage.

° On the basis of the data collected through such examinations, the government should review and, if necessary, regulate the premium.

° When the market become less competitive, the government should establish underwriting pools to make coverage available. The rates charged by these pools, however, should not undercut or discourage a competitive market.

PHYSICIANS' AND SURGEONS' PROFESSIONAL LIABILITY INSURANCE POLICY

INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE

PARTNERSHIP/PROFESSIONAL ASSOCIATION/BUSINESS TRUST/PROPRIETORSHIP PROFESSIONAL LIABILITY INSURANCE

PROFESSIONAL PREMISES LIABILITY INSURANCE

MINNESOTA
mie
MINNESOTA MEDICAL INSURANCE EXCHANGE

MMIE IS A "RECIPROCAL" INSURANCE COMPANY

TO OUR POLICYHOLDERS

This is a "claims-made" Policy. It only covers claims arising from the performance of **Professional Services** subsequent to the retroactive date indicated on the Declarations Page attached hereto and then only to the extent that the provisions of the Policy while the Policy is in force. No coverage is afforded for claims first made prior to the effective date of this Policy, and no coverage is afforded for claims first made after the termination of this Policy unless and to the extent that reporting endorsements are purchased in accordance with Article IV, Section (C) of this Policy. Please review the Policy carefully.

MIE

MINNESOTA MEDICAL INSURANCE EXCHANGE

2221 University Avenue S.E. • Suite 200
Minneapolis, Minnesota 55414
612 623 1132 • 800 462 8326

PROFESSIONAL PREMISES LIABILITY

Name and Address of Insured

Policy Number

In consideration of the required premium the policy is effective from to 12:01 A.M. standard time at the address of the Named Insured as stated

Insurance is afforded only with respect to the Coverage Part(s) for which a premium charge or "NO CHARGE" is indicated. The limit of MMIE's liability shall be as stated, subject to all the provisions of the policy, attached hereto.

PART I PROFESSIONAL LIABILITY INSURANCE

( ) Individual Professional Liability
( ) Partnership, Corporation, Professional Association or Business Trust Professional Liability

Limits of Liability

each claim
aggregate

The Insured's principal specialty is:
The Insured's Basic Retroactive Date is:

SAMPLE

	Class	Premium
Individual Professional Liability		
Partnership, Corporation, Professional Association or Business Trust Professional Liability		
Paramedical Personnel Coverage		

Endorsements Part I

PART II PROFESSIONAL PREMISES LIABILITY COVERAGES

Injury Limits each occurrence Property Damage Limits each occurr

Location Address	Prem
1	
2	
3	
4	

Endorsements Part II

Total Policy Premium

Issued by: Minnesota Medical Insurance Exchange
(A Reciprocal Insurance Company, organized in the State of Minnesota, herein called MMIE)
Issue Date:

Authorized Representative

The Medical Liability Insurance Exchange MMIE in consideration of the premium paid and in reliance upon the representations and warranties contained in the application made a part hereof, and subject to all of the provisions of this Policy, to the person named on the Declarations Page the "Named Insured" as follows:

I. INSURING AGREEMENTS

PART I - PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE

Individual Professional Liability: To pay on behalf of the Named Insured all sums which the Named Insured shall become legally obligated to pay as Damages because of any claim or claims first made against the Named Insured during the Policy Period arising out of the performance of Professional Services rendered or which should have been rendered subsequent to the retroactive date in the practice of the Named Insured's profession as a physician, by the Named Insured or by any person for whose acts or omissions the Named Insured is legally responsible, except when such legal responsibility is related to the Named Insured's status as a member of a Partnership, Professional Association, Business Trust or Proprietorship.

Partnership, Professional Association, Business Trust or Proprietorship Professional Liability: To pay on behalf of the Named Insured all sums which the Named Insured shall become legally obligated to pay as Damages because of any claim or claims first made against the Named Insured during the Policy Period arising out of the performance of Professional Services rendered or which should have been rendered subsequent to the retroactive date in the practice of the profession of physician by any person for whose acts or omissions the Named Insured Partnership, Professional Association, Business Trust or Proprietorship is legally responsible.

MMIE shall have the right and duty to defend any suit against the Named Insured alleging such Damages, even if any of the allegations of the suit are groundless, false, or fraudulent, and may make such investigation or such settlement of any claim or suit as it deems expedient, but MMIE shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of MMIE's liability has been exhausted by payment of judgments or settlements.

Exclusions:

Part I does not apply:

a. to liability of any Named Insured as a proprietor, partner, shareholder, executive officer, administrator, committee member, director, or medical director of any hospital, sanitarium, infirmary, clinic with bed and board facilities, nursing home, abortion clinic, drug abuse clinic, surgi-center, blood bank, commercial laboratory, Health Maintenance Organization, preferred provider organization or other professional or business enterprise, but with respect to the term commercial laboratory this exclusion does not apply to laboratory facilities maintained primarily for testing of the Named Insured's own patients nor to an x-ray or pathological laboratory if the Named Insured is a radiologist or pathologist;

b. to liability of any Named Insured when any Named Insured is enrolled in, and rendering Professional Services pursuant to, a bona fide medical or surgical training program;

c. to liability of others assumed by any Named Insured under contract or agreement;

d. to any obligation for which any Named Insured or any carrier as his insurer may be held liable under any worker's compensation, unemployment compensation or disability benefits law or under any similar law;

e to liability of any Named Insured for Damages resulting from an act or is a willful violation of a statute, ordinance or regulation imposing criminal including punitive damages;

f) to liability of any Named Insured for any punitive Damages;

g) to liability of any Named Insured arising out of acts or omissions which occur at any time the Named Insured's license to practice medicine has been suspended, revoked or voluntarily surrendered;

h) to liability of any Named Insured arising out of acts or omissions of an Employed Physician which occur during any time such Employed Physician's license to practice medicine has been suspended, revoked or voluntarily surrendered;

i) to liability of any Named Insured for Damages arising out of the dispensing or prescribing of controlled substances by any Named Insured during any time such Named Insured's controlled substance registration has been suspended, revoked or surrendered;

j) to liability of any Named Insured for Damages arising out of the dispensing or prescribing of controlled substances by any Employed Physician during any time such Employed Physician's controlled substance registration has been suspended, revoked or voluntarily surrendered;

k) to liability of any Named Insured for Damages with respect to:

(1) any claim made against any Named Insured at any time during any Prior Policy Period, regardless of whether or not such claim has been reported to any applicable liability insurer;

(2) any potential claim against any Named Insured of which any Named Insured is aware, or reasonably should have been aware, as of the date this Policy is issued, regardless of whether or not such claim has yet been made or reported to any applicable liability insurer. For purposes of this section (k)(2), potential claim includes without limitation instances where any Named Insured has received either an oral or written communication from a patient or his legal representative, and/or a request by a patient or his legal representative for copies of medical records under circumstances reasonably indicative of a potential claim;

(3) any claim based, in whole or in part, upon any act or omission of the Named Insured while outside the territorial United States and Canada.

PART II - PROFESSIONAL PREMISES LIABILITY

To pay on behalf of the **Named Insured** all sums which the **Named Insured** shall become legally obligated to pay as **Damages** because of:

BODILY INJURY,
PROPERTY DAMAGE, or
PERSONAL INJURY

caused by **an Occurrence** and arising out of the ownership, maintenance or use, as a **Professional Office**, of the **Insured Premises** and all operations necessary or incidental thereto, and **MMIE** shall have the right and duty to defend any claim or suit against the **Named Insured** alleging **Damages**, even if such suit is groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient, but MMIE shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of MMIE's liability hereunder has been exhausted by payment of judgments or settlements.

Exclusions:

Part II does not apply:

a. to **Bodily Injury** or Property Damage arising out of the ownership, operation, use, loading or unloading of
   (1) any automobile, aircraft or other air, sea or land vehicle owned or operated by or rented or loaned to the **Named Insured**, or
   (2) any other automobile, aircraft or other air, sea or land vehicle operated by any person in the course of his employment by the **Named Insured**;
   (3) this exclusion does not apply to the parking of an automobile on the Named **Insured's professional** office premises, if such automobile is not owned by or rented or loaned to the **Named Insured**;

(b) to any obligation for which the **Named Insured** or any carrier as his insurer may be held liable under any worker's compensation, unemployment compensation or disability benefits law, or under any similar law;

(c) to **Bodily Injury** to any agent or employee, partner, fellow worker or tenant of the **Named Insured** arising out of and in the course of his engagement or employment by the **Named Insured**;

(d) to **property damage** to
   (1) property owned or occupied by or rented to the **Named Insured**,
   (2) property used by the Named Insured, or
   (3) property in the care, custody or control of the **Named Insured** or as to which the **Named Insured** is for any purpose exercising physical control;

but part (3) of this exclusion does not apply with respect to **property damage**, other than to elevators, arising out of the use of an elevator at the insured premises;

(e) to **Bodily Injury** or Property Damage due to nuclear reaction, nuclear radiation or radioactive contamination or escape of pollutants, or to any act or condition incident to any of the foregoing;

(f) with respects to **Personal Injury**, to liability assumed by the **Named Insured** under any contract or agreement;

(g) to liability of any **Named Insured** for **Personal Injury** resulting from an act or ommission which is a willful violation of a statute, ordinance or regulation imposing criminal penalties (including punitive damages);

(h) to **Personal Injury** arising out of any publication or utterance described in Group (2), if the first injurious publication or utterance of the same or similar material by or on behalf of the **Named Insured** was made prior to the effective date of this insurance;

(i) to **Personal Injury** arising out of a publication or utterance described in Group (2) of Section IV, a., (2) hereof concerning any organization or business enterprise, or its products or services, made by or at the direction of any **Named Insured** with knowledge of the falsity thereof;

(j) to any obligation for which the **Named Insured** may be liable arising out of the **performance** of **Professional Services.**

(k) to **liability** of any **Named** Insured with respect to:
   (1) **any claim** made against any **Named Insured** at any time during any **Prior Policy Period**, regardless of whether or not such claim has been reported to any applicable liability insurer;
   (2) any potential claim against any **Named Insured** of which any **Named Insured** is aware, or reasonably should have been aware, as of the date this Policy is issued, regardless of whether or not such claim has yet been made or reported to any applicable liability insurer. For purposes of this Section, k., (2), potential claim includes without limitation instances where any **Named Insured** has received either an oral or written communication from a patient or his legal representative, and/or a request by a patient or his legal representative for copies of medical records under circumstances reasonably indicative of a potential claim;

3 any claim based, in whole or in part, upon any act or omission of the Named Insured while the Named Insured is outside the territorial limits of Canada.

SUPPLEMENTARY PAYMENTS

In addition to the applicable limit of liability, MMIE will pay:

(a) all expenses incurred by MMIE, all costs taxed against the **Named Insured** in any suit defended by MMIE and all interest on that part of any judgment which does not exceed the limit of MMIE's liability thereon which accrues after entry of the judgment and before MMIE has paid or tendered or deposited in court such part of the judgment;

(b) premiums on appeal bonds required in any suit defended and appealed by MMIE and premiums on bonds to release attachments in any such suit for an amount not in excess of the applicable limit of liability of this Policy, but MMIE shall have no obligation to apply for or furnish any such bonds;

(c) expenses incurred by the **Named Insured** for first aid to others at the time of an accident, for **Bodily Injury** to which this Policy applies;

(d) the reasonable expenses incurred by the **Named Insured** for each day or part of a day the **Named Insured** is required to attend the trial of a civil suit against the **Named Insured** for **Damages** resulting from causes of action as described under Parts I and II, not in excess of $200.00 per day;

(e) if coverage is purchased under Part II, reasonable medical expenses for **Bodily Injury** sustained by any person (i) which resulted from an **Occurrence** on the **Named Insured's professional office premises**, or during any operations necessary or incidental thereto regardless of the **Named Insured's** liability for such **Bodily Injury**, and (ii) which were incurred by the **Named Insured** within one (1) year from such **Occurrence**; provided, however, that payments under this provision shall not exceed $1,000 per person and $10,000 per accident, and shall not apply to **Bodily Injury**:

1 arising out of the ownership, maintenance, operation, use, loading or unloading of
   a any automobile, aircraft or other air, sea or land vehicle owned or operated by or rented or loaned to the **Named Insured**, or
   b any other automobile, aircraft or other air, sea or land vehicle operated by any person in the course of his employment by the **Named Insured**;

but this exclusion does not apply to the parking of an automobile on the **Named Insured's professional office premises**, if such automobile is not owned by or rented or loaned to the **Named Insured**;

2 due to war, whether or not declared, civil war, insurrection, rebellion or revolution or to any act or condition incident to any of the foregoing;

3 to the **Named Insured**, any agent, employee, fellow worker, partner, tenant or other person regularly residing on the **Named Insured's professional office premises**, or any employee of any of the foregoing if the **Bodily Injury** arises out of and in the course of his employment therewith;

4 to any other tenant if the **Bodily Injury** occurs on that part of the **Named Insured's professional office** premises rented from the **Named Insured** or to any agent or employee of such a tenant if the **Bodily Injury** occurs on the tenant's part of the insured premises and arises out of and in the course of his employment for the tenant;

5 to any person while engaged in maintenance and repair of or alteration, demolition or new construction at the **Named Insured's professional office premises**;

6 to any person if any benefits for such **Bodily Injury** are payable or required to be provided under any worker's compensation, unemployment compensation or disability benefits law, or under any similar law.

II. DEFINITION OF INSURED

(a) The word **Named Insured** shall mean as respects Part I:

1) Under **Individual Professional Liability** each individual named in the Declarations Page;

2) under **Partnership, Professional Association, Business Trust** or [illegible] **Professional Liability** the Partnership, Professional Association, Business Trust or Proprietorship named on the Declarations Page, and, with respect to the operations of others, provided that the **Named Insured** with respect to liability for his personal acts or omissions of this nature;

3) any **Paramedical Employee** of the **Named Insured**, while acting within the scope of his employment duties, provided that notice of the employment of **Paramedical Employees** is given to MMIE when required;

4) any other employee not a physician or **Paramedical Employee** of the **Named Insured** while acting within the scope of his duties as such.

The insurance afforded applies separately to each **Named Insured** against whom claim is made or suit is brought except with respect to limits of MMIE's liability as provided in Article IV, Section b.

(b) The word **Named Insured** shall mean as respects Part II:
the **Named Insured**, and includes any executive officer, director, or [illegible] thereof while acting within the scope of his duties as such, and any organization or proprietor with respect to real estate management for the **Named Insured**. If the **Named Insured** is a Partnership, Professional Association, Business Trust or Proprietorship, the unqualified words "**Named Insured**" also include any partner, shareholder, beneficiary or proprietor or member therein but only with respect to his liability as such.

III. POLICY PERIOD - TERRITORY

(a) Under Part I the insurance provided hereby only applies to **Professional Services** rendered or which should have been rendered subsequent to the retroactive date stated on the Declarations Page and then only if claim is first made during the Policy Period or a **Reporting Period** purchased in accordance with Article IV, Section c.

A claim shall be considered to be first made when MMIE first receives notice of the claim or of an event which may subsequently give rise to a claim (see Article IV, Section c for **Named Insured's** rights to have extended reporting endorsements issued.

A claim shall be considered to be "first made during the **Policy Period**" or "first made during **a Reporting Period**" only under the following conditions:

(1) **If during** the **Policy Period** or a **Reporting Period** if purchased the **Named Insured shall have** knowledge or become aware of any event, arising out of the rendering **or failure** to render **Professional Services** covered hereby, which may subsequently give rise to a claim and shall, during the **Policy Period** or such **Reporting Period**, give written notice thereof to MMIE in accordance with Article IV, Section [illegible] of this Policy, then such notice shall be considered a claim hereunder;

(2) if any claim is first made during the **Policy Period** or a **Reporting Period** if purchased), alleging injury to an individual that would be covered under this Policy, any additional claims which are made, or suits or proceedings in connection therewith which are brought subsequent to the **Policy Period** [illegible]

Reporting Period for Damages resulting from the same [illegible] Policy Period or the Reporting Period.

b. Under Part II, the insurance provided hereby applies to Bodily Injury, Property Damage or Personal Injury which occurs during the Policy Period in the territory of the United States and Canada.

IV. CONDITIONS

a. Definitions - when used in this Policy or Endorsements forming a part hereof:

1. Applicable to Part I:

"Damages" means all Damages, including Damages for death, which are payable because of injury to which this insurance applies, including any counter claim made in a suit brought by the Named Insured in the process of attempting to collect fees.

"Named Insured" means the person named on the Declarations Page.

"Paramedical Employee" includes medical assistants, technicians including, but not limited to, [illegible] inhalation therapy, laboratory and x-ray, nurse anesthetists [illegible], obstetrical registered nurses, midwives, opticians, optometrists, [illegible], physical therapists, psychologists, psychotherapists, [illegible], nurse practitioners e.g., cardiac specialists, [illegible] and any other nurse practitioner or nurse employed by the Named Insured in the practice of the Named Insured's profession.

"Policy Period" means the period of coverage commencing on the date shown on the Declarations Page attached to this Policy as Policy effective date and ending at the effective date of termination, expiration or cancellation of coverage under this Policy, and specifically excludes any Reporting Period purchased hereunder.

"Policy Year" means each consecutive annual period of the policy.

"Prior Policy Period" means the period of coverage commencing on the retroactive date shown on the Declarations page attached to this policy and ending upon the date shown as Policy Effective Date.

"Professional Services" means those services performed in the practice of the Named Insured's profession as physician including service as 1) a member of any committee of Minnesota Medical Insurance Exchange or Minnesota Medical Management, Inc.; 2) a member of any committee of the American Medical Association or any constituent or component society thereof; 3) a member of any committee of a professional medical society recognized by the American Medical Association or any constituent or component society thereof; 4) a member of the governing body of any hospital accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association; 5) a member of any hospital accreditation or professional standards review board or committee.

"Reporting Period" [illegible]
[illegible]
arise out of Professional Services rendered or [illegible]
subsequent to the retroactive date and prior to the end of the Policy Period.

"Employed Physician" means any duly licensed [illegible]
employed by the Named Insured.

(2) Applicable to Part II:

"Bodily Injury" means Bodily Injury, sickness or disease or death [illegible]
person.

"Damages" means 1. Damages for death and for care and loss of [illegible]
resulting from **Bodily Injury**, 2. Damages for loss of use of property [illegible]
from **Property Damage** and 3. Damages which are payable because of **Personal Injury**.

"Medical Expense" means expenses for necessary medical, surgical, [illegible]
dental services, including prosthetic devices, and necessary ambulance, [illegible]
professional nursing and funeral services.

"Named Insured" means the person named on the Declarations Page.

"Occurrence" means an accident, including injurious exposure to conditions, which results, during the **Policy Period**, in **Bodily Injury**, **Property Damage** or **Personal Injury** neither expected nor intended from the standpoint of the **Named Insured**.

"Personal Injury" means one or more of the following groups of offenses committed during the **Policy Period**:

Group 1. false arrest, detention or imprisonment, or malicious prosecution;

Group 2. the publication or utterance of a libel or slander or of other defamatory or disparaging material, or a publication or utterance in violation of an individual's right of privacy, except publications or utterances in the course of or related to advertising, broadcasting or telecasting activities conducted by or on behalf of the **Named Insured**;

Group 3. wrongful entry or eviction, or other invasion of the right of private occupancy.

"Property Damage" means injury to or destruction of tangible property.

"Professional Office Premises" means (1) the professional office premises designated on the Declarations Page (2) professional office premises alienated by the **Named Insured** other than premises constructed for sale by the **Named Insured**, if possession has been relinquished to others, and 3 professional office premises as to which the **Named Insured** acquires ownership or control and reports his intention to insure such premises under this policy and no other within 30 days after such acquisition; and includes the ways immediately adjoining such premises on land.

c. Limits of Liability

1. Under Part I, the limit of liability stated on the Declarations Page as applicable to "each claim" is the limit of [illegible]'s liability for loss resulting from any claim or suit or [illegible] as to its first made during the Policy Year or Reporting Period, if any, for injury to or death of any one person, subject to the following limits of liability:

If the Named Insured acquires for the Reporting Endorsement [illegible] the limit of liability stated on the Declarations Page as applicable to "each claim," at the time the Policy's term expires, is the limit of [illegible]'s liability for loss resulting from any one claim or suit or all claims [illegible] during each Reporting Endorsement period, subject to an annual aggregate limit for any one person.

Subject to the [illegible] respecting "each claim," the limit of liability stated on the Declarations Page as "aggregate" is the total limit of [illegible]'s liability for [illegible] during the effective Policy Year or during each Reporting Period. If any Reporting Period exceeds one year, the "aggregate" limit applies separately to each annual period commencing with the effective date of the reporting endorsement.

Regardless of the [illegible] Named Insureds under this Policy, the inclusion of more than one Named Insured hereunder shall not operate to increase the limits of [illegible]'s liability.

2. Under Part II:

The limit of liability stated on the Declarations Page as applicable to "each Occurrence" is the limit of [illegible]'s liability for all Damages because of Bodily Injury, Property Damage or Personal Injury regardless of the number of 1. Named Insureds under this Policy, 2. persons or organizations who sustain Bodily Injury, Property Damage or Personal Injury, or 3. claims made or suits brought on account of Bodily Injury, Property Damage or Personal Injury. For the purpose of determining the limit of [illegible]'s liability, all Bodily Injury, Property Damage and Personal Injury arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one Occurrence.

c. Reporting Endorsement

Under Part I, in the event of termination of insurance either by non-renewal or cancellation of this Policy or termination of a Reporting Period, the Named Insured shall have the right upon the payment of an additional premium to be computed in accordance with [illegible]'s rules, rates, rating plans and premiums applicable on the effective date of the endorsement to have issued an endorsement(s) providing additional Reporting Period(s) in which claims otherwise covered by this Policy may be reported. Such right, however, must be exercised by the Named Insured by written notice [illegible] thirty (30) days after such termination date.

c. Named Insured's Duties in the Event of an Occurrence, Claim, or Suit

[illegible] the Named Insured obtaining knowledge or becoming aware of any alleged [illegible] which may potentially give rise to a claim, written notice containing the [illegible] with respect to the circumstances out of which it arose, including the time and address of the injured, the nature and extent of the Professional Services rendered or which should have been rendered and the nature and extent of the type of claim or claims anticipated, shall be given by or for the

Named Insured to MMIE or any of its authorized representatives as practicable.

2) If claim is made or suit is brought against the **Named Insured**, the Named Insured **shall** immediately forward to MMIE every demand, notice, summons or other process received by him or his representative.

3) The **Named Insured** shall cooperate with MMIE and, upon MMIE's request, assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the **Named Insured** because of **Bodily Injury, Property Damage** or Personal Injury with respect to which insurance is afforded under this Policy; and the Named **Insured** shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The **Named Insured** shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for first aid to others at the time of accident.

e. **Action Against MMIE**

No action shall lie against MMIE unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this Policy, nor until the amount of the **Named Insured's** obligation to pay shall have been finally determined either by final judgment after expiration of period for appeal against the **Named Insured** after actual trial or by written agreement of the **Named Insured**, the Claimant and MMIE.

Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this Policy to the extent of the insurance afforded by this Policy. No person or organization shall have any right under this Policy to join MMIE as a party to any action against the Named Insured to determine the Named Insured's liability, nor shall MMIE be impleaded by the **Named Insured** or his legal representative. Bankruptcy or insolvency of the **Named Insured** or of the **Named Insured's** estate shall not relieve MMIE of any of its obligations hereunder.

f. **Other Insurance**

With respect to Part I, if the **Named Insured** has other insurance against a loss covered by this Policy, MMIE shall not be liable under this Policy for a greater proportion of such loss than the limit of liability stated on the Declarations Page bears to the total limit of liability of all valid and collectible insurance against such loss.

With respect to Part II, the insurance afforded by this Policy is primary insurance, **except when stated** to apply in excess of or contingent upon the absence of other **insurance.** When this insurance is primary and the **Named Insured** has other insurance **which is stated** to be applicable to the loss on an excess or contigent basis, the amount of **MMIE's** liability under this Policy shall not be reduced by the existence of such other insurance. When both this insurance and other insurance applies to the loss on the same basis, whether primary, excess or contingent, MMIE shall not be liable under this Policy for a greater proportion of the loss than that stated in the applicable contribution provision below:

(1) **Contribution by Equal Shares**

If all of such other valid and collectible insurance provides for contribution by equal shares, MMIE shall not be liable for a greater proportion of such loss than

...applicable if each insurer contributes an equal share until ... each insurer equals the lowest applicable limit of liability under any ... the full amount of the loss is paid and with respect to any amount of loss ... paid, the remaining insurers continue to contribute equal shares of the remaining amount of the loss until each such insurer has paid its limit ... amount of the loss is paid.

2) Contribution by Limits

If any of such other insurance does not provide for contribution by equal shares, MMIE shall not be liable for a greater proportion of such loss than the applicable limit of liability under this Policy for such loss bears to the total applicable limit of liability of all valid and collectible insurance against such loss.

g. Subrogation

In the event of any payment under this Policy, MMIE shall be subrogated to all the **Named Insured's** rights of recovery therefore against any person or organization excluding, under Part I, employees of the **Named Insured**) and MMIE may require an assignment of such rights from the **Named Insured** to the extent of any payments made under this Policy plus reasonable cost of collection. The **Named Insured** shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The **Named Insured** shall do nothing either before or after loss to prejudice such rights and shall cooperate with MMIE in assisting it to protect its rights under this provision. The **Named Insured** acknowledges that MMIE's rights under this provision shall be considered as the first priority claim against any such person or organization, to be paid before any other claims which may exist. MMIE may, at its option, take such action as may be necessary and appropriate to preserve its rights under this provision, including the right to bring suit in the name of the **Named Insured**. MMIE may, at its option, collect such amounts from the proceeds of any settlement or judgment that may be recovered by the **Named Insured** or his legal representative. Any such proceeds of settlement or judgment shall be held in trust by the **Named Insured** for the benefit of MMIE, and MMIE shall be entitled to recover reasonable attorneys' fees from the **Named Insured** incurred in collecting proceeds held by him.

h. Changes

Notice to any representative or knowledge possessed by any representative or by any other person shall not effect a waiver or a change in any part of this Policy or prevent MMIE from asserting any right under the terms of this Policy; nor shall the terms of this Policy be waived or changed, except by endorsement issued to form a part of this Policy. Failure of MMIE to require performance by the **Named Insured** of any obligations under this Policy shall not affect its right to require performance of such obligation. Any waiver by MMIE of any breach of any provision of this Policy shall not be construed as a waiver of any continuing or succeeding breach of such provision, a waiver or modification of the provision itself, or a waiver or modification of any right under this Policy.

i. Assignment

Assignment of interest under this Policy shall not bind MMIE until its consent is endorsed hereon; if, however, the **Named Insured** shall die, such insurance as is afforded by this Policy shall apply (1) to the **Named Insured's** legal representative as the **Named Insured**, but only while acting within the scope of his duties as such, and (2)

with respect to the property of the **Named Insured**, to the ... temporary custody thereof, as **Named Insured**, but only until the ... qualification of the legal representative.

j. **Cancellation**

This **Policy** may be canceled by the **Named Insured** by surrendering it to ... any of its authorized representatives or by mailing to MMIE written ... when thereafter the cancellation shall be effective. This Policy may be ... MMIE by mailing to the **Named Insured** at the address shown in this Policy ... notice stating a date not less than ten days thereafter when such cancellation ... effective. The mailing of notice as aforesaid shall be sufficient proof of ... The time of surrender or the effective date and hour of cancellation stated in the notice shall become the end of the **Policy Period**. Delivery of such written notice either by the **Named Insured** or by MMIE shall be equivalent to mailing.

If the **Named Insured** cancels this Policy, earned premium shall be computed in accordance with the customary short rate table and procedures. If MMIE cancels, earned premium shall be computed pro-rata. Premium adjustment may be made either at the time cancellation is effected or as soon as practicable after cancellation becomes effective, but tender by MMIE of unearned premium is not a condition of cancellation.

This policy may be canceled by MMIE without cause and made retroactive to the inception of the Policy if fraud by the **Named Insured** with regard to the information the **Named Insured** provided MMIE is proved.

k. **Declarations**

By acceptance of this Policy, the **Named Insured** agrees that the statements in the Declarations Page are his agreements and representations, that this Policy is issued in reliance upon the truth of such representations and that this Policy embodies all agreements existing between himself and MMIE or any of its agents relating to this insurance.

l. **Inspection and Audit**

MMIE shall be permitted but not obligated to inspect the **Named Insured's** premises at any time. Neither MMIE's right to make inspections nor the making thereof nor any report thereon shall constitute an undertaking, on behalf of or for the benefit of the **Named Insured** or others, to determine or warrant that such premises are safe or healthful, or are in compliance with any law, rule or regulation.

MMIE may examine and audit the **Named Insured's** books and records at any time during the **Policy Period** and extensions thereof and within three years after the final termination of this policy, as far as they relate to the subject matter of this insurance.

m. **Governing Law**

The validity, construction and enforceability of this Policy shall be governed in all respects by the law of the State of Minnesota or such other states in which the **Named Insured** performs **Professional Services** and MMIE is qualified to sell insurance. Any and all provisions of this Policy which are in conflict with statutes of these states are understood, declared and agreed to be automatically changed to conform to the laws.

n. Assessability

This Policy is non-assessable. The **Named Insured** hereby acknowledges that he nor other members of MMIE shall be obligated for any debts and liabilities of MMIE.

o. **Severability**

In the event any portion of this Policy shall be held to be invalid, the same shall not affect, in any respect whatsoever, the validity of the remainder of this Policy.

p. **Gender**

Any personal pronoun of the masculine gender used in this Policy shall be deemed to include the feminine gender.

q. **Notices**

Except as otherwise specifically stated in this Policy, all notices or other communications required or contemplated by this Policy shall be addressed:

1) If to MMIE, at its offices;
2) If to the **Named Insured**, at its address stated on the Declarations Page or at such new address as the **Named Insured** may designate by written notice to MMIE.

V. NUCLEAR ENERGY LIABILITY EXCLUSION

A. This Policy does not apply:

1. to injury or death including all forms of radioactive contamination:
   a) with respect to which an **Named Insured** under this Policy is also an **Named Insured** under a nuclear energy liability policy issued by Nuclear Energy Liability Insurance Association, Mutual Atomic Energy Liability Underwriters or Nuclear Insurance Association of Canada, or would be an **Named Insured** under any such policy but for its termination upon exhaustion of its limit of liability; or
   b) resulting from the hazardous properties of nuclear material and with respect to which (1) any person or organization is required to maintain financial protection pursuant to the Atomic Energy Act of 1954, or any law amendatory thereof, or 2) **Named Insured** is, or had this Policy not been issued would be, entitled to indemnity from the United States of America, or any agency thereof, under any agreement entered into by the United States of America, or any agency thereof, with any person or organization.

2. to injury or death including all forms of radioactive contamination) resulting from the hazardous properties of nuclear material, if
   a) the nuclear material 1) is at any nuclear facility owned by, or operated by or on behalf of, an **Named Insured** or 2) has been discharged or dispersed therefrom;
   b) the nuclear material is contained in spent fuel or waste at any time possessed, handled, used, processed, stored, transported or disposed of by or on behalf of **Named Insured**; or

... the ... death arises out of the ... material ... fuel, material, parts or equipment ... construction, maintenance, operation or use ...

B. As used in this exclusion:
"hazardous properties" include radioactive, toxic or explosive ...
"nuclear material" means source material, special nuclear ... material;
"source material," "special nuclear material," and "byproduct material" ... meanings given them in the Atomic Energy Act of 1954 or in any ... thereof;
"spent fuel" means any fuel element or fuel component, solid or ... been used or exposed to radiation in a nuclear reactor;
"waste" means any waste material (1) containing byproduct material ... resulting from the operation by any person or organization of any nuclear ... included within the definition of nuclear facility as set forth herein after ... paragraph (a) or (b);
"nuclear facility" means
(a) any nuclear reactor,
(b) any equipment or device designed or used for (1) separating the ... uranium or plutonium, (2) processing or utilizing spent fuel, or (3) ... processing or packaging waste,
(c) any equipment or device used for the processing fabricating or ... special nuclear material if at any time the total amount of such material in the custody of the insured at the premises where such equipment or device is located consists of or contains more than 25 grams of plutonium or uranium 233 or any combination thereof, or more than 250 grams of uranium 235.

IN WITNESS WHEREOF, the said Minnesota Medical Insurance Exchange has caused this Policy to be signed by its Chairman, and Secretary, but it shall not be valid unless countersigned on the Declarations Page by a duly authorized representative of MMIE.

Secretary
Minnesota Medical Insurance Exchange

Chairman
Minnesota Medical Insurance Exchange

INTRODUCTION

St Paul

This policy protects against a variety of losses. There are also some restrictions. We've written the policy in plain, easy-to-understand English. We encourage you to read it carefully to determine what is and is not covered, as well as the rights and duties of those protected.

The words you, your and yours mean the insured named here:

Which is a:

- = corporation
- = individual
- = partnership
- = joint venture
- = other
- = condominium

We, us, our and ours mean the **St. Paul Fire and Marine Insurance Company.** We're a capital stock company located in St. Paul, Minnesota.

Your policy is composed of General Rules, an explanation of What To Do If You Have A Loss, one or more Coverage Summaries, and one or more Insuring Agreements explaining your coverage. It may also include one or more endorsements. Endorsements are documents that change your policy. The agreements and endorsements included when this policy begins are listed below. One of our authorized representatives must also countersign the policy before it is valid.

This policy will begin on_____
and continue until_____.
Your former policy, number _____
is automatically cancelled on the date this policy begins.

In return for your premium, we'll provide the protection stated in this policy.
Your premium is_____

Forms Included When This Policy Begins

Form number and edition date

Our authorized representative is:

President Secretary

Authorized Representative Date

The St. Paul

Important Note: This is a claims-made coverage. Please read it carefully, especially the When A Claim Is Made and Optional Reporting Endorsement sections.

Physicians' Professional Liability Protection–Claims Made

Policy issued to	Agreement takes effect	Policy number

How this agreement protects you

This agreement provides protection against professional liability claims which might be brought against you in your practice as a physician or surgeon.

Who's protected under this agreement

Name	Retroactive Date	Name	Retroactive Date
Name of Covered Professional Organization			

Each person and organization named above or in the "Who's protected" section of the Introduction page is covered under this agreement. The words you, your and yours refer to these people or this organization.

Limits of your coverage

Two limits apply to the amount we'll pay for professional claims. These limits are shown below or on the Introduction page. The limits apply separately to each covered person. When an organization is also covered, the limits apply separately to that organization.

$ _____ Each person limit. This is the most we'll pay for all claims resulting from the injury or death of any one person.

$ _____ Total limit. This is the most we'll pay for all claims first made in a policy year. By policy year we mean each consecutive annual period of the policy. If no total limit is shown, the total limit is 3 times the each person limit.

When you're covered

To be covered the professional service must have been performed (or should have been performed) after your retroactive date that applies. The claim must also first be made while this agreement is in effect.

When is a claim made?

A claim is made on the date you first report an incident or injury to us or our agent. You must include the following information:

- Date, time and place of the incident.
- What happened and what professional service you performed.
- Type of claim you anticipate.
- Name and address of injured party.
- Name and address of any witness.

What this agreement covers

Individual coverage. Your professional liability protection covers you for damages resulting from
1. Your providing or withholding of professional services.

This agreement must be signed only when it's issued after the effective date of the policy.

Authorized Representative

GENERAL RULES

These rules apply to the entire policy unless you're notified otherwise.

Special Rights And Duties Of The First Named Insured

You agree that when more than one insured is named in the introduction, the first named insured has special rights and duties. These rights and duties are explained in the following General Rules:

- Premiums.
- Cancellation.
- Policy Changes.

Your Policy Period

Insuring agreements in this policy begin at 12:01 a.m., standard time, on the effective date. If this policy replaces policies ending at noon, rather than 12:01 a.m., coverage begins at noon when the old policy ends.

Insuring agreements added to this policy after its effective date begin on the effective date of the added agreement.

Coverage ends at 12:01 a.m., standard time, on the expiration data. If all or part of this policy is cancelled for any reason before that data, that coverage will end at 12:01 a.m., standard time, on the cancellation data.

Premiums

We compute the premium you pay for this policy using information available at the time. So, all or part of your premium may be based on estimates. If estimates are used, we'll compute your actual premium when complete information is available at the end of the policy period. If it's more than you've paid, you'll owe us the difference. If it's less, we'll return the difference. But you won't pay less than any minimum annual premium agreed on. The first named insured is responsible for paying all premiums and will be the one to whom we'll pay any return premiums.

You must keep accurate records of the information we'll need to compute your premium. Your agent can explain the type of records we'll need. The first named insured agrees to send copies of these records at the end of each policy period - or any other time we request them.

Our Right To Inspect And Audit

You agree to let us inspect your property and business operations during normal business hours while this policy is in force. We're not, however, required to make inspections. Nor will we guarantee that your property or operations are safe, or that they conform to any laws, codes, standards or regulations. This rule also applies to any organization which makes insurance inspections, surveys, reports or recommendations for us.

You also agree to let us examine and audit your financial books and records that relate to this insurance at any time up to 3 years after this policy ends.

Policy Changes

This policy contains all the agreements between you and us concerning this insurance. The first named insured is authorized to make changes in this policy with our consent. This policy can only be changed by a written form included as part of the policy. This form must be signed by one of our authorized representatives.

We make changes in our standard insurance policy forms from time to time. These changes must conform to state law and are filed with insurance supervisory authorities for approval. While your coverage is in force we can make any change in the form of this policy that broadens or extends your coverage. If we do, and the change can be added to your policy without increasing the premium, you'll automatically receive the benefit of the extended or broadened

Lawsuits Against Us

No one can sue us to recover under this policy unless all of its terms have been lived up to.

If your policy includes property insurance. Any lawsuit to recover on a property claim must begin within 2 years after the date on which the direct physical loss or damage occurred. State law gives you more time for property located in these states:
- North Dakota, North Carolina, Maryland - 3 years;
- Wyoming - 4 years; and
- Kansas, Nebraska - 5 years.

If your policy includes liability insurance. No one can sue us on a liability claim until the amount of the protected person's liability has been finally decided either by a trial or by a written agreement signed by the protected person, by us and by the party making this claim. Once liability has been determined by judgment or by written agreement, the party making the claim may be able to recover under this policy, up to the limits of coverage that apply. But that party can't sue us directly or join us in a suit against the protected person until liability has been so determined.

If the protected person or his or her estate goes bankrupt or becomes insolvent, we'll still be obligated under this policy.

Provision Required By Law

"This policy is issued under and in pursuance of the laws of the State of Minnesota, relating to Guaranty Surplus and Special Reserve Funds." Chapter 437, General Laws of 1909. (This provision applies only if this policy is issued in the St. Paul Fire and Marine Insurance Company.)

Loss Or Damage To Covered Property

If an accident or incident causes a property loss that's covered under this policy you must:

1. Notify the police if a law may have been broken.

2. Tell us or our agent what happened as soon as possible. Include the time and place of the event, a description of the property and the names and addresses of any witnesses.

3. Do what is reasonable and necessary to protect covered property from further damage. Keep a record of your expenses for consideration in your claim.

4. If feasible, separate the damaged property from the undamaged and make an inventory of the damaged items. This doesn't apply to Auto insurance if included in your policy.

5. Cooperate with us in the investigation and settlement of the claim. Show us the damaged property and any records you have to prove your loss at such times as may reasonably be required. Also permit us to take samples of damaged property for inspection, testing, and analysis. If your loss involves a covered auto, permit us to inspect the auto before it is repaired or disposed of.

6. Allow us to question you under oath at such times as may be reasonably required about any matter relating to this insurance or your claim, including your books and records. If we do, you agree to sign a copy of your answers.

7. Send us a signed, sworn statement of loss containing the information we request to investigate the claim. You must do this within 60 days after our request. We'll supply the forms. We'll pay within 30 days after we reach agreement with you.

Someone Is Injured Or Something Happens Which Can Result In A Liability Claim

If an accident or incident occurs that may involve this policy, you or any other protected person involved must:

1. Notify the police if a law may have been broken.

2. Tell us or our agent what happened as soon as possible. Do this even though no claim has been made but you or another protected person is aware of having done something that may later result in a claim. This notice should include:
- The time and place of the event;
- The protected person involved;
- The specific nature of the incident including the type of claim that may result; and
- The names and addresses of any witnesses and injured people.

Important Exception For Hospitals

If Professional Hospital Liability Protection - Claims Made is included in this policy, we won't consider a "Patient Incident Report" or "Variance Report" to be your report of a claim made - even if you send it to us or one of our agents.

3. Send us copies of all demands or legal documents if someone makes a claim or starts a lawsuit.

4. Cooperate and assist us in securing and giving evidence, attending hearings and trials, and obtaining the attendance of witnesses.

5. Not assume any financial obligation or pay out any money without our consent. But this rule doesn't apply to first aid given to others at the time of an accident.

St Paul Fire and Marine Insurance Co. 1986

PREJUDGMENT INTEREST ENDORSEMENT

St Paul

This endorsement changes your:

How Your Coverage Is Changed

Your Liability Protection is changed by adding the following to the Additional Benefits section.

Prejudgment interest. We'll pay the prejudgment interest awarded on that part of any judgment we pay. But if we make an offer to pay the limit of coverage that applies, we won't pay the prejudgment interest that accumulates after the date of our offer.

Other Terms

All other terms of your policy remain the same.

COMBINED COMPANIES
LOSS EXPERIENCE
MINNESOTA

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	595	$17,889,490	$13,579,982	$ 2,566,569	$ 1,840,000	$ 177,822	$ 18,164,373	101.5%
1983	660	21,186,512	6,584,016	1,888,960	2,890,501	458,015	11,821,492	55.8
1984	662	25,677,303	9,324,311	2,267,169	7,850,000	1,266,545	20,708,025	80.6
1985	811	34,469,869	9,170,537	2,756,639	16,608,353	2,311,973	30,847,502	89.5
1986	635	45,306,249	3,280,682	1,282,389	21,075,356	4,123,340	29,761,767	65.7
1987	659	55,612,065	1,157,647	454,174	26,701,391	5,812,193	34,125,405	61.4
TOTALS	4,022	$200,141,488	$43,097,175	$11,215,900	$76,965,601	$14,149,888	$145,428,564	72.7%

COMBINED COMPANIES
LOSS EXPERIENCE
NORTH DAKOTA

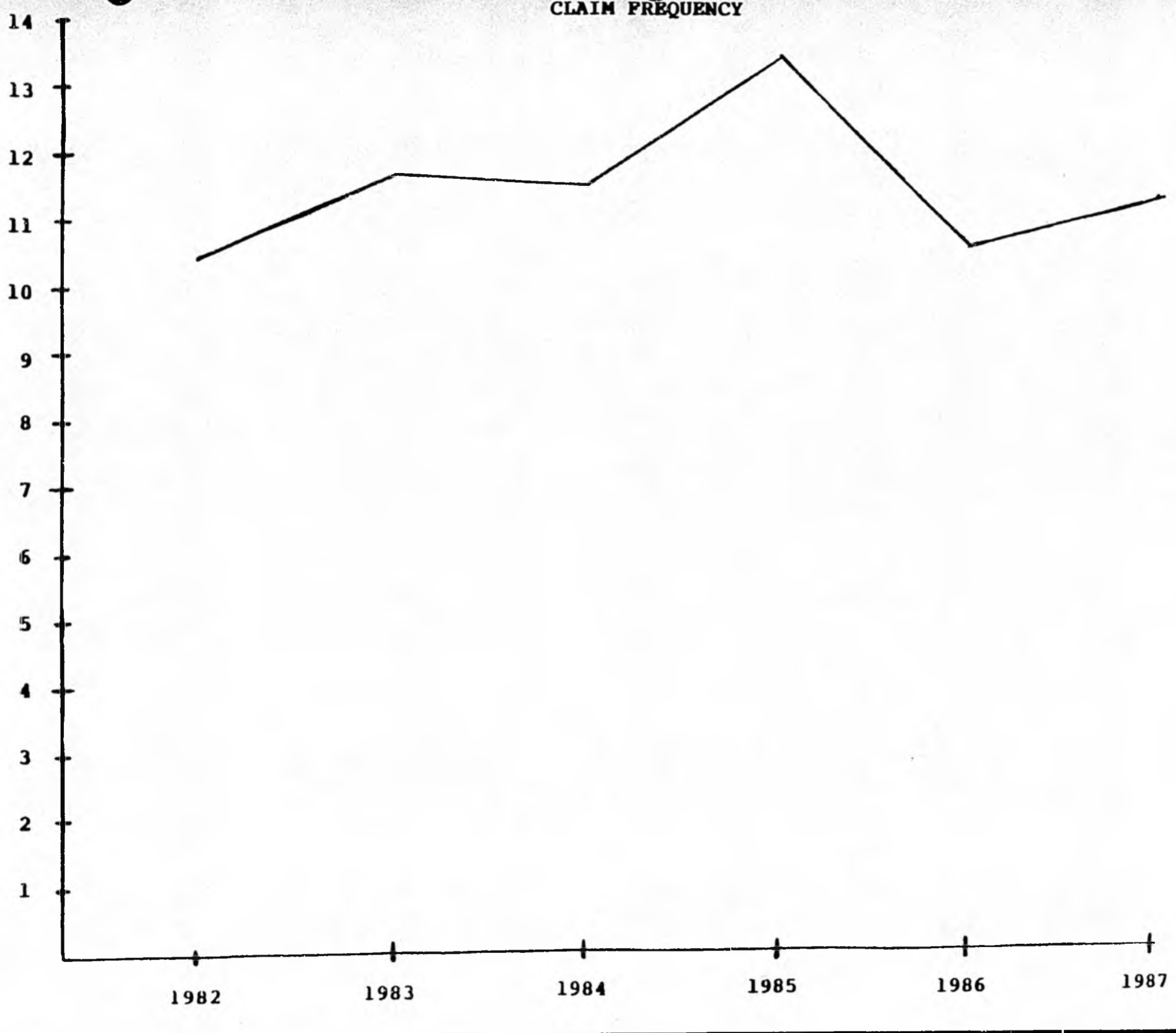
REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	77	$ 2,907,823	$1,152,407	$ 921,361	$ 645,000	$ 91,328	$ 2,810,096	96.6%
1983	66	3,298,398	931,254	507,344	125,000	16,718	1,580,316	47.9
1984	58	3,939,474	2,459,148	1,155,779	880,000	144,862	4,639,789	117.8
1985	67	5,116,721	846,894	663,964	2,126,000	211,323	3,848,181	75.2
1986	69	6,569,294	1,399,882	616,777	3,100,000	1,004,435	6,121,094	93.2
1987	76	9,222,907	149,950	195,066	4,958,000	552,172	5,855,188	63.5
TOTALS	413	$31,054,617	$6,939,535	$4,060,291	$11,834,000	$2,020,838	$24,854,664	80.0%

COMBINED COMPANIES
LOSS EXPERIENCE
SOUTH DAKOTA

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	49	$ 2,572,536	$1,301,980	$ 345,782	$ 70,000	$ 20,855	$ 1,738,617	67.6%
1983	50	2,455,518	214,614	117,394	25,000	73,791	430,799	17.5
1984	48	2,873,114	226,205	123,179	50,000	19,630	419,014	14.6
1985	59	3,864,849	630,623	456,637	940,000	183,685	2,210,945	57.2
1986	54	5,126,260	550,282	172,648	2,944,500	509,662	4,177,092	81.5
1987	52	6,509,527	685,474	111,813	996,500	552,165	2,345,952	36.0
TOTALS	312	$23,401,804	$3,609,178	$1,327,453	$5,026,000	$1,359,788	$11,322,419	48.4%

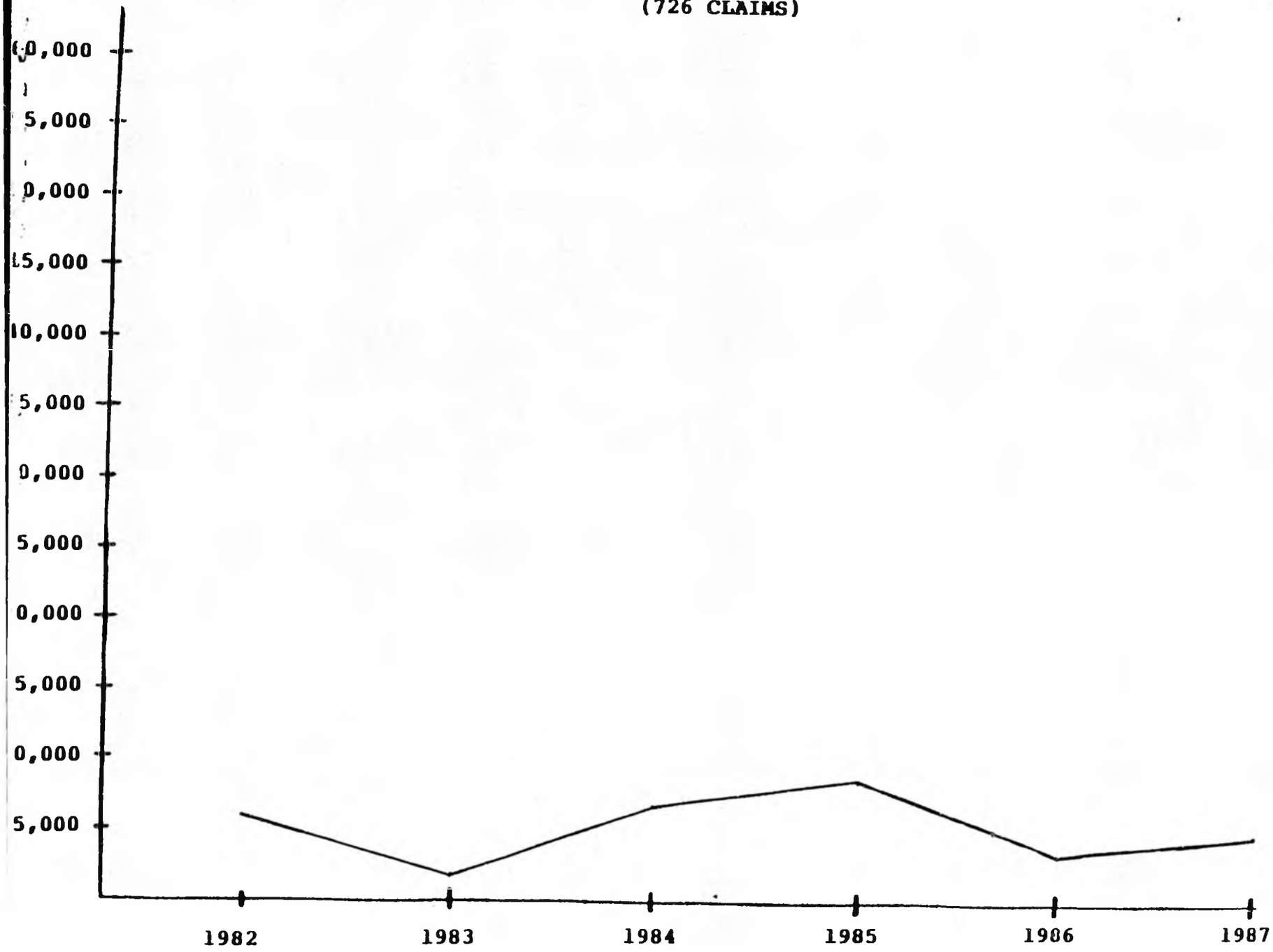
LOSS PAYMENT AND OPEN RESERVE DISTRIBUTION COMPARISON

Payment/Reserve Distribution	Number of Payments (Closed Claims)	Number of Reserves (Open Claims)
$ - 0	2,707	0
1 - 999	82	55
1,000 - 4,999	182	28
5,000 - 14,999	199	165
15,000 - 24,999	111	109
25,000 - 49,999	151	145
50,000 - 99,999	112	179
100,000 - 249,999	97	157
250,000 - 499,999	33	97
500,000 - 999,999	12	26
1,000,000 - Over	3	8
Unknown	0	89
TOTAL	3,689	1,058


CLAIM FREQUENCY
14
13
12
11
10
9
8
7
6
5
4
3
2
1
1982
1983
1984
1985
1986
1987

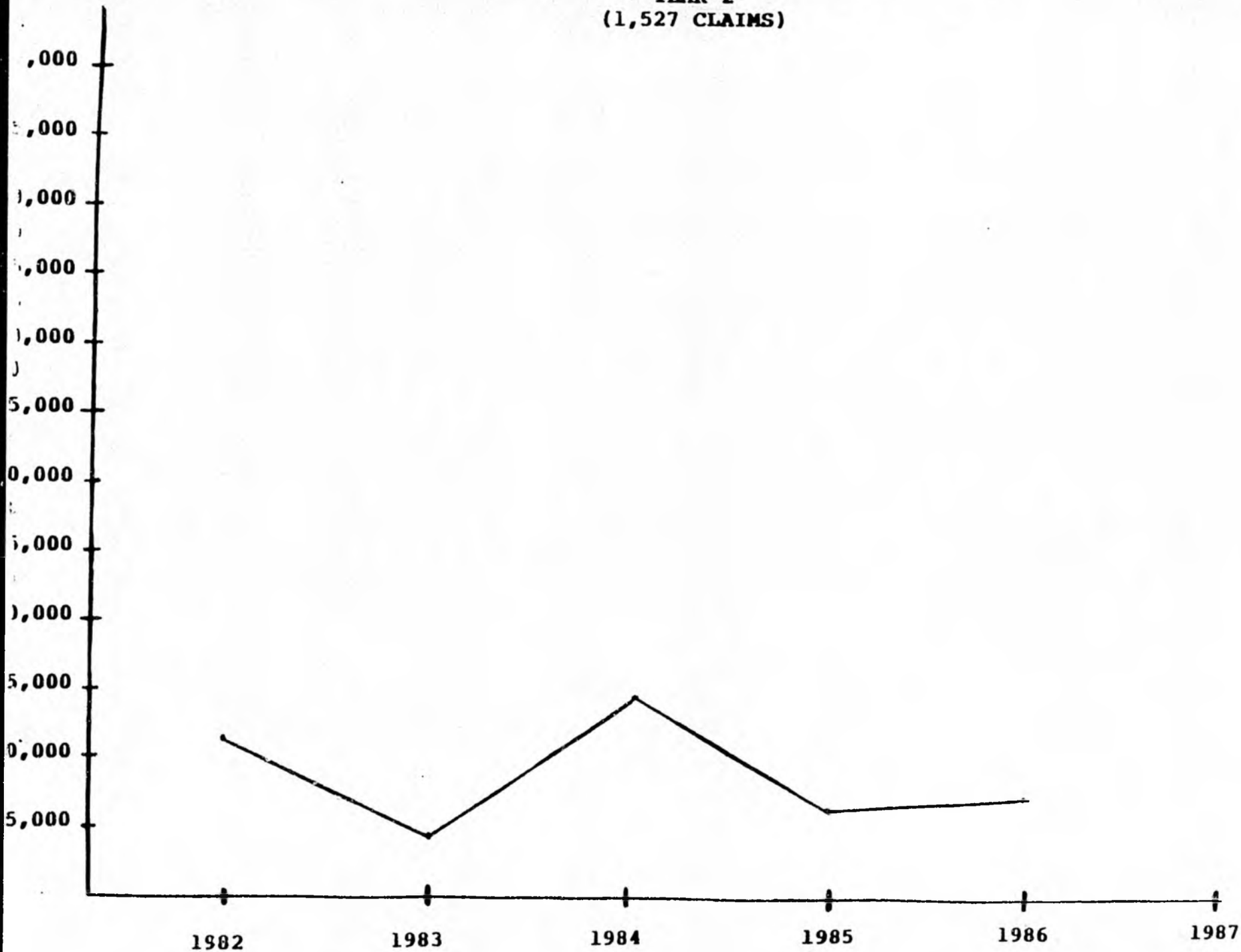
APPENDIX D-1

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 1
(726 CLAIMS)



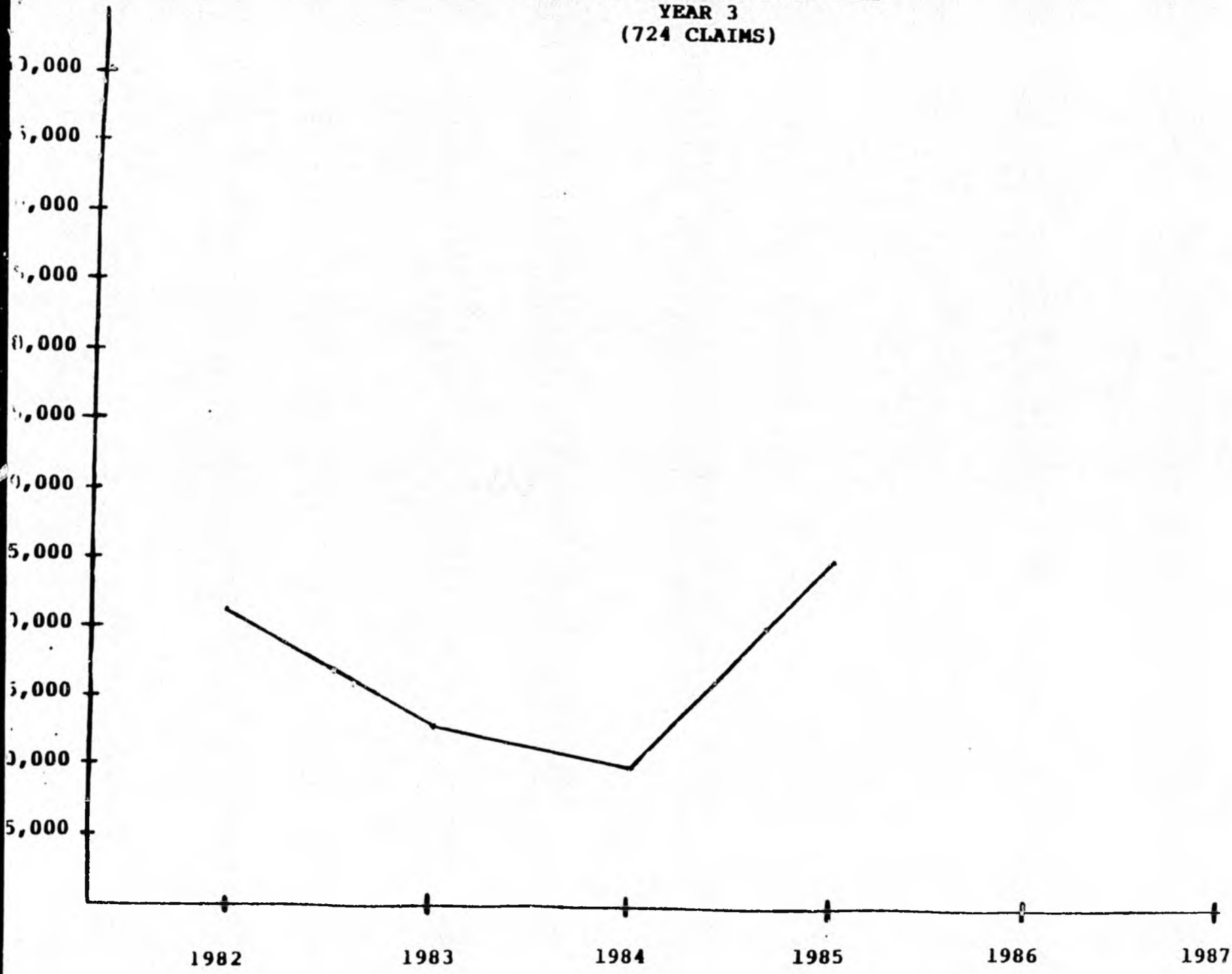
APPENDIX D-2

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 2
(1,527 CLAIMS)



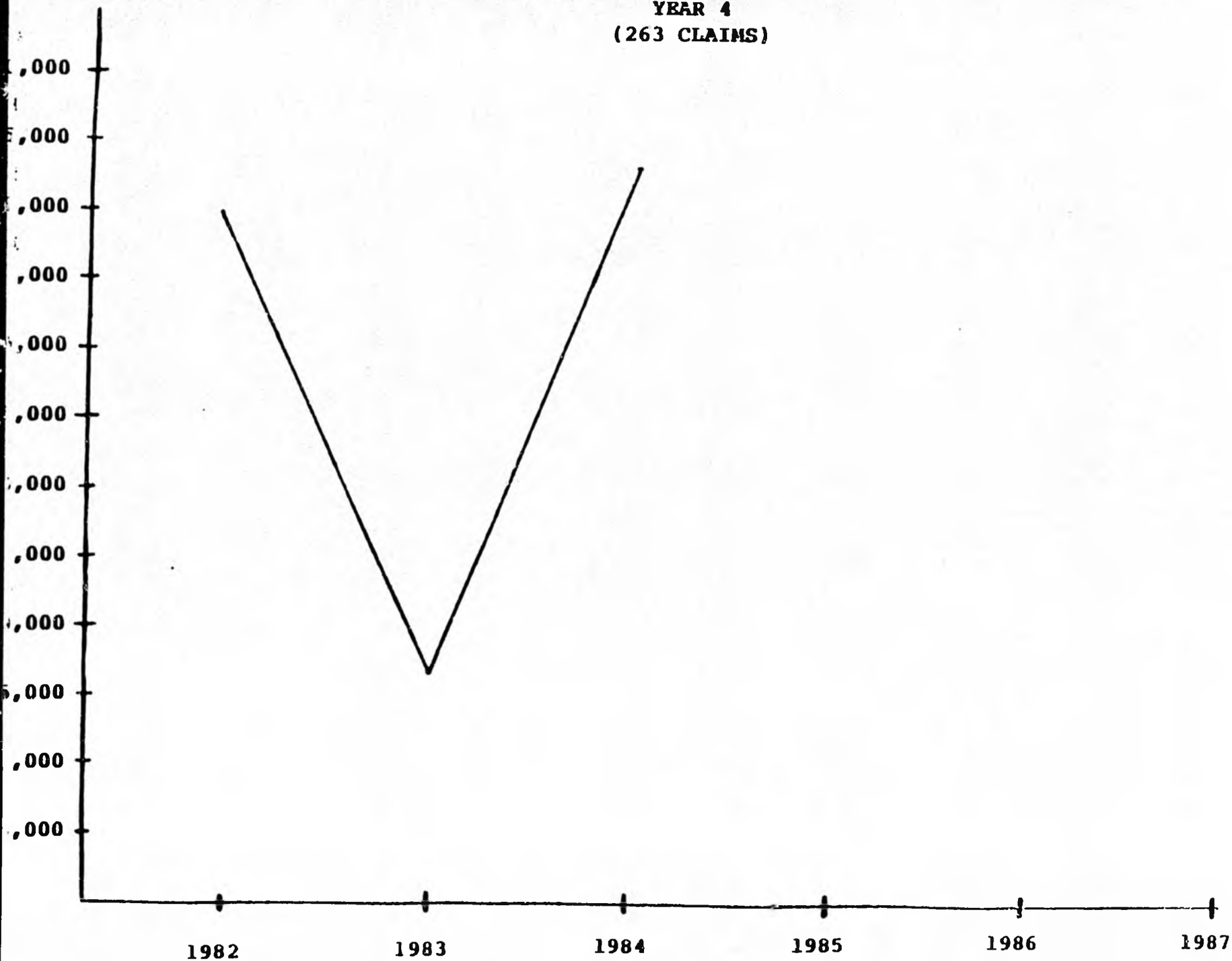
APPENDIX D-3

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 3
(724 CLAIMS)



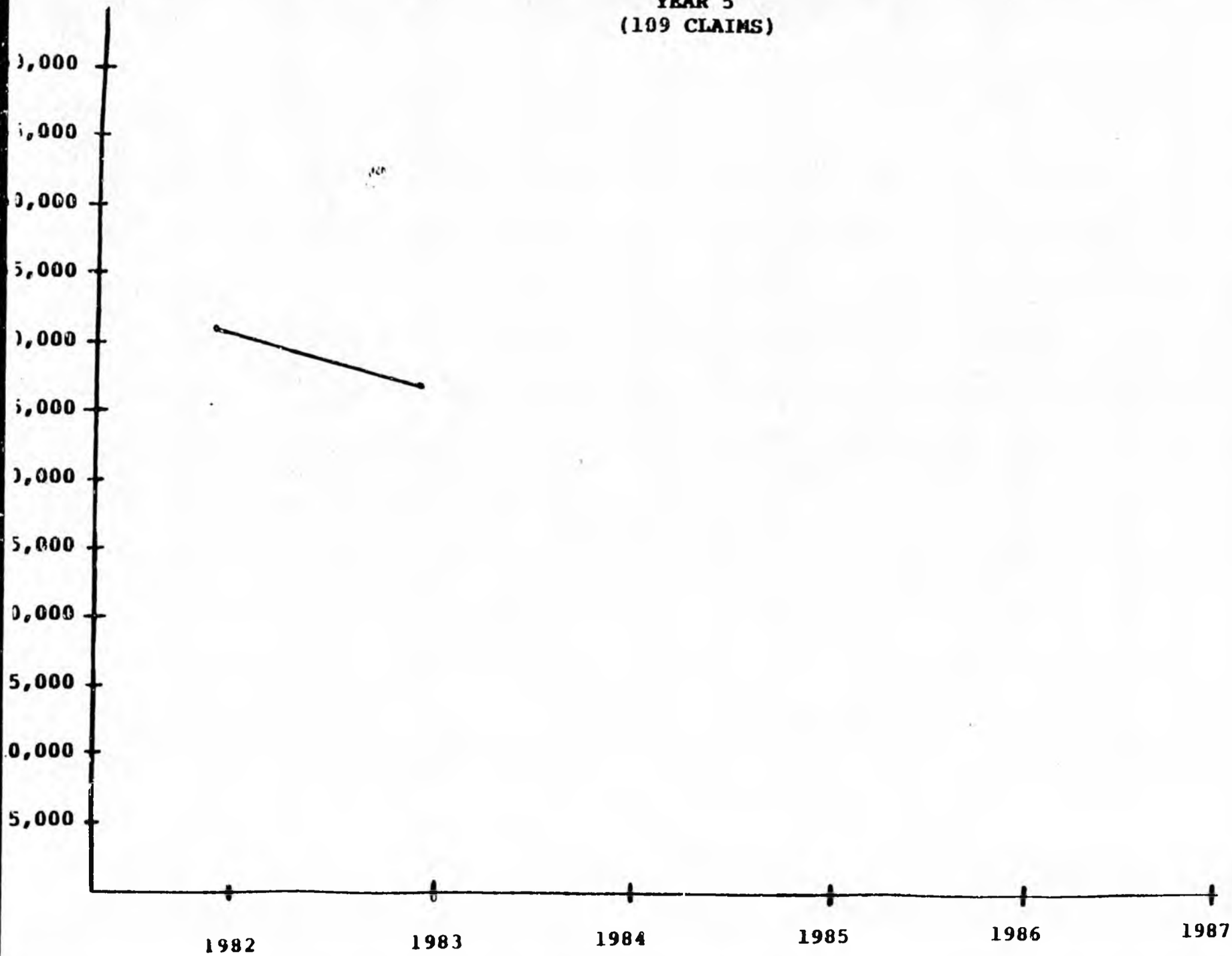
APPENDIX D-4

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 4
(263 CLAIMS)



APPENDIX D-5

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 5
(109 CLAIMS)



APPENDIX D-6

Alaska Action Trust
P.O. Box 102323 • Anchorage, Alaska 99510
Office: 540 L Street, Suite 102 • Anchorage
(907) 258-4040

SECTIONAL ANALYSIS OF HB 166
March 21, 1989

The following is an overview of House Bill 166, which seeks to remedy the high cost of insurance through gutting the civil justice system. For the most part, it is an attempt to modify the comprehensive changes made in 1986 to tort law. Where appropriate, examples have been given to clarify what rights are being taken away from victims.

S E C T I O N 1

This section attempts to justify these deprivations of victims rights. The stated purpose is to more equitably distribute the cost and risk of injury, but the actual effect would be to distribute the costs and risks only to the injured victims. A second stated purpose is to make insurance more available, but nothing in this bill will reduce insurance rates. When changes were made to the tort system in 1986, it was because proponents claimed that insurance rates would go down. Rates have not substantially decreased since that time. More changes should not even be considered unless the legislature gets a written guarantee from the insurance industry that rates will decrease as a result of this proposed legislation. The stated intent of the legislature, as written in this bill, is to reduce the costs associated with the tort system without affecting the rights of injured persons to seek redress through the courts. The true effect of this bill, however, is only to take away the rights of injured persons, without any benefit to them. Section 21 seeks to gather the facts that Section 1 claims the legislature already knows.

S E C T I O N 2

This imposes a six year statute of repose. This means that no claims may be brought six years after an injury-causing product was purchased or a building completed or an action took place.

Examples: A wing falls off of a Boeing 737 six years and one day after the airline bought it. Neither the passengers nor the airline could sue Boeing for their losses. The roof on the gymnasium in Aleknagak collapses shortly after the building is six years old. The school district and the injured children cannot recover their losses against the construction contractors or building designers.

You have surgery and the doctor leaves a sponge inside of you. It does not begin to cause you problems until more than six years later, when you discover this foreign object in your

body. You will not be able to sue the doctor for this negligent act. Similarly, you hire a lawyer to draw up a document for you. Ultimately, because of errors on the lawyer's part, you end up losing a great deal of money, but not until more than six years later. You would not be able to recover your losses from the attorney.

This six year limit applies even to minors or incompetents who were previously protected under AS 09.10.140. The statute of limitations remains two years. For lawsuits not eliminated by this section, see Section 4.

S E C T I O N S 3 & 4

Section 3 eliminates most torts from the current two year statute of limitations. Section 4 reenacts a similar two year statute of limitations for claims for personal injury, death or property damage. The new provision eliminates AS 09.10.140, which currently protects minors and incompetents.

Examples: A person is injured, resulting in a coma that lasts for 18 months. If AS 09.10.140 is eliminated, the person would then have only six months in which to file a lawsuit concerning the injury. Similarly, if a two-year old child were injured, the child would lose its right to sue this wrongdoer when the child was four years old even though a four-year old cannot understand claims for injury.

S E C T I O N 5

Makes it more difficult to obtain punitive damages award. Punitive damages represent the civil justice system's way of punishing defendants for gross, wanton, or willful misconduct. Punitive damages are infrequently awarded and when they are, it is because a jury felt very strongly about the misconduct and wanted to make an example of the defendant. Punitive damages serve as a deterrent so that businesses think twice before safety is sacrificed for profit. The 1986 statute restricted punitive damages to cases where there is clear and convincing evidence to support punitive damages. Under this section the standard would be even more restrictive. Not only would the plaintiff have to show malice, bad motive, or reckless indifference on the part of the defendant, but also would have to show conscious acts showing deliberate disregard. This is similar to a specific intent in criminal law. Wrongdoers would be insulated from punitive damages in spite of their conscious decision to ignore safety.

S E C T I O N 6

In the tort bill passed by the legislature in 1986, a victim who was injured while committing a felony lost the right to seek damages. This section now proposes to take this right from someone who is injured while engaged in any misdemeanor. A misdemeanor is defined as a crime punishable by a year or less in prison.

Examples: A person is hiking in Kachemak Bay State Park and wanders upon a private cabin that is an inholding within the park. The person decides to check out the cabin, opens the door, and a spring-loaded gun goes off, killing or injuring the person. Because the person was trespassing, they have no right to seek damages because they were engaged in a crime at the time that substantially contributed to the injury. Similarly, a citizen fearful of being robbed carries a concealed handgun. Because the gun has a manufacturing defect, it discharges. The injured person could not sue the manufacturer, despite the defect.

S E C T I O N 7

This section allows that if the person responsible for causing injury was also committing a crime, then Section 6 does not apply. In other words, if you were committing a crime and were injured, and the person who injured you was also committing a crime, then you still have recourse for damages through the courts. Two wrongs do appear to make a right in this case.

S E C T I O N 8

After a trial, a judgment is entered by the court. This provision would allow a defendant who lost a trial to prevent the plaintiff from obtaining his or her judgment. Instead, there would be a second mini-trial to set up a payment schedule over time. There are many problems with this.

Such periodic payments are called structured settlements. Structured settlements are very complicated. There is a vast difference between someone paying you $100,000 cash today, or paying you $10,000 per year over the next 10 years. In addition to the difference in value, there is a great difference in security. If payment is made today, you know the debt is satisfied; if all you have is someone's promise to pay, there is no guarantee you will ever receive the money. This problem does not disappear if the defendant buys an annuity from an insurance company that promises to make the payments. Undercapitalized or poorly managed insurance companies regularly fail. They also sell annuities cheaper

than strong companies. To buy a fair structure from a strong company will cost defendants the same amount as if the plaintiff were paid cash today. Why then do defendants and liability insurers want mandatory periodic payments? To cheat injured victims of the compensation the jury found due. Future payments are worth less than cash in hand. A law that said all jury awards will be reduced by 50 percent would clearly be unfair and unconstitutional. This proposal tries to do that in a backhanded manner.

The periodic payment statute sought to be changed by this section was enacted in 1986. Some of the primary proponents were brokers who make their money by selling annuity contracts. Their main pitch was that periodic payments were good for plaintiffs. The law they proposed then, however, allowed defendants to require plaintiffs to take periodic payments. When the bill was on the Senate floor, an amendment was passed that said if it was such a good idea for the injured party, then structured settlements should only be done at the request of the injured party. This legislation again proposes allowing either party to request a structured settlement. An injured party, who is no longer going to be able to continue in the line of work performed before the injury, may want a lump-sum payment to invest in a new business that is compatible with his or her capabilities. This section would allow the wrongdoer, rather than the injured person, to make the decision. The parties would then have a mini-trial about periodic payments. This would be a huge burden on the court system.

The impact of the second sentence of this section is unclear, since attorney fees are already a present value amount and contain no provision to adjust them for future value. Thus there is nothing to reduce to present value.

S E C T I O N 9

Adds a reference to existing law about increases in future payments for anticipated inflation. It does not require that such adjustments be made. What has been created here is a system in which a plaintiff can successfully try a claim, have a structured payout foisted upon him, and not even be compensated for inflation. Additionally, appropriate rates for inflation and discounting are not exact sciences. Mini-trials would be required on these issues with both sides bringing in economists to argue the case. Judges would be required to make decisions without the economic expertise to know what will be best for the claimant in the future. The court system will be controlling the entire future of injured people. By being injured, they will have sacrificed control of their destiny to the court system and insurance industry.

S E C T I O N 1 0

Creates immunity from liability for board members and officers of public corporations, electric cooperatives and telephone cooperatives, as long as they were acting within the scope of their official duties. Reviewing this amendment discloses a glaring error in the 1986 statute. The intent of the statute is to protect board members and officers for managerial decisions. As passed in 1986, it is much broader. It covers all acts within the scope of official duties. Thus, if driving an insured vehicle while dropping off a report to another board member, one of them runs a red light and kills or maims another person, there could be no recovery from the auto insurer for the injuries or death.

S E C T I O N 1 1

Opponents of victims' rights claim the collateral source rule is unfair because it gives a windfall to the victims. This is not true. The most common collateral source is health insurance bought by the victim or his employer. But health insurance policies almost always have subrogation clauses. This means that the health insurer gets paid back when damages are recovered from the wrongdoer. Thus there is no double recovery by the victim. It would be very unfair to have the victim's recovery reduced for such collateral payments because the victim would still be obligated by contract to pay back the health insurer. The collateral source rule ensures that the wrongdoer will properly bear the financial burden of his wrongdoing. It is not fair for a wrongdoer to profit because a plaintiff happens to be protected by insurance.

Example: A wrongdoer injures a person who spent his own money for a disability policy. The wrongdoer would thus receive a windfall. The same is true if the victim received gratuitous wage payments from an employer or help from family and friends.

This section replaces the collateral benefits statute enacted in 1986. Instead of being considered at a post-trial hearing, collateral benefits would now be considered by the jury and reduce the recovery. The 1986 statute served to reduce compensation to victims, but at least allowed the judge to consider countervailing costs to the claimant such as actual costs and fees incurred in the litigation.

This section also requires the jury to be instructed about any tax implications of damage awards. The IRS does not tax injury damages because they are compensation that simply replaces what the victim lost. If your house burns down, the insurance money you collect is not taxable. Damages are

replacement of capital, not new income. The judge or jury decides the amount of the loss. Taxability or non-taxability has nothing to do with that loss. This provision seeks to confuse juries with irrelevant information so they will impose their own "tax" on that which is not legally taxable, by reducing the damages they award.

S E C T I O N 1 2

Reduces the interest rate on judgments from 10.5 to 8 percent. The prime rate is now 11.5 percent. This 8% rate is well below the market rate and will encourage insurers not to settle. Insurers will be able to make money by setting it aside and collecting higher interest on it than they have to pay out, thus they lose any incentive to settle a case.

S E C T I O N 1 3

Under the 1986 statute, interest runs from the date of written notice of a claim. This section eliminates prejudgment interest on future damages, thus again providing a disincentive for insurers to settle cases.

S E C T I O N 1 4

Implements section 15.

S E C T I O N 1 5

Caps non-economic damages in a wrongful death case at $50,000. This is particularly discriminatory to those who operate in a non-cash based society, such as rural people and homemakers. The survivors of a successful orthoscopic surgeon in Anchorage who is killed by a wrongful act stand to receive a great deal of money for the future earning potential of the victim. The survivors of a native person living in the Bush and existing in a subsistence economy with very little actual cash value, will only receive $50,000 as the value of that life. Similarly, homemakers who do not have a W-2 to show for wages earned are only worth $50,000 under this bill. This limit applies regardless of the number of survivors, thus reducing the recovery of each one. If a housewife had a husband and four children, each would get only $10,000 in spite of their huge loss.

S E C T I O N 1 6

Alaska Civil Rule 82 awards partial attorneys' fees to the party who wins a lawsuit. This section would eliminate that partial reimbursement only in claims for injury or death. This is very unfair to injured people. Insurance companies use litigation to wear people down so they will settle for less money than is due them. But injured people typically have to pay their attorneys out of the damages recovered. So an injured person never pockets all her damages. Rule 82 helps ease the burden of using an attorney to protect your rights. This proposed legislation would allow big businesses and insurance companies to get partial fees from each other, but take that right away from an injured person suing an insurance company or an oil company. It is extremely unfair.

S E C T I O N 1 7

This overrules Jackson v. Power, which was a case in which a hospital was found liable for damages caused by a doctor working in its emergency room. The hospital was liable because of duties owed to emergency room patients under state regulations, national hospital accreditation standards, and its own bylaws. This section would give the hospitals immunity, even when the health care provider is the actual agent of the hospital, not just a contract physician. Enactment of this legislation would allow hospitals to avoid liability by merely posting a notice. This does not take into consideration severely injured persons who may be unconscious on the way into the emergency room and not able to read the notice. There is no requirement that the notice be seen or understood by the patient.

S E C T I O N 1 8

Requires that medical malpractice rate information be included in the annual report to the legislature presented by the director of the Division of Insurance under AS 21.06.110.

S E C T I O N 1 9

Current law gives immunity to peace officers or emergency service patrollers who handle intoxicated persons. The purpose of this amendment is unclear. It appears to be an attempt to preclude any legal action, such as an action against the governmental body employing the individual.

S E C T I O N 2 0

This section repeals three statutes. When the $500,000 cap was instituted in 1986, an exception was made for those victims who suffer disfigurement or severe physical impairment. Repeal of AS 09.17.101(c) removes that exception.

Example: A quadriplegic or triple amputee could receive no more than $500,000 general damages.

The second statute repealed here, AS 09.17.040(c), currently makes it possible for parties to stipulate to use the rules of Beaulieau v. Elliott to compute damages. This amendment would require the parties to use an inflation/discounting procedure that is more costly, more time consuming, and ultimately reaches the same result. It will impose an unnecessary burden on the limited resources of the court system. If the parties to litigation agree to follow the simpler procedure, the state has no legitimate reason to prevent them from doing so.

The final repealer in this section eliminates AS 09.55.548, the statute that specifically controls collateral source payments in medical malpractice cases.

S E C T I O N 2 1

Requires reports to the legislature of the effects of all these changes. To a large extent, this seeks the facts that are stated in the purpose section of the bill.

S E C T I O N S 2 2 & 2 3

Clarifies that certain sections of this bill amend the Alaska Rules of Civil Procedure.

S E C T I O N 2 4

Clarifies applicability of this act.

S E C T I O N 2 5

Provides an immediate effective date.

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Balanced Proposals for Product Liability Reform*

JEFFREY O'CONNELL**

I. INTRODUCTION

Injuries resulting from faulty products or conduct not only lead to much personal trauma, but also occasion wild fluctuations in insurance premiums, huge legal costs, and long delays before settlements or verdicts are reached. These costs and the uncertainties of the legal system are in turn blamed for skyrocketing tort liability insurance rates. The result is widespread alarm and cries for tort reform throughout the United States.

Perception of the legal system as a game of chance rather than a sound mechanism for catching unreasonable behavior undercuts the system's ability to raise standards of products and conduct and to deter injuries. Providers of goods and services believe that, in seeking to establish reasonable standards of care, the legal system itself lacks the capacity to be reasonable and, instead, often penalizes only the spurious appearance of fault.

Even more importantly, the system's haphazardness also diminishes its value as a protection for the injured. One seriously injured victim may recover nothing at all or far less than fair compensation, while another, similarly injured, receives far more than actual losses. The inconsistency is exaggerated by allowing juries to award damages for such noneconomic losses as pain and suffering or grief. Because placing a monetary value on such nonmonetary losses is inherently irrational, plaintiffs are encouraged to play upon the jury's sympathy, further distorting the issue of who or what was really at fault.

Although only a small fraction of claims go to trial, the prospect of litigation is still weighed by both defendants and plaintiffs in assessing their settlement prospects. As a result, high costs and long delays are incurred in evaluating claims, whether or not they reach court. Ideally, a system of insurance should call for settlement of typical claims by prompt, periodic payment of the injured party's actual economic loss, but the unpredictable and intensely adversarial nature of liability insurance claims makes such settlements rare indeed.[1]

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* This Article is based on the author's Arent Lecture at The Ohio State University College of Law, April 6, 1987. Portions of the lecture were, in turn, adapted from previous writings of the author, including J. O'CONNELL & C.B. KELLY, THE BLAME GAME: INJURIES, INSURANCE, & INJUSTICE (1987); Moore & O'Connell, *Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss*, 44 LA. L. REV. 1267 (1984). I am grateful to Jam[illegible]uinivan, University of Virginia Law School Class of 1988, for his (as usual) expert research assistance.

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1. For criticisms of the uncertainties and vicissitudes of personal injury law from varying points of view, see, *e.g.*, TORT POLICY WORKING GROUP, REPORT OF THE TORT POLICY WORKING GROUP ON THE CAUSES EXTENT AND POLICY IMPLICATIONS OF THE

II. INADEQUATE REFORMS

What is the solution to this mess? The insurance industry and its institutional insureds urge *tort reform*, which, for them, means new laws that curtail what they perceive as the excesses of the tort system. Specifically, they propose "reforms" that either (1) pay injured parties less, or (2) make it harder for them to be paid, if at all.[2]

In the first category are laws that:

- Limit pain and suffering awards to, say, $100,000 or $250,000 or $500,000.
- Eliminate or severely curb the amount of or the occasions for punitive damages.
- Deduct from the plaintiff's tort award the other insurance monies already payable to the plaintiff from collateral sources, such as from health or disability insurance.

In the second category are laws that:

- Raise the standard of liability—for example, requiring plaintiffs to prove defendant's fault by a more demanding level of proof.
- Limit plaintiffs' lawyers' contingency fees—for example, by setting a ceiling of forty percent of the first $50,000 awarded to the plaintiff, with the share dwindling gradually to only ten percent of recoveries over $200,000.
- Abolish or alter the doctrine of "joint and several liability," under which if two or more defendants are both found to be liable to the plaintiff for an injury, a defendant only marginally responsible can be held liable for all the plaintiff's damages (especially likely if the primarily responsible party is either insolvent or grossly underinsured). Under this reform, a defendant's share of any liability would be limited to its share of responsibility. Thus, a defendant found twenty-five percent responsible would be liable, at most, for twenty-five percent of any damage award.
- Reduce the time allowed for suit under the statute of limitations.
- Penalize those bringing marginal claims.

One or more of these reforms have been or are under consideration in all states, including Ohio, and many have been enacted.[3] But a "solution" that merely further

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CURRENT CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY (1986) (Federal Inter-Agency Study sponsored by the Attorney General); U. S. ATT'Y'S GEN. TORT POLICY WORKING GROUP, AN UPDATE ON THE LIABILITY CRISIS (1987); Sugarman, *Doing Away With Tort Law*, 73 CALIF. L. REV. 555 (1985); Sugarman, *Serious Tort Law Reform*, 24 SAN DIEGO L. REV. (forthcoming 1987).

2. An Ohio tort reform bill passed by the Ohio General Assembly was vetoed by Governor Richard Celeste after protests by consumer advocates, such as Ralph Nader, claimed that it unfairly discriminated against consumers in favor of industry. S.B. 330 (1986). For a report on the bill, the veto, and the failure of an attempt to override the veto, see NATIONAL UNDERWRITER (Prop. & Cas. ed.) Jan. 12, 1987, at 28, cols. 1–5. Further reform bills have been reintroduced in the current session of the Ohio General Assembly. *E.g.*, H.B. 1 (1987).

3. More than a third of the states enacted statutes limiting liability in all, or in a wide range of, cases. Often enacted were these kinds of reforms:

(1) *Limits on joint and several liability*. ALASKA STAT. § 09.17.080 (Supp. 1986); COLO. REV. STAT. § 13-21-111.5 (Supp. 1986); CONN. GEN. STAT. ANN. § 52-572h (West Supp. 1987); FLA. STAT. ANN. § 768.81 (West Supp. 1987); ILL. ANN. STAT. ch. 110, para. 2-1117 (Smith-Hurd 1987); MICH. COMP. LAW ANN. § 27A.6304 (West 1987); N.Y. CIV. PRAC. L. & R. 1601 (McKinney 1987); WASH. REV. CODE ANN. § 4.22.070 (Supp. 1987); WYO. STAT. § 1-1-109(d) (Supp. 1986). These statutes are not all alike, however. Some apply only in particular circumstances, as where the plaintiff himself is negligent.

(2) *Caps on damages*. Some states enacted flat caps, others include escape clauses; one provides for variations in the

limits the amount or availability of compensation to injured persons is a questionable solution indeed. The *least* appealing way to reform the tort system is to make it even harder for injured parties to be paid.

That is not to deny the evils of the present system. Even if liability insurance cases were not rising, and even if sellers of products or services were finding it easy to buy liability insuance, the tort system would still need fundamental change—especially from the point of view of those who are injured. But change is needed not only from the victims' perspective, it is also urgently needed to correct the profligate diversion into litigation of dollars that *all* consumers of products and services are paying, even if the price of insurance made such coverage readily affordable.

That is why it is so sad to see so many consumer groups allying themselves with the trial bar in defense of the present tort liability system.[4] Consumer advocates are right in opposing changes that simply make it more difficult for the injured to get compensation, but they are wrong in wanting to maintain a system that already makes it *much too* difficult to be paid insurance dollars. Trial lawyers, of course, have to concede how difficult it is to get payment from the tort-liability system: else how could they justify charging a third or more to help get it?

Trial lawyers argue that the tort system makes sense in requiring a provider of defective products or services to pay the injured buyer or other victim. But the problem is that product injuries, for example, often happen under very complex circumstances.[5] As a result, unraveling the cause-and-effect relationship between a malfunctioning product and the individual hurt by it usually is difficult, calling for expensive expert engineering testimony and exhaustive discovery techniques. Even in much simpler cases such as those involving automobile accidents, it is often too difficult for the law to determine who is "at fault." Finding fault then is often an extremely expensive business in both simple and complex product liablity cases.

To compound the problem, the second variable mentioned above makes it even more of a nightmare of complexity in product liability suits: injured parties can recover not only their medical expenses and wage loss but also the monetary value of their nonmonetary loss, especially pain and suffering. But what is the monetary value of physical pain? What is an aching back worth? There is no rational answer to that—no market value to consult for the selling price of aching backs.

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cap depending on the age of the claimant and the state's current average wage. *See* ALASKA STAT. § 09.17.010 (Supp. 1986) ($500,000 cap except when involving serious disfigurement); FLA. STAT. ANN. § 768.80 (West Supp. 1987) ($450,000); MD. CTS. & JUD. PROC. CODE ANN. § 11-108(b) (Supp. 1986) ($350,000); N.H. REV. STAT. ANN. § 508:4-d (Supp. 1986) ($875,000); WASH. REV. CODE ANN. § 4.56.250 (Supp. 1987) (cap varies with age of plaintiff and state's economy). MD. CTS. & JUD. PROC. CODE ANN. § 11-108(b) (Supp. 1986) ($350,000); N.H. REV. STAT. ANN. § 508:4-d (Supp. 1986) ($875,000); WASH. REV. CODE ANN. § 4.56.250 (Supp. 1987) (cap varies with age of plaintiff and state's economy).

(3) *Limits on punitive damages recoveries.* Some statutes put limits on punitive damages—imposing a higher standard of proof to recover such damages; putting a cap on such damages; or allocating part of the recovery to a state fund. *E.g.*, N.H. REV. STAT. ANN. § 507:16 (Supp. 1986); FLA. STAT. ANN. § 768.73(2) (West Supp. 1987) (only 40% of punitive damages payable to claimant); IOWA CODE § 668A.1 (only part of punitive damages payable to plaintiff unless tort aimed specifically at plaintiff); OKLA. STAT. ANN. tit. 23, § 9 (West 1987) (clear and convincing evidence required to overcome limit equal to actual damages).

4. *E.g.*, *supra* note 2.

5. The discussion in this Article will focus on product injuries but can be applied equally to all personal injury actions, including those from services such as medical treatment.

Seeing how wildly complex the tort-liability insurance system is in being required to determine not only who or what was at fault, but also the monetary value of nonmonetary losses, we can more appreciate why that system is so unmanageable and why compared with life, health, or fire insurance, it is so uniquely plagued by delay, uncertainty, and costly lawsuits. Although high costs and unavailability of insurance currently highlight the need for change, the system's demand for fundamental change exists quite apart from whether, say, product liability insurance happens to be readily available at a reasonable price at any given time.

III. No-Fault Reforms

Two generations ago the answer to this mess, at least for workplace accidents, was workers' compensation. This was a form of no-fault insurance enacted in Germany in the 1880s, in Great Britain in the 1890s and in the United States roughly between 1910 and 1920. Workers' compensation decrees that workers injured on the job need not go to court to assert their employers' fault and their own freedom from fault, with all the entailing litigation. Rather, injured workers are automatically paid for all their medical costs and for a substantial part of their wage loss with nothing paid for pain and suffering. Thus, the two litigious issues that dominate tort liability—fault and the value of pain and suffering—are eliminated.[6] The result, in turn, is a viable insurance system.

Of course there are problems with our workers' compensation system. It does not always work as well as the reformers said it would—hardly any reform ever does—but it has worked magnificently compared to the tort system. No one (except maybe some trial lawyers) suggests that we go back to litigating over fault and the value of pain and suffering after every workplace mishap.

The next great wave of accidents to engulf modern society came from traffic collisions. And no-fault again has presented itself as the answer to the shortcomings of tort law.[7] One can best illustrate the stunning contrast between the relatively low cost of high payments under no-fault auto insurance and the relatively high cost of low payments under traditional liability coverage by looking at the cost of auto insurance in New York State. There, no-fault benefits pay for medical expenses and wage loss up to a combined total of $50,000—at an average annual premium of $46 in 1983. Lawsuits based on fault, meanwhile, are allowed when the victim is disabled for at least ninety days or when the victim dies or suffers other serious injury. To cover their liability losses in such lawsuits, New York motorists are also required to buy tort-liability insurance providing coverage of at least $10,000 per person and $20,000 per accident. In 1983, the average premium for liability coverage was $118.[8] In other words, no-fault insurance with high limits and automatic payment costs about

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6. For a summary of workers' compensation statutes, see O'Connell & Barker, *Compensation for Injury & Illness: An Update of the Conard-Morgan Tabulations*, 47 Ohio St. L.J. 931–33 (1987).

7. *See id.* at 930; U.S. Dep't of Transp., Compensation Auto Accident Victims: A Follow-Up Report on No-Fault Auto Insurances Experiences (1983); for a summary of the Department of Transportation Report, see O'Connell & Joost, *Giving Motorists a Choice Between Fault and No-Fault Insurance*, 72 Va. L. Rev. 61–72 (1986).

8. U.S. Dept. of Transp. Report, *supra* note 7, at 37.

half what tort-liability insurance, often with low limits and disputed payment, costs. Similar scenarios exist in other no-fault states.[9]

Can we construct a no-fault insurance plan for accidents caused by manufactured products? In a limited sense, we already have. Product sellers are now held to "strict products liability," which means that anyone injured by a defective product is entitled to be reimbursed for his loss by the product seller, whether or not the seller was in any way negligent in letting the product on the market.

But even strict products liability does not really begin to eliminate the basic problems connected with the tort liability system. It may not be necessary to litigate over whether the manufacturer was negligent, but deciding whether a product was "defective" is still necessary—and about as difficult. And once it has been determined that a product was defective, there is the same opportunity for costly wrangling over the monetary value of nonmonetary loss—pain and suffering, loss of consortium, and so forth—that must be reimbursed.

There is a real problem, though, in extending no-fault principles to provide reimbursement of all medical expenses and wage loss (but not noneconomic loss) caused by injury from a product, whether or not the product is "defective." In the field of products liability, the question of who or what should be viewed as "causing" an injury can be just as complicated as the question of "negligence" or "due care" in other settings. If one is in reasonably good physical condition before an auto accident and comes out of the collision with a gash on the cheek or even a severed arm, it is not hard to determine that it was the automobile accident that caused the gash or the amputation. But what if one slips on a throw rug at a neighbor's house and smashes one's head on the marble table top? On a no-fault basis, who should pay for the medical expenses and wage loss? Should the neighbor pay as a homeowner? The marble quarry? The manufacturer of the table? Or the manufacturer of the throw rug (remembering that, under no-fault, it doesn't matter whether or not the manufacturer put a rubber backing on the rug to prevent slips)? Thus, determining liability could often be just as vexing on a no-fault as on a negligence basis.

IV. The Fair-Trade Answer

On the other hand, this does not mean that society has to make do with product liability insurance, either as it exists or as insurance companies and those they insure would like to reform it. The key to both workers' compensation and auto no-fault reforms, unlike those being proposed by insurers and product sellers, is balance: it is easier for the injured party to be paid but he or she is paid less. That is a fair exchange on both sides. If a complete no-fault system for non-workplace and non-auto accidents is not feasible, at least some of the same trade-offs can be obtained.

We should start with the following two benchmarks for reform:

9. *Id.* at 25–40.

- *Make it easier for injured parties to be paid promptly for economic losses without litigating the fault of either products or persons (including the injured themselves) and without significantly increasing current liability costs.*
- *To hold the line—and perhaps even reduce—the costs for any increase in new claims by lowering the costs of litigation and lowering payments for noneconomic loss.*

Proposals being made by the insurance industry and by product sellers do not meet these criteria. By limiting pain and suffering awards, contingent fees, joint and several liability, and other remedies, they would make it no easier—and often indeed harder—for injured parties to be paid promptly for their economic loss. Similarly, proposals that obligate payment of any and all injury claims—or at least an indeterminate number of new ones—offer no guarantee that insurance costs will not rise exponentially.[10]

V. NEO-NO-FAULT

With these benchmarks in mind, I have proposed a law under which any product seller[11] facing a products liability claim would have the option of offering a claimant within, say, a maximum of 180 days, periodic payment of the claimant's net economic loss. That would be prompt payment compared to what the tort system offers. Such payment would cover any further medical expenses, including rehabilitation, and wage loss, not already covered by any other health or disability insurance payable to the claimant. It would also call for a reasonable hourly fee for the claimant's lawyer.

These benefits are lavish compared to those under most health insurance policies in this country; few such policies, for example, cover costs of rehabilitiation. Under the proposed law, if a product seller promptly offers to pay these benefits to the injured customer, further pursuit of a product liability claim in tort would be foreclosed. The claimant, in other words, would be forced to accept such an offer. Indeed, I have elsewhere termed the proposal "Offers That Can't Be Refused."[12] (I would allow the claimant to refuse the offer, under certain restricted circumstances: if the defendant had caused the injury intentionally—a rare occurrence, surely—or if the victim's economic losses were minimal, as with the death of a noneamer. More on this last point later.[13]) Under this proposal, no defendant would be forced to offer such a settlement. Thus, potential defendants would not be saddled with unmanageable new burdens.

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10 *E.g., Product Liability Amendments: Heurings Before the Subcommittee on the Consumer of the Senate Comm. on Commerce, Science and Transporation*, 99th Cong., 1st Sess. (1985); J. O'CONNELL & C.B. KELLY, THE BLAME GAME: INJURIES, INSURANCE, & INJUSTICE 128–29 (1987), *see* text following *supra* note 9.

11. Which term includes anyone in the chain of transmission—manufacturer, wholesaler, or retailer. *See* notes 16–17 *infra* and accompanying text.

12. O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 NW. U.L. REV. 589 (1982).

13. *See infra* note 24 and accompanying text.

But wouldn't such a law give defendants an unfair advantage by allowing them to settle for less than they would be forced to pay in a tort suit but never forcing them to settle for *more* than they would pay in such a suit? I foresee little risk of such one-sided advantage. Rather, the huge costs of defending tort cases and the massive exposure to payment for noneconomic losses in such cases would encourage defendants to save themselves such costs and avoid such exposure by offering to pay claimant's noneconomic losses, not only in cases they are sure to lose, but even in many—perhaps most—cases in which their liability is in doubt. One leading malpractice lawyer has said that if a similar neo-no-fault plan were in effect in the realm of medical malpractice, he would advise making an offer to pay claimants' net economic losses in 200 of the 250 cases his office was then defending.[14]

What about injured products users? Would they be unhappy with this new law? The answer is that most claimants are not happy with the slugfest tort lawyers have created. Few who have been seriously injured have any taste for (1) a lottery to determine whether they will be paid for their medical expenses and wage loss, and (2) a bitter fight that constantly reminds them of the accident, even to the point of being challenged by the other side's lawyer, often snidely, that a jury might consider them liars or cheats. Such battles may be acceptable to lawyers, who do it for a living, but their injured clients hate the process. Indeed, they emerge twice injured: by the accident itself and then by the bruising legal battle that follows. Given a choice between prompt payment of real losses on the one hand, and a warring gamble for long-delayed possible payment of more on the other, the certainty of prompt payment usually will seem more attractive. Most seriously injured buyers will prefer a legal system that encourages prompt payment rather than one that encourages product providers to dig in their heels and incur potentially huge litigation expenses, either out of fear that an award of intangible damages will be yet more costly or out of hope that delay and expense will force the claimant to reduce or drop his demands. The premise of the proposal is that it is foolish and wasteful to spend vast sums on guesswork over whether a product was faulty, then paying some victims much more than their loss and others much less, instead of simply encouraging injured victims to be compensated promptly for their out-of-pocket losses.

Trial lawyers and others claiming to speak in consumers' interests may criticize the proposal on the ground that findings that a product is defective and damage awards for pain and suffering, which the proposal would remove, work to deter businesses from selling unsafe products. But, we have already noted how arbitrary and capricious the tort system often is in imposing damage payments; such caprice tends to undermine whatever deterrent effects the present system may otherwise have. As criminologists have long preached, if sanctions are to be effective as a deterrent they must be both *swift* and *certain*. But swift and certain are two things that tort law surely is not. In addition, whatever deterrence is imposed by tort law is heavily diluted by product liability insurance, which shifts the cost of injury not to the maker

14. Personal communication to author.

or other seller of the supposedly defective product, but to all who are paying (directly or indirectly) for similar insurance coverage.

Also, under this neo-no-fault proposal, a defendant could only foreclose a tort claim by offering to pay the victim's economic losses in perpetuity—a not insufficient commitment in itself. By no means would defendants escape scot-free under this plan. We would not be abandoning the tort liability system. Rather, in a sort of jujitsu maneuver, we would use tort law's bulk and weight as leverage to spin it around and thereby protect ourselves from losses while avoiding the system's own crushing effects.

VI. Some Further Detail

Once a product seller has made a commitment to pay the victim's economic loss, it is required within thirty days to make payments for any losses already incurred and to continue to make them as further losses are incurred. The plan thus contemplates that payments be made as loss accrues. It provides, however, that, if the parties agree, a court-approved lump sum payment may be made to the victim. (The proposed legislation also authorizes the court to make provisions to prevent dissipation of the fund in appropriate circumstances.)

The bill also permits the seller and accident victim to agree that the seller may discharge its liability by a tender of less than full economic loss. It is unwise, and probably impossible, to prevent people from making their own arrangements. However, to avoid the risk that an unscrupulous seller or its insurance company might take undue advantage of an injured victim, any settlement for payment of less than full economic loss (if the economic loss exceeds $5000) would have to be approved by the court to be effective. If such a lesser settlement were required to be submitted to a court, but was not submitted, the settlement would not be effective, and the victim would have the same rights as any victim of a product defect to whom a tender is not made.

The injured victim is assured by the seller's offer that he will be made financially whole for the injury without having to bring suit and suffer the uncertainty and delay of litigation. In exchange for this certainty, and the inducements to the seller to make the offer, the victim gives up an opportunity to participate in the litigation lottery, which admittedly for some victims results in recovery for noneconomic damages.

Under the present tort system, attorneys' fees owed by a successful plaintiff are often paid out of the noneconomic damages; such extra payment thus funds the payment of contingent fees.[15] Because these elements of damages would be eliminated, the bill provides that in addition to paying the victim's net economic loss, the tendering seller would pay reasonable expenses, including attorneys' fees, incurred by the victim in obtaining legal advice about the offer and collecting benefits.

The bill also provides that any product seller—a manufacturer, wholesaler, or retailer—which believes it is at risk of liability for an injury (or illness) may make

15. O'Connell, *A Proposal to Abolish Defendants' Payment for Pain and Suffering in Return for Payment of Claimants' Attorneys' Fees*, 1981 U. Ill. L. Rev. 333, 351.

the offer to the victim. The provider of goods making such an offer may also designate any third person who may be liable as a participant in the offer. The issue of whether or in what amount a third person must contribute to the amount to be tendered would be determined in a separate arbitration.[16] A third party so designated would receive the same protection against personal injury suits as a tendering provider. Although a third party thus can be forced to participate in the tendering process against its will, it will not, as a practical matter, be disadvantaged by being a participant in an offer. It thereby avoids exposure to liability for noneconomic tort damages (including pain and suffering), and can still deny and dispute any liability on its part under the offer. Thus, if a retailer makes an offer, it may designate a manufacturer as a contender. A manufacturer may similarly designate the retailer. Either offeror may also designate a wholesaler or component parts manufacturer or other person who may be liable.

When an offer is made and more than one person is designated as a participant, the participants may agree upon their relative contribution to the compensation to be paid to the victim. It can be expected that this agreement will be made informally and expeditiously among sellers in the chain of distribution and their insurers who know they will be dealing commercially with each other on an ongoing basis, and, consequently, that they will make common-sense settlements. If they fail to do so, however, this question will be submitted to arbitration to be decided on the basis of relative fault among the participants in the offer.[17]

The plan would not permit a product seller to preclude a tort action where a seller's wrongful conduct was intentional.[18] If the victim elected to rely on the exception for intentional conduct, he would notify the party making an offer that he was rejecting that offer. Thus, the victim could not receive payment for economic loss and then sue the tendering party alleging that the exception applied.

Under the above version of the early offers approach, the product seller *may* make an offer. The claimant has no choice; if an offer is made to a claimant, the claimant cannot sue for any pain and suffering. The two greatest problem areas under the proposal are the fact that the claimant has no choice, and further that since pain and suffering damages are totally abolished, a claimant with small economic, but large noneconomic, loss would recover little.

I have in the past said that a first fallback would be a cap: the claimant could be given a choice of whether or not to accept an offer of net economic loss; if she

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16. *See infra* note 18 and accompanying text.

17. At common law, a defendant can implead a third person in a tort action: as a result, involving such third persons in the offer can be viewed as just another form of impleading.

18. The definition of *intentional* should read in the following terms or their equivalent:

> A person intentionally causes or attempts to cause a personal injury when acting or failing to act for the purpose of causing injury or with knowledge that injury is substantially certain to follow; but a person does not intentionally cause or attempt to cause injury merely because the act or failure to act is intentional or is done with the realization only that it creates a grave risk of causing injury without the purpose of causing injury or if the act or omission is for averting bodily harm to oneself or another person.

For the rationalization for rigidly defining intentional conduct in this way, as opposed to including, say, gross negligence, see J. O'Connell, Ending Insult to Injury: No-Fault Insurance for Products and Services 154–55 (1975); P. Keeton, D. Dobbs, R. Keeton, D. Owen, Prosser and Keeton on Torts § 34 (5th ed. 1984).

rejected the offer, she could sue—but a cap would be placed on the amount of pain and suffering she could recover in any such suit.[19] This would be better than the traditional cap discussed above[20] because it would give the claimant something in exchange: the claimant would be subject to the cap only if she had been offered payment of her economic loss without having to go to court. (The usual proposals for a cap, as discussed earlier,[21] would require the plaintiff to go to court and then impose a cap on her when she was successful.)

However, even though the fallback is fairer to the plaintiff than the traditional cap, it will be tarred with the same brush. It is clear that even such a cap may be the lightning rod for opposition to the proposal.

And yet the focus of the early offers approach on reducing litigation is entirely valid. Avoiding litigation is obviously the area where the largest savings can be obtained and where the treatment of victims of malfunctioning products can be most easily improved.

Accordingly, we should consider ways of maintaining the basic structure of the early offers approach but avoiding a unilaterally imposed cap. The bill could provide that the claimant has a choice of whether or not to accept an offer, but that if the claimant rejects an offer, he may go to court subject to certain restrictions, such as:

1. The standard of proof is more stringent than the usual civil standard of preponderance of the evidence. (It is questionable whether a verbal standard makes much difference to a jury,[22] but it does give the trial court and the appellate court a better handle to control a result if they so desire.)

2. The defendant is specifically authorized to offer to finance a second opinion from another lawyer (who cannot be the plaintiff's trial counsel and who cannot have any financial interest in the plaintiff's case) as to whether it is in the plaintiff's interest to reject the defendant's early offer.[23]

3. The plaintiff can recover noneconomic losses, only if he establishes a "substantial" amount of such damages. This would limit rejections of the tender to those cases which underlay the justification for giving the plaintiff a choice—those in which noneconomic loss (including any punitive damages awarded) is much greater than the plaintiff's economic loss. A formula would be used to define "substantial." For instance, a plaintiff could collect nonecomonic damages only if they were at least four times greater than his economic loss.[24] (The risk of this approach, of course, is

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19. J. O'Connell & C.B. Kelly, *supra* note 10, at 135.

20. *Supra* note 3.

21. *Id.*

22. O'Connell, *Jury Trials in Civil Cases?*, 58 Ill. B.J. 796, 807–08 (1970).

23. In a more stringent provision, the bill might provide that an action could not be brought unless the plaintiff had obtained a second opinion from another lawyer (who, as in the above provision, could not be the plaintiff's trial counsel nor have any financial interest in the plaintiff's case) as to whether it is in the plaintiff's interest to reject the defendant's early offer. *See* O'Connell, *A "Neo No-Fault" Contract in Lieu of Tort: Preaccident Guarantees of Postaccident Settlement Offers*, 73 Calif. L. Rev. 898, 909–10 (1985).

24. For the genesis of this provision, see O'Connell, *supra* note 12, at 601–02. Note that under such a provision the plaintiff would be constrained from exaggerating how small his economic losses were in order to prove them less than 20% of his total damages in that he would be limited in what he would be paid for his economic losses, which would be all he would be entitled to if he could not get over the threshold for recovery of noneconomic damages. As a corollary, defendants would be constrained from exaggerating how large the economic losses were in order to prove them more than

that it might be an incentive for juries to increase the standard of proof of the amount of noneconomic loss in order to have their award be effective.)

4. If the plaintiff does not prevail in the subsequent litigation, the plaintiff must pay the defendant's costs, including legal fees, incurred after rejection of the tender. The plaintiff's counsel who brought the action would be jointly and severally liable for this obligation.

The main criticism of the early offers approach is arguably still applicable, namely that it is one-sided, in that the putative tortfeasor may initiate, with sanctions for rejecting, settlement of the case for periodic payment of net economic loss, but the claimant may not. To deflect this, a present version of the bill gives the claimant the opportunity to request speedy arbitration on the issue of fault.[25] If she is successful in same, she can collect net economic loss, plus attorney's fees.

There will be pressure to further revise the early offers approaches to provide that the claimant can offer to settle for net economic loss. If the provider rejects the offer, it becomes subject to sanctions such as those discussed above (particularly payment of attorneys' fees if it loses). This should be resisted. It would give the claimant further leverage to extract settlements and encourage strike suits. The positions of the claimant and defendant in making a settlement offer to cover economic loss are arguably asymmetrical. The bill imposes limitations on the claimant's suit only after he has been offered and rejected prompt payment for his net economic loss. But if the claimant offers to settle for net economic loss, society's interests are arguably not served by tilting the scales against a product seller in subsequent litigation if it rejects the offer. The risk of encouraging too many new claims (some of them of the nuisance variety)—and therefore of rising costs—argue against this approach.[26]

Unlike most proposals for tort reform, these versions of the early offers plan would *not* impose the restrictions across the board. They would demand that a defendant give something in return for its stronger shield against liability. Thus, the proposal would leave intact the tort rights of those victims to whom an offer of settlement had not been made and who therefore had to resort to a lawsuit.[27] Restrictions would only apply when victims reject an opportunity to avoid litigation by accepting what society and insurance theory[28] deem a fair settlement in the typical case.

20% of total damages. Such mutually reinforcing (and therefore healthy) incentives would seem to lead to more settlements in those (relatively few) cases where tort actions seem feasible. *Cf.* Levmore, *Self-Assessed Valuation Systems for Tort and Other Law*, 68 VA. L. REV. 771 (1982).

25. Moore & O'Connell, *Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss*, 44 LA. L. REV. 1267, 1284 n.51 (1984).

26. O'Connell, *supra* note 12, at 605–06. As a further incentive, however, for defendants in product liability cases to proffer claimants' net economic loss, the bill could provide that failure to do so eliminates any defense of claimant fault in a subsequent civil claim, short of intentional self-infliction of injury. *Id.* at 606; O'Connell, *A Proposal to Abolish Contributory and Comparative Fault with Compensatory Savings by Also Abolishing the Collateral Source Rule*, 1979 U. ILL. L. REV. 591–600; for the restricted definition of "intentional" conduct (applicable to either the defendant or plaintiff), see *supra* note 18.

27. Moreover, the proposal may offer the additional advantage of barring the defendant from any potential defense based upon claimant's fault. *See supra* note 26.

28. As to the flagrant violations of insurance theory involved in tort liability for personal injury, see O'Connell, *supra* note 15, at 344–48.

VII. Conclusion

In sum, society ought to avoid, whenever possible, "shin-kicking litigation"[29] as a means of deciding whether injured people receive insurance benefits. After all, it was shortly after 1900 that our grandparents—with comparatively little information, actuarial or otherwise, to go on—abandoned tort liability as a means of paying for workplace injuries. As to other types of injuries—including those from manufactured products—as we approach the next turn of the century, surely we can follow their example and avoid the costs, delays, and uncertainties of lawsuits. Indeed, such a neo-no-fault approach need not be limited to product liability. It could and should apply just as successfully to any or all personal injury claims.[30]

29. As one plaintiff's lawyer put it, after six years of legal battle before settlement of a complex products liability case, "this type of litigation is war—shin-kicking litigation. It often lasts for a long time." N.Y. Times, Aug. 31, 1982, at 10, cols. 1–6.

30. *See, e.g.*, Moore & O'Connell, *supra* note 25. Note that conflicts of laws problems loom especially large in products cases with their manifestly more likely interstate elements. *See* Professor Kozyris' contribution to t symposium.

Proposition 103
California

103 Insurance Rates, Regulation, Commissioner. Initiative Statute

Official Title and Summary Prepared by the Attorney General

INSURANCE RATES, REGULATION, COMMISSIONER. INITIATIVE STATUTE. Requires minimum 20-percent rate reduction from November 8, 1987, levels, for automobile and other property/casualty insurance. Freezes rates until November 8, 1989, unless insurance company is substantially threatened with insolvency. Thereafter requires every insurer offer any eligible person a good-driver policy with 20-percent differential. Requires public hearing and approval by elected Insurance Commissioner for automobile, other property/casualty insurance rate changes. Requires automobile premiums be determined primarily by driving record. Prohibits discrimination, price-fixing, unfair practices by insurance companies. Requires commissioner provide comparative pricing information. Authorizes insurance activities by banks. Summary of Legislative Analyst's estimate of net state and local government impact: Would increase Department of Insurance administrative costs by $10 to $15 million in first year, varying thereafter with workload, to be paid by additional fees on the insurance industry. State and some local governments would have unknown savings from lower insurance rates. Gross premium tax reduction of approximately $125 million for first three years offset by required premium tax rate adjustment. Thereafter, possible state revenue loss if rate reductions and discounts continue but gross premium tax is not adjusted.

Analysis by the Legislative Analyst

Background

Various types of insurance are sold in California, including automobile, liability, fire, health and life. In 1987, companies collected about $50 billion in premiums from the sale of insurance. In turn, the state received about $1 billion from a tax on these premiums.

Motor vehicle insurance is one of the major types of insurance purchased in the state. It accounted for about $12 billion (24 percent) of all premiums collected during 1987. Additionally, fire and liability insurance premiums totaled about $10 billion, or 21 percent, of all premiums.

Rate Setting by Insurance Companies. Currently, insurance companies set rates for various types of insurance, using a number of factors. For motor vehicle insurance, these factors generally include the age, sex, marital status, driving record, type of vehicle and home address of the insured. The insurance companies also take into consideration other factors such as their claims experience, income and expenses. Insurance companies are not required to tell the public what relative weight they give to these factors when setting rates. In addition, insurance companies are not subject to the state's antitrust laws.

Role of the Department of Insurance in Reviewing Rates. Currently, the Department of Insurance does not review and approve insurance rate changes before they take effect. Instead, the Department of Insurance can request insurance companies to justify such rates *after* they take effect, as part of the rate examination process or in response to complaints from consumers. Historically, the scope and frequency of rate examinations has been limited.

Proposal

In summary, this measure:

- Requires insurance companies to reduce rates for various types of insurance, including motor vehicle, fire and liability.
- Requires insurance companies to offer a "Good Driver Discount Plan" and makes other changes regarding automobile insurance.
- Requires the Insurance Commissioner to review and approve rate increases—for various types of insurance—before they can take effect.
- Requires that the Insurance Commissioner be elected.

This measure changes the laws that regulate insurance rates for certain types of insurance. It applies to motor vehicle, fire and liability insurance, but not to life, mortgage and disability insurance.

Rate Reductions

1. **Rate Reduction.** This measure requires that rates for motor vehicle, fire and liability insurance issued or renewed on or after November 8, 1988, be reduced by 20 percent from their levels on November 8, 1987.

2. **Rate Freeze.** The measure requires that the rates be kept at the reduced levels until November 8, 1989. During this period, the rates can be increased only if the Insurance Commissioner determines that the affected insurance company is threatened with insolvency.

Review and Approval of Insurance Rate Filings

Beginning November 8, 1989, the measure requires the Insurance Commissioner to review and approve rate changes before they go into effect. Insurance companies are required to file information with the commissioner to justify the new rates. In general, the commissioner is required to hold a public hearing on the proposed rate change whenever it exceeds certain percentages. Additionally, the commissioner is authorized to hold a hearing when requested by a consumer.

Good Driver Discount Plan and Other Automobile Provisions

1. **"Good Driver" Discount.** This measure requires insurance companies to offer motor vehicle insurance to good drivers at reduced rates. These rates would take effect November 8, 1989, (one year after the general rate reduction) and would be 20 percent below the rate which would otherwise have been paid for the same coverage.

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Text of Proposed Law

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure adds and repeals sections of the Insurance Code, and adds a section to the Revenue and Taxation Code; therefore, existing sections proposed to be deleted are printed in ~~strikeout type~~ and new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. Findings and Declaration.

The People of California find and declare as follows:

Enormous increases in the cost of insurance have made it both unaffordable and unavailable to millions of Californians.

The existing laws inadequately protect consumers and allow insurance companies to charge excessive, unjustified and arbitrary rates.

Therefore, the People of California declare that insurance reform is necessary. First, property-casualty insurance rates shall be immediately rolled back to what they were on November 8, 1987, and reduced no less than an additional 20%. Second, automobile insurance rates shall be determined primarily by a driver's safety record and mileage driven. Third, insurance rates shall be maintained at fair levels by requiring insurers to justify all future increases. Finally, the state Insurance Commissioner shall be elected. Insurance companies shall pay a fee to cover the costs of administering these new laws so that this reform will cost taxpayers nothing.

SECTION 2: Purpose.

The purpose of this chapter is to protect consumers from arbitrary insurance rates and practices, to encourage a competitive insurance marketplace, to provide for an accountable Insurance Commissioner, and to ensure that insurance is fair, available, and affordable for all Californians.

SECTION 3: Reduction and Control of Insurance Rates.

Article 10, commencing with Section 1861.01 is added to Chapter 9 of Part 2 of Division 1 of the Insurance Code to read:

Insurance Rate Rollback

1861.01. (a) For any coverage for a policy for automobile and any other form of insurance subject to this chapter issued or renewed on or after November 8, 1988, every insurer shall reduce its charges to levels which are at least 20% less than the charges for the same coverage which were in effect on November 8, 1987.

(b) Between November 8, 1988, and November 8, 1989, rates and premiums reduced pursuant to subdivision (a) may be only increased if the commissioner finds, after a hearing, that an insurer is substantially threatened with insolvency.

(c) Commencing November 8, 1989, insurance rates subject to this chapter must be approved by the commissioner prior to their use.

(d) For those who apply for an automobile insurance policy for the first time on or after November 8, 1988, the rate shall be 20% less than the rate which was in effect on November 8, 1987, for similarly situated risks.

(e) Any separate affiliate of an insurer, established on or after November 8, 1987, shall be subject to the provisions of this section and shall reduce its charges to levels which are at least 20% less than the insurer's charges in effect on that date.

Automobile Rates & Good Driver Discount Plan

1861.02. (a) Rates and premiums for an automobile insurance policy, as described in subdivision (a) of Section 660, shall be determined by application of the following factors in decreasing order of importance:

(1) The insured's driving safety record.

(2) The number of miles he or she drives annually.

(3) The number of years of driving experience the insured has had.

(4) Such other factors as the commissioner may adopt by regulation that have a substantial relationship to the risk of loss. The regulations shall set forth the respective weight to be given each factor in determining automobile rates and premiums. Notwithstanding any other provision of law, the use of any criterion without such approval shall constitute unfair discrimination.

(b) (1) Every person who (A) has been licensed to drive a motor vehicle for the previous three years and (B) has had, during that period, not more than one conviction for a moving violation which has not eventually been dismissed shall be qualified to purchase a Good Driver Discount policy from the insurer of his or her choice. An insurer shall not refuse to offer and sell a Good Driver Discount policy to any person who meets the standards of this subdivision. (2) The rate charged for a Good Driver Discount policy shall comply with subdivision (a) and shall be at least 20% below the rate the insured would otherwise have been charged for the same coverage. Rates for Good Driver Discount policies shall be approved pursuant to this article.

(c) The absence of prior automobile insurance coverage, in and of itself, shall not be a criterion for determining eligibility for a Good Driver Discount policy, or generally for automobile rates, premiums, or insurability.

(d) This section shall become operative on November 8, 1989. The commissioner shall adopt regulations implementing this section and insurers may submit applications pursuant to this article which comply with such regulations prior to that date, provided that no such application shall be approved prior to that date.

Prohibition on Unfair Insurance Practices

1861.03. (a) The business of insurance shall be subject to the laws of California applicable to any other business, including, but not limited to, the Unruh Civil Rights Act (Civil Code Sections 51 through 53), and the antitrust and unfair business practices laws (Parts 2 and 3, commencing with section 16600 of Division 7, of the Business and Professions Code).

(b) Nothing in this section shall be construed to prohibit (1) any agreement to collect, compile and disseminate historical data on paid claims or reserves for reported claims, provided such data is contemporaneously transmitted to the commissioner, or (2) participation in any joint arrangement established by statute or the commissioner to assure availability of insurance.

(c) Notwithstanding any other provision of law, a notice of cancellation or non-renewal of a policy for automobile insurance shall be effective only if it is based on one or more of the following reasons: (1) non-payment of premium; (2) fraud or material misrepresentation affecting the policy or insured; (3) a substantial increase in the hazard insured against.

Full Disclosure of Insurance Information

1861.04. (a) Upon request, and for a reasonable fee to cover costs, the commissioner shall provide consumers with a comparison of the rate in effect for each personal line of insurance for every insurer.

Approval of Insurance Rates

1861.05. (a) No rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter. In considering whether a rate is excessive, inadequate or unfairly discriminatory, no consideration shall be given to the degree of competition and the commissioner shall consider whether the rate mathematically reflects the insurance company's investment income.

(b) Every insurer which desires to change any rate shall file a complete rate application with the commissioner. A complete rate application shall include all data referred to in Sections 1857.7, 1857.9, 1857.15, and 1864 and such other information as the commissioner may require. The applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this article.

(c) The commissioner shall notify the public of any application by an insurer for a rate change. The application shall be deemed approved sixty days after public notice unless (1) a consumer or his or her representative requests a hearing within forty-five days of public notice and the commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision, or (2) the commissioner on his or her own motion determines to hold a hearing, or (3) the proposed rate adjustment exceeds 7% of the then applicable rate for personal lines or 15% for commercial lines, in which case the commissioner must hold a hearing upon a timely request.

1861.06. Public notice required by this article shall be made through distribution to the news media and to any member of the public who requests placement on a mailing list for that purpose.

1861.07. All information provided to the commissioner pursuant to this article shall be available for public inspection, and the provisions of Section 6254(d) of the Government Code and Section 1857.9 of the Insurance Code shall not apply thereto.

1861.08. Hearings shall be conducted pursuant to Sections 11500 through 11528 of the Government Code, except that: (a) hearings shall be conducted by administrative law judges for purposes of Sections 11512 and 11517, chosen under Section 11502 or appointed by the commissioner; (b) hearings are commenced by a filing of a Notice in lieu of Sections 11503 and 11504; (c) the commissioner shall adopt,

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103 Insurance Rates, Regulation, Commissioner. Initiative Statute

Argument in Favor of Proposition 103

There are important differences between the five insurance initiatives on the November ballot which you should be aware of before voting.

Proposition 103—Voter Revolt to Cut Insurance Rates—is the only insurance initiative written and paid for exclusively by consumers. It alone reduces all of your automobile, home and business insurance premiums to November 1987 prices. Then, it alone cuts them another 20%.

Proposition 103 will also end the insurers' exemption from the antimonopoly laws, allow people to elect the Insurance Commissioner, require a special 20% discount for good drivers, and stop unfair price increases in the future. It specifies that a permanent, independent consumer watchdog system will champion the interests of insurance consumers.

Proposition 103 is written in plain language. There are no loopholes or fine print. Unlike the other propositions, nonlawyers can read it.

Because the polls showed that the insurance industry could not defeat Voter Revolt's 103 directly, the insurance companies came up with a plan to defeat it indirectly. They are pushing Proposition 104—the so-called "no-fault" proposition—and are spending tens of millions of dollars to advertise that it is better for consumers than Proposition 103.

Privately, insurance executives have admitted that their Proposition 104 would actually raise auto insurance premiums for many drivers. Worse, Proposition 104 rewrites the entire California Insurance Code to benefit insurance companies. The 24,000 words of obscure legalese in Proposition 104 turn the law into a "your fault" system. Their fine print cancels out every consumer reform in Voter Revolt's Proposition 103.

Some insurance companies disagree with "no fault," so they're financing Proposition 101, which claims to make the biggest cut in auto insurance. But the big cut they boast about affects only one portion of your auto insurance—they could raise premiums for the rest of your coverage as much as they want. In return, Proposition 101 allows insurance companies to avoid full payment for accidents. It, too, cancels many of the auto insurance reforms in Proposition 103.

Insurance companies are also financing Proposition 106, which restricts your right to quality legal counsel. The insurance companies claim Proposition 106 will cut their costs. In fact, it will limit your ability to make the insurance companies pay up.

Proposition 100, which is paid for by trial lawyers and bankers, simply does not go far enough to protect consumers' interests. Unlike Proposition 103, it does not automatically and immediately cut insurance rates. Nor does it enable consumers to permanently unite to fight against insurance abuse, as Voter Revolt's Proposition 103 does.

Proposition 103 is the only initiative written and paid for exclusively by consumers. It will save you the most money.

To guarantee that every reform in Voter Revolt's Proposition 103 becomes law, it must get more "Yes" votes than any other proposition. Every vote in favor of another insurance proposition cancels your vote for Proposition 103. That's why we advise you to vote "Yes" *only* on Proposition 103.

RALPH NADER
Consumer Advocate

HARVEY ROSENFIELD
Chair, Voter Revolt to Cut Insurance Rates/ Proposition 103

Rebuttal to Argument in Favor of Proposition 103

Proponents of PROP 103 claim that their initiative includes no "fine print," but IT'S FULL OF UNINTENDED CONSEQUENCES THAT WILL WIPE OUT ANY BENEFITS IT PROMISES YOU. VOTE NO ON PROP 103.

The most glaring example of this "fine print" allows for massive government intervention into the insurance industry. A GOVERNMENT-RUN INSURANCE SYSTEM IS NOT THE ANSWER.

In New Jersey, where the government intervened in the insurance business under circumstances similar to those mandated in PROP 103, every driver is paying a surcharge to help foot a $2.5-billion deficit racked up by the state-run insurance system.

PROP 103 advocates also tell you their initiative contains no loopholes. Look again. It's loaded with them.

- RATES WILL INCREASE by an average 22% for two-thirds of the state's drivers, according to the State Department of Insurance, because PROP 103 eliminates rating based on the driving safety record of your neighborhood and forces suburban and rural drivers to subsidize motorists in high-risk areas.
- DRUNK DRIVERS who haven't lost their licenses can qualify for "good driver" discounts.

A MASSIVE BUREAUCRACY IS NOT THE SOLUTION. Only fundamental reform of our auto insurance system will hold down insurance premiums. We need to reduce the cost of litigation, fraud and subsidizing uninsured motorists.

PROP 103 DOES NOT REFORM OUR SYSTEM. IT DOES NOT GUARANTEE YOU LONG-TERM RATE REDUCTIONS.

Vote NO on PROP 103.

ALISTER McALISTER
Former Chair, Assembly Finance and Insurance Committee

ED DAVIS
State Senator, 19th District

KIRK WEST
President, California Chamber of Commerce

Argument Against Proposition 103

KEEP BIG GOVERNMENT OUT OF THE AUTO INSURANCE BUSINESS.

You might think PROP 103's auto insurance rate reductions seem too good to be true. You're right.

Vote NO on PROP 103; it does not enact any cost-cutting reforms. Instead, it attacks the symptoms of our failing auto insurance system. It does not address, let alone begin to grapple with, the real problem—the cost of uninsured motorists, fraud and, most importantly, *runaway auto accident litigation.*

PROP 103 might seem well-intentioned but, unfortunately, it inevitably would lead to a huge, state-run insurance system costing millions of dollars.

Hidden provisions of this measure give the state unprecedented authority to enter the insurance business. If you think lines are long and the bureaucracy impenetrable at government offices today, just wait until you have to deal with the state to purchase insurance.

This sloppily drafted measure will:

- *Raise insurance premiums, in the long term, for the majority of California drivers.* PROP 103 forces insurers to ignore the driving safety record of where you live and, instead, forces you to subsidize drivers in areas that have the highest insurance losses. For example, a 55-year-old suburban driver will end up paying more for insurance so that a young urban driver can pay less. A State Department of Insurance study recently predicted that this aspect of PROP 103 will raise rates for two-thirds of the state's drivers —by an average 22%!
- *Allow convicted drunk drivers who have not lost their licenses to win an additional rate discount for "good driving."*
- *Make the Insurance Commissioner an elected official with* enormous new powers. This "insurance czar" would be a politician first, and a regulator second. As a politician, this official would be preoccupied with raising campaign money from special interests all too willing to "buy" influence.
- *Create a huge government bureaucracy that does nothing to make auto insurance more affordable.* Instead, PROP 103 would add time, expense and lots of lawyers to enact a price-control policy that has failed miserably in New Jersey and other states. To carry out this price-control policy, the measure increases the Department of Insurance's budget by 33% and its staff by at least 100 new bureaucrats.

VOTE NO on PROP 103. Lowering auto premiums for California drivers is a laudable goal, but this measure's flawed methods are not the answer. Please VOTE NO on PROP 103.

KIRK WEST
President, California Chamber of Commerce

WILLIAM CAMPBELL
State Senator, 31st District
Chairman, Joint Legislative Budget Committee

DAVID DAVREUX
Author, Consumers' Guide to Auto Insurance

Rebuttal to Argument Against Proposition 103

The insurance companies want to divert your attention away from the fact that Prop 103 will save *everyone* 20% on their auto insurance as well as their home and business insurance. That's why the statement above employs confusing and often ridiculous arguments against it.

Here are the facts:

- 103 is the *only* initiative that will immediately cut *everyone's* premiums by 20%.
- 103 forces insurance companies to base your rates on your driving record first, rather than on where you live. That means good drivers throughout the state will pay less than they do now, while bad drivers will pay more.
- 103 eliminates the insurance industry's unfair exemption from the antitrust laws. This will reduce rates permanently.
- 103 involves no new government bureaucracy—just a new set of rules to create a competitive marketplace and prohibit excessive rates.
- 103 will actually save money for taxpayers, according to the official California State Legislative Analyst.
- And no wonder the insurance companies don't want an elected Insurance Commissioner—in the states where people elect insurance commissioners, rates average 30% lower than in California.

Voter Revolt's Proposition 103 is the *only* insurance reform initiative written and paid for exclusively by consumers. That's why it is the *only* initiative endorsed by Ralph Nader.

103 will lower insurance rates for everyone. That's why the insurance industry is against it. Don't buy their misleading advertising. Vote YES on Proposition 103.

HARVEY ROSENFIELD
Chair, Voter Revolt to Cut Insurance Rates/ Proposition 103

Proposition 103: Analysis

Continued from page 98

In general, this measure defines a good driver as a person who, during the last three years, has (a) held a driver's license and (b) had no more than one conviction for a moving violation.

2. Determining Factors for Rates. In general, the measure requires that rates and premiums for automobile insurance be determined on the basis of the insured person's driving record, miles driven and number of years of driving experience.

Other Insurance-Related Provisions

1. Antitrust Laws. The measure makes insurance companies subject to the state's antitrust laws.

2. Election of Insurance Commissioner. The measure requires that the Insurance Commissioner be elected, the first election taking place in 1990.

3. Consumer Assistance. The measure requires the establishment of a nonprofit corporation to represent the interests of insurance consumers. Additionally, the measure requires the Insurance Commissioner to provide consumers—upon request and for a reasonable fee—with a comparison of the rates for *each* personal (that is, noncommercial) type of insurance offered in California. In general, this would include rates for private automobile, homeowner's and renter's insurance.

4. Discounts or Rebates. The measure permits insurance agents and brokers to give certain discounts or rebates to those who buy insurance from them. It does so, by eliminating the prohibition in current law against such discounts or rebates.

Fiscal Effect

Costs

Department of Insurance. This measure would increase the Department of Insurance's administrative costs by between $10 million to $15 million during 1988–89. These costs would be financed out of the Insurance Fund which is supported by fees and assessments on the insurance industry. Given the current balance in this fund, fees and assessments would have to be increased to cover these costs.

In years following, these costs could be somewhat lower or higher, depending on workload.

State and Local Governments. While some local governments purchase insurance, most "self-insure" by relying upon their own resources to pay losses and claims. The state is generally self-insured, but does purchase some liability and fire insurance. Because this measure reduces the rates for certain types of insurance, including motor vehicle, fire and liability, it would result in unknown savings to the state and those local governments that purchase such insurance.

Revenues

Insurance companies pay a tax based on the amount of gross premiums they receive each year from insurance sold in California. These tax revenues are deposited in the State General Fund.

Starting in November 1988, this measure requires that rates for motor vehicle, fire and liability insurance be reduced. These lines of insurance account for about 45 percent of all California insurance premiums. A good driver discount takes effect a year later. The Department of Insurance's new role in reviewing and approving proposed rate changes also takes effect in November 1989. The rate reductions and the good driver discounts combined normally would reduce state insurance tax revenues by about $125 million a year. This estimate assumes that about 50 percent of the drivers would qualify for the discount. It also assumes that no offsetting adjustments would be made in other insurance rates. The resulting state revenue loss, however, will not occur because this measure provides that for the period November 1988 to January 1991 the State Board of Equalization shall adjust the state tax rate on gross premiums to offset these premium reductions.

Thereafter, there would be an unknown General Fund revenue loss to the extent these rate reductions and discounts continue.

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amend or reject a decision only under Sectio '1517 (c) and (e) and solely on the basis of the record; (d) Section 11513.5 shall apply to the commissioner; (e) discovery shall be liberally construed and disputes determined by the administrative law judge.

1861.09. Judicial review shall be in accordance with Section 1858.6. For purposes of judicial review, a decision to hold a hearing is not a final order or decision; however, a decision not to hold a hearing is final.

Consumer Participation

1861.10. (a) Any person may initiate or intervene in any proceeding permitted or established pursuant to this chapter, challenge any action of the commissioner under this article, and enforce any provision of this article.

(b) The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that (1) the person represents the interests of consumers, and, (2) that he or she has made a substantial contribution to the adoption of any order, regulation or decision by the commissioner or a court. Where such advocacy occurs in response to a rate application, the award shall be paid by the applicant.

(c) (1) The commissioner shall require every insurer to enclose notices in every policy or renewal premium bill informing policyholders of the opportunity to join an independant, non-profit corporation which shall advocate the interests of insurance consumers in any forum. This organization shall be established by an interim board of public members designated by the commissioner and operated by individuals who are democratically elected from its membership. The corporation shall proportionately reimburse insurers for any additional costs incurred by insertion of the enclosure, except no postage shall be charged for any enclosure weighing less than ½ of an ounce. (2) The commissioner shall by regulation determine the content of the enclosures and other procedures necessary for implementation of this provision. The legislature shall make no appropriation for this subdivision.

Emergency Authority

1861.11. In the event that the commissioner finds that (a) insurers have substantially withdrawn from any insurance market covered by this article, including insurance described by Section 660, and (b) a market assistance plan would not be sufficient to make insurance available, the commissioner shall establish a joint underwriting authority in the manner set forth by Section 11691, without the prior creation of a market assistance plan.

Group Insurance Plans

1861.12. Any insurer may issue any insurance coverage on a group plan, without restriction as to the purpose of the group, occupation or type of group. Group insurance rates shall not be considered to be unfairly discriminatory, if they are averaged broadly among persons insured under the group plan.

Application

1861.13. This article shall apply to all insurance on risks or on operations in this state, except those listed in Section 1851.

Enforcement & Penalties

1861.14. Violations of this article shall be subject to the penalties set forth in Section 1859.1. In addition to the other penalties provided in this chapter, the commissioner may suspend or revoke, in whole or in part, the certificate of authority of any insurer which fails to comply with the provisions of this article.

SECTION 4. Elected Commissioner

Section 12900 is added to the Insurance Code to read:

12900. (a) The commissioner shall be elected by the People in the same time, place and manner and for the same term as the Governor.

SECTION 5. Insurance Company Filing Fees

Section 12979 is added to the Insurance Code to read:

12979. Notwithstanding the provisions of Section 12978, the commissioner shall establish a schedule of filing fees to be paid by insurers to cover any

administrative or operational costs arising from the provisions of Article 10 (commencing with Section 1861.01) of Chapter 9 of Part 2 of Division 1.

SECTION 6. Transitional Adjustment of Gross Premiums Tax

Section 12202.1 is added to the Revenue & Taxation Code to read:

12202.1. Notwithstanding the rate specified by Section 12202, the gross premiums tax rate paid by insurers for any premiums collected between November 8, 1988 and January 1, 1991 shall be adjusted by the Board of Equalization in January of each year so that the gross premium tax revenues collected for each prior calendar year shall be sufficient to compensate for changes in such revenues, if any, including changes in anticipated revenues, arising from this act. In calculating the necessary adjustment, the Board of Equalization shall consider the growth in premiums in the most recent three year period, and the impact of general economic factors including, but not limited to, the inflation and interest rates.

SECTION 7. Repeal of Existing Law

Sections 1643, 1850, 1850.1, 1850.2, 1850.3, 1852, 1853, 1853.5, 1853.7, 1857.5, 12900, Article 3 (commencing with Section 1854) of Chapter 9 of Part 2 of Division 1, and Article 5 (commencing with Section 750) of Chapter 1 of Part 2 of Division 1, of the Insurance Code are repealed.

1643. No bank, or bank holding company, subsidiary, or affiliate thereof, or any officer or employee of a bank, bank holding company, subsidiary, or affiliate, may be licensed as an insurance agent or broker or act as an agent or broker for insurance, in this state, or control a licensed insurance agent or broker, except that a bank or a bank holding company subsidiary, or affiliate of a bank, may be issued a license to act as a life and disability agent limited to the transaction of credit life and disability insurance, or an agent limited to the transaction of insurance which is limited solely to assuring repayment of the outstanding balance due on a specific extension of credit by a bank or bank holding company or its subsidiary in the event of the involuntary unemployment of the debtor, or both. A commercial bank may be licensed to sell insurance or act as an insurance broker as provided in Section 1003 of the Financial Code. This section shall not apply to any bank or bank holding company which, under the authorization of the Federal Reserve Board, had prior to January 1, 1976, a subsidiary or affiliate licensed to sell insurance (except that subsequent authorization to expand such activities shall be subject to this section), or to any bank holding company owning a state-chartered bank which had, prior to January 1, 1976, a subsidiary or affiliate licensed to sell insurance. This section shall not apply to any person authorized or licensed to make loans pursuant to Division 7 (commencing with Section 18000), Division 9 (commencing with Section 22000), Division 10 (commencing with Section 24000), or Division 11 (commencing with Section 26000) of the Financial Code.

For the purposes of this section, the following definitions shall apply:

(a) "Bank" means any institution in this state defined in Section 102 of the Financial Code except that such term does not include a title insurance company authorized to transact a trust business under the provisions of Article 4 (commencing with Section 12390) of Chapter 1 of Part 6 of Division 2 or a trust company controlled by or under common control with a title insurance company.

(b) "Bank holding company" means the same as the definition of that term set forth in Section 2 of the federal Bank Holding Company Act of 1956, as amended, but limited to holding companies which control a bank authorized to accept deposits in this state.

(c) "Subsidiary" means any corporation, association, or partnership, owned in whole or part by a bank or bank holding company.

(d) "Affiliate" means any corporation, association, or partnership connected through the ownership of a 10/percent or greater interest by a common parent.

(e) "Credit life, health, and accident insurance" means insurance on the life and health of a borrower from [illegible] issued to secure the repayment of the amount borrowed.

(f) "Control" means the possession, by any means, of the power to direct or cause the direction of the management or activities of a licensed insurance agent or broker.

1850. The purpose of this chapter is to promote the public welfare by regulating insurance rates as herein provided to the end that they shall not be excessive, inadequate or unfairly discriminatory; to authorize the existence and operation of qualified rating organizations and advisory organizations and require that specified rating services of such rating organizations be generally available to all admitted insurers; and to authorize cooperation between insurers in rate making and other related matters.

It is the express intent of this chapter to permit and encourage competition between insurers on a sound financial basis and nothing in this chapter is intended to give the Commissioner power to fix and determine a rate level by classification or otherwise.

1850.1. In this chapter "rating organization" means every person, other than an admitted insurer, whether located within or outside this State, who has as his object or purpose the making of rates, rating plans or rating systems. Two or more admitted insurers which act in concert for the purpose of making rates, rating plans or rating systems, and which do not operate within the specific authorizations contained in Sections 1853.5, 1853.7, 1853.8, or Article 5 shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

1850.2. In this chapter "advisory organization" means every person, other than an admitted insurer, whether located within or outside this State, who prepares policy forms or makes underwriting rules incident to but not including the making of rates, rating plans or rating systems, or which collects and furnishes to admitted insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a rate making, capacity. No duly authorized attorney at law acting in the usual course of his profession shall be deemed to be an advisory organization.

1850.3. Unless otherwise apparent from the context, in this chapter

(a) "Member" means an insurer who participates in or is entitled to participate in the management of a rating, advisory or other organization.

(b) "Subscriber" means an insurer which is furnished at its request (1) with rates and rating manuals by a rating organization of which it is not a member, or (2) with advisory services by an advisory organization of which it is not a member.

1852. The following standards shall apply to the making and use of rates pertaining to all classes of insurance to which the provisions of this chapter are applicable:

(a) Rates shall not be excessive or inadequate, as herein defined, nor shall they be unfairly discriminatory.

No rate shall be held to be excessive unless (1) such rate is unreasonably high for the insurance provided and (2) a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable.

No rate shall be held to be inadequate unless (1) such rate is unreasonably low for the insurance provided and (2) the continued use of such rate endangers the solvency of the insurer using the same, or unless (3) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same has, or if continued will have, the effect of destroying competition or creating a monopoly.

(b) Consideration shall be given, to the extent applicable, to past and prospective loss experience within and outside this State, to conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to past and prospective expenses both country-wide and those specially applicable to this State, and to all other factors, including judgment factors, deemed relevant within and outside this State; and in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period for which such experience is available.

Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers.

(c) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of any such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.

(d) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Classifications or modifications of classifications of risks may be established based upon size, expense management, individual experience, location or dispersion of hazard, or any other reasonable considerations. Such classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions.

1853. Subject to and in compliance with the provisions of this chapter authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurance, two or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other information and data, or carrying on of research.

1853.5. Members and subscribers of rating or advisory organizations may use the rates, rating systems, underwriting rules or policy or bond forms of such organizations, either consistently or intermittently, but, except as provided in Sections 1853.8, 1853.8, and Article 5, shall not agree with each other or rating organizations or others to adhere thereto. The fact that two or more admitted insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization, or the underwriting rules or policy or bond forms prepared by a rating or advisory organization, shall not be sufficient in itself to support a finding that an agreement to so adhere exists, and may be used only for the purpose of supplementing or explaining direct evidence of the existence of any such agreement.

1853.7. Licensed rating organizations and admitted insurers are authorized to exchange information and experience data with rating organizations and insurers in this and other states and may consult with them with respect to rate-making and the application of rating systems.

1857.5. (a) The commissioner may promulgate reasonable rules and statistical plans, reasonably adapted to each of the rating systems in use within the state, which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and country-wide expense experience, in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in this chapter. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a prorating of country-wide expense experience. In promulgating such rules and plans, the commissioner may give due consideration to the rating systems in use and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system in use by it. The commissioner may designate one or more rating organizations or advisory organizations to assist him in gathering such experience and making compilations thereof, and such compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

(b) Reasonable rules and plans may be promulgated by the commissioner for the interchange of data necessary for the application of rating plans.

(c) In order to further uniform administration or rate regulatory laws, the commissioner and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to ratemaking and the application of rating systems.

12900. The commissioner shall be appointed by the Governor, with the consent of the Senate and shall hold office for a term of four years, coextensive with the term of office of the Governor.

Article 3. Rating Organizations

1851. No rating organization shall conduct its operations in this state without first filing with the commissioner a written application for and securing a license to act as a rating organization. Any rating organization may make application for and obtain a license as a rating organization if it shall meet the requirements for license set forth in this chapter. Every such rating organization shall file with its application (a) a copy of its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules and regulations governing the conduct of its business, all duly certified by the custodian of the originals thereof, (b) a list of its members and subscribers, (c) the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served, and (d) a statement of its qualifications as a rating organization.

The fee for filing an application for license as a rating organization is one hundred seventy-seven dollars ($177) lawful money of the United States, payable in advance to the commissioner.

1851.1. To obtain and retain a license, a rating organization shall provide satisfactory evidence to the commissioner that it will:

(a) Permit any admitted insurer to become a member of or a subscriber to such rating organization at a reasonable cost and without discrimination, or withdraw therefrom.

(b) Neither have nor adopt any rule or enact any agreement, the effect of which would be to require any member or subscriber as a condition to membership or subscribership, to adhere to its rates, rating plans, rating systems, underwriting rules, or policy or bond forms.

(c) Neither adopt any rule nor enact any agreement the effect of which would be to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policy holders, members or subscribers.

(d) Neither practice nor sanction any plan or act of boycott, coercion or intimidation.

(e) Neither enter into nor sanction any contract or act by which any person is restrained from lawfully engaging in the insurance business.

(f) Notify the commissioner promptly of every change in its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules and regulations governing the conduct of its business; its list of members and subscribers, and the name and address of the resident of this State designated by it upon whom notices or orders of the commissioner or process affecting such organization may be served.

(g) Comply with the provisions of Section 1857.

1851.2. The commissioner shall examine each application for license to act as a rating organization and the documents filed therewith and may make such further investigation of the applicant, its affairs and its proposed plan of business, as he deems desirable.

The commissioner shall issue the license applied for within 60 days of its filing with him if from such examination and investigation he is satisfied that:

(a) The business reputation of the applicant and its officers is good.

(b) The facilities of the applicant are adequate to enable it to furnish the services it proposes to furnish.

(c) The applicant and its proposed plan of operation conform to the requirements of this chapter.

Otherwise, but only after hearing upon notice, the commissioner shall in writing deny the application and notify the applicant of his decision and his reasons therefor.

The commissioner may grant an application in part only and issue a license to act as a rating organization for one or more of the classes of insurance or subdivisions thereof or class of risk or a part or combination thereof as are specified in the application if the applicant qualifies for only a portion of the classes applied for.

Licenses issued pursuant to this section shall remain in effect until revoked as provided in this chapter.

1851.25. Notwithstanding the provision of Section 1851.2, each rating organization possessing a license of indefinite term pursuant to such section shall owe and pay to the commissioner an annual fee of one hundred seventy-seven dollars ($177) in lawful money of the United States in advance on account of such license until its final termination. Such fee shall be for periods commencing on July 1, 1961, and on each July 1st thereafter and ending on June 30, 1965, and each June 30th thereafter, and shall be due and payable on March 1, 1961, and on each March 1st thereafter and shall be delinquent on April 1, 1961, and each April 1st thereafter.

1851.3. Subject to the approval of the commissioner licensed rating organizations may make reasonable rules governing eligibility for membership.

1851.4. If two or more insurers having a common ownership or operating in this State under common management are admitted for the classes or types of insurance for which a rating organization is licensed to make rates, the rating organization may require as a condition to membership or subscribership of one or more that all such insurers shall become members or subscribers.

1851.5. A workers' compensation insurance rating organization licensed pursuant to the provisions of Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 which does not make rates, rating plans or rating systems for insurance covering the liability of employers for compensation or damages under the United States Longshoremen's and Harbor Workers' Compensation Act (33 U.S.C. 901, et seq.) shall not be required to be licensed as a rating organization or registered as an advisory organization pursuant to the provisions of this chapter and shall have authority under its license as a workers' compensation insurance rating organization to:

(a) Collect and tabulate loss and expense experience statistics and other information and data relating to insurance covering employers against their liability for compensation under the United States Longshoremen's and Harbor Workers' Compensation Act.

(b) Furnish or exchange such information and experience data to or with rating organizations, advisory organizations and insurers in this and other states.

(c) Adopt and enforce compliance by its insurer members with reasonable rules and statistical plans to be used in the recording and reporting by insurer members of their California longshoremen's and harbor workers' insurance loss and expense experience in order that such experience of all of its insurer members shall be available in such form and detail as will be of aid to the commissioner in the enforcement of, and to its insurer members in complying with, the provisions of this chapter.

(d) Engage in the same activities and carry out the same functions with respect to insurance covering the liability of employers for compensation or damages under the United States Longshoremen's and Harbor Workers' Compensation Act that it is authorized to engage in or carry out with respect to California workers' compensation insurance generally under the provisions of Article 3 (commencing with Section 11750) of Chapter 3 of Part 3 of Division 2 other than the making of rates, rating plans and rating systems.

Article 5. Unlawful Rebates, Profits, and Commissions

750. An insurer, insurance agent, broker, or solicitor, personally or by any other party, shall not offer or pay, directly or indirectly, as an inducement to insurance on any subject/matter in this State, any rebate of the whole or part of the premium payable on an insurance contract, or of the agent's or broker's commission thereon, and such rebate is an unlawful rebate.

750.1. The Legislature hereby finds and declares that the continued regulation of the business practices of insurers and their producers is in the interest of the citizens of the state and that the control and limitations of unlawful rebates, profits, and commissions is an essential component of that regulation which is necessary to effectuate an adequate and complete system and regulation of insurer and producer business practices.

The Legislature finds that the statutes controlling unlawful rebates, profits, and commissions continue to provide critical protection to insureds in this state from the numerous consequences that would occur in the absence of such regulation, including company insolvencies, unfair discrimination between insureds with identical risks creating subsidies from small purchasers of insurance in favor of large purchasers of insurance, decreased quality of services to insurance consumers, increased concentration of insurance distribution and sales mechanisms, and misrepresentation and unethical sales practices such as improper replacement or twisting to the detriment of the public.

It is the intent of the Legislature in enacting this section to clearly set forth the legislative intent supporting the enactment, continuing vitality, and importance of the unlawful rebates, profits, and commissions sections of this code.

751. An insurer, or an insurance agent, broker, or solicitor, personally or otherwise, shall not offer or pay, directly or indirectly, as an inducement to enter into an insurance contract, any valuable consideration which is not clearly specified, promised or provided for in the policy, or application for the insurance, and any such consideration not appearing in the policy is an unlawful rebate.

752. Any person named as the insured in any policy or named as the principal, or obligee, in any surety policy or the agent or representative of any such person who, directly or indirectly, knowingly accepts or receives any unlawful rebate is guilty of a misdemeanor.

753. (a) It is unlawful for any insurance agent or broker, or any insurance solicitor employed thereby, to receive any financial benefit from an automobile repair facility or any other form of direct or indirect consideration from any person for referring insureds to that person or that person's designee for vehicle repairs covered under automobile comprehensive coverage, property damage coverage, or automobile collision coverage, of an insurance policy issued through the insurance agent or broker or by an insurer represented by the insurance agent.

(b) Subdivision (a) applies with respect to commercial and noncommercial policies of automobile insurance.

(c) For purposes of this section, "financial benefit" means the receiving of any commission or gratuity, discount on repair costs, free repairs, or employment by a repair facility.

754. Payments of commissions or fees by insurers or their agents to insurance brokers, when otherwise lawful under this code, are expressly authorized.

755. The paying or allowing of any commission or other valuable consideration on insurance business in this State to other than an admitted insurer or a licensed insurance agent, broker or solicitor is an unlawful rebate.

755.2. If at the time of the solicitation and issuance of a policy of life or disability insurance, or of a surety bond which by its terms continues until canceled, a person may lawfully receive commissions thereon, such person, or in the event of his death, his estate or heirs may continue to receive commissions thereon during the continuance in force or renewal of such policy or bond without being licensed under the provisions of Chapter 5, Part 2, Division 1 of this code, provided:

(a) Such recipient does not transact insurance in connection with such policy or bond while not so licensed, and

(b) The payment is made pursuant to a contract entered into, before such

solicitation and issuance, between the insurer paying or allowing the commission and such person.

755.5. It is unlawful for an insurance agent who is not also licensed as an insurance broker to receive commissions derived from insurance placed with an insurer which has not appointed him to act as its agent in the transaction of such insurance.

It is unlawful for an insurance solicitor to receive commissions on insurance from any source other than the employer for whom he is licensed excepting on life or disability insurance transacted by him under individual licenses as life or disability agent issued to him pursuant to this code.

It is unlawful for any person to pay to an insurance agent or solicitor any commissions which he can not lawfully receive.

Except as provided in Section 763 it is unlawful for an insurer to receive for its own use commissions on insurance placed with another insurer.

755.6. Notwithstanding the provisions of Section 755.5, an insurer participating in any Assigned Risk Plan, as provided for in Article 4 (commencing with Section 11620), Chapter 1, Part 3, Division 2 of the Insurance Code, may pay to a licensed insurance agent, and such agent may receive, a commission or consideration on any automobile or liability coverages written in addition to any commission or consideration required under such plan if such agent has been designated by the applicant for insurance as producer of record for the coverages required under such plan.

755.7. Any person, including but not limited to any person licensed, certificated under this code or exempted under this code from regulation, who for consideration advises, or agrees to advise, any person concerning insurance, insurance policies, insurance needs or insurance programs of any sort and who agrees to, or does, allow credit against such consideration for such services for any portion of any insurance commission which may accrue, directly or indirectly, to such person who so advises or agrees to advise, is guilty of making an unlawful rebate and guilty of a misdemeanor.

756. When the premium on a policy insuring an employer is based upon the amount or segregation of the employer's pay roll, and the employer, personally or knowingly through his employee, procures a lower premium by wilfully misrepresenting the amount or segregation, such misrepresentation is an unlawful rebate as to the employer.

In addition to any penalty provided by law for unlawful rebates, the employer in such case is liable to the State in an amount ten times the difference between the lower premium paid and the premium properly payable. The commissioner shall collect the amount so payable and may bring a civil action in his name as commissioner to enforce collection unless the misrepresentation is made to and lower premium procured from the State Compensation Insurance Fund. In the latter case the liability to the State under this section shall be enforced in a civil action in the name of the State Compensation Insurance Fund and any amount so collected shall become a part of that fund.

757. When a statement of the amount or segregation of a pay roll is materially false, and an insurer, through a person employed by it in a managerial capacity, accepts the statement as the basis for the premium on a policy, the acceptance is an unlawful rebate if the accepting employee knows of the falsity.

758. Every insurer shall exercise reasonable diligence in securing the observance of this article by its agents.

759. It is unlawful for any insurer to appoint an agent for the purpose of enabling such agent, or the employer or person requesting the appointment of the agent, to obtain insurance at a cost less than that specified in the policy, or at a cost less than that specified in the application therefor.

760. As used in this section "personal or controlled insurance" means insurance covering an insurance agent, broker, or solicitor, or

(a) His spouse, his employer or his employer's spouse.

(b) Any person related to him or the persons mentioned in subdivision (a) within the second degree by blood or marriage.

(c) If his employer is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in such corporation.

(d) If his employer is a partnership or association, any person owning any interest in such partnership or association.

(e) If the agent or broker is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in the agent or broker and any corporation which is also similarly directly or indirectly controlled by the person who directly or indirectly controls the agent or broker.

(f) If the agent or broker is a corporation, any corporation making consolidated returns for United States income tax purposes with any corporation described in subdivision (e).

If premiums on personal or controlled insurance transacted by an insurance agent, broker, or solicitor payable in one year exceed the premiums on other insurance transacted by such licensee payable in the same year, the receipt of commissions upon the excess is an unlawful rebate.

Provided that during and after the sixth calendar year following the initial licensing of such agent, broker, or solicitor, in any manner as an agent, broker or solicitor, whether continuously licensed or not, if premiums on personal or controlled insurance transacted by him payable in any one such calendar year exceed 33⅓ percent of the other premiums transacted by him payable in the same calendar year, the receipt of commissions upon the excess over such 33⅓ percent is an unlawful rebate. For the purposes of this paragraph, if the agent or broker be an organization the sixth calendar year shall be the first calendar year beginning five years or more after the initial licensing of the organization, or any predecessor thereof, as an agent or broker.

Provided further, that this section does not apply to an individual licensee who: (1) is licensed during all of such calendar year as a solicitor, or individually as an agent or broker, (2) during such calendar year conducts an individual business, not being named to transact on any organization license nor owning any interest in any corporation or partnership transacting an insurance agency or brokerage business, (3) has been continuously licensed in some manner as an active agent, broker or solicitor for at least 25 years, and (4) is at least 65 years of age at the beginning of the calendar year.

Whenever an officer or director of a corporation acts as agent, broker, or solicitor in the transaction of insurance covering the corporation, he shall be conclusively presumed to have received the full commission on such contract while an employee of the corporation. Whenever the remuneration for services of an employee is decreased by the employer or is made unreasonably small in amount but the employee is permitted, as an insurance agent, broker, or solicitor, to transact personal or controlled insurance, it shall be conclusively presumed that such employee receives the full amount of commission on such personal or controlled insurance.

"Year" as used in this section means the calendar year. Suspension, revocation or denial of license for violation of this section may be ordered at any time within five years after the close of the year in which the violation occurred.

760.5. As used in this section "personal or controlled insurance" means insurance covering a life agent, or

(a) His spouse, his employer, his employer's spouse, or any group of employees under a group policy issued to his employer.

(b) Any person related to him, his spouse, his employer or his employer's spouse within the second degree by blood or marriage.

(c) If his employer is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in such corporation.

(d) If his employer is a partnership or association, any person owning any interest in such partnership or association.

(e) If the agent is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in the agent.

If commissions on personal or controlled insurance transacted by a life agent under his license as a life agent received in one year exceed the commissions received in that year on other insurance transacted by such licensee under his license as life agent, the receipt of commissions upon personal or controlled insurance in excess of those on such other insurance is an unlawful rebate.

Provided that during and after the sixth calendar year following the initial licensing of such life agent in any manner as a life agent, disability agent or life and disability agent, whether continuously licensed or not, if commissions on personal or controlled insurance transacted by him under any or all such licenses received in any such calendar year exceed 33⅓ percent of the commissions received in the same calendar year on other insurance transacted by him under any or all such licenses, the receipt of commissions upon personal or controlled insurance in excess of 33⅓ percent of those on such other insurance is an unlawful rebate. For the purposes of this paragraph, if the license be a joint firm license. The sixth calendar year as respects the firm shall be the first calendar year beginning five years or more after the initial licensing of the firm or any predecessor thereof as a joint firm licensee with any individual, the firm may be charged with a violation of this section separately based upon all joint firm licenses it may have held during the calendar year, and an individual named on one or more joint firm licenses may be charged with a violation of this section separately based upon all life licenses, individual and joint firm, he may have held during the calendar year.

Provided, further, that this section does not apply to an individual licensee who: (1) is licensed during all of such calendar year under one or more kinds of individual life licenses, (2) during all of such calendar year conducts an individual business, not being named in any joint firm license nor owning any interest in a corporation or partnership transacting business under any kind of life license, (3) has been continuously licensed in some manner as an active agent under some kind of life license for at least 25 years, and (4) is at least 65 years of age at the beginning of the calendar year.

"Year" as used in this section means the calendar year. Suspension, revocation or denial of license for violation of this section may be ordered at any time within five years after the close of the year in which the violation occurred.

761. Any insurer, insurance agent, broker, solicitor, or life agent and any officer or employee of an insurer, insurance agent, broker, or life agent that makes or receives an unlawful rebate is guilty of a misdemeanor.

763. The following acts are not unlawful rebates:

(a) The return by an insurer issuing policies on a participating plan, or any portion of the premium as a dividend after the expiration of the term covered by such policy.

(b) The payment of commission by any insurer, or insurance agent, broker or solicitor, to another insurer, or insurance agent, broker or solicitor, upon insurance lawfully transacted in that capacity.

(c) The allowance by any marine insurer, or marine insurance agent, broker, or solicitor to any insured, of such usual discount as is sanctioned by custom among marine insurers as being additional to the agent's or broker's commission.

(d) The paying by an insurer to another insurer, or to an insurance agent, broker, or solicitor, of a commission in respect to a policy under which the payee is insured, or the receiving by such payee of such commission.

(e) The paying by an insurer of bonuses to policyholders on nonparticipating life insurance or otherwise abating their premiums, in whole or in part, out of surplus accumulated from nonparticipating insurance.

(f) The return as a dividend by a life insurer of any portion of the premium on policies issued on a participating plan at any time.

(g) The return, by an insurer transacting industrial insurance on a weekly payment plan, to policyholders who have made premium payments for a period of at least one year directly to the insurer at its home or district office, of a percentage of the premium which the insurer would have paid for the weekly collection of such premiums.

~~(h) The paying by any life insurer, or the receiving by life insurance policyholders of special compensations, or the allowing and receiving of credits already agreed upon in life insurance contracts now in force.~~

~~(i) The payment by an insurer of any portion of life insurance premiums payable by its employees pursuant to a life insurance program under which 75 per cent or more of its employees are required to carry life insurance on their lives so long as they remain in the employment of insurer.~~

~~(j) The payment or allowance of a fee or commission by one surety insurer to another surety insurer in respect to a risk on which both are cosuretics.~~

~~763.5. The sale of the good will, business, list of policyholders or similar assets of an agent or broker in consideration of commissions or portions thereof to be thereafter earned by the use of such assets and payments of such consideration are not unlawful rebates if the purchaser is duly licensed to transact insurance and the receipt of the commissions would not constitute a violation of Section 760 if the person receiving them were licensed as an insurance agent.~~

~~764. Any person may be compelled to testify or produce evidence at the trial or hearing on a charge of violating a provision of this article, even though such testimony or evidence may incriminate him. A prosecution shall not be brought or maintained against such person for any act concerning which he thus testifies or produces evidence, except for perjury committed in so testifying.~~

~~765. If an insurer knowingly violates any provisions of this article, or knowingly permits any officer, agent, or employee so to do, the commissioner, after a hearing in accordance with the procedure provided in Section 704, may suspend the insurer's certificate of authority to do the class of insurance in which the violation of this article occurred.~~

~~766. If an insurance agent, broker, or solicitor knowingly and wilfully violates any of the provisions of this article, the commissioner, after a hearing in accordance with the procedure provided in Article 13 of Chapter 5 of this part may suspend or revoke the violator's license.~~

~~767. Notwithstanding any provision in this article to the contrary, it shall not be unlawful for any licensed insurance broker to pay a commission to an agent or broker licensed under the laws of Mexico when such agent or broker in Mexico refers to the insurance broker licensed in this state a resident of Mexico who wishes to obtain a policy of automobile liability insurance to be effective in this state from an insurer licensed in this state, and such broker negotiates and effects such a policy of insurance for such resident of Mexico.~~

SECTION 8. Technical Matters

(a) This act shall be liberally construed and applied in order to fully promote its underlying purposes.

(b) The provisions of this act shall not be amended by the Legislature except to further its purposes by a statute passed in each house by roll call vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate.

(c) If any provision of this act or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Proposition 104: Analysis

Continued from page 102

- Permits, but does not require, insurance companies to offer an unspecified "good driver" discount.
- Enacts other insurance-related provisions, and reenacts many provisions related to various lines of insurance which are currently in law.
- Provides that if this measure receives a higher number of votes than other measures on this ballot, then those provisions in other measures that relate to the business of insurance shall have no effect.

No-Fault System

Starting July 1, 1989, this measure establishes a no-fault motor vehicle insurance system that (1) applies only to bodily injury and (2) permits individuals to sue for losses which exceed specified limits.

This measure applies to private and commercial motor vehicles including automobiles, trucks, buses and trailers. It does not apply to motorcycles and "off-road-type" vehicles which are not registered with the Department of Motor Vehicles.

This measure contains the following features.

1. **"Basic" Benefits.** Requires the following minimum basic benefits to be paid by insurance companies to injured persons regardless of who is at fault:
   - Up to $10,000 for medical expenses;
   - Up to $15,000 for lost wages; and
   - $5,000 for funeral benefits, in case the injuries result in death.

In general, the basic benefits would not be provided to an uninsured motorist, a person driving a stolen car, or a person engaged in the commission of a felony.

This measure provides that the basic benefits shall be available only to pay medical expenses and lost wages to the extent that these expenses are not covered by workers' compensation and disability benefits.

Any dispute concerning payment of basic benefits would be decided by arbitration, and not by court trial. The arbitration would be conducted in accordance with procedures established by the Insurance Commissioner.

2. **Recovery of Workers' Compensation Costs.** Restricts the ability of employers to be reimbursed for medical expenses and wage losses paid under workers' compensation and other similar programs when employees are injured in motor vehicle accidents. Currently, an employer may recover the cost of benefits—such as workers' compensation—it provides to an employee who was injured in an accident by another person who was at fault.

3. **Additional Recovery.** Permits an injured person to recover costs in excess of the no-fault basic benefits by suing the party at fault for the accident.

4. **Noneconomic Losses.** Pronibits recovery for noneconomic losses (such as pain and suffering), except in cases involving (a) death or (b) serious and permanent disfigurement or injury. It would not limit the right to sue for damages in cases involving (a) the operation of an uninsured vehicle, (b) harm caused intentionally, or (c) specified crimes.

5. **Attorney Fees.** Limits plaintiffs' attorney contingency fees in motor vehicle accident cases involving bodily injury to the following: (a) 15 percent of the basic no-fault benefits recovered; (b) 33.3 percent of the first $50,000 recovered over the basic benefits; (c) 25 percent of the second $50,000 recovered over the basic benefits, and (d) 15 percent of the recovery over $100,000.

6. **Premium Reduction.** Requires insurance companies to reduce—by 20 percent for a two-year period (July 1989 through June 1991)—the average statewide premium rates for specified motor vehicle insurance. This would include basic bodily injury liability, uninsured motorist and basic no-fault benefits provided under this measure. This reduction does not apply to the personal property liability damage, collision and comprehensive portions of a motor vehicle insurance policy.

Other Insurance-Related Provisions

The measure enacts other motor vehicle insurance-related provisions including the following.

1. **Claims Settlement Practices.** Requires that disputes between an insurance company and persons other than policyholders be settled by arbitration rather than by court action.

2. **Penalty.** Increases the penalty from an "infraction" to a "misdemeanor" for second and subsequent convictions for violation of the current financial responsibility laws.

3. **Insurance Fraud.** Increases the authority of the Insurance Commissioner to investigate and prosecute insurance fraud.

4. **Premium Discounts.** Permits, but does not require,

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800-227-4527

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

First Year New Doctor Rule Rates*

Retroactive Date 1/1/88 or Later

DOCTORS COVERAGE CLASSIFICATIONS	LIMITS 1 500,000/1,500,000		LIMITS 2 1,000,000/3,000,000		LIMITS 3 2,000,000/4,000,000		LIMITS 4 5,000,000/5,000,000	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	475	118.75	558	139.50	742	185.50	928	232.00
2. COVERAGE CLASS 2	604	151.00	710	177.50	852	213.00	1,065	266.25
3. COVERAGE CLASS 3	862	215.50	1,015	253.75	1,217	304.25	1,521	380.25
4. COVERAGE CLASS 4	992	248.00	1,167	291.75	1,400	350.00	1,750	437.50
5. COVERAGE CLASS 5	1,509	377.25	1,775	443.75	2,130	532.50	2,662	665.50
6. COVERAGE CLASS 6	1,681	420.25	1,978	494.50	2,373	593.25	2,966	741.50
7. COVERAGE CLASS 7	2,155	538.75	2,536	634.00	3,169	792.25	3,961	990.25
8. COVERAGE CLASS 8	3,103	775.75	3,651	912.75	4,563	1,140.75	5,704	1,426.00
9. COVERAGE CLASS 9	4,310	1,077.50	5,071	1,267.75	6,591	1,647.75	8,239	2,059.75
10. COVERAGE CLASS 10	5,861	1,465.25	6,896	1,724.00	9,240	2,310.00	11,550	2,887.50

ALASKA
DATE PREPARED: MARCH 17,1988
PROCEDURE: NDPREM
USERID: MIECUWK

*These rates apply only to physicians entering the practice of medicine for the first time after completion of a residency, fellowship training or military service.

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MIEC **Medical Insurance Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 5,000,000 Each Claim / 5,000,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	3,712	928	7,296	1,824	9,272	2,318	10,016	2,504	10,880	2,720
2. COVERAGE CLASS 2	4,260	1,065	8,376	2,094	10,648	2,662	11,500	2,875	12,496	3,124
3. COVERAGE CLASS 3	6,084	1,521	11,968	2,992	15,212	3,803	16,428	4,107	17,848	4,462
4. COVERAGE CLASS 4	7,000	1,750	13,760	3,440	17,492	4,373	18,892	4,723	20,524	5,131
5. COVERAGE CLASS 5	10,648	2,662	20,940	5,235	26,620	6,655	28,748	7,187	31,232	7,808
6. COVERAGE CLASS 6	11,864	2,966	23,336	5,834	29,660	7,415	32,036	8,009	34,804	8,701
7. COVERAGE CLASS 7	15,844	3,961	31,160	7,790	39,612	9,903	42,780	10,695	46,476	11,619
8. COVERAGE CLASS 8	22,816	5,704	44,872	11,218	57,040	14,260	61,604	15,401	66,924	16,731
9. COVERAGE CLASS 9	32,956	8,239	64,812	16,203	82,388	20,597	88,980	22,245	96,668	24,167
10. COVERAGE CLASS 10	46,200	11,550	90,856	22,714	115,496	28,874	124,736	31,184	135,516	33,879
11. NURSE/TECHNICIAN	256	64	504	126	640	160	692	173	752	188
12. PHYSIOTHERAPIST	512	128	1,008	252	1,280	320	1,384	346	1,500	375
13. PHYS ASST/NURSE PRAC	612	153	1,200	300	1,524	381	1,644	411	1,788	447

The Retroactive Date is the original date of your first MIEC policy.

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ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 2,000,000 Each Claim / 4,000,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,968	742	5,836	1,459	7,420	1,855	8,012	2,003	8,704	2,176
2. COVERAGE CLASS 2	3,408	852	6,704	1,676	8,520	2,130	9,200	2,300	9,996	2,499
3. COVERAGE CLASS 3	4,868	1,217	9,576	2,394	12,168	3,042	13,144	3,286	14,280	3,570
4. COVERAGE CLASS 4	5,600	1,400	11,008	2,752	13,996	3,499	15,116	3,779	16,420	4,105
5. COVERAGE CLASS 5	8,520	2,130	16,752	4,188	21,296	5,324	23,000	5,750	24,988	6,247
6. COVERAGE CLASS 6	9,492	2,373	18,668	4,667	23,728	5,932	25,628	6,407	27,844	6,961
7. COVERAGE CLASS 7	12,676	3,169	24,928	6,232	31,688	7,922	34,224	8,556	37,184	9,296
8. COVERAGE CLASS 8	18,252	4,563	35,896	8,974	45,632	11,408	49,284	12,321	53,540	13,385
9. COVERAGE CLASS 9	26,364	6,591	51,852	12,963	65,912	16,478	71,184	17,796	77,336	19,334
10. COVERAGE CLASS 10	36,960	9,240	72,688	18,172	92,396	23,099	99,788	24,947	108,412	27,103
11. NURSE/TECHNICIAN	208	52	404	101	512	128	556	139	600	150
12. PHYSIOTHERAPIST	412	103	808	202	1,024	256	1,108	277	1,200	300
13. PHYS ASST/NURSE PRAC	488	122	960	240	1,220	305	1,316	329	1,428	357

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Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 1,000,000 Each Claim / 3,000,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,232	558	4,388	1,097	5,580	1,395	6,024	1,506	6,544	1,636
2. COVERAGE CLASS 2	2,840	710	5,584	1,396	7,100	1,775	7,668	1,917	8,332	2,083
3. COVERAGE CLASS 3	4,060	1,015	7,980	1,995	10,144	2,536	10,952	2,738	11,900	2,975
4. COVERAGE CLASS 4	4,668	1,167	9,176	2,294	11,664	2,916	12,596	3,149	13,684	3,421
5. COVERAGE CLASS 5	7,100	1,775	13,960	3,490	17,748	4,437	19,168	4,792	20,824	5,206
6. COVERAGE CLASS 6	7,912	1,978	15,556	3,889	19,776	4,944	21,356	5,339	23,204	5,801
7. COVERAGE CLASS 7	10,144	2,536	19,944	4,986	25,352	6,338	27,380	6,845	29,748	7,437
8. COVERAGE CLASS 8	14,604	3,651	28,720	7,180	36,508	9,127	39,428	9,857	42,832	10,708
9. COVERAGE CLASS 9	20,284	5,071	39,888	9,972	50,704	12,676	54,760	13,690	59,492	14,873
10. COVERAGE CLASS 10	27,584	6,896	54,244	13,561	68,956	17,239	74,472	18,618	80,904	20,226
11. NURSE/TECHNICIAN	172	43	336	84	428	107	464	116	500	125
12. PHYSIOTHERAPIST	344	86	672	168	856	214	924	231	1,000	250
13. PHYS ASST/NURSE PRAC	408	102	800	200	1,016	254	1,096	274	1,192	298

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MIEC **Medical Insurance Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 500,000 Each Claim / 1,500,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	1,900	475	3,732	933	4,744	1,186	5,120	1,280	5,564	1,391
2. COVERAGE CLASS 2	2,416	604	4,748	1,187	6,036	1,509	6,516	1,629	7,080	1,770
3. COVERAGE CLASS 3	3,448	862	6,784	1,696	8,620	2,155	9,312	2,328	10,116	2,529
4. COVERAGE CLASS 4	3,968	992	7,800	1,950	9,912	2,478	10,708	2,677	11,632	2,908
5. COVERAGE CLASS 5	6,036	1,509	11,868	2,967	15,084	3,771	16,292	4,073	17,700	4,425
6. COVERAGE CLASS 6	6,724	1,681	13,224	3,306	16,808	4,202	18,152	4,538	19,724	4,931
7. COVERAGE CLASS 7	8,620	2,155	16,952	4,238	21,548	5,387	23,272	5,818	25,284	6,321
8. COVERAGE CLASS 8	12,412	3,103	24,412	6,103	31,032	7,758	33,512	8,378	36,408	9,102
9. COVERAGE CLASS 9	17,240	4,310	33,904	8,476	43,096	10,774	46,544	11,636	50,568	12,642
10. COVERAGE CLASS 10	23,444	5,861	46,108	11,527	58,612	14,653	63,300	15,825	68,772	17,193
11. NURSE/TECHNICIAN	148	37	288	72	364	91	392	98	428	10
12 PHYSIOTHERAPIST	292	73	572	143	728	182	784	196	852	213
13. PHYS ASST/NURSE PRAC	348	87	680	170	864	216	932	233	1,012	253

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MIEC Medical Insurance Exchange of California

ALASKA

1988 Coverage Classification and Premium Schedule

If you practice in more than one specialty, use the highest rated specialty.

Class	Specialty
2	Administrative Medicine
2	Allergy
8	Anesthesiology
5	Assisting at Surgery
4	Cardiology*
9	Cardiovascular Surgery
8	Colon & Rectal Surgery
3	Dermatology, Excluding Hair Transplants
5	Dermatology, Including Hair Transplants
7	Dermatology – liposuction
8	Emergency Medicine
3	Endocrinology*
	Family Practice General Practice
3	– No Surgery
5	– Less than 5% of income from performance of Surgery
8	– 5% or more of income from performance of Surgery
10	– Including Obstetrics
9	– Including 5% or more income from any combination of Orthopedics, Gynecology, ENT Surgery
3	Gastroenterology*
3	General Preventive Medicine
8	General Surgery
8	Gynecology (Only)
8	Hand Surgery
8	Head & Neck Surgery
3	Hematology*
6	Industrial Medicine
3	Infectious Diseases*
3	Internal Medicine*
4	Neonatology*
3	Neoplastic Diseases*
3	Nephrology*
4	Neurology, Excluding Invasive Procedures
5	Neurology, Including Invasive Procedures
10	Neurological Surgery
3	Nuclear Medicine*
10	OB-GYN
3	Occupational Medicine (Not Industrial)
4	Ophthalmology, Excluding Radial Keratotomy
7	Ophthalmology, Including Radial Keratotomy or 5% or more from cosmetic surgery
9	Orthopedics, Excluding Spinal Surgery and use of Chymopapain
10	Orthopedics, Including Spinal Surgery and use of Chymopapain
8	Otolaryngology
9	Otolaryngology – 5% or more from Cosmetic Surgery
2	Pathology
3	Pediatrics
4	Pediatric Cardiology
8	Pediatric Surgery
3	Physical Medicine and Rehabilitation
8	Plastic Surgery
1	Psychiatry**
1	Psychiatry, Child**
2	Public Health
3	Pulmonary Diseases*
7	Radiology, Diagnostic and Therapeutic
1	Radiology, Diagnostic Only*
7	Radiology, Therapeutic Only*
3	Rheumatology*
8	Thoracic Surgery, Excluding Cardiovascular
4	Urgent Care Medicine
7	Urology

*Includes all procedures, including Invasive Diagnostic Procedures, considered usual and customary to and within the training and purview of the specialty.
**Without ECT or drug shock therapy. With ECT or drug shock therapy, use Class 3.

Partnership/Corporation Liability and Full Time Employed Physicians — 7% if all partners/shareholders and employed doctors have $500,000/1,500,000 limits; 2.5% if all partners/shareholders and employed doctors have $1,000,000/3,000,000 limits or higher. Full Time Employed Physicians must carry limits at least equal to employer. Employer will be charged a percentage of the premium charged for the employed physician's classification at employer's limits.

Secretaries, Receptionists and Bookkeepers — No charge.

Optional Coverages:

Professional premises/limited non-owned automobile liability

Covers certain liabilities for injuries sustained by the public or for damage to property of third persons at your offices. It also covers certain liabilities to injured parties arising from an employee's use of an automobile (not owned, rented or leased to you) in the course of your professional practice, up to $100,000 for bodily injury and $25,000 for property damage. Refer to the policy for coverage specifics.

LIMITS OF LIABILITY: Bodily injury, $500,000 each claim/aggregate, or $1,000,000 each claim/aggregate (to coincide with professional liability limits, but not higher than $1,000,000); Property damage, $100,000.

PREMIUM: No additional premium for premises occupied as physicians' professional offices. Clinics and other premises: refer to MIEC.

Defense coverage for *miscellaneous* liability

Provides up to $100,000 legal defense coverage only for alleged acts or omissions involving:

- Certain civil actions or proceedings, including a physician's acts or omissions as an officer of a national, state or local medical or specialty society;
- Alleged wrongful termination or discrimination against an employee;
- Breach of contract or other alleged misconduct in the nature of a commercial or fee dispute arising from professional practice;
- Assault, battery, false arrest or personal restraint, malicious prosecution or conspiracy arising from professional practice.

This optional coverage is fully described in Part IV of the MIEC policy and is subject to the terms and conditions of the policy and endorsements actually issued. MIEC pays 90% of legal expenses to a maximum amount of $100,000.

PREMIUM: Individuals and solo professional corporation, $1,800 per year. Individuals with more than 10 employees, medical corporations with more than one physician shareholder, partnerships, laboratories and all other non-individual policyholders should contact MIEC for a special application and premium quotation.

M E M O R A N D U M February 17, 1989

SUBJECT: Civil Actions - HB 166

TO: Representative Sam Cotten

FROM: Michael F. Ford
Legislative Counsel

The following is a sectional analysis of HB 166:

Section 1 - Findings and purpose.

Section 2 - Requires that an action for personal injury, death, or property damage be brought within six years of the date of injury, if caused by a product or by construction, or within six years of the last act alleged to be the cause of the injury. Periods of disability, such as minority, incompetency, or imprisonment do not extend the six year period. This section does not apply if the personal injury, death, or property damage was caused intentionally, or if another shorter period of limitation applies.

Section 3 - Removes actions for personal injury, death, or property damage, from the existing two year statute of limitations.

Section 4 - Requires that an action for personal injury, death, or property damage be brought within two years of the time the person had the right to bring the action. The two year period is not extended for any period of disability, such as minority, incompetency, or imprisonment. The section does not apply if a shorter period of limitation is imposed.

Section 5 - Requires that clear and convincing evidence of malice, bad motive, or reckless indifference to the interests of another exist before punitive damages may be awarded.

Section 6 - Prohibits a person from recovering damages for personal injury or death if the injury or death occurred while the person was committing a crime and the person has been convicted of the crime. Crime includes a felony or a misdemeanor.

Section 7 - Provides that a person who commits a crime that results in personal injuries to that person is not prevented from recovering damages for personal injury or death, if the person liable was also engaged in the commission of a crime and has been convicted of the crime. Also defines the term "crime", to include a felony or a misdemeanor.

Section 8 - Requires that if a portion of a judgment is owed to an attorney under a contingent fee agreement, that portion must be reduced to a present value and paid in a lump sum, rather than as a part of periodic payments ordered by the court.

Section 9 - Requires that the court include an amount for inflation, when ordering that future damages be paid by periodic payments.

Section 10 - Prohibits recovery of damages for personal injury, death, or property damage caused by an act or omission within the official duties of a member of the board of directors or an officer of a public corporation, or electric or telephone cooperative, unless the act or omission constituted gross negligence.

Section 11 - Allows a person to only recover damages that are in excess of compensation received from other sources, such as private or government insurance. Also requires the court or jury to be informed of the tax implications of an award of damages.

Section 12 - Lowers the legal rate of interest that may be awarded on judgments from 10.5% to eight percent, unless otherwise agreed by contract.

Section 13 - Prohibits the award of prejudgment interest for future economic or noneconomic damages.

Section 14 - Technical amendment.

Section 15 - Prohibits an award of nonmonetary damages in excess of $50,000, in a wrongful death action.

Section 16 - Prohibits the court from awarding attorney fees in a civil action for personal injury, death, or property damage, unless specifically authorized by statute or by agreement of the parties.

Section 17 - Limits the liability of a hospital for civil damages caused by a person who is not an employee. Requires the hospital to post notice that certain individuals are not employees. Provides that the limitation does not apply to liability based on the hospital's own negligence or intentional misconduct. Adds certain definitions.

Section 18 - Requires the director of the division of insurance to annually report to the legislature regarding medical malpractice insurance rate changes occurring as a result of certain court decisions.

Section 19 - Limits the right of a person to bring an action against a peace officer or member of the emergency service patrol when taking an intoxicated person into custody, unless the act or commission was grossly negligent, reckless or intentional.

Section 20 - Repeals (1) a limit on recovery of noneconomic damages contained in AS 09.17.010(c),(2) an exception to the award of future damages contained in AS 09.17.040(c), and (3) a section regarding consideration of collateral benefits in a medical malpractice action contained in AS 09.55.548.

Section 21 - Requires the Department of Commerce and Economic Development to report to the legislature regarding the effect of certain insurance claims on the civil justice system.

Section 22 - Notice of amendment to the civil rules of court.

Section 23 - Notice of amendment to the civil rules of court.

Section 24 - Applicability.

Section 25 - Effective date.

MFF:kb
wkk2/022

Alaska State Legislature

C-17

Please enter into the record my testimony to the (H) Interior Delegation Labor & Commerce
committee name

committee on HB 166 , dated 4/1/89 .
bill/subject

1) Please clarify what the exemptions are under Sec. 09.17.030, and what other matters besides felonies this will include.

2) Please explain Sec 15 (g) what is this $50,000 non pecuniary damage mean to victims?

3) I do not feel tort reform is going to be the solution to this problem. I haven't seen any insurance premiums come down whether it's the doctors or whoever.

4) Who is going to be able to afford insurance in another five yrs. No insurance company has said, if you give us tort reform we'll give you 1-2-3 they haven't given us anything! Now they want to limit the victims right to recover more. (over)

Signed: Barbara Gaston
Testifier
(self)
Representing (Optional)
1825 Sheldon Ave
Address
Fbks, Ak 99701
Phone No. 451-8872

(2)

I didn't catch the fellow's name who testified from Matsu but he has said everything I wanted to say. Please send me a copy of his testimony.

If they don't insurance companies make returns a decent offer to begin with? If they have they forced returns to get lawyers just to talk to them?

This bill is an April Fool's joke and no solution. We need insurance reform!

Citizens' Coalition For Tort Reform

March 15, 1989

Rep. Sam Cotten
Speaker of the House
Alaska State Legislature
Juneau, Alaska 99811

Dear Mr. Speaker,

Recently we have received a wide variety of documents in support of our continued quest for comprehensive tort reform. We would like to share some of those letters and resolutions with you.

Submitted, for the record, are communications from:

Alaska Chapter, The American Institute of Architects

Alaska Dental Society

Alaska Society of Professional Engineers

Anchorage Branch, American Society of Civil Engineers

Anchorage Chamber of Commerce

CH2M Hill, Inc. (Including Rationale for Statutes of Repose, American Consulting Engineers Council)

Consulting Engineers Council of Alaska

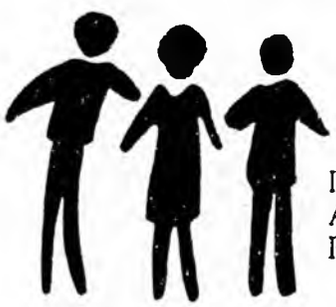
Cordova Medical Clinic

Greater Ketchikan Chamber of Commerce Resolution

Institute of Electrical & Electronics Engineers, Inc., Alaska Section

Maniilaq Association on behalf of its Member Villages; Ambler, Buckland, Deering, Kiana, Kivalina, Kobuk, Kotzebue, Noatak, Noorvik, Selawik, Shungnak

Ouzinkie, City of - Resolution 89-4



P.O. Box 2[illegible]668
Anchorage, Alaska 99520
Phone: 561-6250

Petersburg, City of - Resolution No. 1170-R

PEPP (Professional Engineers in Private Practice), Alaska Chapter

Providence Hospital, Sister Dona Taylor, Administrator

Providence Hospital, Kaaren R. Johnson, Associate Administrator, Program & Service Development

Soldotna, City of - Resolution 89-3

Structural Engineers Association of Alaska

Valdez, City of - Resolution No. 8905

Yukon Equipment, Inc.

We sincerely hope these messages, along with the many others you have received, or will receive, will encourage the House to (1) report HB166 out of committees with "Do Pass" recommendations and then (2) promptly adopt the bill.

The mandate of Alaskan voters will then be fulfilled.

Very truly yours,

David A. McGuire, M.D.
Chairman

ALASKA CHAPTER
THE AMERICAN INSTITUTE OF ARCHITECTS
P.O. BOX 10-3563 • ANCHORAGE, ALASKA 99510

Citizens Coalition For Tort Reform
P.O.Box 201668
Anchorage, Alaska 99520
(907) 561-6250

The Members of the 16th Alaska State Legislature,

We are writing to you to express the Alaska Chapter, American Institute of Architects support for the immediate enactment of Alaska's tort reform agenda.
We cannot emphasize enough the importance of tort reform to Alaska's Architectural and Engineering professions. Our professions liability insurance has become prohibitively expensive and it is tenative on continued availability in Alaska at any price.
It is essential that Tort Reform legislation be passed this year. The practices and future of many A/E firms hang in the balance.
Because insurance underwriters will not positively respond to a vauge or impotent bill, it is imperative that the Legislature develope effective Tort Reform legislation.
Tort Reform (in general) and reinstating the Statute of Limitation and repose is the Alaska Chapter American Institute of Architectures number one legislative priorty. Our goal is to rest only when such significant legislation is enacted.
The Alaska Chapter American Institute of Architecture desires that the 16th Legislature enact Alask's Tort Reform Agenda.

Sincerely,
Joel G. Chamberlain 1/16/89
Joel G. Chamberlain
President,
AIA, Alaska Chapter
American Institute of Architects

Alaska Dental Society
3400 Spenard Road, Suite 10
Anchorage, Alaska 99503
(907) 277-4675

January 20, 1989

David A. McGuire, M.D., Chairman
Citizens' Coalition for Tort Reform
P.O. Box 201668
Anchorage, Alaska 99520

Dear Dr. McGuire:

The Alaska Dental Society has heartily endorsed the newest agenda for tort reform legislation and would like to communicate our support to Coalition members and to the members of the 16th Alaska State Legislature.

Certainly, our most immediate appeal is to emphasize the importance of passing this particular agenda during this legislative session. The mandate for constructive tort reform was overwhelmingly stated by the Alaska electorate last November, and it appears the once heard opposition that the matter is too complicated has been defeated at the polls. This proposed agenda, issue by issue, presents effective, comprehensive tort reform legislation....badly needed in Alaska. We vote YES!

Sincerely,

Kerry D. Kennedy, D.D.S.
President
Alaska Dental Society

cc: Sam Kito

Alaska Society of Professional Engineers

Anchorage Chapter
P.O. Box 10-0833 Anchorage, Alaska 99510-0833

January 19, 1989

Members of the 16th Alaska State Legislature
c/o Citizen's Coalition for Tort Reform
P.O.Box 201668
Anchorage, AK 99520

Re: Tort Reform Legislation

Senators and Representatives of the 16th Legislature:

The Anchorage Chapter of the Alaska Society of Professional Engineers (ASPE) is a strong supporter of the Coalition's efforts to secure passage of **comprehensive and efficient tort reform legislation.** In fact, many of our members helped obtain signatures for the initiative petition process which resulted in Ballot Measure #2.

Our chapter membership of approximately 110 professional engineers supports the eleven reforms the Coalition is asking the legislature to pass this session. Some of these reforms, such as the statutes of limitations and repose, and the cap on non-economic damage awards, are of more importance to the design profession that others, however, I believe all are important to us as citizens. It is evident that the present tort laws are costing us all money, not just the plaintiffs and defendants. This is apparent through the ever-increasing cost of insurance - business insurance, automobile insurance, homeowner's insurance, etc.

The tort reform legislation is not intended to deprive injured parties of fair and just compensation. Rather it is intended to introduce fairness and predictability to the process.

Our society supports these reforms. I believe the people of Alaska support these reforms as evidenced by the recent overwhelming passage of Ballot Initiative #2. ASPE urges each and everyone of you to seriously consider and support meaningful tort reform legislation this session. We ask that you not allow the proposed legislation be butchered, so that what is passed in the name of tort reform has little practical meaning, as was done in 1986.

Many of us will be monitoring the progress of this important legislation. Please don't allow it to become stuck in one committee or another.

We look forward to a successful and productive legislative session. Good luck!

Very truly yours,

Anchorage Chapter,
Alaska Society of Professional Engineers

Stephen D. Shrader, P.E.
Chapter President

ANCHORAGE BRANCH
AMERICAN SOCIETY OF CIVIL ENGINEERS

January 16, 1989

Dear Members of the 16th Alaska State Legislature:

RE: TORT REFORM LEGISLATION

As President of the Anchorage Branch of the American Society of Civil Engineers, I represent nearly 600 civil engineers in the Anchorage area. These civil engineers come from the private sector, the public sector and academia. One issue that continues to be of interest to this diverse group of professionals is the enactment of effective, comprehensive tort reform legislation.

Members of the Anchorage Branch were encouraged by the passage of Ballot Measure #2 which takes joint liability off the books in Alaska. The Alaska voters passed Ballot Measure #2 by an overwhelming majority - 72% voted "yes". It is now incumbent on the 16th Alaska State Legislature to take this mandate and enact effective, comprehensive tort reform legislation.

The Anchorage Branch fully supports the continuing efforts of the Citizen's Coalition for Tort Reform to seek the reforms necessary to enable Alaska to have a justice system that serves everyone's interests. In particular, the Anchorage Branch expects the Legislature to address the following reforms this year:

- clarify the conditions under which punitive damages can be awarded;
- preclude a person from recovering damages when his/her injuries or death occurred while committing a crime (felony or misdemeanor), unless the person liable for the damages was committing a crime when the death of injury occurred;
- at the request of any party in the suit, allow the court to order that a judgement award for future damages (economic and non-economic) be paid to the maximum extent feasible in periodic payments rather than lump sum and, in such cases, require the attorney's contingent fee to be reduced to present value and paid in a lump-sum;
- add electrical and telephone cooperative board members and officials to the list of persons with limited liability when carrying out their official duties;

- o exempt personal injury, death and property damage suits from the application of Alaska Civil Rule 82, so that the court cannot award payment of the prevailing party's attorneys fees unless authorized to do so by statute or by an agreement between the parties to the suit;
- o limit the liability of hospitals for the negligence of non-employees;
- o prevent a person from taking civil action against a peace officer or an emergency service patrol member for a non-malicious decision to take or not to take an intoxicated or incapacitated person into protective custody or to release such a person from custody;
- o cap the amount of non-economic damage awards for all personal injuries at $500,000;
- o reduce the amount the injured party may recover by the amount he or she is compensated for those injuries from collateral sources, e.g. another successful lawsuit;
- o repeal the existing provision that allows parties to agree not to reduce the award of future damages, such as lost income, to present day value and;
- o provide for equal and uniform application of Alaska's statutes of repose and limitation.

Tort reform is of utmost importance to the nearly 600 members of the Anchorage Branch of the American Society of Civil Engineers. We will be closely following the 16th Alaska Legislature. Our members expect the Legislators we sent to Juneau to pass nothing short of effective, comprehensive tort reform legislation this year.

Sincerely,

THOMAS S. WOLF, P.E.
President, Anchorage Branch
American Society of Civil Engineers

Anchorage • *Star of the North*
Chamber of Commerce

1989 LEGISLATIVE PRIORITIES

February 1, 1989

Executive Summary

I. The State needs to develop a strategic financial plan to reduce spending to a sustainable level.

Two constitutional amendments are needed:

(1) A 40/30/30 allocation of Permanent Fund earnings
(2) Limitations on State spending.

II. Provide economic development incentives to foster development:

(1) Stable taxes
(2) Anchorage Economic Development Corporation's seven incentives
(3) Establish an independent Anchorage Airport Authority
(4) Increased tourism funding will yield rapid returns to Alaska
(5) Revise Alaska Industrial Development and Export Authority statutes
(6) Develop the mariculture industry

III. Regulatory and statutory reform to include:

(1) Tort reform
(2) Revise the "Right to Return Transportation"
(3) Allow alternative methods of compensation for overtime
(4) Emphasize "one stop shopping"
(5) Reform procurement policies

IV. Capital projects:

(1) Maintain the Railbelt Fund for railbelt energy projects
(2) Support area-wide cooperative capital projects
(3) Study a deep water Fire Island port
(4) Fund a scaled down Anchorage courthouse

V. Land and natural resource issues:

(1) Adequately fund ANWR promotion
(2) Oppose further wilderness designation in Alaska
(3) Allow reasonable military training on State lands

VI. Support quality of life issues:

(1) Keep Alaska Psychiatric Institute in Anchorage
(2) Maintain social service block grant funding
(3) Provide for needed "base level" arts funding
(4) Support adequate highway maintenance
(5) Adopt Crime Commission proposals

Representing: ***1,200 Member businesses***
38,000 Employees
18 Committees
over 400 Volunteers

Engineers
Planners
Economists
Scientists

February 21, 1989

Representative Dave Donley
Chairman, House Labor & Commerce Committee
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Donley:

Subject: House Bill No. 166, Tort Reform

I am writing to urge your favorable consideration of HB 166, the omnibus tort reform bill.

This bill will bring essential judicial reform to many public and private business sectors. In the case of my own business, reestablishing Statutes of Repose and Limitation, as provided in Sections 09.10.052 and 09.10.070 of the bill, is especially vital.

A copy of a "rationale" paper put out by the American Consulting Engineers Council is attached. This paper lists five important reasons for a strong statute of repose. These are all patently fair reasons which we believe should transcend any argument that a statute of repose is a special interest issue.

The stated purpose of HB 166 is, ". . . to create a more equitable distribution of the cost and risk of injury and increase the availability and affordability of insurance." For companies such as CH2M HILL, which has been established in Alaska for over 20 years, the fulfillment of that purpose by passing statutes of repose and limitation is essential to the future stability of our business.

Thank you in advance for your positive support of HB 166.

Sincerely,

Dan M. Rowley

Dan M. Rowley, P.E.
Alaska Regional Manager

bja:079:34

CH2M HILL INC. Anchorage Office Denali Towers North, 2550 Denali Street, 8th Floor, Anchorage, Alaska 99503 907.278.2551

Engineers
Planners
Economists
Scientists

February 21, 1989

Representative Max F. Gruenberg, Jr.
Co-Chairman, House Judiciary Committee
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Gruenberg:

Subject: House Bill No. 166, Tort Reform

I am writing to urge your favorable consideration of HB 166, the omnibus tort reform bill.

This bill will bring essential judicial reform to many public and private business sectors. In the case of my own business, reestablishing Statutes of Repose and Limitation, as provided in Sections 09.10.052 and 09.10.070 of the bill, is especially vital.

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Thank you in advance for your positive support of HB 166.

Sincerely,

Dan M. Rowley

Dan M. Rowley, P.E.
Alaska Regional Manager

bja:079:34

CH2M HILL, INC. Anchorage Office Denali Towers North, 2550 Denali Street, 8th Floor, Anchorage, Alaska 99503 907.278.2551

Engineers
Planners
Economists
Scientists

February 21, 1989

Representative Peter Goll
Co-Chairman, House Judiciary Committee
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Goll:

Subject: House Bill No. 166, Tort Reform

I am writing to urge your favorable consideration of HB 166, the omnibus tort reform bill.

This bill will bring essential judicial reform to many public and private business sectors. In the case of my own business, reestablishing Statutes of Repose and Limitation, as provided in Sections 09.10.052 and 09.10.070 of the bill, is especially vital.

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Thank you in advance for your positive support of HB 166.

Sincerely,

Dan M. Rowley

Dan M. Rowley, P.E.
Alaska Regional Manager

bja:079:34

American Consulting Engineers Council
1015 Fifteenth Street, N.W., Washington, D.C. 20005 202-347-7474

December, 1987

Rationale for

STATUTES OF REPOSE

For actions arising out of "improvements to real property" a special statute exists in many states to limit the time a claim can be brought for design deficiencies. These special statutes are commonly called "statutes of repose." They differ from statutes of limitations in that the time period in which to bring an action usually begins to run from the date of substantial completion of the project. Under a statute of limitations, the time period begins on the date of injury or discovery thereof.

There are several important reasons to support a strong statute of repose:

1. Unlike most products, the useful life of an improvement to real property can last for decades and even centuries. Evidence relative to any claim brought years after completion might be lost or destroyed, and witnesses may no longer be available. In addition, it is terribly expensive and virtually impossible to maintain records involving all past projects.

2. Data on claims filed for design deficiencies demonstrate conclusively that the vast majority of design cases arise within the first five years after completion of a project.

3. Once the owner accepts the project, all maintenance and subsequent improvements are beyond the control of other parties, including the designers of the project. Improper maintenance and repairs (or inattention to necessary maintenance and upgrading) can lead to numerous claims, and it is not fair to bring the design professional into the suit.

4. Without a statute of repose, design professionals may be unfairly exposed to evolving standards and technology being applied to a dated project. Often, it is very difficult for a defendant to prove what the "state-of-the-art" standards were at the time the project was designed. As a result, a defendant's design might be judged against current standards.

5. The expense of living with liability exposure for an infinite period of time is an unfair burden both for design professionals and their clients. The cost of insurance to cover all past work, no matter how long ago it was designed, against the threat of litigation is an expense carried by design professional and client alike.

It should be understood that even if the time period to make a claim against a design professional has expired under a statute of repose, an injured plaintiff still has recourse to seek and obtain compensation. A statute of repose for design deficiencies merely helps the plaintiff to focus the action on the party or parties who may be truly at fault.

CONSULTING ENGINEERS
COUNCIL OF ALASKA

P. O. BOX 200345
ANCHORAGE, AK 99520-0345

Members of the 16th Alaska
State Legislature
Pouch V
Juneau, Alaska 99811

Honorable Representatives and Senators
of the 16th Legislature:

The Consulting Engineers Council of Alaska (CECA) fully supports tort reform and, in turn, urges your support of the reforms the Citizens Coalition for Tort Reform intends to ask the Alaska State Legislature to address this year.

In 1988, consulting engineers nationwide spent over $250 million on professional liability insurance. Overall, firms paid 4.5 percent of their annual gross billings for professional liability insurance. On an individual basis, insurance premium costs were highest (over 7 percent) for small (1- to 5-person) firms.

We estimate that the average cost for a firm to defend itself against a lawsuit is over $20,000 per claim. In 1988, one-third of the claims brought against consulting engineering firms were settled without payment to the claimant. We are living in an environment that fosters frivolous claims and, unfortunately, Alaska has more than its fair share of litigious opportunists.

Until a legal climate is created in this state that presents reasonable insurance risks, we are going to be faced with exorbitant premium and defense costs that force many firms to operate without professional liability insurance. Operating without PL insurance is not in anyone's best interest, least of all the public's. Tort reform is absolutely essential to restore the level of professional service and insurance protection that our public and private Alaskan clients need and deserve.

Sincerely,

Dan M. Rowley

Dan M. Rowley, P.E.
President

bja:076:70

CORDOVA MEDICAL CLINIC

Arthur D. Tilgner, M.D. *Larry A. Ermold, M.D.* *Oliver S. Osborn, M.D.*

P.O. Box 310
Cordova, Alaska 99574
(907) 424-8200

March 3, 1989

Representative Dave Donley
P.O. Box V
Juneau, AK 99811

Dear Representative Donley:

I'm a physician in Cordova. I've been in practice here for 18 years. I and my two partners are the only available medical care in the area. We have been unable to afford medical malpractice insurance for over two years. Our situation is desperate. I've never been sued but, as you know, you can do something right thousands of times but, one mistake will cost you dearly. I and my family stand to lose everything that we've worked for should something like that occur. We need your help.

Would you please make every effort to get House Bill 166 through your committee and on its way to the floor.

Thank you so much for your consideration.

Sincerely yours,

A.D. Tilgner, M.D.

ADT:tw

cc: Citizens's Coalition for Tort Reform

Greater Ketchikan Chamber of Commerce
p.o. Box 3957, Ketchikan, Alaska 99901
(907) 225-3184

February 22, 1989

David McGuire, M.D.
CITIZENS' COALITION FOR TORT REFORM
P.O. Box 201668
Anchorage, AK 99520

Dear Dr. David McGuire:

With regard to your letter of January 12, 1989, please find enclosed a copy of the Greater Ketchikan Chamber of Commerce Resolution on Tort Reform.

Copies of the Resolution have been sent to Senator Jones, Representative Taylor and Representative Davis.

Sincerely,

Leslie

Ms. L. J. Bartholomew
President
Greater Ketchikan Chamber of Commerce

Enc.

Let me know if we can do anything!

LJB

Greater Ketchikan Chamber of Commerce
p.o. Box 5957, Ketchikan, Alaska 99901
(907) 225-3184

COMPREHENSIVE TORT REFORM LEGISLATION
RESOLUTION

WHEREAS: The voters of Alaska demonstrated their strong support for tort reform by passing Ballot Measure #2, enacting pure several liability, in the 1988 General Election by an overwhelming majority of 71.8%; and

WHEREAS: It is clear that the citizens of the State of Alaska want a fair, efficient and consistent civil justice system; and

WHEREAS: Enacting pure several liability is only the beginning of the reforms needed if Alaska is to have a civil justice system that will 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; and

WHEREAS: The chaotic state of the civil justice system in Alaska adding to the high cost of obtaining adequate insurance coverage is jeopardizing the ability of local governments to provide the facilities and services that communities in Alaska desire and need; and

WHEREAS: The 16th Alaska State Legislature has the opportunity to enact comprehensive legislation that will result in a justice system that will best serve the interests of all Alaskans;

NOW, THEREFORE, BE IT RESOLVED: That the Greater Ketchikan Chamber of Commerce urges the 16th Alaska State Legislature to enact comprehensive tort reform legislation in 1989.

DATED AT KETCHIKAN, ALASKA this 22nd day of February, 1989.

L Bartholomew

Ms. L. J. Bartholomew
President
Greater Ketchikan Chamber of Commerce

THE INSTITUTE OF
ELECTRICAL AND
ELECTRONICS
ENGINEERS, INC.

Alaska Section

PLEASE REPLY TO:

P.O. Box 111193
Anchorage, AK 99511-1193

January 11, 1989

Members of the 16th Alaska State Legislature
Juneau, AK

Reference: TORT REFORM LEGISLATION

Dear Legislator:

The Alaska Section of the Institute of Electrical and Electronics Engineers is very concerned about the lack of fairness in the current civil justice system in Alaska. As technical and design professionals, we have joined with other interested organizations including health care professionals, businesses, and local government agencies in calling for effective, comprehensive tort reform legislation. Compromises, such as occurred in the 1986 legislation, will only erode and confuse the justice system further.

The results of Ballot Measure #2 should give all legislators a clear mandate on this issue. On behalf of the IEEE Alaska Section Executive Committee and over 300 electrical, electronics, and computer professionals throughout our great State, we urge your support for passage of equitable tort reform legislation this year.

Sincerely,

IEEE ALASKA SECTION

Calvin L. Hoggard

Calvin L. Hoggard, Chairman

90111.1/L1/rme

Maniilaq Association

P.O. Box 256
Kotzebue, Alaska 99752
(907) 442-3311

February 16, 1989

David A. McGuire, M.D.
Citizens Coalition for Tort Reform.
P.O. Box 201668
Anchorage, Alaska 99520

Dear Dr. McGuire:

I would like to add my support to your efforts to reform the Civil Justice Tort System in Alaska.

The spiraling cost of liability insurance to local government and non-profit agencies is becoming a burden impossible to bear. Services to our constituents have been and will be further limited unless we can feel a lesser degree of fear of lawsuits and excessive awards.

You are right! It's time for the Legislature to act for a fair and consistent Civil Justice System.

Sincerely,

Berend Roeters, Administrator
Maniilaq Medical Center
P.O. Box 43
Kotzebue, Alaska 99752

A RESOLUTION
89-4

REQUESTING THE 16TH ALASKA STATE LEGISLATURE TO ENACT COMPREHENSIVE TORT REFORM LEGISLATION

WHEREAS, Alaska's voters demonstrated their strong support for tort reform by passing Ballot Measure #2, enacting pure several liability, in the 1988 General Election by an overwhelming majority of 71.8%; and

WHEREAS, it is clear Alaskan's want a fair, efficient and consistent civil justice system; and

WHEREAS, enacting pure several liability is only the beginning of the reforms needed if Alaska is to have a civil justice system that will 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; and

WHEREAS, the chaotic state of Alaska's civil justice system adding to the high cost of obtaining adequate insurance coverage is jeopardizing the ability of local governments to provide the facilities and services Alaska's communities desire and need; and

WHEREAS, the 16th Alaska State Legislature has the opportunity to enact comprehensive legislation that will result in a justice system that will best serve the interest of all Alaskans.

NOW THEREFORE BE IT RESOLVED BY THE Ouzinkie City Council

THAT:

The 16th Alaska State Legislature is urged to enact comprehensive tort reform legislation in 1989.

Dated: February 9, 1989

Zack Chichenoff

Debra Garner, Clerk

City of Ouzinkie
P.O. Box 109
Ouzinkie, Alaska 99644

City of Petersburg
P. O. Box 329
Petersburg, Alaska 99833

February 10, 1989

David A. McGuire, M.D., Chair
Citizens' Coalition For Tort Reform
PO Box 201668
Anchorage, Alaska 99520

Dear Dr. McGuire:

Enclosed please find a copy of City of Petersburg Resolution No. 1170-R, requesting the 16th Alaska State Legislature to enact comprehensive tort reform legislation.

The City Council of the City of Petersburg supports the Citizens' Coalition For Tort Reform in its efforts to make our civil justice system fair and consistent and making Alaska's local governments' exposure to law suits more reasonable so they can provide the services our communities need and deserve.

Sincerely,

Arlene Pence

Arlene Pence, Mayor
City of Petersburg

Resolution No. 1170-R

REQUESTING THE 16TH ALASKA STATE LEGISLATURE TO ENACT COMPREHENSIVE TORT REFORM LEGISLATION

WHEREAS, Alaska's voters demonstrated their strong support for tort reform by passing Ballot Measure #2, enacting pure several liability, in the 1988 General Election by an overwhelming majority of 71.8%; and

WHEREAS, it is clear Alaskan's want a fair, efficient and consistent civil justice system; and

WHEREAS, enacting pure several liability is only the beginning of the reforms needed if Alaska is to have a civil justice system that will 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; and

WHEREAS, the chaotic state of Alaska's civil justice system adding to the high cost of obtaining adequate insurance coverage is jeopardizing the ability of local governments to provide the facilities and services Alaska's communities desire and need; and

WHEREAS, the 16th Alaska State Legislature has the opportunity to enact comprehensive legislation that will result in a justice system that will best serve the interest of all Alaskans.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF PETERSBURG, ALASKA

THAT:

The 16th Alaska State Legislature is urged to enact comprehensive tort legislation in 1989.

PASSED and APPROVED this 16 date of February 1989.

Arlene Lence
Mayor

ATTEST:

Patricia Curtiss
City Clerk

PEPP

PROFESSIONAL ENGINEERS IN PRIVATE PRACTICE

- Alaska Chapter -

January 18, 1989

The 16th Legislature
State of Alaska
Juneau, AK 99801

Re: Tort Reform

Dear Members of the 16th Alaska Legislature:

Meaningful tort reform is of vital interest to the nearly 70 owners and senior principals represented by our State Chapter of Professional Engineer's in Private Practice (PEPP). We strongly support the eleven reforms The Coalition is presenting for enactment this session.

While we believe tort reform legislation passed in 1986 was a positive beginning, it is essential that effective legislation be passed this year to address the outstanding issues identified by The Coalition. The public is not ultimately well served when victim status is merely transferred from one party or group to another, as is now frequently the case in civil actions. The cost of not enacting legislation to address the existing philosophy operative in the court system is not merely passed off to out-of-state insurance underwriters, it is transferred to the public as a cost of doing business. We all pay for it.

We support comprehensive tort reform legislation as proposed by the Citizen's Coalition. We will be monitoring the progress of legislation dealing with this issue through the session, and hope that you will work to make our civil justice system predictable and equitable for all.

Respectfully,

Mark D. Anderson

Mark D. Anderson, P.E.
State Chairman, PEPP

NATIONAL SOCIETY OF PROFESSIONAL ENGINEERS

PROVIDENCE HOSPITAL
3200 PROVIDENCE DRIVE
P.O. BOX 196604
ANCHORAGE, ALASKA 99519-6604
PHONE: (907) 562-2211

COPY

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

February 22, 1989

Honorable Dave Donley, Chairman
House Labor and Commerce Committee
P.O. Box V
Juneau, AK 99811

Dear Chairman Donley:

As the new Administrator at Providence Hospital, I am writing to urge you to hold hearings on House Bill 166 in the Labor and Commerce Committee and to pass it out of committee, as soon as possible.

The recent 72% approval by the voters of the State for Ballot Measure #2 is a clear expression that it is time for comprehensive tort reform in Alaska. House Bill 166 is an excellent vehicle to enact such reform. This overwhelming support for tort reform will most certainly make your job of hearing and passing HB 166 an easy one.

Thank you in advance, Representative Donley, for your attention to this request, and for expediting hearings on House Bill 166.

On another note, I will be in Juneau in mid-March for the meetings of the Healthcare Association of Alaska. I look forward to meeting you and other members of the Legislature when I am there. Thank you again for your attention to this issue.

Sincerely,

Sister Dona Taylor
Administrator

cc H.B. 166 Sponsors:
Labor and Commerce Committee Members

SISTERS OF PROVIDENCE INSTITUTIONS—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—OUR LADY OF COMPASSION CARE CENTER, ANCHORAGE—WASHINGTON: PROVIDENCE CENTRAL MEMORIAL HOSPITAL, TOPPENISH—PROVIDENCE HOSPITAL, EVERETT—PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST. VINCENT NURSING CENTER, SEATTLE—ST. ELIZABETH MEDICAL CENTER, YAKIMA—ST. PETER HOSPITAL, OLYMPIA—PROVIDENCE CHEHALIS, CHEHALIS—PROVIDENCE HOSPITAL, CENTRALIA—OREGON: PROVIDENCE CHILD CENTER, PORTLAND—PROVIDENCE MEDICAL CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—SEASIDE GENERAL HOSPITAL, SEASIDE—PROVIDENCE HOSPITAL, MEDFORD—PROVIDENCE MILWAUKIE HOSPITAL, MILWAUKIE—CALIFORNIA: PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK

PROVIDENCE HOSPITAL
3200 PROVIDENCE DRIVE
P.O. BOX 196604
ANCHORAGE, ALASKA 99519-6604
PHONE (907) 562-2211

COPY

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

February 22, 1989

Honorable Sam Cotten, Speaker
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Cotten:

This letter is to thank you so very much for your sponsorship of House Bill 166, to bring about comprehensive tort reform for the State of Alaska.

As the newly appointed Administrator of Providence Hospital, and a returned resident to Alaska, I am very impressed with the overwhelming support for tort reform expressed by the voters in November with 72% voting for Ballot Initiative #2. That is a clear mandate. Your leadership in this movement is greatly appreciated.

In mid-March, I will be in Juneau for the Health Association of Alaska meetings. I would like to take that opportunity to meet you and discuss tort reform and other issues which may be of interest. We will be contacting your office for an appointment.

Again, thank you for your sponsorship. I look forward to meeting with you soon.

Sincerely,

Sister Dona Taylor
Administrator

SISTERS OF PROVIDENCE INSTITUTIONS—ALASKA: PROVIDENCE HOSPITAL, ANCHORAGE—OUR LADY OF COMPASSION CARE CENTER, ANCHORAGE—WASHINGTON: PROVIDENCE CENTRAL MEMORIAL HOSPITAL, TOPPENISH—PROVIDENCE HOSPITAL, EVERETT—PROVIDENCE MEDICAL CENTER, SEATTLE—THE DePAUL RETIREMENT RESIDENCE AND MOUNT ST. VINCENT NURSING CENTER, SEATTLE—ST. ELIZABETH MEDICAL CENTER, YAKIMA—ST. PETER HOSPITAL, OLYMPIA—PROVIDENCE CHEHALIS, CHEHALIS—PROVIDENCE HOSPITAL, CENTRALIA—OREGON: PROVIDENCE CHILD CENTER, PORTLAND—PROVIDENCE MEDICAL CENTER, PORTLAND—ST. VINCENT HOSPITAL AND MEDICAL CENTER, PORTLAND—SEASIDE GENERAL HOSPITAL, SEASIDE—PROVIDENCE HOSPITAL, MEDFORD—PROVIDENCE MILWAUKIE HOSPITAL, MILWAUKIE—CALIFORNIA: PROVIDENCE HOSPITAL, OAKLAND—PROVIDENCE HIGH SCHOOL, BURBANK—SAINT JOSEPH MEDICAL CENTER, BURBANK.

PROVIDENCE HOSPITAL
3200 PROVIDENCE DRIVE
P.O. BOX 196604
ANCHORAGE, ALASKA 99519-6604
PHONE: (907) 562-2211

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

January 20, 1989

Senator Tim Kelly, President of the Senate,
Representative Sam Cotten, Speaker of the House and
Members of the 16th Alaska State Legislature
P.O. Box V
Juneau, Alaska 99811

Dear Members of the 16th Alaska State Legislature:

As you know, Providence Hospital is very interested in comprehensive tort reform legislation. We are very pleased with the enormous success that Ballot Measure #2 had in the recent elections; that vote clearly expressed the interest of the citizens of Alaska in having effective, comprehensive tort reform for the State.

The 15th Legislature did enact Conference Committee Substitute for Senate Bill 377, effecting a new Chapter 17 to Title 9. This was a good beginning towards tort reform.

Now we urge you to take the necessary steps, this year, to complete those efforts. We urge you to enact a comprehensive, effective tort reform bill, which will make Alaska's civil justice system fair and predictable. In this comprehensive bill, we urge you to:

- o clarify that punitive damages can be awarded in the case of fraud, malice, gross negligence or reckless disregard by the defendant;
- o preclude a person from recovering damages when his/her injuries or death occurred while committing a crime, unless the person liable was committing a crime when the injury occurred;
- o allow the court to order that a judgement award for future damages be paid in periodic payments rather than lump sum, and require the attorney's contingent fee to be reduced to present value and paid in a lump-sum;
- o exempt personal injury, death and property damage suits from the application of Alaska Civil Rule 82;
- o limit the liability of hospitals for the negligence of non-employees, known as the "Jackson v Powers" section;

- o repeal AS 47.37.170(g), and reenact it to protect civil servants from being held liable for non-malicious actions while carrying out their duties with regard to intoxicated and incapacitated persons;
- o cap the amount of non-economic damage awards for all personal injuries at $500,000;
- o reduce the amount the injured party may recover by the amount he or she is compensated for those injuries from collateral sources (eg. another successful lawsuit);
- o repeal the provision that allows parties to agree not to reduce the award of future damages to present day value (eg. repeal Beaulieu v Elliott);
- o provide for equal and uniform application of Alaska's statutes of limitation and repose.

The mandate from the citizens of the state is clear because of the overwhelming support for Ballot Initiative #2. We urge you to complete the task of enacting comprehensive tort reform during this year.

Thank you for your attention and prompt action. Providence Hospital stands ready to support those efforts, and to answer any questions you may have.

Sincerely,

Kaaren R. Johnson,
Associate Administrator,
Program and Service Development

cc: Citizens' Coalition For Tort Reform
Sisters of Providence Public Policy Task Force

City of Soldotna

P.O. Box 409 • 177 North Birch • Soldotna, Alaska 99669 • Phone: 262-9107

February 21, 1989

David A. McGuire, M.D.
Chair
Citizens' Coalition For Tort Reform
P.O. Box 201668
Anchorage, Alaska 99520

Dear Dr. McGuire:

Enclosed is Resolution 89-3 of the City of Soldotna requesting the 16th Alaska State Legislature to enact comprehensive tort reform legislation per your request.

Sincerely,

Patricia C. Burdick, CMC
City Clerk

Encl.

CITY OF SOLDOTNA

RESOLUTION 89-3

(Proposed by the Citizens' Coalition for Tort Reform)

REQUESTING THE 16TH ALASKA STATE LEGISLATURE TO ENACT COMPREHENSIVE TORT REFORM LEGISLATION

WHEREAS, Alaska's voters demonstrated their strong support for tort reform by passing Ballot Measure #2, enacting pure several liability, in the 1988 General Election by an overwhelming majority of 71.8%; and

WHEREAS, it is clear Alaskans want a fair, efficient and consistent civil justice system; and

WHEREAS, enacting pure several liability is only the beginning of the reforms needed if Alaska is to have a civil justice system that will 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; and

WHEREAS, the chaotic state of Alaska's civil justice system adding to the high cost of obtaining adequate insurance coverage is jeopardizing the ability of local governments to provide the facilities and services Alaska's communities desire and need; and

WHEREAS, the 16th Alaska State Legislature has the opportunity to enact comprehensive legislation that will result in a justice system that will best serve the interest of all Alaskans;

NOW THEREFORE BE IT RESOLVED, BY THE CITY COUNCIL OF THE CITY OF SOLDOTNA, ALASKA THAT:

The 16th Alaska State Legislature is urged to enact comprehensive tort reform legislation in 1989.

ADOPTED this 21st day of February, 1989.

Dolly M. Farnsworth

Dolly M. Farnsworth, Mayor

ATTEST:

Patricia C. Burdick

Patricia C. Burdick, CMC
City Clerk

STRUCTURAL ENGINEERS ASSOCIATION OF ALASKA

January 20, 1989

The 16th Legislature
State of Alaska
Juneau, AK 99801

Re: Tort Reform

Honorable Senators and Representatives
of The 16th Legislature:

The Structural Engineer's Association of Alaska is vitally interested in the passage of effective tort reform legislation this year. The design profession represented by our association is among those most dramatically impacted by the issues addressed in the reforms presented by the Citizen's Coalition.

In 1985, five carriers offered Alaskan architects and engineers professional liability insurance on an admitted basis, and three on a surplus basis. Only one carrier refused to insure Alaskan design professionals. Now, four years later, when the insurance market is "soft", only one program is available to A/Es on an admitted basis. Three carriers supply coverage on a surplus basis and five refuse to insure Alaskan A/Es. The picture is even more grim for structural engineers.

We strongly support the eleven reforms presented by The Coalition for enactment this year, and will be looking for your effective effort is this regard.

Respectfully,

STRUCTURAL ENGINEER'S ASSN. OF ALASKA

Mark D. Anderson

Mark D. Anderson, P.E.
President, SEAA

c/o KCM, Inc.
3701 E. Tudor Rd., Ste. 205
Anchorage, AK 99507

February 13, 1989

David A. McGuire, M.D.
Citizens' Coalition for Tort Reform
P.O. Box 201668
Anchorage, AK 99520

Dear Dr. McGuire:

The City Council of the City of Valdez passed Resolution No. 8905 supporting comprehensive tort reform at its last regular meeting on February 6. A copy of the resolution is enclosed.

We are especially concerned about the issues of limiting the liability of hospitals for the negligence of non-employees and preventing a person from taking civil action against a peace officer for a non-malicious decision to take or not to take an intoxicated or incapacitated person into protective custody.

Tort reform is critical for the survival of hospitals. Quality of care is jeopardized to the extent any health care decision is influenced by liability more than appropriateness. The Alaska Supreme Court ruled in Jackson v. Powers that a general acute care hospital has a nondelegable duty to provide emergency room services and, therefore, the hospital is vicariously liable for the negligence of an emergency room physician. Because of this decision, no new hospital malpractice insurance carriers have been willing to come to Alaska. Rates have escalated to the point that hospitals do not know how they can afford the rates, surcharges, and excess liability exposure.

It has been alleged by certain groups that tort reform will result in police officers neglecting their duty to provide protection to incapacitated persons. Because of the "grey area" that exists between the terms "intoxicated" and "incapacitated", police officers have the burden of balancing the impaired individual's personal freedom and their physical safety. False arrest and false imprisonment suits can be very costly. The myriad of factors involved in taking someone into custody make each case different.

P.O. BOX 307 • VALDEZ, ALASKA 99686
TELEPHONE (907) 835-4313 • TELEX 25-381 • TELECOPIER (907) 835-2992

Tort reform will ease this burden somewhat and officers will be more willing to take action to protect the impaired person.

We appreciate your consideration of this legislation.

Sincerely,

John Devens

John Devens, Ph.D.
Mayor

JD:tc

Enc.

CITY OF VALDEZ, ALASKA

RESOLUTION NO. 8905

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF VALDEZ, ALASKA, REQUESTING THE 16TH ALASKA STATE LEGISLATURE TO ENACT COMPREHENSIVE TORT REFORM LEGISLATION.

WHEREAS, Alaska's voters demonstrated their strong support for tort reform by passing Ballot Measure #2, enacting pure several liability, in the 1988 General Election by an overwhelming majority of 71.8%; and

WHEREAS, it is clear Alaskan's want a fair, efficient and consistent civil justice system; and

WHEREAS, enacting pure several liability is only the beginning of the reforms needed if Alaska is to have a civil justice system that will 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; and

WHEREAS, the chaotic state of Alaska's civil justice system adding to the high cost of obtaining adequate insurance coverage is jeopardizing the ability of local governments to provide the facilities and services Alaska's communities desire and need; and

WHEREAS, the 16th Alaska State Legislature has the opportunity to enact comprehensive legislation that will result in a justice system that will best serve the interest of all Alaskans.

NOW, THEREFORE, BE IT RESOLVED BY THE CITY COUNCIL OF THE CITY OF VALDEZ, ALASKA, that

The 16th Alaska State Legislature is urged to enact comprehensive tort reform legislation in 1989.

PASSED AND APPROVED BY THE CITY COUNCIL OF THE CITY OF VALDEZ, ALASKA, this 6th day of February, 1989.

CITY OF VALDEZ, ALASKA

John Devens

John Devens, Mayor

ATTEST:

Jeanne Donald

Jeanne Donald, City Clerk

SERVING ALASKA SINCE 1945

ARCTIC CIRCLE

YUKON EQUIPMENT, INC.

ANCHORAGE
FAIRBANKS

January 23, 1989

Citizens' Coalition for Tort Reform
David A. McGuire, M.D.
Chairman
P.O. Box 201668
Anchorage, Alaska 99520

Dear David:

Our state and our nation desperately need effective and comprehensive Tort Reform. As long as our legislature keeps passing meaningless and impotent bills under the guise of "Tort Reform", no true changes in insurance premiums and fairness will take place.

Premiums can be lowered and fairness can be put back into the system with complete tort reform legislation. Most insurance people we have talked to tell us this will never happen without complete and comprehensive changes in our tort system.

I was recently back at an Association of Equipment Distributors Meeting in Anehiem, California. They had a guest speaker, Mr. James Watt, former U.S. Secretary of the Interior. He spoke to us about the lack of courage in today's politicians. The statement was made about how the typical legislator is constantly being pulled between special interest groups, his constituants, the press, and the strong need to get re-elected. What he felt was missing was the ability of the typical legislator to do what was right for America instead of what was needed to get re-elected.

How do we get our legislators to do what is right for Alaska? How do we make them understand that nothing will change until sweeping tort reform legislation is passed into law? How can they keep overlooking Alaska's problems simply to keep attracting compaign contributions from special interest groups (trial lawyers)?

We have got to get a complete tort reform bill passed into law this session. Doing what is right for Alaska is essential. Count on our continued support to do whatever is possible to bring about these much needed changes for Alaska and our nation.

Sincerely,

YUKON EQUIPMENT, INC.

Morry Hollowell

Morry Hollowell
President

MH/dc

BRISTOL BAY AREA HEALTH CORPORATION

P.O. BOX 130 • DILLINGHAM, ALASKA 99576

(907) 842-5201 or (907) 842-5202

April 21, 1989

Representative David Donley and
Representative Max F. Gruenberg Jr.
Chairman and Vice Chairman
Labor and Commence Committee
Room 17, Capitol
P.O. Box V
Juneau, AK 99811

Dear Representative's Donley and Gruenberg:

My organization on behalf of 32 villages in the Bristol Bay Area was very involved and together with 72% of the voters of your State overwhelmingly approved Ballot Measure #2 as a message to you folks in Juneau to pass legislation about Tort Reform.

We want you to get HB166 to the full floor to become law.

In looking up your committee, and I see from the biographical information in the "Alaska State Legislature" Directory that you both are attorneys. I assume that you are trial attorneys. I hope that as public servants on behalf of all Alaskans, and in particular 72% of all voters, that what might be viewed as a "conflict of interest" is not clouding your passing HB166 out of your committee so that it can be passed by the full legislature. Please put your personal occupation aside and pass HB166 out of your committee so that it shows clearly you are willing to fulfill the wishes of the people.

Thank you for your help.

Sincerely,

Robert J. Clark
Executive Director

cc: Rep. George Jacko
Senator Fred Zharoff
BBAHC Board of Dirs.
BBNA
BBNC
AFN
ANHB
Citizen's Coalition for Tort Reform

Citizens' Coalition For Tort Reform

April 13,1989

Dear Friend:

Its hard to believe, but some legislators haven't got the message about tort reform. And we need your help to set them straight.

Alaskans overwhelmingly approved Ballot Measure #2, our tort reform initiative. In fact, 72% of all voters approved its passage. With that kind of demonstrated support you would think legislators would sit up, take notice, and amend their ways. But some still haven't.

Right now, Representatives Donley and Gruenberg are sitting on the bill that would complete the much needed reforms to our civil justice system. HB166 is simply stuck in their House Labor and Commerce Committee. And while they say they are holding hearings, they are in truth merely stalling its passage.

You can help. Call or write to both Donley and Gruenberg today. Let them know that you support HB166, and want to see it pass the legislature. You can reach them at:

Rep. David Donley	Rep. Max Gruenberg
P. O. Box V	P. O. Box V
Juneau, AK 99811	Juneau, AK 99811
465-3892/3893	465-4968/4986

Your contacting them will help us convince Donley and Gruenberg to move the bill from their Committee. We also need your help in another way.

In order to bring more attention to this issue, and the treatment that 72% of the voting public are receiving at the hands of Donley and Gruenberg we need to publicize their actions. Unfortunately, that takes money. A contribution from you at this critical point can mean the difference in gaining meaningful reform now, or letting the trial lawyers get their way for another year. Please help by sending in a contribution today.

Your early and constant support was vital to passage of Ballot Measure #2. With your help now, I know we can be successful again.

Sincerely,

David A. McGuire, M.D.
Chairman

P.O. Box 201668
Anchorage, Alaska 99520
Phone: 561-6250

HB1166 - INSURANCE INDUSTRY PROFITS

United States General Accounting Office

GAO

Testimony

For Release
On Delivery
Expected at

Tuesday
April 21, 1987

Profitability of the Medical Malpractice and General Liability Lines of Insurance

Statement of
William J. Anderson, Assistant Comptroller
General, General Government Programs

Before the Subcommittee on Commerce,
Consumer Protection, and Competitiveness
Committee on Energy and Commerce
House of Representatives

GAO/T-GGD-87-13

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear before the Subcommittee today to present the results of our work on the profitability of the property/casualty insurance industry, particularly the profitability of the medical malpractice and general liability insurance lines. Our testimony today is in response to your request for information on insurance industry profitability.

In our testimony, we make the following points on the basis of our estimates:

-- Despite substantial underwriting losses, the property/casualty industry, as a whole, has been profitable over the 10-year period from 1976 through 1985. Its profitability was made possible by the industry's investment gains.

-- Profitability in the property/casualty industry has been cyclical. In recent years, returns on net worth have been lower than many industries. However, over the past 10 years the average return has been comparable to other industries.

-- The medical malpractice line of insurance suffered a cumulative after-tax loss for the 11-year period 1975 through 1985 if reserves for future payments are booked

at their full payout value. If, however, these reserves are discounted to their present value, a procedure we recommended and is now required for tax purposes, the medical malpractice line showed an after-tax profit for this period.

-- The general liability line showed an after-tax profit from 1975 through 1985 even when its reserves are booked at their full payout value. If its reserves are discounted to present value, the line's profitability increases significantly.

-- If the established reserves proved inadequate by 10 or 20 percent, the medical malpractice and general liability lines would be profitable, provided that the reserves are discounted to present value.

I would first like to briefly discuss the profitability of the property/casualty insurance industry as a whole, and then I will discuss in more detail the medical malpractice and general liability lines. I would also like to note that our analysis pertains to industry aggregates; therefore, the experience of individual companies may differ.

PROFITABILITY OF THE PROPERTY/CASUALTY INDUSTRY

In July 1986, we testified that over the 10-year period 1976 through 1985, the property/casualty industry was profitable. As shown in the table below we estimated that the industry had about $81 billion in after-tax income despite almost $65 billion in underwriting losses. This income resulted primarily from the investments the industry made with funds collected from premiums. Over this 10-year period, the industry had investment income and capital gains of approximately $144 billion. Thus, profitability in the insurance industry is determined by combining both underwriting results and investment results.

All Companies--Consolidated Basis
1976 through 1985
($ in billions)

Underwriting gain/loss[a]	Investment gain	Net gain	Federal income tax	Total gain after-tax
($64.8)	$144.3	$79.5	($1.6)	$81.1

unaccounted "compound estimate is $10 Billion MORE"

[a]Reserves used in this calculation were not discounted.

These figures are derived from our computations, and the industry disagrees with our assumptions about including unrealized capital gains and excluding policyholder dividends. If we eliminate those assumptions from our computations, the after-tax net gain was about $54 billion. Furthermore, we testified that the industry's profitability in terms of its rate of return on net worth over this period was comparable to that of

other industries, such as the banking, transportation, and utility industries. At that time, we pointed out that over the last few years rates of return earned by the property/casualty industry have been substantially lower than those earned by comparable industries.

Looking at attachment I, you can see that the property/casualty industry is subject to profitability cycles. Column 1, "underwriting gains/losses" demonstrates the most recent cycle. This underwriting cycle peaked in 1978. Since then it has declined until it bottomed out in 1985 when the industry experienced record underwriting losses. Because of the industry's cyclical nature, we believe that data covering an entire cycle gives a better picture of the industry's profitability.

Since our July testimony, the Insurance Information Institute has reported that the property/casualty industry's earnings improved substantially in 1986. On the basis of its data, we calculate that the industry's after-tax net gain increased from $9.7 billion in 1985 to about $19 billion in 1986. Undiscounted

We turn now to our analysis of the profitability of the medical malpractice and general liability lines, two lines that over the past few years have been in the news due to consumers'

difficulties in obtaining coverage at prices they could afford. As we testified last July, and as shown in attachment II, these two lines represent about 8 percent of the property/casualty industry's business but have accounted for over a quarter of the industry's underwriting losses. It should be noted that these losses did not reflect the investment gains applicable to these lines.

PROFITABILITY OF SPECIFIC LINES

To analyze the profitability of the medical malpractice and general liability insurance lines, we used publicly available data reported by the A.M. Best Company in its Casualty Loss Reserve Development on premiums, losses, and expenses. We used Best's data because it is the only aggregated data base readily available to perform such an analysis. Best gathers its data from the annual financial statements the insurance companies file with state regulators. We did not test the accuracy or adequacy of the data reported by the companies or by Best.

Because Best does not allocate all investment income and gains by insurance line, we had to estimate the investment results for these lines. Our estimates were derived by calculating net cash flow after federal income taxes and by assuming that the results had been invested in a representative investment vehicle, 10-year Treasury securities. Treasury

securities were selected because they are virtually risk free, and because claims in the medical malpractice and general liability lines are not settled, in many cases, for 10 years or longer after the premiums are written.

The data reported by Best do not cover the entire industry. Among those not included in the Best data are (1) joint underwriting associations, (2) a small portion of physician-owned insurance companies, (3) reinsurers, (4) small commercial insurers, and (5) self-insurance mechanisms.

We should also note that medical malpractice insurers are not a homogeneous group. Medical malpractice insurance providers are comprised of both stock and mutual insurance companies. Among the mutual insurers are insurance companies formed by medical professionals to assure the availability of medical malpractice insurance at the lowest possible cost. Thus, their motivation is not necessarily profit oriented. The physician-owned and hospital-owned companies included in our analysis comprised approximately 38 percent of our data base. However, to determine the profitability of the medical malpractice insurance line both stock and mutual insurers have been included.

Our analysis of the profitability of the medical malpractice and general liability insurance lines depends primarily on the manner in which reserves for future payment of claims are

established by the industry. These reserves, which are an operating expense are actuarial estimates of claims that are expected to be paid out in the future. Furthermore, these reserves are adjusted periodically to reflect revisions to prior claim and loss expense estimates. Thus, depending on the ultimate loss experience, profitability may be understated or overstated in any given year.

Additionally important is that for legitimate solvency considerations state regulations require that reserves be generally booked at the full value of expected future loss payouts. We have recommended in the past that for tax purposes reserves be set aside on a "discounted" basis because, in reality, this amount invested at interest will be sufficient to meet expected future losses as long as expectations do not substantially change. In its consideration of the Tax Reform Act of 1986, the Congress agreed with our recommendation and required insurers to discount their reserves for tax purposes.

In this testimony, we present four different estimates of medical malpractice and general liability profitability. The first set of estimates assumes that the industry's reserves are adequate to meet expected claims. The second also assumes that the reserves are adequate, but it discounts the reserves. The third estimate assumes the industry has underreserved by 10 and 20 percent. The fourth estimate discounts the reserves derived

in the third estimate. We will first present our estimates for the medical malpractice line, which we show in attachment III, and then our estimates for general liability, which we present in attachment IV.

Profitability when reserves
are not discounted

We initially computed the annual earnings using reserves that had not been discounted. In the case of the medical malpractice line, as you see in attachment III in column 1, we computed a cumulative $653 million loss over the 11-year period 1975 through 1985, with a cumulative rate of return, expressed as a percent of premiums earned, of a negative 4.6 percent.

Profitability improves when
reserves are discounted

However, this estimate does not in our view present a completely accurate picture. Both the medical malpractice and general liability lines are typical of insurance lines in which claims are commonly paid many years after the reserves for those claims have been established. In order to compute such a line's profitability, the established reserves need to be discounted to recognize the time value of money. For example, if a claim will cost $100 in 10 years, should a $100 reserve be immediately

established for that claim or should a reserve of a lesser amount--a discounted amount--be established that, when invested over the 10-year period, will yield $100? If a discounted reserve is established, then a greater amount of that year's annual cash flow will be credited to the line's earnings. Thus, discounting the reserves increases current earnings.

We discounted the reserves by the average annual interest rate earned on 10-year Treasury securities. As you can see in attachment III in column 2, if the reserves are discounted in this manner, the medical malpractice line yielded a profit of $2.2 billion over the 11-year period 1975 through 1985. As a percentage of premiums earned, the medical malpractice line's cumulative rate of return increases from a negative 4.6 percent to a positive 15.3 percent when the reserves are discounted in this manner.

Profitability deteriorates if the reserves established are not adequate to cover claims

In deriving the profitability estimates we have just presented, we assumed that industry-established reserves are sufficient to settle future claims. We made this assumption because companies review their reserve estimates at least annually and are bound by state regulators to provide for fully adequate reserves. Future events, however, may show that the

reserves were either excessive or inadequate. Some in the industry believe that the reserves are inadequate. If, due to unforeseen circumstances, the reserves proved insufficient, then the profitability of the lines would deteriorate. To provide an appropriate degree of conservatism in light of this possibility, we are supplying calculations of profitability on the alternative assumptions that the estimated reserve requirements are inadequate to the extent of 10 percent or 20 percent of their current stated value.

If the reserves needed to be increased by 10 percent, the medical malpractice line's profitability based upon undiscounted reserves for the 11-year period 1975 through 1985 would decline from a $653 million loss to a $1.2 billion loss. Its rate of return as a percentage of premiums earned would decline from a negative 4.6 percent to a negative 8.8 percent.

If the undiscounted reserves proved to be 20-percent deficient, the profitability and rate of return on the medical malpractice line would decline from a $653 million loss to a negative $1.8 billion loss and from a negative 4.6 percent rate of return to a negative 13.0 percent.

Similarly, if the reserves proved to be 10-percent deficient then the medical malpractice line's profitability and rate of return on a discounted basis would decline from a $2.2 billion

profit to a $1.9 billion profit and from a 15.3 percent rate of return to a 13.1 percent rate of return. If the reserves needed boosting by 20 percent to be sufficient, the profitability and rate of return on the medical malpractice line on a discounted basis would decline further to a $1.6 billion profit and a 10.9 percent return.

Profitability of the
general liability line

In attachment IV we show our profitability estimates for the general liability insurance line, which we calculated by using the same methodology as for the medical malpractice line. As column 1 shows, if reserves are not discounted, the general liability line yielded a profit of $2.0 billion for the period 1975 through 1985, with a cumulative rate of return of 3.4 percent. As column 2 shows, with reserve discounting the general liability line yielded a profit of $8.0 billion over the same period, with a cumulative rate of return of 13.4 per cent.

If we assume that reserves were insufficient and needed to be increased by 10 percent, the general liability line's profit based upon undiscounted reserves would decline from $2.0 billion to $783 million, and the rate of return would decline from 3.4 percent to 1.3 percent. If undiscounted reserves were 20-percent

deficient, the general liability line's profitability would decline from $2.0 billion to a negative $462 million, with the rate of return decreasing from a positive 3.4 percent to a negative 0.8 percent.

If we base our estimates on discounted reserves and assume a 10 percent reserve deficiency, then the profitability of the general liability line would be $7.4 billion, as opposed to $8.0 billion on a discounted basis with no deficiency assumed and a rate of return of 12.3 percent as opposed to 13.4 percent. If we assume a 20-percent deficiency, the general liability line on a discounted basis shows a $6.7 billion profit and a rate of return of 11.2 percent.

CONCLUSIONS

Although cyclical in nature, the property/casualty industry, as a whole, has been profitable over the 10-year period 1976 through 1985. Despite faring poorly in recent years, the industry's profitability in terms of its rate of return on net worth over this 10-year period was comparable to that of other industries, such as the banking, transportation, and utility industries. Data for 1986 shows that the underwriting cycle has turned and is now moving in a positive direction.

The profitability of the medical malpractice and general liability lines depends primarily on the manner in which reserves for future payments of claims are established--the adequacy of the reserves and whether those reserves are discounted to reflect their present values. If the reserves established to cover future loss payouts are inadequate, boosting the reserve to cover those losses will decrease the profitability of the line. Conversely, the profitability of the line improves if the reserves are discounted. We have recommended in the past, and the Congress has agreed, that for tax purposes reserves should be established on a discounted basis.

Using reserve amounts as established by the industry and applying different assumptions about reserve adequacies and discounting, we developed four profitability estimates for each line. Essentially, those estimates show that the medical malpractice line incurred losses when the reserves were valued at their full estimated payout, but the line was profitable when the reserves were discounted to present values. On the other hand, the general liability line was profitable under all but one of our estimating assumptions. In that estimate we assumed that the reserves were not discounted to present values and that they were 20-percent deficient.

This concludes my prepared statement. We would be pleased to respond to any questions.

ATTACHMENT I

Combined After-Tax Gains for the Property/Casualty Insurance Industry by Year for the Period 1976-1985 (Consolidated Basis)[a]
($ in millions)

ear	Underwriting gains/losses[b]	Investment gains/losses[c]	Pre-tax total	Federal income tax[d]	After-tax total
976	($1,726)	$7,173	$5,447	$148	$5,299
977	1,926	5,063	6,989	1,015	5,974
978	2,548	7,758	10,306	1,389	8,917
979	24	11,610	11,634	896	10,738
980	(1,712)	15,870	14,158	593	13,565
981	(4,464)	10,858	6,394	55	6,339
982	(8,303)	18,387	10,084	(716)	10,800
983	(11,088)	19,441	8,353	(1,218)	9,571
984	(19,379)	17,875	(1,504)	(1,732)	228
985	(22,597)	30,219	7,622	(2,030)	9,652
976-1985	**($64,771)**	**$144,254**	**$79,483**	**($1,600)**	**$81,083**

Consolidated totals eliminate "double counting" by excluding intercompany transactions between parent and subsidiary companies.

Net premiums earned, less losses and expenses.

Net investment income, plus realized and unrealized capital gains.

Negative federal income tax occurs because companies report losses for tax purposes and consequently generate negative income taxes. Negative income taxes can be applied to past taxes paid, and they generate refunds or are carried forward to apply against future tax liabilities.

Source: Data used in the preparation of this table obtained from A.M. Best Company publications.

ATTACHMENT II

Net Premiums Earned, Underwriting Gains/Losses, and Combined Ratios by Insurance Line for the Period 1976-1985
($ in millions)

Insurance lines	Net premiums earned	Premiums as a percent of all lines	Underwriting gains/losses[a]	Underwriting gains/losses as a percent of all lines	Combined ratios
Auto liability (Private passenger)	$192,432	20.49	($16,509)	25.49	107.9
Auto physical damage (Private passenger)	134,515	14.32	815	(1.26)	98.6
Workers' compensation	128,099	13.64	(1,589)	2.45	100.9
Homeowners multiple peril	96,376	10.26	(3,813)	5.89	102.4
Commercial multiple peril	66,002	7.03	(7,014)	10.83	108.5
General liability	**61,746**	**6.57**	**(13,255)**	**20.46**	**120.0**
Auto liability (Commercial)	46,150	4.91	(8,746)	13.50	117.6
Auto physical damage (Commercial)	25,599	2.73	(94)	0.15	99.1
Medical malpractice	**14,143**	**1.51**	**(5,177)**	**7.99**	**135.7**
All other lines	174,066	18.54	(9,389)	14.50	--[b]
Total - all lines	$939,128	100.00%	($64,771)	100.00%	105.9

[a]Net premiums earned, less losses and expenses. This column does not include investment gains allocated by insurance line.

[b]All other lines includes: reinsurance (114.9); fire (96.9); inland marine (98.0); group accident and health (111.7); allied lines (97.1); burglary and theft (81.2); surety (95.7); ocean marine (108.0); other accident and health (101.8); farmowners multiple peril (109.5); fidelity (104.8); boiler and machinery (93.8); aircraft (104.1); and miscellaneous (111.0).

Source: Data used in the preparation of this table obtained from A.M. Best Company publications.

ATTACHMENT III

Summary of Profitability of the Medical Malpractice Insurance Line, 1975-1985[a]
($ in millions)

Using company-established reserves:

	Not discounted by GAO	Discounted by GAO
Net premiums earned	$14,187	$14,187
Interest earned (estimated)	4,352	4,352
Revenues	18,539	18,539
Payments & expenses	8,772	8,772
Reserves	10,976[b]	8,152
Taxes	(556)	(556)
Expenses	19,192	16,368
Earnings	($ 653)	$ 2,171

	Not discounted by GAO		Discounted by GAO	
Reserves	Earnings	Percent rate of return[c]	Earnings	Percent rate of return[c]
Adequate	**($ 653)**	**(4.6)**	**$2,171**	**15.3**
10% inadequate	**(1,245)**	**(8.8)**	**1,861**	**13.1**
20% inadequate	**(1,838)**	**(13.0)**	**1,551**	**10.9**

[a]Medical malpractice profitability, as shown above, depends on (1) the adequacy of reserves established to settle claims, and (2) the degree to which the reserves are discounted. This table shows the level of profitability assuming three levels of reserve adequacy, not discounted and discounted.

[b]Of this $10,976 million reserve $2,660 million is shown in the statements of the Physician Insurers Association of America as already having been discounted. The reserve shown in the second column is the result of discounting the remaining $8,316 million and adding the result to the $2,660 million already discounted by the companies.

[c]Rate of return as percent of net premiums earned.

Source: Data used in the preparation of this table obtained from A.M. Best Company publications and the Physician Insurers Association of America.

ATTACHMENT IV

Summary of Profitability of the General Liability Insurance Line, 1975-1985[a]
($ in millions)

	Using company-established reserves:	
	Not discounted by GAO	Discounted by GAO
Net premiums earned	$59,812	$59,812
Interest earned (estimated)	12,234	12,234
Revenues	72,046	72,046
Payments & expenses	45,235	45,235
Reserves	23,056	17,069
Taxes	1,726	1,726
Expenses	70,017	64,030
Earnings[b]	$ 2,028	$ 8,014

	Not discounted by GAO		Discounted by GAO	
Reserves	Earnings	Percent rate of return[c]	Earnings	Percent rate of return[c]
Adequate	$2,028	3.4	$ 8,014	13.4
10% inadequate	783	1.3	7,368	12.3
20% inadequate	(462)	(0.8)	6,721	11.2

[a]General liability profitability, as shown above, depends on (1) the adequacy of reserves established to settle claims, and (2) the degree to which the reserves are discounted. This data shows the level of profitability assuming various levels of reserve adequacy and discounting.

[b]Does not add due to rounding.

[c]Rate of return as percent of net premiums earned.

Source: Data used in the preparation of this table obtained from A.M. Best Company publications.

MAR 28 '89 16:20 J.C.SCHNEEPER M P

Bill - HB168
I hope this helps.
AJA
Statute of Repose

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March 9, 1989

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ALASKA CHAPTER
THE AMERICAN INSTITUTE OF ARCHITECTS
P.O. BOX 10-3563 • ANCHORAGE, ALASKA 99510-3563

Dear Mike:

Upon my return from the Park City meeting I found the decision of the Wisconsin Supreme Court in Funk v. Wollin Silo & Equipment, Inc., courtesy of Brian Mullins. I have since received several additional copies from others and particularly the draft legislation from Judith A. Whalen and Robert Brandenburg, respectively. I understand this draft legislation was prepared before the Supreme Court decision was handed down, and hence presumably does not reflect the impact of that decision.

Now, as to the draft legislation itself, it is a good idea to include a detailed statement of legislative intent and justification for a new statute. That technique worked in Florida, where the original statute had been rejected twice, and upheld on the third try largely on the basis of the legislative findings. In that decision the Florida Court of Appeals pointedly said, after noting the detailed legislative findings justifying the statute:

> "The legislature has the last word on declaration of public policy. The courts are bound to give great weight to legislative determinations of fact. It is not unusual for a subsequent legislative determination of the legality of purpose to be served by an undertaking to be deemed sufficient to overcome a prior judicial decision to the contrary." (American Liberty Insurance Co. v. West & Convers, Architects and Engineers, Inc., 491 So. 2d 573 (Fla. App. 2 Dist. 1986)

We can only hope that the Wisconsin Supreme Court will heed those words of wisdom if you are able to enact the statute for a third time.

Expanding the statutory cut-off period from six years to ten years is probably a good idea, at least politically. And it would not make much of a major difference as between the two figures.

I have some qualms about including the owner of real property in the class of persons protected by the 10-year period. I understand why that is included in view of the comments of your court in the earlier case. But, politically, if nothing else, that would be a blank check to protect owners who fail to maintain the property and thereby escape liability for that failure leading to injuries. The justification for a different treatment as between designers and constructors and owners was pointedly noted by the Connecticut Supreme Court in upholding that state's statute of repose --

> "It is our view that rational distinctions do exist between architects and engineers and others involved in the construction process. The owner of real estate has the continuing duty and ability to maintain the property after the architect or engineer has completed his work. With the passage of time it is more likely that any defect is caused by improper maintenance rather than defects in design. After acceptance by the owner, the architect or engineer ordinarily lacks control of the improvement." (Citations omitted- Zapata v. Burns, 342 A. 2d 700 (Conn. 1988)

Other courts have spoken similarly on the same point. But, as noted, I understand the reason for including owners. I would have some concern, however, that in a particularly egregious case down the road the courts might find the new statute unconstitutional for cutting off the right of a party injured through inadequate maintenance of the property, 15, 20 or even 30, or more, years after substantial completion.

The only thought I have to deal with this dilemma would possibly be to include some kind of specific legislative finding or policy in the statute's preamble to explain the legislative reasoning in not including owners in the protected class.

I will be very interested, of course, in future developments in this matter. Needless to say, if I can help in any way let me know.

Regards and best wishes,

Very truly yours,

MFL:sam

TALKING POINTS ON
WHY THE STATE OF NEW YORK NEEDS A STATUTE OF REPOSE

Buildings Can Last Forever

- The Empire State Building which was designed by Shreve, Lamb & Harmon was completed in 1931.
- The State of New York Capitol Building was completed in 1899. It was designed by Augustus Laver, Thomas Fuller and H. H. Hunt among others.
- Buffalo's Guaranty Building (recently renamed the Prudential Building) was completed in 1896, having been designed by Dankmar Adler and Louis H. Sullivan.

States Without Statutes of Repose Permit Their Architects to be Sued Forever

- In New York, which has no statute of repose, any architect can be sued by anyone for any injury, real or imagined, that occurred in or around a building designed by an architect.
- If any of the above named architects were alive today, anyone who tripped and fell in any of their buildings could sue them, alleging design defect caused the fall. This is so, even though millions of people have used the buildings from the day they were substantially completed without injury.

A State Without a Statute of Repose is Harming Architects and Architecture

- To protect themselves, architects have to store at great expense shopping carts full of contract documents for years on end on the off-chance someone may sue them.
- In a society as litigious as ours, a State without a statute of repose forces its design professionals to live with the constant anxiety of wondering if and when they will become victim to a person with a grievance.
- Good architecture requires architects to respond to the demands of modern technology. Unlimited liability delimits that response.
- An architect can only affect a building project while under contract to the project's owner to provide services. After substantial completion, the architect has no power to do anything with respect to that building. Eternal liability imposes responsibility on the architect, even after he has no authority or power to deter wrong-doing or otherwise protect the public.

- By way of comparison, while a New York architect faces eternal liability, a New York Class A unapprehended felon, such as an armed rapist enjoys a five-year statute of repose.

A State Without a Statute of Repose is Harming Its Public

- Unlimited architect liability provides the public strawmen to sue, but no real protection. A 1987 study of claims against New York architects shows that the farther in time from substantial completion the injury occurs, the less likely the architect will be required to compensate the plaintiff. In fact, in that study, all the claimants who received indemnity payments were injured within eleven years of building completion; 95% were injured within nine years of building completion. Claimants injured later than eleven years may have filed cases with courts, may have paid legal expenses, but they received no compensation from the architect's insurer.

- These statistics on indemnification suggest that the farther from substantial completion the injury takes place, the more likely it is caused by poor owner maintenance and not faulty design. For New York State to permit plaintiffs to sue architects years after substantial completion undermines owner incentive to maintain their buildings, as it transfers the burden of injury prevention from the owner to to the architect.

- In the absence of a statute of repose, plaintiffs' attorneys file suits against architects, unaware that the probability of client compensation decreases substantially the "older" the claim is. As a result, backlogged courts are further backlogged though no one is compensated for the effort, save for both sides' attorneys. Cases that could result in compensation for injured plaintiffs languish, awaiting their day in court.

Statutes of Repose Are Reasonable

- While six States, including New York, do not have statutes of repose, 33 States do. The constitutionality of these statutes have been upheld by those States' courts.

- Statutes of repose, when drafted carefully, balance the needs of society to protect all their citizens, including architects.

Statutes of Repose Can be Drafted to Meet Various Goals and Objectives

- If the New York State Legislature decides that "deterring architect wrongdoing" is the value to be protected, a six to eight year statute of repose is most reasonable. By six to eight years from the date of substantial completion, most architects who are going to be sued have been sued. And while, by and large, most architects are not found liable, if any architect is to be found liable, it is most likely an

architect from this group. In fact, 80 to 90 percent of the architects who are going to have indemnity payments made on their behalf will have been sued because of injuries that occurred within six to eight years of substantial completion.

- If the New York State Legislature decides that "deterring owner wrongdoing" is the value to be protected, a six to eight year statute is most reasonable. After that period, most claims involve users of the building -- third parties who have been injured most probably by negligent maintenance.

- If the New York State Legislature decides that "providing plaintiff compensation" is the value to be protected, a ten year statute of repose is most reasonable. Within this time most injuries (close to 95 percent) that are going to be compensated occur.

- If the New York State Legislature decides that "promoting commerce and architecture" is the value to be protected, a six year statute of repose is the most reasonable. The claims study shows that by year six, 96 percent of the claims are filed that involve parties to the design and construction process, such as owners, design professionals, contractors, material men, construction workers and the like. After that time, most of the claims involve third parties who use the building.

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FROM FIGURES

BEST'S EXECUTIVE DATA SERVICE

1987 ALASKA

EXPERIENCE BY STATE
- OTHER LIABILITY

A2-02-17

COMPANY	MKT. SHR.	DIRECT PREMIUMS		DIVIDENDS TO POLICYHLDRS	DIRECT LOSSES		LOSS RATIOS			Group Rank		Overall Rank	
		WRITTEN w	EARNED e	DIRECT d	PAID p	INCURRED i	p/w	i/e	Adj.	Prem.	Ratio	Prem.	Ratio
AETNA LIFE & CAS GRP	1.8	1 168	1 366		87	864	7.5	63.3	63.3	8	9	15	30
AMER FINANCIAL GROUP	1.2	793	896		211	312	26.6	34.8	34.8	10	5	20	13
AMER GENERAL GROUP		8	8			3		32.0	32.0	23		71	
AMER INTERN GROUP	23.2	15 139	13 187		5 750	8 294	38.0	62.9	62.9	1	8	1	29
ATLANTIC MUTUAL COS		1	1			-1		-99.9	-99.9	28		91	
CHUBB GRP OF INS COS	1.9	1 255	1 168			212		18.1	18.1	7	3	14	7
CIGNA GROUP	6.9	4 509	4 282		-1 325	-3 209	-29.4	-74.9	-74.9	2		3	
CNA INS COMPANIES	4.4	2 878	3 111	7	481	1 571	16.7	50.5	50.6	5	6	6	20
COMM UNION INS COS		2	2			-14		-99.9	-99.9	26		86	
CONTINENTAL INS COS	1.5	967	960		1 515	-1 265	156.7	-99.9	-99.9	9		18	
CRUM & FORSTER COS	6.2	4 047	4 175		2 427	2 704	60.0	64.8	64.8	3	10	4	32
FIREMAN'S FUND COS	3.8	2 457	2 491	1	457	1 805	18.6	72.5	72.5	5	11	7	33
GENERAL ACC GROUP		1	11		1 865	1 155	999.9	999.9	999.9	27		89	
HANOVER INS COS		3	4					7.6	7.6	25		82	
HARTFORD INS GROUP	.9	565	618		2 881	3 880	510.3	628.2	628.2	12	16	24	42
HOME INS GROUP	1.1	739	566		4 359	1 789	589.5	316.2	316.2	11	15	22	41
KEMPER GROUP	.2	156	148			21		14.0	14.0	17	1	43	3
LINCOLN NAT GROUP		1								29		92	
NORTHWESTERN NAT GRP					-95	-100	999.9	999.9	999.9				
ORION GROUP	2.3	1 479	1 418			-54		-3.8	-3.8	6		11	
RELIANCE INS COS	.1	72	73		31	10	43.5	14.1	14.1	21	2	53	4
ROYAL INS GROUP	.5	348	297		1	-152	.3	-51.2	-51.2	14		27	
SAFECO INS COMPANIES	.3	170	134		27	75	15.9	56.0	56.0	15	7	40	21
ST PAUL GROUP	.1	74	106			34		31.8	1.8	19	4	51	10
TRANSAMERICA INS GRP	.2	133	105		12	78	9.3	74.3	74.3	18	12	44	34
TRAVELERS INS GROUP	.3	164	159		1 215	-523	738.8	-99.9	-99.9	16		41	
UNIGARD INS GROUP		5	24							24		80	
UNITED STATES F&G GR	.6	418	643		122	782	29.1	121.6	121.6	13	14	25	38
UTICA NATIONAL GROUP		11	6			2		32.7	32.7	22		68	
ZURICH INS GROUP-U S	.1	72	149			128		82.9	82.9	20	13	52	35
NATL.AGENCY COS 30=	57.6	37 635	36 106	8	20 021	18 394	53.2	51.0	51.0				
ALASKA NATIONAL INS	11.8	7 706	7 917		1 736	2 672	22.5	33.8	33.8	1	6	2	11
AMER MODERN HOME GRP	.1	63	63		4	9	7.0	13.9	13.9	27	2	55	2
AMERICAS INS CO	.3	215	266			604		227.0	227.0	14	18	32	40
W R BERKLEY CP GROUP	1.9	1 268	1 897		751	328	59.2	17.3	17.3	5	3	13	6
BERKSHIRE HATHAWAY	.5	345	543		7	75	2.0	13.8	13.8	11	1	28	1
CLARENDON INS GROUP	.1	42	42			52		123.4	123.4	28		56	
ELITE INS CO USB	.1	40	34			-1		-2.2	-2.2	29		58	
EMPLOYERS CAS GRP TX		14	24							34		66	
EMPLOYERS RE GROUP	.5	319	323		121	115	38.0	35.5	35.5	12	8	29	14
EVANSTON GROUP	1.5	1 009	1 231		282	481	28.0	39.1	39.1	7	9	17	15
FOREMOST CORP GROUP		32	45		32	14	98.5	30.3	30.3	30		60	
FREMONT INS GROUP		17	31		321	1 444	999.9	999.9	999.9	33		65	
GENERAL AGENTS GROUP	.3	177	187		4	-113	2.4	-60.5	-60.5	19		37	
GUARANTY NAT CORP GR	.3	173	96			33		34.8	34.8	20	7	39	12
HIGHLANDS INS GROUP	1.7	1 088	1 105		-157	-130	-14.4	-11.7	-11.7	6		16	
ILL. EXCH. COMPOSITE	.3	193	227			-190		-83.6	-83.6	18		36	
IMPERIAL CAS & INDEM		23	4		-5	-3	-20.6	-77.1	-77.1	32		63	
INTEGON CORP GROUP		14	1				1.0	32.1	32.1	35		67	
NORTH ATLANTIC C & S	.1	69	43			10		24.0	24.0	26		54	
NORTHLAND GROUP	2.3	1 522	1 200		7	737	.4	61.4	61.4	3	14	10	27
OLD REPUBLIC GROUP	1.2	775	1 329		567	1 401	73.1	105.4	105.4	8	16	21	36
PACIFIC MARINE GROUP	.9	582	979		294	-364	50.5	-37.2	-37.2	9		23	
PENN-AMERICA INS CO	.1	82	99		25	-4	30.3	-3.9	-3.9	25		50	
PROGRESSIVE GROUP	.2	103	76			44		58.1	58.1	22	12	47	24
PROVIDENCE WASH GRP	2.1	1 399	1 380		2 386	254	167.7	18.4	18.4	4	4	12	8
RLI GROUP	.1	96	59			66		111.6	111.6	23	17	48	37
ROCKWOOD GROUP	.6	377	443		25	203	6.5	45.9	45.9	10	11	26	17
SAFETY MUTUAL CAS CP	2.6	1 687	1 679		91	1 031	5.4	61.4	61.4	2	13	8	26
TOKIO MAR & FIRE GRP	.3	205	182		4	117	2.1	64.0	64.0	16	15	34	31
TOPA INS CO		11	40		14	65	122.1	160.9	160.9	36		69	
UMIALIK INS CO	.3	203	188		681	54	335.8	28.7	28.7	17	5	35	9
UNITED CAPITOL INS	.4	267	200			90		44.7	44.7	13	10	31	16
UNITED NATIONAL GRP	.2	110	85		500	781	454.3	895.9	895.9	21	20	46	44
WESTCO INS GROUP	.3	212	304		3 135	2 610	999.9	858.3	858.3	15	19	33	43
WILLIS FABER GROUP		25	39			4		11.4	11.4	31		62	
YASUDA FIRE & MARINE	.1	92	21			9	.1	41.6	41.6	24		49	
OTHER COS 33=	-.1	-76	-331		6 473	-1 745	-99.9	526.9	526.9				
STATE AGENCY CO 69=	31.3	20 479	22 052		17 258	10 733	84.3	48.7	48.7				
ALLSTATE INS GROUP	.5	298	275		50	168	16.9	61.1	61.1	4	6	30	25
COLONIAL PENN GRP		11	28		11	487	102.2	999.9	999.9	12		70	
CUNA MUT INS GROUP		32	32			3		8.7	8.7	10		61	
GEICO CORP GROUP		2	3					-6.1	-6.1	20		85	
GENERAL RE GROUP	2.6	1 671	1 616			1 006		62.2	62.2	2	7	9	28
JOHN DEERE GROUP	.3	174	144		13	83	7.3	57.6	57.6	5	5	38	23
LIBERTY MUTUAL GROUP	.3	164	170		61	27	37.2	15.9	15.9	6	1	42	5
MOTORS INS GROUP		21	23			29		125.7	125.7	11		64	
NATIONWIDE GROUP	5.9	3 826	3 774		2 115	1 898	55.3	50.3	50.3	4	3	5	19
NAVIGATORS INS CO	.1	41	19			13		65.0	65.0	8		57	
PRUDENTIAL OF AM GRP	.1	34	4		2	-93	7.1	-99.9	-99.9	9		59	
SENTRY INS GROUP		8	7					4.3	4.3	13		72	
STATE FARM GROUP	1.3	864	759		468	435	54.2	57.3	57.3	3	4	19	22
USAA GROUP	.2	115	123	8	4	56	3.3	45.8	49.2	7	2	45	18
OTHER COS 14=		-14	483		586	-335	-99.9	-69.2	-69.2				
DIRECT WRITERS 28=	11.1	7 247	7 460	9	3 310	3 776	45.7	50.6	50.7				
TOTAL = 127=	100.0	65 361	65 618	17	40 589	32 904	62.1	50.1	50.2				

REF 1 (PAGE)

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000 OMITTED
FROM FIGURES

BEST'S EXECUTIVE DATA SERVICE

1987
ALASKA

EXPERIENCE BY STATE
- MEDICAL MALPRACTICE

A2-02-50

COMPANY	MKT. SHR.	DIRECT PREMIUMS		DIVIDENDS TO POLICYHLDRS	DIRECT LOSSES		LOSS RATIOS			Group Rank		Overall Rank	
		WRITTEN w	EARNED e	DIRECT d	PAID p	INCURRED i	p/w	i/e	Adj.	Prem.	Ratio	Prem.	Ratio
AETNA LIFE & CAS GRP	.8	130	130		500	-279	383.4	-99.9	-99.9	4		8	
AMER INTERN GROUP	2.9	447	298			158		53.0	53.0	2	2	5	5
CHUBB GRP OF INS COS					116	25							
CIGNA GROUP	.1	10	8		33	-379	345.2	-99.9	-99.9	8		15	
CNA INS COMPANIES	10.7	1 670	1 698		590	1 129	35.3	66.5	66.5	1	3	3	7
CONTINENTAL INS COS	.4	66	45			16		36.1	36.1	5		10	
CRUM & FORSTER COS		-2				-183		-99.9	-99.9				
FIREMAN'S FUND COS	.4	64	59			-21		-36.3	-36.3	6		11	
HARTFORD INS GROUP		2	4					.1	.1	9		19	
HOME INS GROUP													
ST PAUL GROUP	1.0	162	96			3		3.6	3.6	3	1	7	1
TRAVELERS INS GROUP	.4	59	59		-1	51	-1.7	86.3	86.3	7	4	12	9
NATL.AGENCY COS 12=	16.7	2 608	2 398		1 238	521	47.5	21.7	21.7				
W R BERKLEY GP GROUP	.2	34	31			25		82.3	82.3	2		13	
DOCTORS CO INTER EX		2	2							7		20	
EVANSTON GROUP	1.1	174	668			521		78.0	78.0	1	1	6	8
ILL. EXCH. COMPOSITE		4	1							6		18	
JEFFERSON INS GROUP		2	2			1		48.1	48.1	8		21	
MMI COMPANIES GROUP		5	2			1		68.0	68.0	5		17	
RLI GROUP	.1	9	8			8		96.1	96.1	4		16	
HESTCO INS GROUP	.1	13	18			-13		-72.9	-72.9	3		14	
OTHER COS 2=													
STATE AGENCY CO 10=	1.6	242	731			542		74.1	74.1				
ALLSTATE INS GROUP						773							
HEALTH CARE INDEMN	5.9	920	964		152	545	16.5	56.6	56.6	3	4	4	6
MEDICAL INDEMN ALASK	44.6	6 937	6 937		5 928	3 524	85.5	50.8	50.8	1	3	1	4
MEDICAL INS EXCH CAL	30.7	4 777	3 724		1 281	1 265	26.8	34.0	34.0	2	1	2	2
NAT CHIROPRACTIC MUT	.5	85	77			31		41.0	41.0	4	2	9	3
OTHER COS 1=						-1							
DIRECT WRITERS 6=	81.7	12 719	11 701		7 362	6 138	57.9	52.5	52.5				
TOTAL 28=	100.0	15 569	14 831		8 599	7 201	55.2	48.6	48.6				

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TELECOPY COVER SHEET

Anchorage Legislative Information Office

Office - (907) 561-7007 Fax - (907) 562-4376

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FROM: Anchorage LIO PHONE: 561-7007

INSTRUCTIONS: _____

RECEIVED: Date _____ Time _____

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DISPOSAL OF ORIGINAL: Discard ____ Hold for Pickup ____

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SENT BY: Mary Ann

FRANKLIN & ALLEN
Consulting Engineers

SUBJECT	LEGISLATIVE AFFAIRS
	HB 166 WORK SHOP. H L & C.

PREPARED BY	N. FRANKLIN
DATE	3-21-89
SHEET	1 OF 1
JOB NO	

1.) I AM TESTIFYING IN SUPPORT OF H.B. 166.

2.) MY SPECIAL AREA OF INTEREST IS THE INCLUSION OF A 6 YEAR STATUTE OF REPOSE. THIS STATUTE WAS IN PLACE UNTIL RECENTLY, AND IN FACT BY FAR THE MAJORITY OF STATES HAVE A SIMILAR STATUTE OF REPOSE FOR THE CONSTRUCTION INDUSTRY.

3.) NOT HAVING THAT IN-PLACE HAS GENERATED AN ATMOSPHERE OF UNPREDICTIBILITY AMONG THE DESIGN COMMUNITY AND HAS LEFT THE PROFESSIONAL DESIGNER SUBJECT TO POTENTIAL LAWSUITS FOR THE REMAINDER OF HIS LIFE.

4.) WITHOUT GETTING INTO CASES AND DETAILS I URGE PLEASE MOVE THIS BILL ON SO THAT WE CAN GET A STATUTE OF REPOSE IN PLACE THIS YEAR.

NELSON M. FRANKLIN P.E.

Nelson M. Franklin

FRANKLIN & ALLEN
Consulting Engineers

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	HB 166 WORK SHOP. H.L. & C.
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3.) NOT HAVING THAT IN-PLACE HAS GENERATED AN ATMOSPHERE OF UNPREDICTIBILITY AMONG THE DESIGN COMMUNITY + AND HAS LEFT THE PROFESSIONAL DESIGNERS SUBJECT TO POTENTIAL LAWSUITS FOR THE REMAINDER OF HIS LIFE.

4.) WITHOUT GETTING INTO CASES AND DETAILS I URGE PLEASE MOVE THIS BILL ON SO THAT WE CAN GET A STATUTE OF REPOSE IN PLACE THIS YEAR.

NELSON M. FRANKLIN P.E.

Mr. Kelly

Lawsuits' chronology accuses insurers of conspiracy on coverage

In the lawsuits accusing several of the nation's largest insurers with conspiring to manipulate the commercial liability market, the attorneys general of nine states present a picture of a behind-the-scenes conspiracy to restrict coverage. The insurers deny any wrongdoing. Here is a chronology of the events, as charged in the lawsuits:

■ In 1977, the Insurance Services Office Inc., an industry trade group, began a project to revise the standard commercial general liability policy form. The project resulted in a new set of policy forms that the ISO filed with state insurance regulators in March 1984. The ISO offered two variations: the traditional "occurrence" coverage, which pays for accidents occuring during the life of the policy even if the claims are filed years later, and a new "claims made" coverage, which pays claims made only while the policy is in effect.

■ Within ISO, Hartford Fire Insurance Co. and Allstate Insurance Co. unsuccessfully had opposed the new forms. The insurers urged the organization to adopt more restrictive policies. The Hartford, according to the suit, wanted the new forms to eliminate occurrence coverage and add a pollution exclusion.

■ After their positions were rejected, the lawsuit says, Hartford Fire and Allstate, together with Aetna Casualty and Surety Co. and Cigna Corp., began to pressure ISO to restrict liability coverage available to the consumer.

■ March 2, 1984, representatives of Hartford Fire met with representatives of General Reinsurance Corp. to develop a strategy to force changes in the new forms. The suit says the companies agreed to "derail" the forms unless ISO adopted their demands.

■ March 13, 1984, at a meeting of the executive committee of the Reinsurance Association of America, another trade group, General Re launched a "coordinated effort" with the reinsurance association to force revisions in the newly filed ISO claims-made form.

■ May 26, 1984, the reinsurance association's executive committee formed a special liability committee made up of five reinsurance companies. Reinsurers help insurance companies reduce their risk, agreeing to pay a portion of a policy's claims in return for some of its premium.

■ June 15, 1984, the special committee agreed to boycott the 1984 ISO forms unless a pollution exclusion was added and other changes were made to limit coverage.

■ June 19, 1984, in a letter to the ISO, the reinsurance association said its members would not provide reinsurance for insurance written on the 1984 ISO forms.

March 2, 1984, representatives of Hartford Fire met with representatives of General Reinsurance Corp. to develop a strategy to force changes in the new forms.

■ June 21, 1984, Thomas A. Greene & Co. Inc., a New York-based broker, spoke to the ISO board of directors and, at the suggestion of Hartford Fire and General Re, "conveyed the boycott message."

■ At the same time, the suit says, Hartford Fire, Aetna, Cigna and Allstate encouraged a boycott of the forms by key Lloyd's of London syndicates.

■ In July 1984, ISO representatives visited London to explain and promote the new forms. Before the trip, the lawsuit says, Hartford Fire and Allstate worked with Greene and another broker to coordinate the London reinsurers' response to the forms.

■ July 4, 1984, at a dinner hosted by the ISO at the Garrick Club, a private men's club, London reinsurers threatened a boycott of the 1984 forms unless changes similar to those demanded by the Reinsurance Association of America were made.

■ After returning from London, ISO staff met with Hartford Fire at its headquarters in Hartford.

■ Sometime between Aug. 12 and Aug. 22, 1984, ISO staff agreed to reconsider changes in the 1984 forms.

■ Sept. 20, 1984, the ISO executive committee met, with representatives of both the foreign and domestic casualty reinsurance markets in attendance. This was the first time representatives of the markets had been invited to speak at an ISO executive committee meeting. The representatives presented their stance: Change the 1984 forms or no reinsurance. The executive committee agreed to make two changes to the forms, including the exclusion of all pollution coverage, but it did not change its plan to offer a new occurrence form.

■ After the meeting, Lloyd's reinsurers continued to work to eliminate use of the occurrence form. Among other strategies, they said in public forums and the trade press that there would be no reinsurance for coverage written on the occurrence form.

■ The lawsuit says the London reinsurers also boycotted reinsurance for pollution liability coverage, even if written on claims-made forms. Lead reinsurance underwriters in London met Nov. 6, 1985, and agreed that all North American casualty contracts would be written with a pollution exclusion.

New York Stock Exchange Issues

Continued from previous page

Sales Net | Sales Net | Sales Net

DATE: April 13, 1989

FROM: Kathleen Dinius, Ph.D.
35477 Spur Highway, Suite 209
Soldotna, AK 99669
262-1260

TO: Juneau LIO
House Labor and Commerce Committee
House of Representatives
Alaska State Legislature

RE: House Bill No. 166

TIME: 3:30

TOTAL NUMBER OF PAGES INCLUDING COVER: 8

OTHER INSTRUCTIONS:

The following is requested to be included as written testimony on the hearing on House Bill 166 in House Labor and Commerce Committee

KATHLEEN DINIUS, PH.D.
LICENSED PSYCHOLOGIST
35477 SPUR HIGHWAY, SUITE 209
SECOND FLOOR, 4-D COMMERCIAL BUILDING
SOLDOTNA, ALASKA 99669

907-262-1260

April 13, 1989

House Labor and Commerce Committee
House of Representatives
Alaska State Legislature

RE: House Bill No. 166

Dear Committee Members:

On April 1, 1988, I attended a statewide teleconference on House Bill No. 166. During that session, I testified regarding the psychological effects to individuals who have been injured and experiencing enduring effects of those injuries. I was asked if I would provide additional information about this to members of the Legislature. I am happy to do so.

I am a licensed psychologist in the State of Alaska. I am also licensed as a psychologist in the states of Wisconsin and Indiana. I have worked in the community mental health systems in Indiana and Alaska for eighteen years. I am currently in private practice in Soldotna. During my career, I have worked with a fair number of clients who have experienced chronic pain and physical limitations as the result of injuries they have sustained. I have counseled with them to help them deal them with the emotional, social and physical consequences of these injuries.

Individuals who have sustained injuries that are either acute and traumatic in nature or which are long-term in their effects almost always experience some psychological consequences along with the physical ones. Most frequently, people experience anxiety, depression, or both. The anxiety often is connected with the actual event which caused the injury. For example, individuals injured in a car may develop a fear of driving or riding in cars. One client with whom I have worked developed phobias of being in small places after she was injured by chemical fumes in a bathroom. The anxieties can generalize to many situations and hamper many apparently unrelated, common everyday life experiences for these individuals. If there has been any physical disfigurement, the individual must also face anxiety about the reactions of others to their physical appearance. Because accidents may lead to injuries which prevent people from continuing to work, they are often also beset with financial troubles and the inability to provide an income for themselves and their families. This can lead to anxiety on the part of the injured person, tension in the marriage and family, and depression on the part of the wage earner who can no longer provide support for the family. The latter is most intense for men, as they have much greater difficulty accepting an inability to follow through on their role as bread winner.

When an individual must sustain long-term consequences of an injury, or if they experience chronic pain, they usually develop symptoms of significant depression in addition to any symptoms of anxiety they may have. Even relatively mild pain becomes very wearing on the individual if it is of a chronic nature. People begin to become focused on the pain in an effort to find relief for it. They have difficulty accepting the limitations of activities, as do those around them. Family members often become angry at the injured person because he or she can no longer engage in many family activities with them. The injured individual may feel guilty about their limitations and they may also become angry at family or friends who do not understand their position. This is especially true if the injured person does not physically appear to be injured, that is if they have an injury such as a back injury that is not immediately to others. Although the injured person is preoccupied with the effects of his injury and the pain he experiences, others begin to tire of hearing him talk about it. Eventually, the injured person may withdraw from social contacts. I am enclosing a copy of a section of the book Mastering Pain by Richard A. Sternbach. Dr. Sternbach has done research on pain since 1960 and has worked with pain patients since 1964. He has been the director of the Pain Treatment Center at the Scripps Clinic and Research Foundation in California since 1975. Dr. Sternbach gives an excellent description of what happens to individuals who experience chronic pain as they progress from the initial stages through the enduring stages of their condition.

Individuals who have been permanently impaired or disfigured have additional problems in dealing with the fact that they are no longer the person they were before. They must go through the trauma of looking different physically and redefining their concept of themselves. If they experience paralysis or inability to use parts of their body, including senses and speech, they must totally reorganize their lives. They experience the depression of giving up and grieving for the life they had expected to have. Even more acute are the effects of individuals who sustain brain damage which affects body motion, speech, use of mental functions and processes or emotional control. Not only must these individuals deal with the fact that they are no longer the same person they were prior to their injury, they must also often do this with limited mental abilities. When a person must cope with the experience of losing his losing his sense of self, the resulting depression and anxiety can be intense and very real.

There are many repercussions for individuals, particularly family members, where a death is involved. Most extreme of these is the case of a child dying. Even the death of an adult child is extremely difficult for the parent to handle. However, the death

of a minor child usually creates extreme emotional distress for family members and particularly for the parents. The Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association classifies the death of a child as a catastrophic stressor. It is classified in the same level as having experienced a concentration camp. It is the most extreme of stressors. Likewise, for a child experiencing the death of both parents, this is also categorized as catastrophic. The death of a spouse or the death of one parent in the case of a child is listed as extreme, which is the next most severe classification of stressors. In the case of the death of a child, even where the parents had no fault in that death, divorce of the parents is common. Parents go through stages of blaming themselves, blaming the other spouse, and simply having difficulty accepting the child's death at all. These consequences can follow and frequently do follow the parents for years, sometimes throughout their lifetime. As parents who have lost children have told me years later, nothing and no one ever replaces their child.

I appreciate the opportunity to provide this information to you. Knowing the distress that individuals experience in these kinds of tragedies, I would ask you to consider these factors when making decisions about House Bill 166. Particularly pertinent is the section for compensation to individuals or family members which are not based on medical costs or loss of income. Although compensation for emotional distress cannot stop that distress from happening, it can help the individual have the means and opportunity to do some restructuring of their lives. If you have any questions about what I presented or would wish to talk with me further, I would be most happy to talk with you. You could contact me at 262-1260 during daytime business hours or at home at 262-1058.

Yours very truly,

Kathleen Dinius, Ph.D

Kathleen Dinius, Ph.D.
Licensed Psychologist

KD/mp

FROM LAW OFFICE JL KASHI 4.13.1989 15:44 P.27

Also by Richard A. Sternbach, M.D.:

PAIN PATIENTS: Traits & Treatments
THE PSYCHOLOGY OF PAIN
THE PSYCHOLOGY OF PAIN, 2nd ed.

MASTERING PAIN

A Twelve-step program for coping with chronic pain

by Dr. Richard A. Sternbach

BALLANTINE BOOKS • NEW YORK

FROM LAW OFFICE JL KASHI 4.13.1989 15:46 P.28

What Chronic Pain Does to Us

Probably the commonest complaint of those with chronic pain is that their sleep is disturbed. Before the pain began, they always slept well. Since the pain developed, they have trouble falling asleep because they cannot get comfortable. As they finally settle into a less uncomfortable position, they find the pain becoming more prominent in their minds as there is less to distract them. Finally, exhausted, they drift into a restless sleep, only to awaken every hour or so as they roll over or change position and the pain awakens them.

They finally remain awake until three or four in the morning, unable to get back to sleep, and at such times find it impossible not to think about what the pain means—whether the doctors have made an incorrect diagnosis or are keeping some terrible secret, whether it is worth trying to go on living with such pain, whether there is any other way out.

Even the minority who are able to sleep well report that they feel quite exhausted all the time, drained of energy as though they had the flu. The continuous pain wears them down. If, in addition to this fatigue, there is the disturbance of sleep, the people feel even less able to bear the pain; indeed, they become less tolerant of any pain. Even minor injuries, such as those caused by bumping into a piece of furniture or stubbing a toe, seem like major calamities.

Usually those with chronic pain are taking analgesics. One of the side effects of such drugs is to upset the stomach and gut. Patients frequently complain of heartburn and constipation, feeling nauseated and bilious. They find the analgesics becoming less effective over time; they need to take larger amounts just to "take the edge off" the pain, and so still more severe side effects develop.

How miserable these people feel. In addition to being

in pain, they are tired all the time, they cannot sleep and their bowels don't function properly. And yet these physical problems are only part of the chronic-pain syndrome. There are psychological effects too.

Those with chronic pain complain of having become very irritable and short-tempered. They find themselves flaring up in anger over the minor actions and trivial comments of those around them. They say hurtful things to family members for insufficient reasons, then feel guilty and promise to keep their tempers and hold their tongues, only to lose control again and again. They then begin to seclude themselves to avoid further attacking those they are close to. They thus find themselves withdrawing more and more, often becoming almost homebound, sometimes even spending most of the time in the bedroom, alone, with little to distract them from their pain.

Some persons with chronic pain feel so nauseated by their pain and analgesics that they lose their appetites, need to force themselves to eat a minimum amount of food and slowly but steadily lose weight. Others find themselves restless and on edge and do a great deal of nervous snacking and excessive eating. This, combined with their inactivity, causes them to steadily gain weight, often becoming somewhat obese, and to become disgusted with themselves.

The disturbances of sleep and appetite and the resulting social withdrawal are some of the elements underlying depression. Almost all reports of psychiatric and psychological studies of chronic-pain patients report significant depression as one of the results. It is not exactly the same as the kind of depression that psychiatric patients show, but it is a depression nevertheless. Some of the persons with chronic pain admit to feeling depressed, but many do not, insisting that it is pain and not depression that spoils their sleep, makes them withdraw and so on.

In addition to this kind of depression, many of those with chronic pain begin to think of themselves as chronic invalids or, at least, chronically disabled. They are often unable to continue working, and receive disability or workers' compensation income, which only partly compensates for the lost salary or wages, and this begins to contribute to a shift in the family dynamics and power structure.

With one of the wage earners unable to bring in the accustomed income, unable to help with the household chores and more and more withdrawn, the center of the family shifts away from the person with pain to those who are more active and involved, and the patient becomes (and feels) less important. The other family members, for their part, feel sorry for the one with pain, frustrated and guilty because they cannot help relieve the pain and—so secretly that they hardly admit it to themselves—somewhat resentful that they have to do more chores now.

Some families remain in this state of strain and tension. In others, the patient begins to lose his or her sense of status and, without realizing it, begins to tyrannize the family. This may occur directly, through irritability and temper outbursts, or indirectly, through manipulating others to do things the person could do for himself or herself. These manipulations are made possible through the guilt feelings of the family members, who are powerless to help the sufferer and resent his or her disability.

The physical problems (sleep disturbance, appetite disturbance, fatigue, etc.) and psychological problems (irritability, depression, social withdrawal) and family problems are serious enough, but that is not all there is to the chronic-pain syndrome. There are serious prob-

lems as well with doctors, with the health-care system and with the insurance and disability systems.

The person with chronic pain usually has a much higher proportion of medical contacts than do other patients. Because, despite the patient's insistent requests, the physician cannot provide relief, the patient may begin soliciting help from other physicians, requesting intervention in the form of surgery or analgesic prescriptions. The doctors become frustrated because their ability to cure or at least provide relief is stymied, and they begin to wonder whether the patient is or will become a drug addict, or whether psychological symptoms may be causing the pain. The patient and physician become increasingly irritated and frustrated with each other, and mutual suspicion begins to develop.

Partly in desperation, partly because of hope, the patient begins to try alternative health-care systems. Various forms of massage and manipulation, nutritional plans and food supplements are tried, with some possible slight but temporary improvement noted. As the patient reports this to his or her doctor, the physician becomes more annoyed, and notes about the patient's emotional problems and drug use become more prominent in the record. The medical-insurance or health-plan system begins not only to refuse reimbursement for the nontraditional treatments the patient has received, but to question the need for even the more orthodox medical treatments.

Many patients begin to find that much of their time is spent filling out claim forms. Not only are requests for reimbursement of medical expenses slow in being filled, but more and more of them are being denied and must be appealed. Disability checks suddenly stop arriving, without explanation, and the patient learns only weeks or months later that this is due to a casual comment by one or another physician to the effect that she or he does not think the patient is really all that disabled, and that

psychological factors seem to be prominent in the case. Some patients find themselves being followed and photographed by insurance investigators who are hired to take films of the patient to prove that he or she is not really disabled. The patient becomes increasingly angry and embittered and—like it or not—poorer.

The chronic-pain syndrome consists of the physical, mental, familial and social problems we have just described. These are not imaginary. They do not cause the pain, but they certainly make the pain seem worse and harder to deal with. They do cause *excessive* pain and *excessive* disability. We will deal with these problems specifically and in some detail in later chapters. At this point we are only mentioning them to give an idea of the extent of the problem and to help you to realize that the problems you may have encountered are not unique, but are well known. And furthermore, there are specific ways of dealing with them that make it possible to have better means of pain control and to live a more satisfying life.

But the effects of chronic pain on the individual and the family and on social contacts are still only part of the story. There are many such individuals, and when the total costs of acute and chronic pain are estimated, they are truly staggering.

What Is Pain?

Each of us believes that we know, from our own experiences, what pain is. But different persons have different experiences, and the word "pain" may mean something different to each one of us. The following definition is the one adopted by the International Association for the Study of Pain.

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage,

END

Attachment 1A
FCC 86-2172

Commercial Insurance Division
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123

August 8, 1986

RECEIVED
AUG 13
FORMS AND CONTRACTS

Honorable Bill Gunter
INSURANCE COMMISSIONER
Florida Department of Insurance
Tallahassee, FL 32301

ATTN: Mr. Charlie Gray, Chief
Bureau of Policy and Contract Review

Dear Mr. Gray:

RATE REVISION
CONTRACTORS LIABILITY POLICY PROGRAM
THE AETNA CASUALTY AND SURETY COMPANY
THE STANDARD FIRE INSURANCE COMPANY
THE AUTOMOBILE INSURANCE COMPANY OF HARTFORD, CONNECTICUT

In accordance with your Insurance Laws, our Companies file a revised liability rate level which results in an overall selected premium increase of 17.2% with an annual premium effect of $622,250.

Our Companies' decision to revise rates results only after a thorough and comprehensive analysis. We evaluated our experience, market conditions, tort reform, and other relevant factors as they affect the establishment of adequate rate levels. The enclosed exhibits prepared by actuarial unit are submitted in support of our rate filing decision, and demonstrate that the resultant rates are neither excessive, inadequate, nor unfairly discriminatory.

We propose to implement this filing with respect to all policies written on or after January 1, 1987. So as to not delay the filing of our rate level decision, revised rate pages will be forwarded under separate cover when available.

A stamped, self-addressed envelope is enclosed for your convenience in responding.

Sincerely,

Thomas L. Rudd

Thomas L. Rudd, Superintendent
Insurance Department Affairs - Commercial Lines

BODILY INJURY CLAIM COST IMPACT OF FLORIDA TORT LAW CHANGE

Summary

The following table summarizes the expected impact of the new Florida law on bodily injury claims costs (including Allocated Loss Adjustment Expenses). The impacts shown were developed from data gathered via a special claim study conducted by the AEtna. The claim study and the analysis are detailed in the succeeding sections of this memorandum.

Impact of Tort Law Changes

Impact of Tort Law Changes

Tort Law Change	Line of Business: Products Bodily Injury	Line of Business: All Other General Liability
Collateral Source Offset	0	(0.4%)
Joint & Several	0	0
Limitation of Noneconomic Damages to $450,000	0	0
Punitive Damages	0	0
Future Economic Damages over $250,000 Paid at Present Value	0	0

All Other General Liability includes the bodily injury liability portion of package policies, SMP Section II, and monoline General Liability policies. The analysis as shown is based solely on AEtna data and, therefore, is applicable only to AEtna's book of business.

Claim Study

The attached special claim analysis form, designed to gather data on the impact of the tort reforms, was completed by experienced Branch Office claim personnel. Claims eligible for analysis were selected according to the following criteria:

1. Commercial Casualty claims (excluding National Accounts business) for policy years 1981 through 1985
   a. reported prior to January 1, 1986
   b. open as of May, 1986
   c. closed during the last six months

2. All claims in category (1) with indemnity payments or reserves over $25,000 were analyzed (total of 55 claims).

3. Fifty closed claims with indemnity of less that $25,000 were randomly selected.

The completed forms were reviewed for internal consistency prior to coding and analysis.

Collateral Source Analysis

Exhibits I and II detail the analysis of the revision in the collateral source rules. Exhibit I is for claims over $25,000 indemnity. Exhibit II is for claims under $25,000 indemnity.

Exhibit I shows that since the right of subrogation exists for many collateral sources available to the plaintiff, the economic losses incurred are not expected to be substantially reduced due to the law change. Furthermore, current AEtna claim settlement practices recognize, in part, the existence of collateral sources as part of the negotiating process used in arriving at a mutually satisfactory damage value with the plaintiff.

Exhibit II shows that for claims under $25,000, no additional savings are expected due to the change in Florida law.

Joint and Several Analysis

Exhibit III details the analysis of joint and several additional payments made by AEtna. Total joint and several payments were 4.5% of indemnity payments over $25,000. A review of each claim generating additional payments due to joint and several liability indicated no reduction in those payment due to the interaction of economic damages sustained by the plaintiff, the percentage of liability assigned to AEtna's insured, and the policy limits purchased.

Analysis of Limitation of Noneconomic Damages to $450,000

Nine claims had the potential for coming under the new limitation for noneconomic losses. The nine cases were identified on the basis of full liability value—not our insured's share of the liability. Data in the above format allowed for a review of whether total claim value could be reduced and whether such a reduction would impact on AEtna's incurred claim cost.

The review of the actual data submitted on these cases indicated no reduction of cost. This result is due to the impact of degree of disability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff; all seemed to reduce the expected noneconomic component of damages to less than $450,000.

Analysis of Punitive Damages

Only two cases were found where punitive damages had an impact on the claim settlement value. The total impact was estimated at less than $15,000 or less than 0.1% of total indemnity payments. Consequently, it appears that there will be no impact on AEtna's claim values due to changes in the allocation of the punitive damages awarded.

Analysis of Installment Payment of Future Economic Damages Over $250,000

Ten claims had the potential for coming under this section of the law. The review of individual cases indicated no net savings to AEtna for the following reasons:

1. interaction of policy limits, past economic losses, and future economic losses

2. settlement value of the case

3. apparent implicit recognition of the periodic nature of future damages

Overall Summary

The expected net reduction in claim costs is based on an analysis of AEtna claims. As such, the analysis is applicable only to AEtna's book of business.

Due to the level of detail of the historical claim data, informed claim judgement was required in some instances to ascertain some of the detail required for the analysis. The judgement, if any, was exercised by experienced claim adjustors and is implicit in the analysis.

The analysis shown represents the best estimate of future cost reductions if the law as currently structured remains in effect. However, the sunset provision of the law takes effect in four years. Furthermore, the law applies only to cases filed under the law, and the Florida statute of limitations is four years. Consequently, it is possible that any plaintiff who might be severely impacted by the provisions of the law would delay filing until after the law expires. If this situation arises, then the expected reductions will be lower than those indicated in this memorandum.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM

In 1986, Florida passed a number of changes to the tort system. We have reviewed the tort changes and their potential effect on our medical professional liability experience. Our review is based on a study of over 300 Florida closed claims. The total effect of the bill based on this evaluation was very small.

Evaluation:

Of the 313 closed claims that were studied, only four claims would have been effected by the law for a total effect of about 1% savings. (Exhibit A) Furthermore, all of these savings would have been eliminated if the courts had assigned only 10% more of the blame on our insureds than our claim department had estimated. It's highly likely that there would have been no savings on these claims had the bill been in effect. (Exhibit B)

Our study covered all of our Florida physicians, surgeons and hospital claims that closed in 1983 and 1984. Economic loss was determined based on the plaintiff's medical loss, weekly wage, and time lost from work. These losses were reduced for the time value of money.

We added the noneconomic loss cap to the total economic losses. The cap is $450,000 times the portion of negligence assigned to our insured. We compared this maximum award under the new law to the amount that the St. Paul actually paid on behalf of our insured.

The conclusion of the study is that the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice.

Comments on other provisions of the bill:

a. Collateral source offset

The medical malpractice provisions prior to this act provided for subrogation against collateral providers. The effect of this subrogation would be similar to the effect of the collateral source rule. Therefore, the net effect of eliminating the subrogation and allowing collateral sources is negligible.

b. Itemization of Damages

Damages were itemized in our evaluation of this tort reform and no savings were shown. They are probably already implicitly itemized by either juries or our claim department when settling claims. We expect no savings from this provision.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM
(Continued)

c. Frivolous Suit Protection

This provision can either work for or against us depending on who wins the case. No savings are expected from it.

d. Additur/Remittitur

This provision can also work for or against us. No savings are expected.

e. Punitive Damages

The legislation reduces the monetary incentive for punitive damage cases, but not total award amounts. Since these cases often have a retaliatory incentive, no savings are expected.

f. Timing of Effects

The tort changes made in Florida apply to losses occurring on or after July 1, 1986. On a claims-made policy, they will effect only the portion of our expected losses with accident date after July 1, 1986. This will impact the equivalent of our first year losses.

g. Conclusion

The tort law changes effective July 1, 1986 in Florida will, hopefully, have a positive impact on loss costs for occurrences after that date. However, to forecast the effect is highly speculative. Our evaluation of prior losses showed little or no savings under key provisions of the law and our analysis of other provisions show no expected savings. Our best estimate is no effect from the tort changes.

It can be hoped that the adoption of these tort changes will have an intangible effect on society, and further work to mitigate future loss trends. However, the trends in medical malpractice have been very high. The effect of the reform needs to be very strong to stem such trends.

Attachment 2

State Farm Fire and Casualty Company

State Farm General Insurance Company

112 E. WASHINGTON ST.
BLOOMINGTON, ILLINOIS 61701

October 21, 1986

Mr. Ray Rathert
Kansas Insurance Department
420 S. W. 9th Street
Topeka, Kansas 66612

Ray:

Before any discussion of State Farm and tort reform, it must first be clearly understood that most of the problems in the liability field are in lines which State Farm does not write. Because of this, the impact of tort reform on our book of business is going to be considerably different from that of a major liability writer.

We have been requested by several insurance departments to come up with some estimate of the effect of newly passed tort reform ~~legislation on our~~ rates in their states. We know of no way this can be done actuarially. Consequently, we resorted to judgement.

The few enacted tort reform statutes usually include items such as:

1) Collateral source of indemnity

2) A non-economic cap

3) Joint and several restriction

4) Punitive damage limitation

5) Alternate methods of payment.

A sampling of commercial liability claims provided the following:

1) Collateral source of indemnity. The sample indicated that approximately 7% of our total indemnity losses were potentially subject to a collateral source. Only about a quarter of these reflected a known collateral source. In our judgement, 50% would be a very liberal estimate of the success in reducing damages due to the existance of a collateral source. The net savings from the collateral source change is thus about 1% (7% X 25% X 50%).

2) Non-economic cap. Non-economic caps are established at such a level that our sample indicated only very few claims would exceed the cap. It is our judgement that the loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses.

3) Joint and several restriction. In our sample of liability claims, no claim was found that would have been affected by the joint and several restriction.

4) Punitive damage limitation. Again, in our sample, no punitive damage awards were found.

5) Alternative methods of payment. On our book of business, the savings due to alternative payment methods on future economic losses would be negligible in relation to our total indemnity losses.

Although we believe the effect of tort reform on our book of business would be small, we do believe that effective tort reform legislation can have a positive impact on not only pricing but also availability. It is important to keep in mind that tort reform, or absence thereof, is only one of many factors which influence pricing and availability. Any of these other factors can produce an opposite effect which could equal or outweigh any positive effect of tort reform.

Attached are liability rate comparisons for Kansas and surrounding states. As you know, we use ISO rates for monoline policies. Even in our package policies, the original liability loadings were also derived from ISO rates.

Again, as you know, we do review our rate levels at least annually. It will probably be several years before any effect from tort reform legislation can be expected to influence our experience. Anyway, hope these brief comments will be of some use to you in your discussions of this subject.

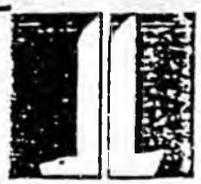
Best regards,

Bob

Robert J. Nagel
Assistant Vice President
State Filings Division

RJN:kc/1021

Attachment 4



GREAT AMERICAN·WEST, INC.

200 S. MANCHESTER AVENUE
ORANGE, CA 92668
714/634-4600

April 23, 1986

Mr. Norman Figon
Rate Analyst
Washington Insurance Department
Insurance Building
Olympia, WA 98504

Re: American National Fire Insurance Company
Select Driver I Program
Select Driver II Program
Private Passenger Automobile
Rate and Rule Revision

Dear Mr. Figon:

In your letter of March 25, 1986, you indicated that we need to place a provision in our ratemaking to reflect the impact of the "tort reform" law. As an attempt to quantify, we reviewed twenty-four claim files, which represented all of our Private Passenger Automobile claims over $50,000 in the state of Washington since 1983. Of these twenty-four claims, we believe that the new law could have an impact on three claims. One claim involved a driver that was intoxicated. We estimate that we would not have paid $20,000 of the claim. On the other hand, there were two claims in which American National Fire would see an increase in its loss liability. These are contributory negligence cases in which our percent of the entire loss liability would increase. The impact of the law on these two is at least $100,000 on each of them.

From the above study, it does not appear that the "tort reform" law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the "tort reform" law.

We request, therefore, that you reconsider the original filing of January 19, 1986, with an amended effective date rule of:

"For all policies written on or after June 2, 1986".

In our telephone conversation you mentioned a concern that we are selecting an increase less than our indications. Our plan of action is to take this increase, which we estimate to be slightly more than 14%, and to review the rates in the near future, such that we can effect a rate change six months after the effective date of this revision. We believe that this method will prove to be less disruptive on our book of business than other courses that we might have chosen.

We hope the above includes all the information that you need to expedite an approval of the filing.

Sincerely,

Kevin J. Kelley
Director of Actuarial

KK/nk

CHIEF EXECUTIVE
circular

Attachment 5

RECEIVED
OCT 14 1986
ISO DALLAS

DIB
RAI.
KAS

October 3, 1986

ISO POLICY DECISION ON TORT REFORM ANNOUNCED

Chief Executive CE-86-31

BACKGROUND

Various tort reform measures have been enacted or are still under active consideration in many states. It is clear that meaningful tort reform will have a favorable, prospective impact on loss severity and/or frequency, variable by state and line of insurance which, ultimately, will be reflected in state loss experience.

However, in some jurisdictions, an immediate rate reflection in response to tort reform is being demanded. Statutes in Florida, New York and Hawaii mandate that insurers reflect tort reform legislation in their filings. The New York Insurance Department has already advised companies of its estimates of the cost reductive effects of tort reform. Florida has mandated a 1987 rollback to adjusted 1984 rates, unless companies file 1987 rates reflecting the impact of tort reform by October 15, 1986. Hawaii has mandated a 10% decrease in rates on October 1st to reflect tort reform, with further reductions required in future years. The Washington Insurance Department is requiring that future rate filings reflect enacted tort reform even without a specific statutory requirement.

Insurance Services Office, Inc., 160 Water Street, New York, New York 10038 (212) 487-5000

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ISO POSITION

ISO is unable to quantify, and to reflect in its filings with a reasonable degree of certainty, any immediate cost effects of tort reform. ISO believes that the reflection of any beneficial effect of tort reform on insurance pricing, where mandated, is a matter of individual insurer judgment and not a precise actuarial exercise. Such judgment is consequently more properly applied by individual insurers, rather than by ISO in its role of acting on behalf of those affiliated insurers which elect to use ISO's services.

Therefore, the ISO Board of Directors has established — as ISO policy — that, inasmuch as ISO cannot immediately reflect any cost effects of tort reform in its filings, any such effects are best determined by the judgment of each insurer, taking into account the distribution by coverage, class, and limits on its own book of business.

ISO ACTION

Consistent with this policy, ISO advisory rates will not reflect tort reform and each company must make its own assessment as to the immediate effect, if any, of tort reform on its book of business.

In New York, in order to assist companies in complying with the refiling requirements of the new law, ISO released Commercial Lines Circular CL-86-29 which contained revised manual rules utilizing the cost reductive effects promulgated by the Superintendent of Insurance, without commenting on their appropriateness.

In Florida, ISO has developed a filing procedure -- which has been approved by the Insurance Department -- whereby individual companies must supplement the ISO filing with their own individual estimates of the impact of tort reform. At the direction of the Insurance Department, ISO will collect these individual estimates and file them on behalf of each insurer. Refer to ISO Commercial Lines Circular CL-86-33 for specific details.

ADDITIONAL INFORMATION

ISO plans to shortly provide insurers with information which could be considered by each company in reflecting any effect of tort reform, including an analysis of the tort reform measures enacted in individual states.

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Within the next several days, ISO will release such information to insurers via Commercial Lines and Technical Services Circulars. In anticipating receipt of this material, each insurer should note ISO's strong belief that any beneficial effects of tort reform cannot be quantified with any degree of accuracy. Accordingly, providing any quantitative information does not imply that any actuarial precision can be applied to what is -- in effect -- an imprecise subject. However, the information may aid individual insurers in supplementing their judgment which, ultimately, will be the major factor in determining any beneficial pricing effect of tort reform.

CAUTION

In Circular CL-86-33 we detailed the Florida filing procedures which must be completed by October 15th. Since -- to avoid the rollback -- Florida rate filings require individual insurer estimates of the cost effects of tort reform and, since the judgment of each insurer will be the major component in arriving at these estimates, we urge individual insurers to promptly begin developing their own estimates, without waiting for the ISO material on tort reform which, as heretofore mentioned, will not produce precise results.

Daniel J. McNamara
President

cc: ISO Board of Directors
Actuarial Committee
Commercial Lines Committee
Personal Lines Committee

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Attachment 3

NATIONAL INSURANCE
CONSUMER ORGANIZATION

Effect on Insurance Rates of Florida Tort Reforms -

for all companies filing as of 11/01/86

% Reduction	Number of Filings				
	Commercial General Liability	Commercial Package	Auto	Other	Total
Ø	72	28	31	44	175
Ø-2.5%	12	25	5	3	45
2.5-5%	18	14	6	Ø	38
5-7.5%	7	1	7	1	16
7.5-1Ø%	2	1	Ø	Ø	3
Over 1Ø%	Ø	Ø	Ø	Ø	Ø
Total number of filings	111	69	49	48	277
Average Reduction	-1.3%	-1.5%	-1.5%	-Ø.2%	-1.2%

Average calculated by assuming all filings are of equal premium weight. Companies that filed rates and did not calculate the effect of the new tort reforms are not included.

Source: Florida Department of Insurance

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

Attachment 6

INSURANCE SERVICES OFFICE

160 WATER STREET NEW YORK, N. Y. 10038

TELEPHONE: (212) 487-5000

COMMERCIAL CASUALTY ACTUARIAL DIVISION
RICHARD B. MONDI, ASSOCIATE ACTUARY & MANAGER

October 15, 1975

RECEIVED
AUTO & COMPENSATION
INSURANCE BUREAU

OCT 15 1975

INSURANCE DEPT.
STATE OF N. Y.

Mr. Stanley A. Dorf, Chief Actuary
New York Insurance Department
2 World Trade Center
New York, New York 10038

Re: Comparative/Contributory Negligence -
Automobile Liability Rate Change Proposal

Dear Mr. Dorf:

Because of the change in the New York law from contributory negligence to comparative negligence, I.S.O. proposes to increase Automobile Liability (including Uninsured Motorists) rates by 5%. This proposed increase is based on a study of closed Automobile Liability claims in California, comparing the actual settlement under the comparative negligence law with the estimate of what it would have been under the earlier contributory negligence law. Enclosed is Exhibit 1 displaying the indicated rate changes by line and coverage based on the survey, and also the proposed changes of 5% for the liability coverages and "no change" for Personal Injury Protection. Exhibit 2 details the results of the claim study survey, showing number of claims, losses under both negligence laws, and comparative/contributory ratios, by line and coverage.

We have also enclosed a copy of the "Call" letter used for this survey; in it can be found a sample copy of the questionnaire form and the general instructions for completing the form. The companies participating in the study write approximately 75% of the Automobile Liability premiums written by Insurance Services Office affiliated companies. All claims reported to us were settled very shortly after the changeover in negligence laws in California; thus, claims personnel completing these forms were in a good position to compare comparative vs. contributory settlements for their claims.

Very truly yours,

George Burger

GB:cm
Enc.

George Burger
Actuarial Assistant

New York

Automobile Liability Insurance

I.S.O. Proposed Rate Increases to Reflect the Change from Contributory to Comparative Negligence*

Coverage	Indicated Rate Change	Proposed Rate Change
Private Passenger		
Residual Bodily Injury	+ 4.1%	+ 5.0%
Personal Injury Protection	-	0.0
Property Damage	+ 4.6	+ 5.0
Uninsured Motorists	+13.0	+ 5.0
Total	+ 4.8	+ 4.4
Commercial		
Residual Bodily Injury	+ 6.8%	+ 5.0%
Personal Injury Protection	-	0.0
Property Damage	+ 6.9	+ 5.0
Uninsured Motorists	+ 0.1	+ 5.0
Total	+ 6.5	+ 4.7
Grand Total	+ 5.4%	+ 4.4%

*Note that all percent changes are weighted on New York's premium distribution.

AUTOMOBILE LIABILITY INSURANCE
Effect of Change from Contributory to Comparative Negligence*

Coverage	(1) Number of claims	(2) Losses Under Contributory Negligence	(3) Losses Under Comparative Negligence	(4) Ratio ((3)÷(2))
Private Passenger Automobiles				
Bodily Injury	521	$1,098,811	$1,144,407	1.041
Property Damage	1,622	574,730	601,305	1.046
Uninsured Motorists	43	101,872	115,072	1.130
Total	2,186	$1,775,413	$1,860,784	1.048
Commercial Automobile				
Bodily Injury	318	517,285	552,522	1.068
Property Damage	1,018	361,123	386,135	1.069
Uninsured Motorists	9	48,305	48,339	1.001
Total	1,345	926,713	986,996	1.065
Grand Total	3,531	$2,702,126	$2,847,780	1.054

* NOTE: The above experience was taken from ISO's California Closed Claim Survey.

CLAIMS NEWS

MICA Medical Indemnity Corporation of Alaska

June 1988

THE ALASKA SUPREME COURT: Believe It Or Not!

This issue of CLAIM NEWS is devoted to articles highlighting recent decisions by the Alaska Supreme Court and cases in which those decisions have factored prominently.

Critics of the insurance industry, who would have the public believe that the current crisis in liability insurance is simply a contrivance of the industry to justify higher premiums and greater profits, should consider the impact these decisions have on insurance companies and their clients. For example underwriters of hospitals in 1981, the year in which Jackson was injured, collected premium for that and subsequent years that could hardly have anticipated or reflected the exposure dumped on Alaskan hospitals in October of 1987, when the Court made hospitals responsible for E.R. physicians. Companies, such as MICA, having spent years building a claims department based on in-house expertise, could hardly have anticipated or budgeted for the enormously increased defense attorney costs necessitated by the Langdon vs. Champion decision.

The decisions of the Alaska Supreme Court, generally acknowledged to be one of the most, if not the most, liberal high court in the land, factor prominently in MICA's cost of doing business and, consequently, in its premium structure. It is interesting that our several-year experience of diminished severity and frequency of claims continues; but the cost of doing business, including defense attorney costs, escalates.

The crisis in the insurance industry is a complex one with many facets. Certainly, physicians are part of the problem and need to increase their awareness of, and attention to, management of risk in their own practices and the achievement of quality patient care. We believe that Alaskan physicians, particularly MICA policyholders, have been responsive to this company's efforts in risk management and that is one of the primary causes of the diminished frequency and severity of claims. To be sure, there is work left to be done in that direction, but the legislative, executive, and particularly the judicial branch of government in this state play an enormous role in the problem which should be recognized and for which they should be held accountable.

Supreme Court Decision Raises Discoverability Concern Over Adjuster's File

In early April of 1988, the Alaska Supreme Court handed down a decision in a case entitled Langdon v. Champion. In this case the court dealt with the familiar question of what parts of an insurance adjuster's file are subject to discovery in a suit brought by a claimant against the insured.

The action did not involve a professional liability issue. It involved a personal injury claim against the defendant insured. The defendant's insurer became aware of the plaintiff's claim some nine months after the incident and immediately an adjuster took a recorded statement from the insured. Over the ensuing months and prior to the filing of suit, the adjuster corresponded with the claimant's attorney. At the time suit was filed, the defense was assigned to legal counsel.

The plaintiff made a request for production of all recorded and written statements, investigative reports and a complete copy of the adjuster's file. The trial court denied the motion to compel production. Plaintiff filed a petition for review with the Alaska Supreme Court which was granted.

The court considered, first, whether the defendant's recorded statement was protected by the attorney-client privilege. The court concluded that an insurer was not a "representative" of an attorney under the Alaska Rules of Evidence and concluded that statements made by an insured to his insurer were not protected by the attorney-client privilege and were, therefore, discoverable.

Secondly, the court discussed the work product privilege applicable to materials prepared in anticipation of litigation and held that materials contained in an insurer's files would be conclusively presumed to have been compiled in the ordinary course of business absent a showing that they were prepared at the request or under the supervision of the insured's attorney. In other words, prior to attorney involvement, materials held by insurers are subject to discovery without regard to any work product restrictions.

This decision has profound and very worrisome implications for MICA. In many types of insurance the work product of the adjuster in investigating and evaluating the case may not be very informative to plaintiff's attorney. In MICA's case, we have always prided ourselves as a company having the claims staff and physician peer review committees necessary to carry out intense early investigation and analysis prior to involvement of legal counsel. This has resulted in not only a better work product but in susbstantial cost containment. Claims staff and physician peer review committees have done what they do best, namely the investigation and analysis of claims of medical negligence. Attorneys have been reserved to do what they do best, namely defend law suits.

continued on page 2

Duty of Confidentiality

A recent New York case generated a good deal of concern among Alaskan physicians as to whether or not medical records could be supplied to their professional liability insurance company without risking a suit for breach of confidentiality. The decision reached in the trial court was worrisome but has recently been overturned in the New York appellate court. It seems timely to review the facts of the case, the lower court's reasoning, and the reversal by the appellate court.

FACTS OF CASE

The patient's attorney sent a letter to the physician requesting copies of the patient's medical records. Enclosed with the letter was an authorization to release the records. The physician did not respond to the attorney's letter, but instead contacted his medical liability insurer and informed it of the letter and authorization. The insurer told the physician to submit the patient's records to the company for its review, and the physician complied with the request. The insurer used the records only to investigate and evaluate the patient's potential malpractice claim against the physician. The records were not disclosed to anyone outside the company.

The patient later sued both the physician and the insurer for breach of confidentiality. In granting summary judgment for the patient, the trial court rejected defendant's contention that the authorization constituted a waiver of the patient s confidentiality rights. The trial court also rejected the contention that disclosure of the records was justified by the notice and cooperation terms of the insurance policy. Finally, the trial court rejected the physician's claim that the disclosure was justified because it was obvious that the patient was going to sue him. The court characterized the physician's belief that a suit was imminent as "mere speculation" and "conjecture".

In reversing, the appellate court ruled that the physician's disclosure of his patient's medical records to the insurer, and the insurer's solicitation of such disclosure, were justified responses to the patient's authorization of disclosure of those records to his attorney. Noting that a patient's right of confidentiality is not absolute, the court explained that the legal and economic interests of a physician and his liability insurer justified disclosure of a patient's medical records where the physician has a reasonable belief that the patient will make a medical malpractice claim against him. The court concluded that the physician's anticipation of a suit was reasonable and was not, as the trial court had found, based on speculation and conjecture. The patient's authorization of the release of his medical records, in the appellate court's view, was an affirmative act from which the physician could infer that a suit would be brought against him. Accordingly, the court ordered that summary judgment be entered for the physician and his insurer.

This case was widely publicized at the time of the lower court ruling and has lead to a good deal of concern on the part of physicians as to whether or not they should comply with their insurer's request for providing medical records on patients short of suit being brought. This has led to a real problem with the doctor being caught between the proverbial rock and hard spot. Most carriers require prompt and full disclosure to the company of any patient care occurrence likely to materialize into a claim or a law suit. Doctors have had understandable concern about how they can best meet the terms of their policy and assist in preparation of their own defense without engendering a suit for breach of confidentiality.

What happened in the New York court, either at the lower level or at the appellate level, is not applicable to Alaska. The issue has not been litigated in Alaska, and there is no law in this state on the topic. Nevertheless, it is reassuring to note the New York appellate court overturning the decision by the lower court.

MICA insured physicians, having any further questions about this issue, are encouraged to call the Claims Manager at MICA for further discussion.

Discoverability Concern

continued from page 1

The Langdon v. Champion decision necessitates a change in our approach to claims management. Upon the report of any occurrence, claim or suit to MICA, the insured may expect to receive a confirmation of notice letter with the name of an attorney who has been assigned to his case. Claims staff will be in immediate contact with defense counsel. An attorney will open a file on the matter in his/her office and consult with claims staff as to needed investigation. That investigation and peer review will continue to be carried out insofar as possible by MICA staff and physician committees, however, it will be undertaken at the direction and request of assigned defense counsel. This will be in fact, as well as in name, since we believe that it would be counter productive to run a sham operation designed to comply with the letter but not the intent of the law.

Needless to say this is going to involve significant added expense.

This is yet another example of the manner in which Supreme Court decisions can radically change the way in which we do business and profoundly impact the cost of doing business.

Policyholders should understand that your company is making every effort to structure its operations to protect the investigation and analysis of reported occurrences, claims and suits. Policyholders remain under the same obligations imposed by their policy and the participatory risk management role is to promptly report occurrences and claims to the company for investigation and management.

Reprinted courtesy of Health Week

Jackson Case Settles

In the previous issues of CLAIMS NEWS, the Alaska Supreme Court decision on Jackson v. Fairbanks Hospital was extensively reported.

The Jackson v. Fairbanks Hospital case is a fairly complex one and the purpose of this article is to trace the history of that case and its ultimate settlement.

Brett Jackson was a 16-year-old boy brought into the Fairbanks Hospital in May of 1981, following a traumatic injury. Jackson was seen in the Emergency Room by Dr. Power who was a physician employed by E.R., Inc., a group of physicians contracting to supply Emergency Room coverage to the hospital. Dr. Power examined the patient and admitted Jackson to the hospital to the service of orthopedic surgeon, George Vrablik, M.D. The admission occurred in the middle of the night and, although there was telephone contact between the Emergency Room physician and the orthopedic surgeon, the orthopedic surgeon was not asked to, and did not, come in to examine Jackson.

Despite obvious trauma to the area over the kidneys, Jackson was not catheterized when he was unable to void. A voided specimen collected four to five hours after admission was grossly bloody and was shown to the Emergency Room physician. The attending physician was not called in. No action was taken until the attending physician arrived at the hospital at 9 a.m., at which time further testing was undertaken and Jackson moved rather rapidly to surgery. Surgery on both kidneys was done by William Montano, M.D. of Fairbanks. One of the kidneys was not salvageable. The other seemed to revascularize, only to succumb to medications given to deal with infection. Jackson had a stormy post-operative course including a pericardial effusion and arrest necessitating the opening of his chest with cardiac massage in his bed.

Jackson ultimately ended up with a kidney transplant which has remained viable for almost three years. He is on high dose steroids and is having signicant demineralization of bones sufficient to necessitate recommendation of a shoulder reconstruction.

Suit was brought in 1984 against the Fairbanks Memorial Hospital and all of the doctors who participated in Jackson's care. Physicians insured by MICA were Dr. Power and the Emergency Room, Inc. group; Dr. Montano and his partner, James Borden, M.D.

During the course of the litigation, plaintiff attorney filed a motion to have the hospital declared liable, as a matter of law, for the actions of the Emergency Room physician. This issue was carried all the way to the Alaska Supreme Court where it resided for several years pending decision. Activity on the basic case was stayed during that period of time.

While awaiting the Alaska Supreme Court's decision, several defendant physicians settled with payment to plaintiffs being made. CNA paid $40,000 on behalf of Dr. Davis and $250,000 on behalf of Dr. Vrablik. James Borden, M.D., insured by MICA, was dropped from the law suit with no payment.

In October of 1987, the Alaska Supreme Court rendered its landmark decision stating that hospitals are liable, as a matter of law, for the actions of Emergency Room Physicians on the basis of nondelegable duty. Following resolution of this issue the basic case proceeded with trial scheduled for May 2, 1988. During the four years between filing of the law suit and the date set for trial, MICA had launched an intense effort to find a medical expert supportive of the decisions made by our Emergency Room physician. We were unable to find a medical expert to support our insured.

Because three years had been lost between the date of this occurrence and the filing of suit and because several years had been lost while awaiting the Supreme Court decision on the liability issue, the case involved significant exposure for prejudgment interest. Prior to the tort reform act of 1986, prejudgment interest accrued at 10.5 percent per annum from the date of occurrence to the date of payment of a judgment. Consequently, we were looking at prejudgment interest in excess of 70 percent being added on to a jury verdict. An additional 10 percent court-awarded plaintiff attorney fees brought the total anticipated add-ons to any jury verdict to approximately 85 percent. In other words, a jury verdict of one million, with prejudgment interest and Rule 82 attorney fees added on, would result in a $1,850,000 judgment.

Brett Jackson's past medical expenses were approaching a half million dollars with a substantial portion of them being paid from federal sources arguably not subject to Alaska's collateral source provision. The remainder of his medical bills were paid from state funded sources but Jackson had committed himself to repay those.

The assessment of the remaining defendants was that there was an overwhelming prospect of a plaintiff verdict. It was felt that a verdict of less than $1.5 million was improbable and a verdict of $5 million or more was not impossible. Considering the potential doubling of the verdict due to prejudgment interest, the prospect of proceeding to trial with no medical experts supportive of care provided by the Emergency Room physician was not palatable for either the ER doctor or the hospital now legally liable for his actions.

The Emergency Room physician, Dr. Power, had very understandable and realistic concerns about a verdict in excess of his policy limits. Despite the hospital being legally responsible for his actions he continued to have individual responsibility. He continued to be a named defendant in the law suit. Even if he had been dropped on the eve of the trial the hospital would have had a common law right of indemnification against him and a statutory right of contribution. The hospital attorney was threatening to assert both of those rights in the event that Power was dropped from the litigation.

Settlement was achieved the week prior to the commencement of trial. Three defendants remained in the law suit at that time: Fairbanks Memorial Hospital and Lutheran Hospitals and Homes Society; Emergency Room, Inc., Jack Power, M.D.; and William Montano, M.D. MICA would agree to no contribution to this settlement on behalf of Dr. Montano whose care was judged to be totally defensible. The entire case was settled with payment of $3.4 million which was divided between the hospital and Dr. Power respectively, $1.6 and $1.8 million. As indicated, $290,000 had already been paid by other carriers insuring other defendant physicians involved in the case.

Settlement monies were divided into up-front cash and purchase of an annuity for Jackson. Plaintiff attorney fees amounted to 40 percent of the total recovery.

Claims News is a publication of MICA's Claims Department. Janet Johnston, Manager. Information contained in this newsletter was obtained from reliable sources, but accuracy cannot be absolutely guaranteed. It is not intended as legal advice. A qualified attorney should be contacted when seeking legal advice.

MICA CLAIM HOTLINE

561-LOSS

Please use this direct line to report a claim, suit or occurrence.

Justice vs. Humana Case Settled

In the last CLAIMS NEWS issue the Justice vs. Humana Hospital case was reported in some detail. At press time the case had gone to trial and the jury had returned a verdict of $1,304,244 against the defendant hospital. The judge had not rendered a judgment. The judgment is the final monetary figure arrived at by the judge taking the jury verdict and adding on such things as pre-judgment interest and court-appointed plaintiff attorney fees (Rule 82 attorney fees) and subtracting things such as payments that fall under the collateral source provision of the law.

ENTRY OF JUDGMENT

Attorneys for both sides submitted voluminous briefs to the court, arguing the add-ons and off-sets that should be applied to the jury verdict. The suggested judgment range was spread from $300,000 to $2,500,000.

Plaintiffs brought heavy pressure on the defendant hospital and its insurer to settle the case prior to entry of judgment. A written settlement offer of $1,850,000 was made on February 11, 1988. Humana Hospital's corporate headquarters in Louisville, Kentucky made a written demand on MICA to effect settlement within the terms of the plaintiff's demand letter. They further charged MICA with the responsibility of indemnifying Humana for any dollar amounts in excess of their $2 million policy in the event that MICA failed to comply with their instructions to settle.

MICA's Board and claims manager declined to settle the case prior to entry of judgment. The lowest written settlement offer received from plaintiffs was $1,750,000.00.

Judgment was entered on March 18, 1988, in the amount of $1,859,518.90, Judge Gonzales having leaned toward plaintiff's analysis of the add-ons and off-sets in preference to the defendant's.

SETTLE OR APPEAL?

From the time of the jury verdict through entry of judgement, discussion continued as to whether the case should be appealed or settled, either by payment of the judgment amount or some other negotiated figure. The defendant hospital, MICA and the medical community in general were appalled at the outcon. of the trial and felt there was reason to appeal. Supporters of tort reform understandably felt this was a textbook case demonstrating the need for reform and that an appeal would be useful to further publicize that issue.

While there was general agreement that the verdict was a disaster, there was a difference of opinion as to whether or not to appeal. Initially there was a great deal of sentiment on the MICA Board that the case should be appealed. The judgment as entered, however, came very close to the hospital's policy limits. An appeal was expected to take several years during which time post-judgment interest at 10.5 percent annually would accumulate. Additionally, the legal cost of taking an appeal plus the cost of the supercedeas bond required during the appeal would have exceeded the hospital's policy limits. Humana's corporate headquarters in Kentucky reiterated the demand that the case be settled within policy limits. There was considerable and prolonged discussion on the MICA Board as to whether or not MICA, given its fiduciary responsibility to all of its policyholders, could ignore Humana Hospital's demand that settlement be made within their $2 million policy limit, thereby making MICA financially responsible for the outcome. It was the eventual conclusion of the majority of the Board that it was our contractual obligation to respect the wishes of our policyholder. Further, the majority of the Board concluded that it was inappropriate to spend policyholder dollars in pursuing an appeal in defiance of our insured's wishes because it fit in with a political agenda.

Concurrent with prolonged discussions over whether or not the case should be appealed, continuing settlement negotiations went on. Eventually, the case was settled for a combination of up-front cash and money to purchase an annuity for the plaintiff. The total settlement amount was less than the judgment entered by the court.

HUMANA FOREGOES INDEMNITY CLAIM AGAINST PHYSICIANS

As indicated in the previous issue of CLAIMS NEWS, plaintiff had dropped the defendant physicians on the eve of trial and pursued the hospital alone. The Humana Hospital had a right of indemnification against the physicians. On March 29, 1988, Humana's corporate headquarters informed MICA that they had decided not to pursue the codefendant physicians in this case for either indemnity or contribution.

MICA Medical Indemnity Corporation of Alaska

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Risk Management News

MICA
Medical Indemnity Corporation of Alaska

July 1988

GAO REPORT: A FRAMEWORK FOR ACTION

In the fall of 1987, MICA summarized a recent study done by the United States General Accounting Office (GAO), the investigative arm of congress. The GAO had conducted a major review of the medical malpractice situation in the United States. No objective statistical data had been available since 1980, when the National Association of Insurance Commissioners collected and published a similar study.

What risk management lessons can be learned from the study? GAO concluded that reform of state court law, reasonable insurance regulation, better self policing and risk management by health care providers, and consumer education must be part of efforts to resolve the problem.

Appropriate tort reforms would include caps on noneconomic damages, shortening statutes of limitations for filing claims, revising joint and several liability laws, and allowing periodic rather than lump sum payments for large damage rewards.

The report called for more aggressive action against incompetent physicians, better peer review, and thorough hospital based risk management programs. Specific recommendations included enactment of HR1444 and S.661. These bills would prevent physicians who violate Medicare or Medicaid laws or who have had their licenses revoked from participation in either program. Another recommendation included requiring physicians to participate in risk management programs for state licensure.

The GAO study further suggested that the insurance industry's role in alleviating the malpractice liability problem is to maintain appropriate reserves and adhere to sound investment practices. The report indicated that state regulatory departments must ensure that insurance rates are not discriminatory or excessive.

Finally the GAO recommended that the public must be educated as to what to realistically expect from the health care system. Physician/patient communication must be improved to achieve better patient understanding and more reasonable expectations of medical professionals. Included in that would be the physician's need to fully communicate to patients the potential risks associated with the medical treatment.

CLAIMS "HOTLINE"

As of May 5, 1988 MICA will have a Claims "Hotline". The number for that "hotline" will be 561-LOSS (561-5677).

This number will be only for the reporting of incidents or potential claims.

P.R.M.P. ALERT

TO: Mica Insureds
FROM: Art Stanford
Underwriting Manager

MICA's Participatory Risk Management Program, if it is to be effective, must also be adhered to by mid-level practitioners in your employ or those under your supervision.

An example of this failure was a recent and very serious occurrence which was reported to MICA not by the mid-level practitioner most directly involved in the patient's care nor by his supervising physician, but rather by another medical provider subsequently involved in the ongoing care.

This lack of prompt notice of an occurrence, clearly within the reporting perimeters of P.R.M.P., was a serious violation of its criteria and a result of the mid-level practitioners total unawareness of the P.R.M.P. which had never been transmitted to him by his supervising physician.

We cannot over emphasize the need to share the P.R.M.P. with any mid-level practitioner whom you employ or for whom you are otherwise responsible and the need for them to immediately report an occurrence which qualifies under the P.R.M.P. criteria directly to you (for further transmittal to MICA) or directly to the company if you are unavailable.

We expect strict adherence to the P.R.M.P. occurrence reporting requirements by those under your supervision and violations by them

will be considered noncompliance by the supervising physician.

MICA will be sending a notice in the near future to all its policyholders reminding them of the need to share the P.R.M.P. with their medical staff or those they supervise and the absolute necessity for complying with occurrence reporting along with the other criteria, depending upon the scope of the mid-level practitioner's responsibilities.

CONFIDENTIALITY

A paper shredder in the office ensures that records, files, and correspondence are disposed of and confidentiality maintained.

SELF ASSESSMENT TEST

Do your office procedures include a mechanism for follow-up when a patient misses an appointment? _____yes _____no

Do you, as a consultant, always contact the referring physician to discuss your findings regarding his/her patient? _____yes _____no

When you refer a patient to another physician do you ever verify that the patient was indeed seen by the consultant and determine the results of that consultation? _____yes _____no

If you order tests on an office patient, do you or your staff follow-up to confirm that the tests were performed and that the test results were communicated to you, entered into the patient's chart, and related to the patient? _____yes _____no

If you answered "no" to any of the above, it's time to establish and implement routine office procedures in this regard.

FOLLOW-UP SYSTEMS

You may wonder where the patient's responsibility lies in returning for follow-up. In general, court decisions have held it is the health care professional's responsibility to make an attempt to contact and encourage the patient to return for needed follow-up. It is felt that the health care professional appreciates the "seriousness" more than the patient.

A "failure to diagnose" claim can be one of the most serious types of malpractice cases today. Many of these cases results in a detrimental delay in following the patient. Often times the doctor is totally unaware that the patient failed to return, as requested, so months elapse and the condition worsens.

A good example of this type of case is a woman who presents with a lump in her breast. A mammogram is ordered and she is told to return prn. The problem is one woman in several hundred will return in a few months with a cancer in the same location or nearby.

A follow-up procedure must be developed by the physician and his/her office staff to ensure that all diagnostic test results are seen by the physician upon receipt in the office. Malpractice actions have often resulted after a lab or x-ray report was filed in the patient's chart but was never reviewed by the physician through some oversight on the part of the physician or staff.

If a doctor can show some chart documentation that attempts were made to contact the patient to return for follow-up, then this documentation provides a better defense. It can help prove contributory negligence on the patient's part.

Patients are sometimes charged with "contributory negligence" when the jury feels that the patient contributed to some degree in the damage. Awards may then be reduced by the amount or percentage the jury felt the patient was responsible.

When a patient misses an appointment it is very good practice to have an established mechanism whereby office staff attempts to contact the patient.

Generally, follow-up attempts include one phone call and if that is not successful, then a post card or letter should be sent. These attempts should be documented in the record, even if the phone call(s) went unanswered and the patient was never reached. If the condition is serious, i.e., following a potential cancer patient, you may want to send a certified letter with return receipt requested. This receipt is filed in the chart with a copy of the letter for documentation.

The area of follow-up most frequently missed is follow-up to ensure that the patient sought consultation.

A referring physician has a responsibility to see that the consultation did indeed occur and to obtain results of that consultation. The referring physician has a responsibility to inform the patient of those results and to act upon the information derived from the consultation. All aspects of the consultation process must be documented in the patient's chart.

MICA'S RISK MANAGEMENT DEPT.
Committee Members
Frederick Hood, M.D. (Chairman)
Roger Holmes, Esquire
William Compton, M.D.; Gilbert Dickie, M.D.; Burton Janis, M.D.; Ron Keller, M.D.; Karen O'Neill, M.D.; George Pfaltzgraff, M.D.; Theodore Shohl, M.D.; Steve Sitter, M.D.; David Werner, M.D.
Staff Members
Penne Chmielewski, R.N. (R.M. Coordinator)
Sheri Mendez (R.M. Assistant)

The conusltant also has the responsibility to communicate the results of his/her consultation to the referring physician. Follow-up is especially important when a consultation is deemed necessary because of a suspected cancer. There have been cases where a breakdown in the consultation process led to serious problems for the patient and ultimately, for the involved physicians when litigation resulted.

When considering the potentially grave consequences of an inadequate follow-up system, it helps to keep in mind what tack, even a novice lawyer, would follow in presenting a malpractice claim against you for an adverse outcome directly attributed to the lack of follow-up. The attorney's questions might inlcude:

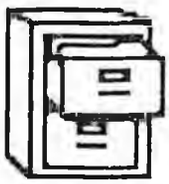
"Doctor, don't you receive regular periodic notices from your dentist (just for innocuous check-up) and possibly even from the veterinarian for your pet's annual innoculations"? It doesn't take much imagination to visualize the attorney's next question.

LOSS PREVENTION
563-3414

MICA is organized to give insureds optimal support in addressing unexpected situations. If you enounter unusual or questionable circumstances during a course of patient treatment, please report this promptly to MICA. We can help.

Penny Chmielewski, R.N.,
Risk Management Coordinator

Janet Johnston
Claims Manager



TICKLER FILE

Many computer programs have excellent recall and follow-up capabilities. If your office is not computerized it is fairly simple to develop a manual system.

1. Obtain a 3 x 5 card file with monthly dividers; i.e., January through December.

2. When a patient needs to return for a follow-up condition a card is filled out with the following information:
   - patient's name
   - patient's file number
   - telephone number
   - address
   - reason patient needs to return (i.e. pap smear, check up, etc.)
   - month and year the follow-up is due

This system can also be used to follow-up on patients referred for outside consultation.

3. Place this card in the file box in the month the patient needs to return.

4. There are two ways to complete the process:

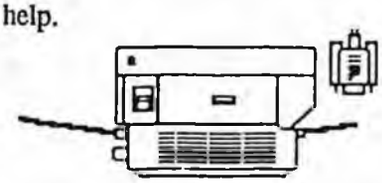
   • Pre-Contact:

If you wish to reach the patient prior to the due date, then pull all the cards in the month before the patients are due for a return visit. Call or send a reminder card/letter to them. It is important to keep the cards until the end of the month that the patients were supposed to return. You need to check these at the end of the month and notify those patients who failed to keep their appointment.

   • Post-Check

You may wish to eliminate the double check system and simply pull all the cards at the end of the month and check the chart to verify the patient did return for follow-up. The patient who did not return for follow-up will then be notified.

If you have any questions regarding developing follow-up systems, please contact the MICA Risk Management Department for further help.



EQUIPMENT MALFUNCTION PRECAUTIONS

Defined procedures, clear communication and system routines in a medical office are everyone's responsibility. The office staff can make a vital contribution to achieving a pleasant, effecient, office where very few mistakes occur and preventable errors are eliminated. The reward is that everyone benefits; the patient, the physician and the staff.

Most equipment-related suits involve electric burns. The following guidelines can be used to make using office equipment safer:

- Be sure to check all electrical equipment to be sure that it is properly gounded.
- A staff member needs to be assigned responsibility for assuring that new personnel are instructed in the correct use of office equipment.
- The initial utilization of the equipment needs to be supervised by an experienced person.
- Immediately stop using defective equipment.
- Report all equipment malfunctions of a significant nature to the appropriate person in the office.
- Resume using the equipment, only after it is repaired.

TO: MICA Insureds
FROM: Mary Pierce
Executive Director

Over the past few months we have been receiving confidential documents (medical records and incident reports) sent to our Post Office Box. This box is at our bank data processing center, used for the purpose of automatic deposit for all premium payments received and it should only be used for the submission of premium payments. All mail received at this box is opened and then forwarded to us.

In an effort to protect the confidentiality of all sensitive documents sent to MICA, we are requesting all mail other than premium payments be sent to our office location, 4000 Old Seward Highway, Suite 203, Anchorage, Alaska 99503.

Thank you very much for your assistance in this matter.

Risk Management News is a publication of MICA's Risk Management Department, Penne Chmielewski, Coordinator.
Information contained in this newsletter was obtained from reliable sources, but accuracy cannot be absolutely guaranteed. It is not intended as legal advice. A qualified attorney should be contacted when seeking legal advice.

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Risk Management News

MICA Medical Indemnity Corporation of Alaska

August 1988

TO: ALL MICA INSUREDS

Pediatricians, Obstetricians, Family Practitioners, General Practitioners, Neonatologists, Neurologists, Neurosurgeons, General Surgeons

"**THE SCENE:** A newborn has just arrived! Immediately prior to the delivery or C-section there was evidence of fetal distress! The newborn has low APGARS and is not rapidly recovering"!

"Inevitably, a progress note will mention "hypoxia, 'birth trauma' or another term suggesting that an otherwise normal fetus has recently suffered damage. Such notes suggest to those later evaluating a potential medical liability claim that someone may have made an error during labor and delivery which caused the resultant brain damage.

There is increasing evidence that placental abnormalities occuring much earlier in pregnancy may be the cause of many or most brain damaged newborns. The mechanism of this is not totally clear at this point. In the mean-time, however, it might be well to refer to the evidence of newborn damage in progress notes and leave out words which suggest the etiology of that damage. It is becoming increasingly clear that the time honored concept of a normal term fetus suffering central nervous system damage as a result of an event during labor and delivery may be far less frequent than previously thought. Indeed, it is possible that most, if not all, such damage is predestined by a pre-existing placental condition. To suggest by words such as 'hypoxia' or 'brain damage' that damage occurred solely because of the events of labor and delivery is possibly a major disservice to all involved".

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MICA encourages accurate notes. In light of this report, some added thought or diagnostic work may result in more accurate reports.

MICA recommends obtaining a cord PH at the time of delivery for all neonates who demostrate signs of fetal distress.

PARACERVICAL BLOCK ANESTHESIA PRESENTS RISKS

Paracervical block for regional anesthesia, during first stage labor, continues to be controversial. Though used in only 5% of births, there is a concomitant 25% increase of fetal bradycardia attributed to this method. Often transient bradycardia can persist, resulting in untoward complications and death to the fetus.

Settlements against physicians involved in these cases have been substantial. The following California case illustrates the potential liability and outcome.

CASE

During an otherwise uneventful course of labor the patient, a 31 year old primagavida, requested and received minimal anesthesia via a paracervical block. This mother had anticipated a natural childbirth, with little or no need for anesthesia. A paracervical block was chosen, by mutual agreement, from a number of options described by the physician just prior to admission. None of the risks for any type of anesthesia were presented to the patient.

Internal fetal monitoring, that had demonstrated good variability and accelerations, changed within four minutes of the administration of 12 ccs. of Bupivacaine (Marcaine) .25% use for the paracervical block.

The fetal heart rate dropped from 140-160 to 90 beats per minute with a loss of beat-to-beat variability. Within the next minute the rate declined further, to 60 beats per minute, where it remained. Little, if any, anesthetic effect was reported by the mother.

An oxytocin drip was discontinued.

The mother was turned on her left side and 100% oxygen was administered with the goal of inhibiting further contractions and enhancing maternal-fetal blood exchange. An emergency Caesarean Section was considered contraindicated by the physician. He supported this inaction with the theory that maximal clearance of any toxic effect is best accomplished in utero, via the placenta. Accordingly, he waited 40 minutes. The fetal heart rate remained at 60 beats per minute then ceased, 60 minutes from the time Marcaine was administered. The stillborn infant was delivered vaginally.

The cord blood specimen demonstrated high, potentially toxic, levels of Marcaine in the fetal circulation. It was hypothesized that transplacental uptake had occurred via maternal, paracervical vessels that were entered during the administration of the anesthetic.

The case was settled against the defendant physician with a substantial award to the plaintiff.

GUIDELINES

The following guidelines are recommended to physicians who continue to administer paracervical blocks.

1. Obtain informed consent before administering any anesthesia. Include a discussion of risks involved for both the mother and the baby. Specifically mention the potential for complications and the alternatives for anesthesia and vaginal delivery. When recording your decision, document your decision with the patient and the father, if he is present.

2. Do not routinely administer a paracervical block for pain during the first stage of labor. Evaluate each patient, her response to pain, and the progression of labor on an individual basis.

3. Consider employing alternative modalities of analgesia/anesthesia exclusive of paracervical blocks. This modality is definitely contraindicated when there is uteroplacental insufficiency, evidence of preexisting fetal distress or prematurity. Judicious use of narcotic analgesia is a suitable alternative.

4. If a paracervical block is to be administered, do not use Bupivavaine (Marcaine or Sensorcaine). It is not recommended for obstetrical anesthesia by the manufacturer. Xylocaine or Mepericaine are suitable agents. If used, these agents should not contain Epinepherine.

To summarize, paracervical block continues to decline as a recognized method of choice for obstetrical anesthesia. If a paracervical block is administered, the physician must anticipate the potential complications and be prepared to manage them. The decision to employ this technique carries a responsibility to consider potential hazards to the fetus.

These risks must be communicated and documented when you obtain informed consent. Alternatives must be considered. If a paracervical block is administered, your technique must follow recognized standards, including the correct use of approved agents.

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OBSTETRICS AND FAMILY PRACTICE

Pregnant women and their families may be uniquely angry if their physician is unavailable for the delivery. Physicians usually explain to all patients that since delivery can not be scheduled, their doctor may be unavailable. However it may be helpful to not only explain this to all OB patients but to have them complete a form such as the following;

"In order to assure quality care for you at all times, Dr._____ is directly associated with three other physicians, Dr._____, Dr. _____, and Dr. _____.

Dr. _____ will care for you through your pregnancy, and in most cases will be with you for your delivery. However if you were to deliver in his absence, one of the other physicians will assume responsibility for your care.

We want our patients to be happy with this arrangement and if you have any questions, please feel free to discuss them with us."

*Patient*_____
*Father of the baby*_____
*Date*_____

MICA suggests that this would help decrease anger in a patient, especially the husband, when the regular Obstetrician or Family Practitioner is away and another physician delivers the baby.

HOSPITAL RISK CONTROL OBSTETRICS

Medical Records
Does the medical record include:

- prenatal information?
- time that patient arrived at hospital?
- time that obstetrician responded?
- time of last meal?
- discharge summary?
- fetal strips?
- evidence of informed consent?
- reasons for cesarean delivery?

Are medical record audits performed?

ADVICE ON AFP TESTING

Neural tube defects (NTDs) are among the most commonly occuring major congenital malformations with an incidence of 1 to 2 per 1,000 live births in the United States.

Alpha-Fetoprotein (AFP) is a protein produced by the fetus which is transferred in small amounts across the placenta into the mother's blood stream. The amount of AFP in the mother's blood can be measured and compared with the amount normally expected for a given week of pregnancy.

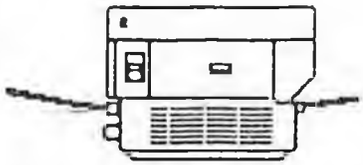
In early pregnancy maternal serum AFP is low but rises rapidly to a peak value at about 30 weeks' gestation. In the second trimester the level of fetal serum AFP is approximately 100 times that of maternal serum AFP.

The level of AFP is elevated in pregnancies when the fetus has a neural tube defect. However it should be noted that incorrect assessment of gestational age may create false high (or low) levels, particularly of maternal serum AFP, because the rapidly changing range of normal AFP values depends so critically upon gestational age.

Some states, such as California, have a mandatory AFP screening program. All prenatal care providers are required by law to provide all pregnant women with information about AFP screening and the opportunity to participate in the program. Patient participation is strictly voluntary. The duty to inform and obtain written consent or refusal is mandatory for physicians providing prenatal care anytime through the nineteenth week of gestational age.

The MICA Risk Management Subcommittee on Obstetrics reviewed the various AFP programs and the ACOG recommended guidelines "Prenatal Detection of Neural Tube Defects". They concluded that the "standard of care" in Alaska at this time supports informing pregnant women about the availability of AFP testing. Although the value and implications of this test continue to be debated, MICA recognizes the areas of potential liability risk and advises the following:

- Obtain, review and integrate into your practice, educational materials that are available for AFP testing.
- For patients receiving prenatal care before the 20th week of gestational age, obtain a signed consent or refusal to have the patient participate in the AFP testing. Retain this document in the patient's medical record.
- For patients electing to have AFP testing, a careful and sensitive approach to counseling must be observed. Document your discussions, the patient's response and plans.
- Recognize the importance of using the most reliable and appropriate methods for dating gestational age; that both false negative and false positive blood test results can arise from incorrect dating.
- Follow-up on all patient's questions and test results.



HOSPITAL RISK CONTROL ELECTRONIC FETAL MONITORING

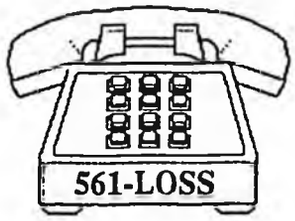
The most common known hazard of EFM is infection. In the fetus, this is usually a minor scalp infection or abscess caused by the scalp electrode. In the mother, EFM related infection is difficult to separate from infection related to C-Sections. Less frequent complications are caused by errors in applying the fetal scalp electrode and intrauterine pressure catheter.

In a joint statement ACOG and the Nurses Association of the ACOG (NAACOG) stated that "it is the responsibility of the hospital to verify the knowledge base of health professionals in the clinical application of electronic fetal monitoring and to encourage continuous updating of their skills."

ALPHA FETO PROTEIN

POTENTIAL FALSE RESULTS

AFP RESULT	POSSIBLE REASON	POTENTIAL OUTCOME
False negative (NTD present)	Actual gestational age younger than estimated.	Neural tube defect not diagnosed.
False positive (NTD not present)	Actual gestational age older than estimated.	Unnecessary anxiety for the patient until retested.



CLAIMS "HOTLINE"

As of May 5, 1988 MICA has a Claims "Hotline". The number for that "hotline" is 561-LOSS (561-5677).

This number is only for the reporting of incidents or potential claims.

Risk Management News is a publication of MICA's Risk Management Department, Penne Chmielewski, RN, Coordinator. Information contained in this newsletter was obtained from reliable sources, but accuracy cannot he absolutely guaranteed. It is not intended as legal advice. A qualified attorney should be contacted when seeking legal advice.

MICA's Risk Management OB Subcommittee

Members

William Compton, M.D. (Chairman)
Cathy Baldwin-Johnson, M.D.; Theodore Barton, M.D.; Clarice Dukeminier, M.D.; Lydia Eastburn, M.D.; Sarah Isto, M.D.; Jack Jacob, M.D.; Rodney Vaught, M.D.
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PARTICIPATORY RISK MANAGEMENT CRITERIA #1

OCCURRENCE REPORTING

OCCURRENCE REPORTING — EXPLANATION

The value of early OCCURRENCE REPORTING can be clearly demonstrated in the claims files of MICA and other medical liability insurance companies. OCCURRENCE REPORTING is one way in which individual physicians and hospitals can favorably impact liability insurance premiums. MICA has emphasized early OCCURRENCE REPORTING in all of its risk management programs for the past 2 years.

The MICA policy language has always required it (see section entitled Insured's Duty in the Event of an Occurrence, Claim or Suit).

Despite these efforts, many occurrences now reported:

1. are not reported until an attorney requests records or a suit is filed (usually many months or years after the event).

2. are events that should be unequivocally reported at the time of the occurrence and are not.

It is unfair that the real or potential savings generated by those who report early should be shared by those who don't or won't. Following the initiation of the Participatory Risk Management Program (PRMP) on 1/1/87, MICA will expect an occurrence report within a reasonable time after the event is known or should have been known by the physician or hospital. Usually this will be within 24 to 72 hours. Telephone notice must be followed by written notice. MICA may choose to accept extenuating circumstances for delays beyond this prescribed time interval.

When an occurrence is reported in writing, MICA will mail a verification form to the reporting physician or hospital. MICA will consider that an occurrence has been reported when any MICA insured physician or hospital caring for the patient has submitted written notice and received verification. However, it is anticipated that the physician primarily responsible for that aspect of the patient's care related to the occurrence will report. OCCURRENCE REPORTS can be made to either the Claims Department or Risk Management Department of MICA.

Misconceptions about OCCURRENCE REPORTING

Many hospitals and physicians have fallacious beliefs about MICA's position on OCCURRENCE REPORTING. These include:

1. "I will be penalized for reporting occurrences." Not true! You may indeed be penalized for the facts of the case, but never for the act of OCCURRENCE REPORTING. As a matter of fact, a penalty will be assessed for failure to report.

2. "I don't know what to report." The criteria for reporting have been presented. If in doubt, call and discuss the issue with MICA's Risk Management or Claims Department. It is clearly not necessary to report each and every expected and/or minor complication.

3. "Increased reporting will raise premiums." Not true! Premiums are now higher to some extent because MICA and its reinsurers know, from past experience, that there are many unreported occurrences which will eventually become claims.

4. "There's nothing that MICA can do to help prevent a suit or keep losses down." Not true! MICA's Claims and Risk Management departments can be helpful in reducing the risk of suit and preventing excessive losses.

5. "If I report an occurrence MICA will try to contact the patient, their family or an attorney." Not true! If this is an occurrence report and there has been no attorney involvement, MICA will make no contact or decision without your concurrence.

6. "I don't think they'll sue me." On occasion this may be true. Certainly the patient/physician relationship is a prime way to prevent medical liability actions. However, never assume this. Report occurrences regardless of your feelings about your relationship with the patient.

OCCURRENCE REPORTING — CRITERIA

MICA will use the following criteria as the standard by which it will judge the adequacy of OCCURRENCE REPORTING for occurrences after 1/1/87.

1. Some litigation cannot be anticipated. On these occasions MICA will expect an occurrence report:

   a. When suit papers, notice of suit or notice of intention to sue becomes known to the insured.

   b. When the insured knows of an attorney request for information or records. Exception: in a Workman's Compensation or automobile accident case where the patient did not substantially deteriorate while under care.

2. MICA will expect an OCCURRENCE REPORT for every negligent act which adversely affects the patient. For example:

   a. Unanticipated foreign bodies left within the patient.

   b. Wrong medication or wrong dosage with adverse sequelae.

   c. Operation on wrong side or at wrong level.

3. MICA will expect an OCCURRENCE REPORT for every major unexpected injury occurring to a patient under your care and resulting from any aspect of that care. The words "major" and "unexpected" are, to some degree, vague and open to interpretation. The list below is not meant to be complete or exhaustive, but is meant to portray the type of event for which MICA expects an OCCURRENCE REPORT.

   a. Any major unanticipated fetal damage. For example: brain damage, major injury or death.

   b. Any unanticipated death. This is not meant to include cases where the medical record reflects that death is a likely possibility of the patient's disease or the medical or surgical care.

c. An unanticipated major surgical complication. For example: brain damage, quadriplegia, paraplegia, incontinence, organ perforation, nerve injury, blindness, deafness, loss of an extremity, death, etc. This is not meant to include relatively minor expected surgical complications such as wound infection, dehiscence, phlebitis, urinary tract infection, etc., unless these conditions continue to major unexpected disability.

d. Failure to diagnose. This category is expected to include those occasions when the physician had a clear opportunity to diagnose a serious condition, but didn't and later learns that the condition existed. For example, breast carcinoma, other carcinoma, meningitis, surgical abdomen, fracture, myocardial infarction, intracranial hematoma, obviously missed radiological or pathological diagnosis, etc.

e. Fall in hospital or office which results in injury that extends patient disability and/or requires significant additional care thus increasing the bill.

PARTICIPATORY RISK MANAGEMENT CRITERIA #2

CONSENT FORMS

CONSENT FORMS — EXPLANATION

The doctrine of INFORMED CONSENT is generally understood by most physicians. In the simplest terms it affirms that the patient has the sole authority to determine what medical treatment, if any, he or she will allow to be performed upon his/her body. Exceptions to this self-determination usually include minors, life-threatening emergencies and incompetency.

INFORMED CONSENT is, by its very nature, verbal (perhaps supplemented with pictures), interpersonal, private and specific. In most cases, the exact nature of what transpired will never be known except to the participants. However, medical liability claims frequently require that the essence of what was said and understood be provable at a later date. Hence, the absolute need for a suitable CONSENT FORM.

MICA will require an acceptable CONSENT FORM in all elective surgical procedures and certain other invasive procedures to be documented. However, MICA recommends evidence of CONSENT whenever there is substantial risk included in the proposed therapy or procedure. MICA will provide a standard form, assist in generating specific forms, and answer questions regarding INFORMED CONSENT and CONSENT FORMS.

CONSENT FORMS — CRITERIA

For any future claims involving an occurrence date after 1/1/87 MICA will consider a CONSENT FORM acceptable under the PRMP only if it:

1. is consummated when the patient consents. The "night before surgery (procedure)" would only be acceptable if the facts clearly demonstrate that the decision was made then or the person performing the procedure became involved then;

2. is dated;

3. is written in language generally understandable by a lay person;

4. is signed by the patient (or other appropriate party) immediately after a short paragraph stating that an explanation has been given, that their questions have been answered and they wish to proceed;

5. is signed by the physician immediately after a short paragraph which states that the physician has explained, answered questions, and believes that the patient understands and wishes to proceed;

6. contains reference to a few general complications that may occur with any procedure (e.g. infection, bleeding, nerve injury, blood clots, pneumonia, etc.);

7. contains reference to the specific/serious complications that may occur with this operation. This requirement may be in the form of a blank on a standard form which is filled in by the physician at the time consent is requested. Examples of specific complications for operations are:

   a. Paralysis after spinal surgery;
   b. Brain damage after brain surgery;
   c. Blindness after eye surgery;

d. Deafness after ear surgery;
e. Perforation with bowel injury after D & C abortion;
f. Perforation after endoscopy;
g. Bile duct injury after gallbladder surgery;
h. Voice box nerve injury after thyroid surgery;
i. Amputation after lower extremity vascular surgery;
j. Fertility after sterilization procedure;
k. Etc.

To assist the insured physicians in understanding those procedures for which MICA will require an acceptable CONSENT FORM, the following lists have been compiled:

1. Required:

   a. All surgical procedures usually requiring general or regional anesthesia
   b. Any other procedure usually requiring general or regional anesthesia
   c. Cerebral and coronary angiography
   d. Endoscopy
   e. All sterilization procedure
   f. Any procedure where the usual risk is substantially increased because of some aspect of the patient's medical condition
   g. All plastic surgical procedures
   h. All surgical procedures upon the eye
   i. All surgical procedure upon the middle and inner ear
   j. Needle biopsy of internal organs

2. Not mandatory, but recommended, that there be at least a note in the doctor's handwriting about consent. However, CONSENT FORMS, if generated, would be most appreciated for:

   a. Minor procedures generally done under local anesthesia, e.g., skin biopsy
   b. Other contrast material injection
   c. The following drug or drugs with similar problems: Long-term anticoagulation, long-term steroids, antibiotics which damage the eighth nerve, chemotherapeutic agents, drugs commonly known to impact bone marrow adversely (Chloromycetin, Butazolidin, etc.).

PARTICIPATORY RISK MANAGEMENT CRITERIA #3

ALTERED MEDICAL RECORDS

ALTERED MEDICAL RECORDS — EXPLANATION

The medical record is critical to the defense of nearly every medical liability claim. Any portion of the record which appears to have been ALTERED may decrease the effectiveness of that record. ALTERED records may cause the award of punitive damages in addition to compensatory damages. ALTERATIONS of the medical record raise questions about the honesty of the physician and thus may render him/her indefensible regardless of the facts of the case.

CLARIFICATION of the medical record may be necessary. To be acceptable to MICA, a CLARIFICATION shall appear only at the end of the progress notes which existed on the date the CLARIFICATION was made. This CLARIFICATION shall also contain an explanation of why the note was added or changed; be clearly timed and dated; and be signed.

ALTERED MEDICAL RECORDS — CRITERIA

For any future claim with an occurrence date after 1/1/87, MICA shall consider any record to have been ALTERED where the insured or the insured's employee shall have caused:

1. Any change or addition to a medical record when it:

   a. attempts to hide the time the change or addition is made;
   b. attempts to hide the original meaning; or
   c. attempts to change the meaning of the record without an explanation as to why.

2. Any erasure, white-out or obliteration of information.

3. Any writing between lines or in margins except:

   a. spelling corrections,
   b. filling in blanks left by a typist; or
   c. adding a word or phrase inadvertently left out which in no way can be construed as changing the content of the original writing.

PARTICIPATORY RISK MANAGEMENT CRITERIA #4

DIAGNOSIS OF BREAST CARCINOMA— EXPLANATION

Certain patient complaints or findings should cause physicians to consider a diagnosis of carcinoma and to initiate a diagnostic program to substantiate or rule out that diagnosis. Failure to diagnose a carcinoma, which is later proven, may lead to litigation. Theoretically, any patient whose carcinoma is not diagnosed in a timely fashion might initiate a lawsuit. However, MICA and other medical liability insurance carriers see most cases of this type when they involve a failure to diagnose carcinoma of the breast. Probably this failed diagnosis is most commonly litigated because of society's focus upon this disease and because of the frequency with which women "find" breast lumps and report them to their physician.

MICA has identified several situations which repeatedly cause high exposure involving the diagnosis of breast carcinoma.

1. The woman reports a breast concern and the physician determines, based upon clinical examination alone or combined with mammography (or another imaging technique), that it is benign. The patient is told to return p.r.n..

2. The physician conducts a workup for the area of concern with questionable or suspicious results. The patent is told to return p.r.n..

3. A woman of any age is at risk of breast carcinoma. However, the American Cancer Society has identified certain women whose age and/or family history place them in a higher risk group. A woman fitting these criteria is not appropriately studied and followed.

DIAGNOSIS OF BREAST CARCINOMA-- CRITERIA

The records kept by physicians treating patients in the following categories shall document that the indicated treatment was recommended or accomplished. If such studies are refused by the patient, there will be adequate documentation of the fact that she has refused and that she has been fully informed of the reasons for the recommended study and the risk, including death, of non-compliance.

1. All patients with breast complaints shall have a documented breast and lymphatic examination.

2. In those patients with a palpable dominant mass, the nature of the lesion will be determined by aspiration or biopsy unless spontaneous resolution has occurred within a period of 8 weeks.

3. It should be recognized that the role of mammography is only to evaluate the status of breast tissue elsewhere in both breasts and is not to be used to judge whether the mass in question is benign or malignant.

4. Non-palpable lesions demonstrated by mammography or other imaging techniques shall be resolved by biopsy or sequential repeat imaging studies.

5. All patients 40 years of age and older with a family history of breast cancer in close female relations shall have an annual documented breast and lymphatic exam, annual mammogram and documented instruction on breast self-examination. This criteria shall be held for physicians whose charts clearly demonstrate that they are either the patient's primary physician or are regularly following this patient periodically for other female examinations such as PAP smears, pelvic exams, etc.

6. Patients with a personal history of breast cancer shall have an annual documented breast and lymphatic exam, an annual mammogram and documented instruction on breast self-examination. This criteria shall be held for physicians whose charts clearly demonstrate that they are either the patient's primary physician or are regularly following this patient periodically for other female examinations such as PAP smears, pelvic exams, etc.

7. For patients receiving informed consent for total or partial mastectomy, the record shall reflect discussion of alternative methods of treatment.

PARTICIPATORY RISK MANAGEMENT CRITERIA #5

ANESTHESIA MONITORING — EXPLANATION

Although there is a wide spectrum of causes for anesthesia medical liability claims and losses, the devastating results of sudden, unexpected cardio/pulmonary arrest or failure accounts for well in excess of 75% of anesthesia dollar losses. In nearly all of these cases, there is expert testimony that there was a failure to adequately monitor the patient. The allegation of failure to monitor adequately nearly always involves a failure to utilize commonly accepted monitoring techniques: monitors which are not working at the time of the catastrophe; or inattention or lack of vigilance to the monitors.

ANESTHESIA MONITORING — CRITERIA

For any future MICA claim with an occurrence date after 1/1/87, MICA will utilize the following guidelines for assessing adequacy of monitoring:

1. Physical presence: The primary anesthesiologist or nurse anesthetist shall be physically present in the Operating Room at all times during regional and general anesthesia. If required to leave, that person may be replaced by another anesthesiologist or CRNA.

2. Emergency: In the event that an unexpected emergency requires the temporary absence of the person primarily responsible for the anesthetic, it will be expected that the best judgement will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person left responsible for the anesthesia.

3. Monitoring:

   a. General Anesthetic (all cases)

      1. Auditory monitoring of the heartbeat (except for planned asystole) and breath sounds

      2. Intermittent or continuous blood pressure monitoring

      3. Continuous electrocardiographic display

      4. Inspired oxygen monitor (oximeter)

      5. There shall be immediately and readily available a means to measure the patient's temperature

      6. Airway pressure gauge

         (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

   b. General Anesthetic (intubated and controlled ventilation)

      1. All of the above, plus

2. Airway disconnect alarm (e.g. pressure disconnect or CO_2 monitor)

   (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

c. Major regional anesthesia (e.g. spinal or epidural)

   1. Intermittent or continuous blood pressure monitoring

   2. Continuous electrocardiographic display (during initial injection and establishment of a safe level).

      (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

d. Obstetrical (vaginal delivery) regional

   1. Intermittent or continuous blood pressure monitoring

   2. Continuous electrocardiographic display (during initial injection and establishment of a safe level)

      (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

e. Minor (single extremity) regional

   1. Intermittent or continuous blood pressure monitoring

   2. Continuous electrocardiographic display (during initial injection).
      EXCEPTION: should be continuous for a Bier block

      (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

   3. EXCEPTION: For extremity regional anesthesia, i.e., brachial plexus and lumbosacral plexus block, the patient must be attended and monitored for thirty minutes or until the block is found to be adequate. If additional supplementation is required, the anesthetic will be attended and monitored as any other. In all cases, periodic block pressure determinations, as well as continuous ECG and pulse oximetry with audible alarms, will be employed while in the operating room.

PARTICIPATORY RISK MANAGEMENT CRITERIA #6

OBSTETRICS — EXPLANATION

Obstetrical claims are the singularly most expensive medical malpractice claims of the day. The reasons for this are multiple and include rapidly expanding technology in the field of obstetrics: enhanced patient expectations; the right of the patient to be informed; media education; child birth preparation classes; and an increasing litigious society. Claimant attorneys, ever on the look out for serious injury cases, have taken advantage of the opportunity to sue on behalf of the unfortunate child with neurologic deficits regardless of whether or not the injury, by most objective standards, was the fault of the physician.

As a result, the physician who delivers babies is a primary target, and his insurance carrier has many of its most serious cases in this area.

Recent studies carried out by physician owned insurance companies have revealed that there are several areas of obstetrical care and record keeping that give rise to the preponderance of claims. These include: identification and documentation of high risk pregnancy; problems with identification of gestational age; fetal size and presentation; fetal monitoring; and transfer tissues.

The obstetrical criteria outlined here, if followed and adequately documented, will be of great assistance to the physician in defending himself in an obstetrical malpractice case.

OBSTETRICS — CRITERIA

1. Identification of High Risk Pregnancy

   a. Complete a comprehensive obstetrical form which identifies and documents prenatal risk factors.

   b. Use progress notes to detail the evaluation of risk factors when it cannot be carried out on the standard form.

2. Determination of EDC

   a. EDC should be correlated with menstrual dates, previous use of oral contraceptives, early pregnancy testing, quickening, appearance of fetal heart tones with doppler and fetascope as well as uterine size throughout the pregnancy.

   b. Significant discrepancy between uterine size and these factors should be evaluated with ultrasound.

3. Evaluation of Gestational Age Problem

   a. Evaluate for IUGR when:

      1. There is no apparent uterine growth over a two month time period; or

      2. There is a lack of maternal weight gain in the last two trimesters of a nonobese patient.

b. The evaluation of suspected IUGR will consist of:

1. Serial ultrasounds; and

2. O. B. Consultation: When ultrasound shows evidence of IUGR, the practitioners will be expected to arrange for the patient to be seen by an obstetrician for consultation. Non-Ob/Gyn practitioners in rural areas with no obstetrician available will consult by telephone and document the advice received in the medical record.

c. Appropriate evaluation of post date pregnancy should include:

1. Twice weekly nonstress testing (with the addition of contraction stress testing when the NST is inconclusive), and weekly ultrasound starting by two weeks past EDC. (In communities where these tests are unavailable, the record shall reflect that the patient was informed of the role these tests play in evaluation of pregnancy, the options for obtaining such testing, and the risks of not obtaining such testing, including fetal demise or damage. In the event the patient refuses such tests, the record will reflect the facts of informed patient refusal.)

2. Documentation of consideration of induction by 42 weeks gestation and the rationale for proceeding with or delaying induction.

4. Evaluation of Fetal Size

a. Anticipate shoulder dystocia by:

1. Estimating fetal weight in prenatal visits and in early labor when fundal height is equal to or greater than 40 cm;

2. Document in the last weeks of pregnancy that a problem with disproportion is or is not anticipated;

3. For anticipated problems, if physician is not experienced in management of shoulder dystocia, the record shall reflect appropriate consultation with an obstetrician or a physician experienced in the management of shoulder dystocia. Unavailability of such expertise shall prompt discussion of transfer as discussed in paragraph 6.

b. Because of the high risk of vaginal breech deliveries, the decision as to method of delivery should be well documented, and all breech presentation pregnancies should be considered potential candidates for Caesarean Section. The record shall reflect the evaluation by the attending physician and the full informed consent or refusal of the patient regarding referral, Caesarean Section vs. vaginal delivery and/or transfer. OB consult shall be obtained for proposed vaginal delivery of breech.

5. Fetal Monitoring.

   Continuous electronic fetal monitoring is indicated with labor of all high risk pregnancies (see #1). Documentation of prompt response by the attending physician to an indication of abnormal fetal heart tracings is imperative. Use of fetal monitoring requires expertise in the interpretation by the physician and nursing staff in attendance. If the patient refuses electronic fetal monitoring at any time, that circumstance should be well documented, including the discussion of risk and alternatives with the patient.

6. Transfer Issues.

   When ultrasound is indicated but not available, practitioners in rural areas will inform patient of the role ultrasound could play in evaluating the pregnancy, the options available for obtaining such tests and the risk of refusing such testing, including fetal death or damage. If the patient refuses such tests, the record shall reflect informed patient refusal.

   Transfer to a level 2 or a level 3 perinatal unit should be accomplished on a timely basis with complication or high risk pregnancy. The record shall clearly indicate that the attending physician has fully informed the patient of her potential need for a level of care exceeding that available in the community; the options for obtaining such care; and the risks of refusing transfer including fetal death or damage. In the event the patient refuses transfer, her informed refusal should be well documented.

STATE OF ALASKA

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April 7, 1989

M E M O R A N D U M

TO: All Representatives

FROM: Representative Lyman F. Hoffman Lyman

RE: Summary of Oil Spill Statutes and Laws

Attached please find a summary of financial remedies possible under State and Federal laws.

Thank you.

Attachment

P.O. Box 763 BETHEL, ALASKA 99559 (907) 543-3543

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

M E M O R A N D U M April 6, 1989

SUBJECT: Overview of Oil Pollution Statutes
(Work Order No. 6-1171)

TO: Representative Lyman Hoffman

FROM: Terri Lauterbach
Legislative Counsel

You have asked for a general summary of state and federal statutes that are relevant to the Prince William Sound oil disaster, including statutes under which the state has financial remedies for damages and costs of cleanup.

As I'm sure you realize, many lawyers will be litigating many questions about the liability of Exxon and Alyeska for this disaster. Some will be litigating questions about state liability as well. Not all the facts are even available yet about some matters, such as who actually owned the Exxon Valdez, who owned the oil that was discharged, and who is responsible for the apparent lack of containment action in the critical first three days after the discharge.

Therefore, the following summary of statutes is intended as a general guide only. It is impossible at this point in time to express a well-founded opinion about the outcome of potential litigation on some of the issues that will be noted. If you desire a more full explanation on any point or in-depth legal research about any issue raised, feel free to ask for further assistance. In the meantime, I hope this general summary answers some of the basic questions about the statutes that will be at issue in future litigation or settlements concerning the Prince William Sound disaster.

BASIC LIABILITY STATUTES

The basic statutes that have apparently been violated are AS 46.03.740 and AS 46.03.822. They read, in pertinent part, as follows:

> Sec. 46.03.740. OIL POLLUTION. A person may not discharge, cause to be discharged, or permit the discharge of petroleum, acid, coal or oil tar, lampblack, aniline, asphalt, bitumen, or a residuary product of petroleum, into, or upon the waters or land of the state except in quantities, and at times and locations or under circumstances and conditions as the department may by regulation permit or where permitted under art. IV of the International Convention for the Prevention of Pollution of the Sea by Oil, 1954, as amended.
>
> Sec. 46.03.822. STRICT LIABILITY FOR THE DISCHARGE OF HAZARDOUS SUBSTANCES. To the extent not otherwise preempted by federal law, a person owning or having control over a hazardous substance which enters in or upon the waters, surface or subsurface lands of the state is strictly liable, without regard to fault, for the damages to persons or property, public or private, caused by the entry. (For purposes of this statute, "hazardous substance" includes oil.)

It is important to note that AS 46.03.822 is a strict liability statute. Liability does not depend upon any showing of negligence. It should be noted, also, that the statute is directed at the person owning or having control over the substance. Therefore, liability does not depend solely on who owned the Exxon Valdez itself.

However, I do not personally know who owned the oil on the Exxon Valdez or whether Exxon had control over the oil even if it didn't own it. I also do not know whether a judgment-proof subsidiary of Exxon was involved in either the owning or transporting of the oil. Even if a subsidiary was involved, of course, there are probably ways of holding the parent company liable. Exxon appears to be accepting full responsibility at this point in time, but as the extent of damages mounts and civil penalties are brought to bear, and Exxon is tempted to deny full responsibility, these kinds of issues could become important.

In addition to these state statutes, there are federal laws that have apparently been violated. One of these is a section of the federal Clean Water Act, 33 U.S.C. 1321(b), which provides:

> The discharge of oil...into or upon the navigable waters of the United States...in such quantities as may be harmful...is prohibited.

Another federal law under which liability will probably be found is 43 U.S.C. 1653(c), which provides:

> If oil that has been transported through the trans-Alaska pipeline is loaded on a vessel at the terminal facilities of the pipeline, the owner and operator of the vessel (jointly and severally) and the Trans-Alaska Pipeline Liability Fund established by this subsection, shall be strictly liable without regard to fault in accordance with the provisions of this subsection for all damages, including clean-up costs, sustained by any person or entity, public or private, including residents of Canada, as the result of discharges of oil from such vessel.

These federal statutes are substantially parallel to the two state statutes cited above. One generally prohibits discharges; the other places strict liability on persons who discharge oil. The second federal statute cited is a strict liability statute like AS 46.03.822, and as such, involves issues similar to those discussed in relation to AS 46.03.-822.

In addition to these basic statutes prohibiting unauthorized oil discharges, there are other statutes that may have been violated during the Prince William Sound disaster. These will be discussed next.

OTHER POSSIBLE BASES OF LIABILITY

It is possible that some liability will attach to Exxon's or Alyeska's failure to properly implement their oil discharge contingency plans. Those plans are required under AS 46.04.-030. Regulations implementing that section require availability of equipment and other resources to effectively contain a discharge. The regulations also require notification to the state if some equipment is not readily available. See 18 AAC 75.305 - 18 AAC 75.395.

Once issues of liability for the discharge have been determined, the relevant aspect of ensuing litigation or settlement will be to determine what types of damages and costs are recoverable from the liable party or parties. These will be discussed next.

TYPES OF DAMAGES AND COSTS RECOVERABLE

To some extent, the types of damages and costs recoverable for environmental disasters are described in the liability statutes cited previously. AS 46.03.822 refers to "damages to persons or property, public or private." The federal strict liability statute, 43 U.S.C. 1653(c), refers to "all damages, including clean-up costs, sustained by any person or entity, public or private."

Further descriptions of the types of damages and costs recoverable are contained in additional statutes. For instance, AS 46.03.824 provides as follows:

> Sec. 46.03.824. DAMAGES. Damages include but are not limited to injury to or loss of persons or property, real or personal, loss of income, loss of the means of producing income, or the loss of an economic benefit.

In addition, AS 46.03.760(e) provides:

> (e) In addition to liability under (a) - (d) of this section, a person who violates or causes or permits to be violated a provision of AS 46.03.740 - 46.03.750 is liable to the state, in a civil action brought under AS 46.03.822, for the full amount of actual damages caused to the state by the violation, including direct and indirect costs associated with the abatement, containment or removal of the pollutant, restoration of the environment to its former state, and all incidental administrative costs.

Furthermore, AS 46.03.780 provides:

> Sec. 46.03.780. LIABILITY FOR RESTORATION. (a) A person who violates a provision of this chapter, AS 46.04, or AS 46.09, or who fails to perform a duty imposed by this chapter, AS 46.04, or AS 46.09, or violates or disregards an order, permit, or other determination of the department made under the provisions of this chapter, AS 46.04, or AS 46.09, respectively, and thereby causes the death of fish, animals, or vegetation or otherwise injures or degrades the environment of the state is liable to the state for damages.
>
> (b) Liability for damages under (a) of this section includes an amount equal to the sum of money required

> to restock injured land or waters, to replenish a damaged or degraded resource, or to otherwise restore the environment of the state to its condition before the injury.
>
> (c) Damages under (a) of this section shall be recovered by the attorney general on behalf of the state.

The federal Clean Water Act also specifies that some types of damages are recoverable by the state under the federal law. 33 U.S.C. 1321(f)(4) - (5) provides:

> (4) The costs of removal of oil...for which the owner or operator of a vessel...is liable under subsection (f) of this section shall include any costs or expenses incurred by...any State government in the restoration or replacement of natural resources damaged or destroyed as a result of a discharge of oil...in violation of subsection (b) of this section.
>
> (5) The President, or the authorized representative of any State, shall act on behalf of the public as trustee of the natural resources to recover for the costs of replacing or restoring such resources. Sums recovered shall be used to restore, rehabilitate, or acquire the equivalent of such natural resources by the appropriate agencies of the Federal Government, or the State government.

In light of these statutes, it appears to me that the types of damages and costs that may ultimately be recoverable by the state are very broadly stated. With respect to all of these damages provisions, it will be important for the state to be able to quantify the damages caused by the oil discharge. This will not be particularly hard with respect to containment and cleanup costs, but will be more difficult with respect to loss of income, restoration of the environment, and replacement of natural resources.

In addition to this practical limit on recovery, there have been arguments made that there are caps on Exxon's liability under various statutes. These will be discussed next.

POSSIBLE LIABILITY CAPS

One possible liability cap arises from 43 U.S.C. 1653(c), the federal law related specifically to liability for discharge of TAPS oil.

43 U.S.C. 1653(c)(3) provides:

> (3) Strict liability for all claims arising out of any one incident shall not exceed $100,000,000. The owner and operator of the vessel shall be jointly and severally liable for the first $14,000,000 of such claims that are allowed...The Fund shall be liable for the balance of the claims that are allowed up to $100,000,000. If the total claims allowed exceed $100,000,000, they shall be reduced proportionately. The unpaid portion of any claim may be asserted and adjudicated under other applicable Federal or state law.

The "Fund" this section refers to is a fund that has been set up under federal law that has been financed by a $.05 per barrel fee collected by the operator of the TAPS. Some may call the $14,000,000 and $100,000,000 figures "liability caps," but I think that term would be erroneously applied, given the entire context of the section. It should be noted that the last sentence of the cited material says that the unpaid portion of any claim may be pursued under other applicable laws. The law further provides that it is "not to be interpreted to preempt the field of strict liability or to preclude any State from imposing additional requirements." 43 U.S.C. 1653(f)(9). Therefore, I think it is clear that the figures cited are caps only with regard to the money payable by the federal fund; they are not caps on Exxon's or anyone else's liability for damages and costs of cleanup. Other state and federal laws previously cited provide ample basis for collection above the limits recoverable under 43 U.S.C. 1653(c).

A second possible basis for a liability cap arises from a federal law called the Liability Limitation Act (the LLA). It is found at 46 U.S.C. 183, and reads in pertinent part:

> The liability of the owner of any vessel...for any loss, damage, or forfeiture, done, occasioned, or incurred, without the privity or knowledge of such owner...shall not...exceed the amount or value of the interest of such owner in such vessel, and her freight then pending.

Notice, however, that this law only limits the liability of the vessel owner. It was intended to encourage the building of ships by limiting the liability of a ship owner who had

no other interest involved. In the Prince William Sound disaster, Exxon probably wears at least two hats: as the owner of the vessel and as the owner of the oil on board the vessel. The LLA could only limit Exxon's liability while it wore the vessel owner's hat, not under its other hat. Moreover, the LLA does not serve to limit liability when negligence is involved. So, to the extent that negligence is shown, Exxon's liability even as the vessel owner would not be limited by the LLA.

A third kind of cap on Exxon's liability arises from a cap on civil penalties under AS 46.03.758(e). This subsection provides for a $100,000,000 cap on civil penalties assessable. However, as discussed in the following section, the per gallon maximum penalty under AS 46.03.758 is modified to such an extent in regulations that the cap, in all likelihood would never be reached.

CIVIL PENALTIES THAT CAN BE ASSESSED

The state statute under which civil penalties may be assessed in relation to the Prince William Sound disaster is AS 46.03.758, which provides, in part:

> (b) No later than the 10th day after the convening of the Second Session of the Tenth Alaska Legislature, the department shall submit to the legislature regulations establishing the following schedule of fixed penalties for discharges of oil:
>
> (1) Subject to (2) of this subsection, the penalties for the following categories of receiving environments may not exceed;
>
> (A) $10 per gallon of oil which enters an anadromous stream or other freshwater environment with significant aquatic resources;
>
> (B) $2.50 per gallon of oil which enters an estuarine, intertidal or confined saltwater environment; and
>
> (C) $1 per gallon of oil which enters an unconfined saltwater environment, public land or freshwater environment without significant aquatic resources.
>
> (2) For discharges of oil which are caused by the gross negligence or intentional act of the discharger, or

when the court finds that the discharger did not take reasonable measures to contain and clean up the discharged oil, the penalty shall be determined by multiplying the penalty established under (1) of this subsection by a factor of five.

* * *

(d) The schedule shall vary according to the toxicity, degradability and dispersal characteristics of the oil. The schedule shall also vary according to the sensitivity and productivity of the receiving environment. Variations under this subsection may be by subcategories of receiving environments, specific receiving environments, or both. The maximum penalties established in (b) of this section shall apply to discharges in the most sensitive and productive of receiving environments within each category of receiving environment, and the penalty shall decrease for less productive or sensitive receiving environments.

(e) After April 19, 1978, if a discharge of oil in excess of 18,000 gallons not permitted under applicable state and federal law occurs within the territorial jurisdiction of the state, or into or upon the adjacent outer continental shelf of the state, the following persons, in addition to the person causing or permitting the discharge, are jointly and severally liable to the state, in a civil action, for the full amount of penalties established in the regulations, or $100,000,000, whichever is less,

(1) if the discharge occurs from any commercial or industrial facility other than a vessel or offshore platform, the owner, lessee or permittee, and operator of the facility;

(2) if the discharge occurs from a vessel,

(A) the owner and operator of the vessel; and

(B) the owner of the oil carried as cargo on the vessel at the time the vessel was loaded, if the loading occurred within the territorial jurisdiction of the state, or at a deepwater port or other offshore storage facility adjacent to the state; however, if the owner of the oil temporarily transfers ownership of the oil

to another person, and the transfer has the purpose or effect of evading the vicarious liability imposed by this section, the transferor will be considered the owner of the oil for the purposes of this subsection; and

(3) if the discharge occurs from an offshore platform, the lessee or permittee of the tract or acreage upon which the platform is situated, and the operator of the platform.

(f) The court shall deduct from the penalties for which the person charged is liable under (e) of this section that amount of oil which was removed from the environment as a result of a cleanup operation undertaken in conformity with applicable state and federal law, unless the oil was removed by an agency of state, local or federal government. The dispersal of oil through the use of chemical agents or other means is not considered removal for the purposes of this subsection. The court may estimate the amount of oil removed.

(g) Except as provided in (f) and (j) of this section, the entire penalty specified in the regulations shall be imposed, except that a person who discharges oil into a receiving environment may demonstrate, by a preponderance of evidence, that mitigating circumstances relating to the effects of the discharge would make imposition of the full penalty inappropriate. In determining whether mitigating circumstances exist, the court shall recognize that scientific knowledge pertaining to oil spills is very limited and if there is insufficient knowledge either to predict a base case or to show mitigating circumstances varying from that base case, the administratively established schedule of penalties shall apply. If mitigating circumstances are proven by a preponderance of the evidence, the court may reduce or totally eliminate the penalty, in accordance with the purposes of this section. (Emphasis added)

* * * * * *

The schedule of civil penalties required to be adopted by regulation under this statute are contained in 18 AAC 75.500 - 18 AAC 75.600. The Department of Environmental Conservation determined that crude oil was medium in its toxicity,

degradibility, and dispersability and Prince William Sound was determined to be a sensitive environment, although not a "critical" area. (According to one source, the oil industry asserted during the development of regulations that the Sound should be designated as "without significant aquatic resources." See "Oil Spill Liability and Compensation: A Review and Evaluation of Alaska's Civil Penalty Scheme," a report prepared for The Institute for Marine Studies, University of Washington, by Wendy J. Graham (January 1989), page 33, hereafter "Civil Penalty Scheme".)

Under the regulations in 18 AAC, the base penalty for discharge into a sensitive saltwater environment is $2.00 and the factor applied based on the characteristics of crude oil is approximately .575. (See, "Civil Penalty Scheme," page 42.) Therefore, the penalty for the discharge in Prince William Sound would be something on the order of $1.15 per gallon, or $11.5 million for the approximately 10 million gallons discharged there. For the amount of oil that reached critical environments, there would be a base penalty of $2.50 per gallon, but that would still be multiplied by the .575 factor for crude oil, so the resulting penalty would not be significantly increased for those areas.

There is some discussion in "Civil Penalty Scheme," at pages 45 - 47, that the collection of civil penalties under AS 46.03.758 might offset the recovery of other types of damages, even quantifiable damages, despite the original intent that the civil penalties be a way to recover only the unquantifiable damages attributable to a discharge. Since all cases that I am aware of in which the civil penalties may have been applicable have been settled out of court, this is not a clear area of law.

It is clear, however, that the maximum civil damages available to the state for the Prince William Sound disaster will not even approach the $100 million cap in AS 46.03.758(e), being more on the order of $10 - 15 million, multiplied to $50 - 55 million if gross negligence is shown.

In addition to these civil penalties, there are criminal penalties that could be assessed. These will be discussed next.

CRIMINAL PENALTIES THAT CAN BE ASSESSED

Criminal penalties related to the Prince William Sound disaster could be assessed under AS 46.03.790, which provides, in part:

> Sec. 46.03.790. CRIMINAL PENALTIES. (a) Except as provided in (d) - (f) of this section, a person who negligently violates a provision of this chapter, AS 46.04, or AS 46.09, or of a regulation, lawful order of the department, or permit, approval, or acceptance, or term or condition of a permit, approval, or acceptance issued under this chapter, AS 46.04, or AS 46.09 is guilty of a class B misdemeanor.
>
> * * *
>
> (f) Notwithstanding the penalty provisions of (a) - (e) of this section, a defendant that is an organization is, upon conviction of a violation of any of the provisions listed in this section, subject to the penalties set out in AS 12.55.035(c).

The fine for a misdemeanor under AS 12.55.035(c) is $100,000. Since Exxon is an organization, this is the likely penalty that could be criminally assessed upon a finding of negligence.

HOW AND WHEN THE STATE MIGHT RECOVER MONEY

As described above, there are many statutes under which the state could seek to recover its expenses of cleanup and its damages. With respect to cleanup expenses, both AS 46.04.-010 and AS 46.08.070 require the Department of Environmental Conservation to "promptly" seek reimbursement. There are no particular directives in any other statutes for the commencement of civil suits to recover costs or damages. The state could sue the Fund established under federal law. The state could also directly sue Exxon's insurer under AS 46.-04.040(e).

Regardless of where suits are filed, they will need to be filed within the applicable statute of limitations period, but, even if they were filed yesterday, it is quite possible that no money would be recovered for years.

There are several reasons why litigation related to the Prince William Sound disaster might take many years:

(1) The state will need time to determine all its damages and costs. It seems likely that cleanup will take more than a few months, and the state will need to monitor future salmon runs, among other things, in order to fully determine the disaster's effect on the fisheries. Effects on tourism will not be immediately ascertainable either.

(2) Claims under the federal fund will need to be aggregated to determine how much proration of claims will be needed to stay under the fund's $100,000,000 cap. Therefore, it seems to me that the fund administrators will need to wait for claims to be filed from all sources before honoring any claims against the fund.

(3) Exxon may, in good faith, disagree with the state's assessment of Exxon's extent of liability and the quantification of damages. It will take time to sort out those differences of opinion.

(4) Given the high amount of financial exposure from this disaster, it will be in Exxon's economic interest to delay payment. It may also be in Exxon's interest to delay payment to put pressure on the state to settle for less money. It may be Exxon's judgment that there will be political and economic pressure on the state to get money back quickly, even if the state needs to sacrifice in terms of total amount recovered.

Eventually, the state is likely to recover significant amounts of money, although I cannot at this point judge whether that amount will be close to the actual damages suffered or cleanup money spent. Regardless of how much money is recovered, it is important to consider the statutes affecting how that recovered money is to be used. This topic will be discussed next.

USE OF RECOVERED MONEY

There are two state statutes under which the legislature has expressed its intent that money recovered from environmental actions be put into special accounts to be used for future cleanup responsibilities.

One of these statutes is AS 46.04.010, which provides for reimbursements of cleanup costs to be credited to a special

account in the general fund called the "oil and hazardous substance release mitigation account." The other statute is AS 46.08.020, which provides that "fines, penalties, or damages recovered under...law for costs incurred by the state as a result of the release...of oil" should be specially accounted for in the general fund so that the legislature may appropriate the estimated balance of the account to the oil and hazardous substance release response fund established in AS 46.08.

Neither of these two state statutes is binding because dedicated funds are prohibited in Alaska. However, they do evidence a strong legislative intent that money recovered in environmental actions be available for use related to future environmental problems.

A more binding statute in this area is a federal one. 33 U.S.C. 1321(f)(5) in the Clean Water Act requires that money recovered under that Act "shall be used to restore, rehabilitate, or acquire the equivalent of [the natural resources that were damaged]." So, to the extent that the state recovers money under that federal law, the state may be required to spend it on restoring lost resources.

SUMMARY

The state has several avenues for recovery of damages and costs based on the Prince William Sound disaster. Liability can probably be established under more than one law, especially considering the existence of federal laws. Actions can be filed against a number of parties, including Exxon, its insurer, and a federal fund set up to cover such disasters. Money may be recoverable for many types of damages and for reimbursement of the state's cleanup expenses. However, the time at which significant amounts of recoverable money may be expected to be received by the state is probably several years away.

- - - - - - - - - - -

As stated earlier, this memorandum is only a general overview. Issues involving admiralty law and common law have not been discussed. They may or may not be significantly relevant. There are, in addition to state penalties, some federal penalties that Exxon might face; I have not discussed those here because your interest seemed to be the recovery of money by the state.

If you wish to have a more in-depth analysis on any particular issue, please let me know. As time allows and newly discovered facts permit, we would be happy to respond to further inquiries. Also, if you would like a copy of Ms. Graham's report about Alaska's civil penalty scheme, one could be made available.

TL:kb
wkk3/073

STATE OF ALASKA

DEPARTMENT OF LAW

OFFICE OF THE ATTORNEY GENERAL

STEVE COWPER, GOVERNOR

REPLY TO:

☑ *1031 W 4th AVENUE*
SUITE 200
ANCHORAGE, ALASKA 99501-1994
PHONE: (907) 276-3550

☐ *1st NATIONAL CENTER*
100 CUSHMAN ST.
SUITE 400
FAIRBANKS, ALASKA 99701-4679

☐ *P.O. BOX K—STATE CAPITOL*
JUNEAU, ALASKA 99811-0300
PHONE: (907) 465-3600

January 24, 1989

The Honorable Curt Menard
Alaska State Legislature
House of Representatives
P.O. Box V
Juneau, Alaska 99811

Re: HB 68 and Ballot Measure No. 2
Our File No. 661-89-0302

Dear Representative Menard:

You have asked for our opinion on whether HB 68, which concerns strict and joint and several liability for hazardous substances releases, would conflict with the intent of Ballot Measure No. 2 adopted by the voters during the most recent general election. You have also made a generic inquiry regarding legislative repeal or amendment of laws enacted by initiative.

The short answer to your first question is no. The summary response to your second inquiry is that an initiative may not be repealed by the legislature for a period of two years after its effective date, but it may be amended at any time. Our analysis follows.

First, Ballot Measure No. 2 effected two very specific and discrete changes in the manner in which liability and damages for traditional personal injury torts will be assessed: it limits a party's liability to its actual percentage of fault and it repeals a statutory right of contribution among two or more persons who were jointly and severally liable for the tort. 1/ Ballot Measure No. 2 did not expressly repeal any other statutory provision concerning strict and joint and several liability. Most pointedly, it is silent on the strict and joint and several liability provisions of AS 46.03.758(e) and other statutes set forth in AS. 46.03 and AS 46.04 concerning oil and hazardous substance releases. For this reason, we do not believe that HB 68 would infringe upon Ballot Measure No. 2.

1/ The precise language of Ballot Measure No. 2 amends a portion of AS 09.17.080(d) and repeals AS 09.16.

Furthermore, the intent of the voters in approving Ballot Measure No. 2 can be ascertained from the arguments made in support of the initiative. In Re Lance W., 694 P. 2d 744, 753 (Cal. 1985). See also Carman v. Alford, 644 P. 2d 192 (Cal. 1982) (election materials helpful in discerning voters' intent); Los Angeles County Transp. Comm. v. Richmond, 643 P. 2d 941 (Cal. 1982) (ambiguities in initiative resolved by referring to arguments in support). In this case, that it a relatively easy task.

The attached advertisement paid for by the coalition supporting Ballot Measure No. 2 unequivocally states that:

> Ballot Measure No. 2 will have no impact on Alaska's environmental protection laws.

(emphasis in original). See Attachment 1. In addition, the coalition supporting Ballot Measure No. 2 explicitly agreed with legislative counsel that it would have no effect on state environmental laws. Id. This advertisement is direct evidence of the voters' intent not to affect the liability provisions, including strict and joint and several liability, of state environmental laws. Enactment of HB 68, amending the provisions of AS. 46.03.822, will thus not violate the intent of the voters in approving Ballot Measure No. 2.

As to your second question, section 6 of article XI of the state constitution provides that the legislature may amend a law enacted by initiative, but may not repeal the initiative within two years of its effective date. "[T]he legislature has broad powers to amend an initiative." Warren v. Thomas, 568 P.2d 400, 402 (Alaska 1977)(fn. omitted). There could be a point at which amendment and repeal tend to converge where, for example, "the legislature has exceeded that broad power by passing an amendment which so vitiates the initiative as to 'constitute its repeal'". Supra, 568 P.2d at 402 (citation omitted). 2/ The passage of HB 68, however, does not raise this spectre.

"[A]n amendment of an act operates as a repeal of its provisions to the extent that they are materially changed by, and

---

2/ The Alaska Supreme Court has reserved judgment on the precise question of when an amendment might constitute a repeal of an initiative. Warren v. Thomas, supra, 568 P. 2d at 404.

rendered repugnant to, the amendatory act." Id. (citation omitted). Nothing in HB 68 is repugnant to Ballot Measure No. 2. Nothing in Ballot Measure No. 2 is materially changed by HB 68. Ballot Measure No. 2 simply did not address the liability provisions of environmental laws, which is precisely what HB 68 does. Since the subject matter of HB 68 was not even contemplated in the adoption of Ballot Measure No. 2, it can hardly be said to materially change or be repugnant to the ballot measure.

We hope that this adequately responds to your questions. Please feel free to contact us for further information.

Very truly yours,

GRACE BERG SCHAIBLE
ATTORNEY GENERAL

By: Madeleine R. Levy
Assistant Attorney General

MRL:jem

Attachment

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

MEMORANDUM January 18, 1989

SUBJECT: HB 68 and repeal or amendment of an initiative (HB 68)

TO: Representative Curt Menard, Co-chair
House Resources Committee

FROM: Terri Lauterbach TL
Legislative Counsel

You have asked whether HB 68's amendment of AS 46.03.822(a) to provide for joint and several liability for the release or threatened release of a hazardous substance violates constitutional restrictions on amendment and repeal of initiatives. You have also asked for a general discussion of the extent to which the legislature may amend or repeal a law that has been enacted by initiative.

With regard to HB 68, it is my opinion that its amendment of AS 46.03.822(a) to provide for joint and several liability for damages described by that section does not violate constitutional restrictions on amendment and repeal of initiatives. It has the effect of amending Initiative 87-02 in a permissibly narrow way.

The constitutional provision governing this question is sec. 6, art. XI, Constitution of the State of Alaska, which provides:

> SECTION 6. ENACTMENT. If a majority of the votes cast on the proposition favor its adoption, the initiated measure is enacted. If a majority of the votes cast on the proposition favor the rejection of an act referred, it is rejected. The lieutenant governor shall certify the election returns. An initiated law becomes effective ninety days after certification, is not subject to veto, and may not be repealed by the legislature within two years of its effective date. It may be amended at any time. An act rejected by referendum is void thirty

> days after certification. Additional procedures for the initiative and referendum may be prescribed by law. (Emphasis added.)

The Alaska Supreme Court has addressed the question whether a law may be amended and has shown a tendency to approve amendments quite broadly. Thus a reduction in penalties in an initiated law was approved in Warren v. Thomas, 568 P.2d 400 (Alaska 1977). And, in Warren v. Boucher, 543 P.2d 731 (Alaska 1975), the Alaska Supreme Court acknowledged that the power to amend an initiative was an explicit "check or balance" against the initiative process.

Furthermore, an Attorney General's opinion concluded that the legislature could alter or delete an initiative's requirement that the capital site contain no less than 100 square miles of state land as well as the requirement that the site selected be more than 30 miles from either Anchorage or Fairbanks. Op. Att'y Gen., August 19, 1975.

In my view, the Constitution asks the legislature to give deference to the wishes of the people as expressed in an initiative, at the same time recognizing that an initiative may present policy problems that the legislature may need to resolve. Because the people may not themselves address the difficulties in a particular initiative by amending it but rather must vote it up or down, the constitution permits the legislature to amend it at any time.

The Thomas court suggested that there could be situations in which an amendment so vitiates an act passed by initiative that it constitutes its repeal. In my opinion, that issue is not raised by the amendment in HB 68. The amendment in HB 68 changes the initiative's general rule of several liability with respect to only a limited type of tort action. In being so narrow, the amendment could not be said to vitiate the initiative.

In discussing HB 68, I hope the general parameters of legislative power to amend or repeal an initiative have been clear. The legislature may amend an initiative at any time as long as that amendment does not change the law passed by the initiative so much that it amounts to a repeal of that law. The legislature may repeal an initiative within two years of its effective date.

I hope this discussion is helpful to you. If I may be of further assistance, please let me know.

TL:gc
WKG5/105

FROM LAW RNCH CIVIL 01/24/89 11:14 P. 5 TOTAL P. 5

It's time to clear the air about the effect of tort reform on the environment.

Trial lawyers opposed to Ballot Measure No. 2 would have you believe that this measure poses a threat to our environment. They maintain that if this measure passes, polluters will escape paying for the environmental damage they cause. That's simply not true.

According to the legislature's own independent lawyer, Ballot Measure No. 2 will have *no impact* on Alaska's environmental protection laws. Similarly, it will have *no impact* on federal environmental protection laws.

The truth of the matter is that since 1986, 39 states have passed some form of tort reform. And on November 8th, it will be your turn to set the record straight.

Ballot Measure No. 2 will make Alaska's liability law more equitable. At the same time it will protect the right of the victim to receive compensation from those who are responsible.

These are the facts. Don't allow a lot of legal double-talk to cloud the issue.

VOTE FOR #2 ON NOV. 8

Support tort reform.
Vote for Ballot Measure No. 2 on November 8th.

Paid for by Citizens' Coalition for Tort Reform, P.O. Box 201644, Anchorage, Alaska 99520. David McGuire, M.D., Chairman.

ATTACHMENT 1
PAGE 1 OF 1 PAGES

Alaska Academy of Trial Lawyers
P.O. Box 102323 • Anchorage, Alaska 99510 • (907) 258-4040
Office: 540 I. Street, Suite 102 • Anchorage

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April 11, 1989

The Honorable Dave Donley
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99811

Re: H.B. 166

Dear Representative Donley:

As you know, I am the president of the Alaska Academy of Trial Lawyers, an organization of nearly 200 lawyers from all over Alaska. The recent hearings held by your committee have been the subject of much discussion and concern by the members of the Academy in relation to the lack of scheduled hearings to address toxic and environmental issues. I understand there now will be hearings to address these areas, and you are to be congratulated for this. We believe the hearings will clearly reflect that H.B. 166 is harmful to the civil rights of those victims harmed by toxic or environmental torts.

The recent disaster in Valdez has highlighted the inappropriate nature of many aspects of this bill. This bill will have an absolutely devastating effect upon the abilities of victims of future environmental or toxic torts to recover full compensation for their damages and injuries under state law.

The impact of the bill is such that it will not only harm individuals such as fisherman, but it will also harm organizations such as native corporations. For instance, have you considered, in any depth, how this bill is going to impact the rights of native corporations to recover for damages to their lands as a result of toxic or environmental torts? This is presently a very interesting question. The previously passed tort reform bill (AS 09.17.010) contains a $500,000.00 limit for non-economic damages. Therefore, it is certainly arguable that every native corporation in the

Prince William Sound has been limited by the legislature to $500,000.00 for non-economic loss as a result of the damage to their ancestral lands. Certainly, this defense is going to be raised, and it will ultimately be litigated, but this is simply one example of the devastating nature that so-called "tort reform" can have in the environmental area.

Of equal concern in relation to the $500,000.00 limitation in AS 09.17.010 is the argument that it limits punitive damages claims to $500,000.00. Imagine that! In Valdez, where the gross, criminal negligence has resulted in hundreds of millions, if not billions, of dollars in damages the punitive damages claims of each native corporation, each fisherman, each processor, etc. may be limited to $500,000.00 under state law! Even the State of Alaska's claims may be limited to $500,000.00!

As another example, the recent initiative doing away with joint and several liability is going to have a severe impact in the Valdez disaster. You can bet that the oil companies and the insurance companies are going to ultimately sue everybody in sight trying to lay off some liability, claiming that other parties are responsible for a portion of the incredible damages that have occurred. In this respect a terrible disservice to the citizens of Alaska was performed by the Coalition For Tort Reform.

Further, the six-year statute of repose proposed in the present bill H.B. 166 is disastrous in relation to environmental and toxic torts. In many instances, the damages caused by environmental pollution go on for many, many years beyond the six years. In other instances, the acts of neglect are not discovered as they have been hidden by the polluters. This has occurred over and over again across the United States. Polluters don't generally advertise that they have polluted, and quite often the environmental disaster is not apparent immediately -- unlike the Valdez situation.

As you know, environmental interests are coming together across this state, nationally and internationally, to address the Valdez situation. The so-called contingency plan of the oil companies has been found to be grossly inadequate, and governmental controls to protect us all need to be erected and strengthened. Similarly, we would hope that your committee would step back a pace or two and re-examine this bill in light of the Valdez disaster.

Frankly, I believe you will see increasing efforts to link so-called "tort reformers" with the Valdez disaster as the public becomes more aware of the limitations of liability passed in Alaska in the last several years. I am sure neither you nor your committee wish to be seen as assisting the oil companies and other special interests in further dismantling the legal system which provides at least some protection for victims of environmental disasters.

Indeed, the legislature would be doing a far greater service to consider repealing the limitations passed in 1986 rather than extending them further. At the very least, exceptions for toxic and environmental torts should be made and clearly the limitations provisions of AS 09.17.010 should be clarified or eliminated.

On behalf of the Academy membership, I urge you to reconsider this bill in light of the Valdez disaster. I look forward to reporting to the membership the actions of yourself and your committee in this regard.

Sincerely yours,

ALASKA ACADEMY OF TRIAL LAWYERS

Dennis M. Mestas
President

cc: House Labor & Commerce Committee:

Max F. Gruenberg, Jr.
David Finkelstein
H. A. "Red" Boucher
Virginia M. Collins
Loren Leman
Mark Boyer

ALL CLAIMS - INCEPTION THROUGH 1988

By Payment Size

INDEMNITY PAYMENT	#OF SUITS/CLAIMS	PERCENTAGE
0	165	61
1-1,000	6	2
1,001-5,000	14	5
5,001-10,000	12	4
10,001-25,000	14	5
25,001-50,000	17	6
50,001-75,000	7	3
75,001-100,000	10	4
100,001-150,000	6	2
150,001-200,000	8	3
200,001-500,000	4	1
500,001-750,000	4	1
750,001-2,000,000	2	1
2,000,001-3,000,000	2	1
	271	

Average Claim - $48,731

Average Claim where indemnity payment was made - $124,353

	Physician Claims	Physician's Named	Number of Physicians Insured
1976	2		58
1977	4		88
1978	5		88
1979	2		97
1980	10		121
1981	7		144
1982	15		200
1983	15		230
1984	29	39	285
1985	43	63	325
1986	35	67	315
1987	27	29	303
1988	20	21	279

MILLIMAN & ROBERTSON, INC.
CONSULTING ACTUARIES

TWO PENNSYLVANIA PLAZA NEW YORK, N.Y. 10001
TELEPHONE: 212/279-7166
FAX: MANHATTAN 212/629-5657, ELMWOOD PARK 201/794-6029

ROBERT P. ALDORISIO, F.C.A.S.
RICHARD J. BARNEY, F.S.A.
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RICHARD S. BIONDI, F.C.A.S.
MARK ALAN CHESNER, F.S.A.
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STEVEN G. SORRENTINO, F.S.A.

WENDELL MILLIMAN, F.S.A. (1976)
STUART A. ROBERTSON, F.S.A.
CHAIRMAN EMERITUS

August 5, 1988

Mary A. Pierce
Executive Director
Medical Indemnity Corporation of Alaska
4000 Old Seward Highway, Suite 203
Anchorage, Alaska 99503

Re: Effective Tort Reform Legislation

Dear Ms. Pierce:

You, like many other executive officers of medical societies and physician sponsored insurers, are likely involved in continuing efforts to obtain passage of effective tort reform.

At the May 1988 Physician Insurers' Association of America Annual Meeting I had the opportunity to discuss the importance of the "fine print" in tort reform legislation. So many people in the audience requested copies of my slides that I prepared the attached annotated version of those slides.

The information on pages two through four can be used as a checklist in reviewing tort reforms you may be considering. Actuarial techniques can be used to evaluate how much "fine print" in the tort reform language might affect the value of the reforms.

If you have any questions about this material, or if I can be of any other assistance to you, please feel free to call me or my associate, Spencer Gluck.

Very truly yours,

Allan Kaufman -SG.

Allan Kaufman, F.C.A.S.

RECEIVED
AUG 15 1988
MICA

AK/pr
cc: D. Bickerstaff

How Effective is Tort Reform?

Read the Fine Print

Tort reform can work.

The largest "laboratory" to date has been the medical professioanl liability system in California. Here, a package of tort reforms including many of the currently popular elements was passed following the mid-seventies medical malpractice insurance crisis. At that time, California joined New York and Florida among the national leaders in medical liability costs. Today, California's medical liability costs are far closer to the national average.

Patricia Danzon, currently at University of Pennsylvania, compared medical liability costs from 1975 to 1984 in a number of states with and without tort reforms, calculating these average savings associated with various types of tort reforms:

Caps on non-economic loss	23%
Collateral sources offsets	11-18%
Contingency fees limitations	3%
Reduced statute of limitations	8% per year
Structured settlements	Not tested
Joint & Several Liability	Not tested

Of course, these estimates of savings are in comparison to what costs otherwise would have been, and represent average results for the states studied.

Remember, successful tort reform means that costs are lower than they otherwise would have been. It is unlikely that tort reform will produce costs below the starting point for an extended period.

Tort reform can also fail.

Or be relatively ineffective. Or be less effective than it might have been. For each of the types of reform listed above, there have been a number of variations in bills which have passed, and even more in bills which have been considered. Small differences in wording can have profound implications, some of which may be unintended. To evaluate an existing or proposed tort reform, be sure to read the "fine print".

We've worked on many variations of tort reforms in proposals, bills, and laws in a number of states. The following list illustrates some of the possible variations and important factors which affect the value of those reforms. The list begins with a bali-park estimate of the savings which the reforms might produce for medical professional liability.

Limitations on Non-Economic Loss

Estimated savings can range from zero to fifty percent, depending on:

1. Amount of Limitation. Proposals range from complete elimination to a $1,000,000 limitation.

2. Per Incident or Per Claimant. This distinction is significant, but without proper attention the wording of the law may not even be clear.

3. Flat or Graded. Flat limitations are more common. Graded limitations usually apply the maximum to only the most serious cases and then grade the limitation down for less serious cases (e.g. in proportion to "capacity to enjoy life").

4. Definition of Non-Economic Loss. For example, future wage loss in one jurisdiction is considered speculative and therefore non-economic.

5. Variation by Claimant Characteristic. For example, the limitation may vary by age of claimant and/or degree of injury.

6. Indexation of the Limitation for Inflation.

Collateral Source Offsets

We've estimated savings in this area from zero to fifteen percent.

1. Mandatory or Judgmental Offset. Possible wordings include: "evidence may be introduced"; "judge/jury may consider"; or "judge/jury shall reduce".

2. Offset by Judge or Jury. There's opinion (although no evidence) that offset by the judge produces greater savings.

3. Exceptions to Offset. Possibilities include medicare, life insurance, public insurance, insurance paid by claimant, insurance with subrogation provisions, insurance paid by employer.

4. Past Damages Only or Past and Future Damages. The language of a number of current laws appears to apply to past damages only, whether or not this was intended when the law was written.

5. Offset for Premium Paid by Claimant.

Contingency Fee Limitations

Estimated savings range from zero to ten percent.

1. Selected Schedule. Most limitations take the form of some kind of schedule. That schedule may include percentages higher than current prevailing fees.

2. Schedule Variations. Most schedules vary the percentage by size of award. Others may also vary the percentage by case disposition (i.e., claim, suit, trial, appeal).

3. Treatment of expenses. Are trial, court and expert fees counted as part of the schedule or in addition to the schedule fee? Alternatively, is the award/settlement reduced by expenses before the fee is applied?

Statute of Limitations

We've estimated savings ranging from zero to fifteen percent.

1. Cutoff Period. We've seen anywhere from two years to ten years.

2. Cutoff by Occurrence Date or Discovery Date. Another possibility is both, e.g. "four years from incident or two from discovery, whichever is later".

3. Definition of Discovery Date. "Did discover" or "could have discovered" or "should have discovered" etc.

4. Statute of Repose or Statute of Limitations. A statute of repose operates more restrictively. The courts may decide which it is; careful wording in the law can cause it to operate as a statute of repose.

5. Exceptions. The potential list includes infants, foreign objects, continuing treatment, drugs or radiation, and concealment or fraud.

Periodic or Structured Settlements

Estimated savings range from zero to ten percent.

1. Optional or Mandatory.

2. Size Requirements. For example, "awards over $250,000" or "awards with future damages over $100,000".

3. Applied to Economic Loss, Non-Economic Loss, or both.

4. Treatment of Inflation. Examples include inflation calculated at the jury's discretion, at a fixed rate specified by statute, or at a fixed relationship with a stated index.

5. Court Rules on Treatment of Inflation and Interest. This item refers to conditions before the change in law. Previous assumptions regarding inflation and interest may have been specified in statute or in case law. In other instances it may be difficult to determine prevailing assumptions.

6. Payment Periods. Possibilities include a specified payment period (e.g., 10 years), a specified maximum payment period, payment for life expectancy.

7. Payments May or May Not Terminate at Death. Frequently, some payments terminate (e.g., medical costs) while others may not (e.g., wage loss).

8. Financial Guarantees Required. For example, insurer with specified Best's rating.

9. Treatment of Attorney's Fees. In some instances, attorney's fees may be completely exempted from periodic payments. Other possibilities include lump-sum payments with required present value calculations or separate rules for scheduled payments.

Joint and Several Liability

We haven't estimated significant savings to doctors in this area.

1. Economic Versus Non-Economic Losses. A number of existing versions abolish joint and several liability for non-economic losses only.

2. Proportionate Liability in All Cases or Only Below A Threshhold. For example, some laws establish proportionate liability for those under 50% liable, but provide that all damages may be assessed against those over 50% liable.

3. Among Whom are Damages Apportioned. For example, in a case involving a work-related injury, may the employer be included?

* * * *

Summary and Conclusion

There is evidence that tort reform can be an effective means for reducing the growth in liability costs. Still, simply passing a tort reform bill by no means ensures that savings will be realized. It is no accident that we included zero in each possible range of results. Some versions of tort reform may even increase costs. The fine print of the law, the court instructions used to implement the law, and court interpretations of the law will all act to determine the effectiveness of a tort reform measure. An important first step is to read the fine print.

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503

COVER SHEET FOR FACIMILE TRANSMITTAL

(OUR FAX NUMBER IS - 562-7804)

TO: Bill Brock

Juneau, Alaska

FAX # 00

ATTENTION: Mary Pierce

FROM: Art Stanford

RE: Prenatal Coverage Only

PAGES:

IF YOU SHOULD NOT RECEIVE THE NUMBER OF PAGES INDICATED ON THIS COVER SHEET, PLEASE CONTACT OUR OFFICE AT 563-3414.

Attached is the form letter we sent last summer to all of our policyholders regarding this new specialty class.

Only Crossroads Medical Center (Glennallen) responded and they also submitted the written protocols with the delivering physician in Anchorage.

Stan Jones, M.D. of Haines had supported and pushed for this re-classification but declined the coverage when it was finally made available because "it was still to expensive for his low volume of O.B. patients".

MICA Medical Indemnity
Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 308
ANCHORAGE, ALASKA 99503

Bulletin

RE: New Specialty Class: Prenatal Coverage Only

Dear Policyholder:

Your Board of Governors is pleased to announce the creation of a new specialty class for those physicians who wish to continue providing prenatal care to their patients with delivery being performed elsewhere by a collaborating OB/GYN or Family Practictioner in an urban area hospital.

This new specialty classification has been assigned a class 2 rating which represents a premium reduction of approximately 48% over the rate for complete Family Practitioner obstetrical coverage.

The only requirements for this specific coverage are that the collaborating physician must have malpractice insurance (not necessarily with MICA) and approval by MICA of the written protocols between yourself and the physician doing the actual delivery. The protocols must be signed by both physicians, be specific as to the number of patient visits to the delivering physician prior to the due date as well as the frequency and type of the prenatal procedures that will be performed.

Your company is pleased to provide this new coverage which has been tailored to meet specific and current needs of many of our rural physician policyholders. The coverage will allow our physicians to continue providing virtually full term obstetrical services to their patients while at the same time providing optimal facilities for the actual delivery.

Please contact the MICA Underwriting Department if you have any questions regarding this new prenatal only coverage.

Very truly yours,

Art Stanford
Underwriting Manager

AS:sm

7/29/88

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 166
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act relating to civil actions amending Civil Rules 68 and 82
Sponsor: Cotten
Requester: Labor & Commerce

Agency Affected: Commerce & Economic Dev.
BRU: Division of Insurance
Components: Operations

EXPENDITURES / REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL		350.0	300.0	250.0	100.0	100.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		350.0	300.0	250.0	100.0	100.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of dollars)

GENERAL FUND		350.0	300.0	250.0	100.0	100.0
FEDERAL FUNDS						
OTHER						
TOTAL		350.0	300.0	250.0	100.0	100.0

POSITIONS:

FULL-TIME		0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

See attached

Prepared by: Don Koch, Chief of Market Surveillance
Division: Insurance
Phone: 465-2515
Date: _____

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Phone: 465-2500
Date: _____

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

3527D-2/031089a

ANALYSIS:

Section 18 requires an analysis of medical malpractice rate changes occurring as a result of court decisions in the state involving personal injury or death. This requires a review that present staff lacks the needed expertise to conduct. We estimate that such a review could be conducted by an independent actuarial firm. This review is structured as ongoing, hence, we have estimated $110,000 per year for this work. The depth of review would be subject to negotiation and design.

Section 21 requires an extensive review with a report due by February 1992. The report would review closed insurance claims to determine the impact of the legal system on increased insurance rates or coverage decreases in crisis lines which are not defined. It would further evaluate how victims are faring under the present system and the actual impact of tort reform measures adopted. It would review actual impact on this legislation on insurance rates.

Section 21 also provides for a study of insurance finances to evaluate the cost justification of insurance rates for fault based on personal injury, death or property damage awards, settlements and court decisions. This requires considerable actuarial, economic, and legal evaluation which the Division of Insurance is not capable of providing. Initial design will result in increased expense in the first year. These figures are estimates that can only be refined through a proposal from persons capable of conducting such a study.

PRESS PACKET

NATIONAL INSURANCE
CONSUMER ORGANIZATION

NATIONAL INSURANCE
CONSUMER ORGANIZATION

Embargo until 11 AM, Tuesday,
December 9, 1986
For information contact:
Bob Hunter - (305) 239-4200
Jay Angoff - (703) 549-8050

Tort Reform Will Not Reduce Insurance Rates, Say 100+ Florida Insurers

More than 100 insurance companies have told the Florida Insurance Department that the state's recently enacted "tort reform" law will reduce general liability insurance premiums by an average of just over 1%, according to newly-released documents filed with and analyzed by the Florida Insurance Department.

At the annual meeting of the National Association of Insurance Commissioners in Orlando, Florida, National Insurance Consumer Organization President J. Robert Hunter released a summary of 277 filings by 104 insurers licensed in Florida which calculate the effect of the 1986 Florida tort reform law. 175 of the filings, or 63%, show no savings from tort reform, while none show a savings of more than 10%. The average reduction for all property/casualty lines was 1.2%; for general liability -- which includes day-care, municipal and products liability -- the average reduction was 1.3%. In contrast, Florida general liability insurers increased premiums by an estimated 120% in 1985 and 1986.

Hunter also released documents prepared by State Farm Fire and Casualty Co., Great American West, Inc., and the Insurance Services Office -- the insurance industry group that issues "advisory" rates -- demonstrating that tort reform in general would have little or no effect on rates. State Farm, for example, told the Kansas Insurance Department that restricting joint and several liability and limiting punitive damages would have no impact, while capping damages for pain

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

and suffering would reduce rates by no more than 1%. Great American West, on the other hand, told the Washington Insurance Department that tort reform could well raise rates.

The Insurance Services Office said its advisory rates would not reflect any reduction due to tort reform, and emphasized to its member companies that "any beneficial effects of tort reform cannot be quantified with any degree of accuracy" (emphasis ISO's). On the other hand, when in 1975 New York enacted tort reform that would expand liability and thus raise insurance costs, ISO immediately raised its advisory rates by 5% and provided complete actuarial justification for the increase, according to another document released by Hunter.

"It is ironic that ISO can tell us how much rates should rise when tort law expands, but can't tell us how much rates should fall when tort law is limited," Hunter said.

On the basis of the State Farm, Great American West, Florida Insurance Department and ISO documents, as well as previously released rate filings by Aetna and St. Paul, Hunter asked the President of the NAIC to take emergency action to ensure that insurance commissioners in states enacting tort reform roll back all rate increases that have taken effect since the reforms were enacted. "While reasonable minds may differ on whether it is good public policy to reduce insurance rates by limiting compensation to seriously injured people, it is surely not good policy to limit compensation to injury victims and get nothing in return," Hunter said.

The National Insurance Consumer Organization is an independent, non-profit, non-partisan consumer organization which monitors the insurance industry. It was founded by Hunter, an actuary and a former Federal Insurance Administrator, in 1980.

NATIONAL INSURANCE
CONSUMER ORGANIZATION

December 9, 1986

Ms. Josephine Driscoll
President
National Association of
Insurance Commissioners
1125 Grand Avenue
Kansas City, MO 64106

Dear Madam President:

We are writing to ask that you call an emergency meeting of the insurance commissioners in states that have enacted tort reform, so that the commissioners may determine how best to ensure that the benefits of tort reform are reflected in lower insurance prices.

We are making this request because substantial evidence has recently come to light which indicates that, in general, insurance companies are not reducing rates in response to tort reforms. This evidence includes:

1. The Aetna and St. Paul Filings. Aetna Casualty and Surety Co. and St. Paul Fire and Marine Co. have undertaken closed claim studies purporting to demonstrate that the savings resulting from five major tort reforms enacted in Florida -- eliminating the collateral source rule, capping non-economic damages, restricting joint and several liability, limiting punitive damages, and requiring periodic payment of future economic damages -- would be negligible. See attachments 1A and 1B.

2. The State Farm letter. State Farm has now corroborated the Aetna and St. Paul results. In a letter to the Kansas Insurance Department State Farm concludes, on the basis of "a sampling of commercial liability claims," that the following tort reforms would bring about the following savings:

(a) eliminating the collateral source rule -- "about 1%";

(b) non-economic cap -- "will not exceed 1%";

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

(c) restricting joint and several liability -- "in our sample of liability claims, no claim was found that would have been affected by the joint and several restriction";

(d) limiting punitive damages -- "in our sample, no punitive damage awards were found";

(e) alternative payment of future economic losses -- savings "would be negligible."

State Farm also emphasized that "it will probably be several years before any effect from tort reform legislation can be expected to influence our experience." See Attachment 2.

3. The Florida Insurance Department data. As of September 30, 1986, 277 rate filings purporting to calculate the effect of the Florida tort reforms were on file with the Florida Insurance Deparment. 175, or 63%, showed no effect from the Florida tort changes, and the average reduction in all 277 filings was 1.2%. See Attachment 3. By way of contrast, insurance companies increased premiums in Florida by 62% in 1985, according to NAIC data, and are increasing them by a similar amount in 1986.

4. The Great American West letter. In Washington state, which enacted perhaps the most comprehensive tort reform package in the nation in 1986, Great American West, Inc. calculated that the new law would, if anything, raise insurance rates. Great American West concluded:

"It does not appear that the 'tort reform' law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the 'tort reform' law." See Attachment 4.

5. The ISO Chief Executive Circular. Perhaps most disturbing, the Insurance Services Office has recently announced that it is issuing "advisory" rates that show no reduction resulting from tort reform, and has emphasized to its member companies that "any beneficial effects of tort reform cannot be quantified with any degree of accuracy" (emphasis ISO's). See Attachment 5. Yet when in 1975 New York enacted tort reform that would expand liability by replacing contributory negligence with comparative negligence, and would thus raise insurance costs, ISO immediately raised its advisory rates by 5%, and provided full actuarial justification for the increase. See Attachment 6. It is not readily apparent why ISO can tell us how much rates should rise when tort law expands, but can't tell us how much rates should fall when tort law is limited.

Whether it is good public policy to reduce insurance

rates by limiting compensation to seriously injured people is a question on which reasonable minds can differ. But it is clearly not good policy to limit compensation to injury victims and get nothing in return. Consistent with this view, Commissioner Gunter of Florida has recently reduced the new rates filed by Florida commercial liability insurers after the Florida tort reform law was enacted by $112 million. We ask that you take emergency action to ensure that insurance commissioners in all other states enacting tort reform do everything in their power to pass the benefits of tort reform through to insurance consumers in the form of lower insurance rates; and that they roll back, to the extent not prohibited by law, all rate increases that have taken effect since the enactment of such reforms.

Sincerely,

J. Robert Hunter,
President

Jay Angoff,
Counsel

JA/ljb

attachments: as stated

Attachment 1A
FCC 86-2172

Commercial Insurance Division
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123

August 8, 1986

RECEIVED
AUG 11
FORMS AND CONTRACTS

Honorable Bill Gunter
INSURANCE COMMISSIONER
Florida Department of Insurance
Tallahassee, FL 32301

ATTN: Mr. Charlie Gray, Chief
Bureau of Policy and Contract Review

Dear Mr. Gray:

RATE REVISION
CONTRACTORS LIABILITY POLICY PROGRAM
THE AETNA CASUALTY AND SURETY COMPANY
THE STANDARD FIRE INSURANCE COMPANY
THE AUTOMOBILE INSURANCE COMPANY OF HARTFORD, CONNECTICUT

In accordance with your Insurance Laws, our Companies file a revised liability rate level which results in an overall selected premium increase of 17.2% with an annual premium effect of $622,250.

Our Companies' decision to revise rates results only after a thorough and comprehensive analysis. We evaluated our experience, market conditions, tort reform, and other relevant factors as they affect the establishment of adequate rate levels. The enclosed exhibits prepared by actuarial unit are submitted in support of our rate filing decision, and demonstrate that the resultant rates are neither excessive, inadequate, nor unfairly discriminatory.

We propose to implement this filing with respect to all policies written on or after January 1, 1987. So as to not delay the filing of our rate level decision, revised rate pages will be forwarded under separate cover when available.

A stamped, self-addressed envelope is enclosed for your convenience in responding.

Sincerely,

Thomas L. Rudd

Thomas L. Rudd, Superintendent
Insurance Department Affairs - Commercial Lines

BODILY INJURY CLAIM COST IMPACT OF FLORIDA TORT LAW CHANGE

Summary

The following table summarizes the expected impact of the new Florida law on bodily injury claims costs (including Allocated Loss Adjustment Expenses). The impacts shown were developed from data gathered via a special claim study conducted by the AEtna. The claim study and the analysis are detailed in the succeeding sections of this memorandum.

Impact of Tort Law Changes

Impact of Tort Law Changes

Tort Law Change	Line of Business: Products Bodily Injury	Line of Business: All Other General Liability
Collateral Source Offset	0	(0.4%)
Joint & Several	0	0
Limitation of Noneconomic Damages to $450,000	0	0
Punitive Damages	0	0
Future Economic Damages over $250,000 Paid at Present Value	0	0

All Other General Liability includes the bodily injury liability portion of package policies, SMP Section II, and monoline General Liability policies. The analysis as shown is based solely on AEtna data and, therefore, is applicable only to AEtna's book of business.

Claim Study

The attached special claim analysis form, designed to gather data on the impact of the tort reforms, was completed by experienced Branch Office claim personnel. Claims eligible for analysis were selected according to the following criteria:

1. Commercial Casualty claims (excluding National Accounts business) for policy years 1981 through 1985
   a. reported prior to January 1, 1986
   b. open as of May, 1986
   c. closed during the last six months

2. All claims in category (1) with indemnity payments or reserves over $25,000 were analyzed (total of 55 claims).

3. Fifty closed claims with indemnity of less that $25,000 were randomly selected.

The completed forms were reviewed for internal consistency prior to coding and analysis.

Collateral Source Analysis

Exhibits I and II detail the analysis of the revision in the collateral source rules. Exhibit I is for claims over $25,000 indemnity. Exhibit II is for claims under $25,000 indemnity.

Exhibit I shows that since the right of subrogation exists for many collateral sources available to the plaintiff, the economic losses incurred are not expected to be substantially reduced due to the law change. Furthermore, current AEtna claim settlement practices recognize, in part, the existence of collateral sources as part of the negotiating process used in arriving at a mutually satisfactory damage value with the plaintiff.

Exhibit II shows that for claims under $25,000, no additional savings are expected due to the change in Florida law.

Joint and Several Analysis

Exhibit III details the analysis of joint and several additional payments made by AEtna. Total joint and several payments were 4.5% of indemnity payments over $25,000. A review of each claim generating additional payments due to joint and several liability indicated no reduction in those payment due to the interaction of economic damages sustained by the plaintiff, the percentage of liability assigned to AEtna's insured, and the policy limits purchased.

Analysis of Limitation of Noneconomic Damages to $450,000

Nine claims had the potential for coming under the new limitation for noneconomic losses. The nine cases were identified on the basis of full liability value—not our insured's share of the liability. Data in the above format allowed for a review of whether total claim value could be reduced and whether such a reduction would impact on AEtna's incurred claim cost.

The review of the actual data submitted on these cases indicated no reduction of cost. This result is due to the impact of degree of disability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff; all seemed to reduce the expected noneconomic component of damages to less than $450,000.

Analysis of Punitive Damages

Only two cases were found where punitive damages had an impact on the claim settlement value. The total impact was estimated at less than $15,000 or less than 0.1% of total indemnity payments. Consequently, it appears that there will be no impact on AEtna's claim values due to changes in the allocation of the punitive damages awarded.

Analysis of Installment Payment of Future Economic Damages Over $250,000

Ten claims had the potential for coming under this section of the law. The review of individual cases indicated no net savings to AEtna for the following reasons:

1. interaction of policy limits, past economic losses, and future economic losses

2. settlement value of the case

3. apparent implicit recognition of the periodic nature of future damages

Overall Summary

The expected net reduction in claim costs is based on an analysis of AEtna claims. As such, the analysis is applicable only to AEtna's book of business.

Due to the level of detail of the historical claim data, informed claim judgement was required in some instances to ascertain some of the detail required for the analysis. The judgement, if any, was exercised by experienced claim adjustors and is implicit in the analysis.

The analysis shown represents the best estimate of future cost reductions if the law as currently structured remains in effect. However, the sunset provision of the law takes affect in four years. Furthermore, the law applies only to cases filed under the law, and the Florida statute of limitations is four years. Consequently, it is possible that any plaintiff who might be severely impacted by the provisions of the law would delay filing until after the law expires. If this situation arises, then the expected reductions will be lower than those indicated in this memorandum.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM

In 1986, Florida passed a number of changes to the tort system. We have reviewed the tort changes and their potential effect on our medical professional liability experience. Our review is based on a study of over 300 Florida closed claims. The total effect of the bill based on this evaluation was very small.

Evaluation:

Of the 313 closed claims that were studied, only four claims would have been effected by the law for a total effect of about 1% savings. (Exhibit A) Furthermore, all of these savings would have been eliminated if the courts had assigned only 10% more of the blame on our insureds than our claim department had estimated. It's highly likely that there would have been no savings on these claims had the bill been in effect. (Exhibit B)

Our study covered all of our Florida physicians, surgeons and hospital claims that closed in 1983 and 1984. Economic loss was determined based on the plaintiff's medical loss, weekly wage, and time lost from work. These losses were reduced for the time value of money.

We added the noneconomic loss cap to the total economic losses. The cap is $450,000 times the portion of negligence assigned to our insured. We compared this maximum award under the new law to the amount that the St. Paul actually paid on behalf of our insured.

The conclusion of the study is that the noneconomic cap of $450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above $250,000 will produce little or no savings to the tort system as it pertains to medical malpractice.

Comments on other provisions of the bill:

a. Collateral source offset

The medical malpractice provisions prior to this act provided for subrogation against collateral providers. The effect of this subrogation would be similar to the effect of the collateral source rule. Therefore, the net effect of eliminating the subrogation and allowing collateral sources is negligible.

b. Itemization of Damages

Damages were itemized in our evaluation of this tort reform and no savings were shown. They are probably already implicitly itemized by either juries or our claim department when settling claims. We expect no savings from this provision.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM
(Continued)

c. Frivolous Suit Protection

This provision can either work for or against us depending on who wins the case. No savings are expected from it.

d. Additur/Remittitur

This provision can also work for or against us. No savings are expected.

e. Punitive Damages

The legislation reduces the monetary incentive for punitive damage cases, but not total award amounts. Since these cases often have a retaliatory incentive, no savings are expected.

f. Timing of Effects

The tort changes made in Florida apply to losses occurring on or after July 1, 1986. On a claims-made policy, they will effect only the portion of our expected losses with accident date after July 1, 1986. This will impact the equivalent of our first year losses.

g. Conclusion

The tort law changes effective July 1, 1986 in Florida will, hopefully, have a positive impact on loss costs for occurrences after that date. However, to forecast the effect is highly speculative. Our evaluation of prior losses showed little or no savings under key provisions of the law and our analysis of other provisions show no expected savings. Our best estimate is no effect from the tort changes.

It can be hoped that the adoption of these tort changes will have an intangible effect on society, and further work to mitigate future loss trends. However, the trends in medical malpractice have been very high. The effect of the reform needs to be very strong to stem such trends.

Attachment 2

State Farm Fire and Casualty Company

State Farm General Insurance Company

112 E. WASHINGTON ST.
BLOOMINGTON, ILLINOIS 61701

October 21, 1986

Mr. Ray Rathert
Kansas Insurance Department
420 S. W. 9th Street
Topeka, Kansas 66612

Ray:

Before any discussion of State Farm and tort reform, it must first be clearly understood that most of the problems in the liability field are in lines which State Farm does not write. Because of this, the impact of tort reform on our book of business is going to be considerably different from that of a major liability writer.

We have been requested by several insurance departments to come up with some estimate of the effect of newly passed tort reform legislation on our rates in their states. We know of no way this can be done actuarially. Consequently, we resorted to judgement.

The few enacted tort reform statutes usually include items such as:

1) Collateral source of indemnity

2) A non-economic cap

3) Joint and several restriction

4) Punitive damage limitation

5) Alternate methods of payment.

A sampling of commercial liability claims provided the following:

1) Collateral source of indemnity. The sample indicated that approximately 7% of our total indemnity losses were potentially subject to a collateral source. Only about a quarter of these reflected a known collateral source. In our judgement, 50% would be a very liberal estimate of the success in reducing damages due to the existance of a collateral source. The net savings from the collateral source change is thus about 1% (7% X 25% X 50%).

2) Non-economic cap. Non-economic caps are established at such a level that our sample indicated only very few claims would exceed the cap. It is our judgement that the loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses.

3) Joint and several restriction. In our sample of liability claims, no claim was found that would have been affected by the joint and several restriction.

4) Punitive damage limitation. Again, in our sample, no punitive damage awards were found.

5) Alternative methods of payment. On our book of business, the savings due to alternative payment methods on future economic losses would be negligible in relation to our total indemnity losses.

Although we believe the effect of tort reform on our book of business would be small, we do believe that effective tort reform legislation can have a positive impact on not only pricing but also availability. It is important to keep in mind that tort reform, or absence thereof, is only one of many factors which influence pricing and availability. Any of these other factors can produce an opposite effect which could equal or outweigh any positive effect of tort reform.

Attached are liability rate comparisons for Kansas and surrounding states. As you know, we use ISO rates for monoline policies. Even in our package policies, the original liability loadings were also derived from ISO rates.

Again, as you know, we do review our rate levels at least annually. It will probably be several years before any effect from tort reform legislation can be expected to influence our experience. Anyway, hope these brief comments will be of some use to you in your discussions of this subject.

Best regards,

Bob

Robert J. Nagel
Assistant Vice President
State Filings Division

RJN:kc/1021

NATIONAL INSURANCE
CONSUMER ORGANIZATION

Effect on Insurance Rates of Florida Tort Reforms -

for all companies filing as of 11/01/86

% Reduction	Number of Filings				
	Commercial General Liability	Commercial Package	Auto	Other	Total
Ø	72	28	31	44	175
Ø-2.5%	12	25	5	3	45
2.5-5%	18	14	6	Ø	38
5-7.5%	7	1	7	1	16
7.5-10%	2	1	Ø	Ø	3
Over 10%	Ø	Ø	Ø	Ø	Ø
Total number of filings	111	69	49	48	277
Average Reduction	-1.3%	-1.5%	-1.5%	-Ø.2%	-1.2%

Average calculated by assuming all filings are of equal premium weight. Companies that filed rates and did not calculate the effect of the new tort reforms are not included.

Source: Florida Department of Insurance

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

Attachment 4

GREAT AMERICAN·WEST, INC.

200 S. MANCHESTER AVENUE
ORANGE, CA 92668
714/634-4600

April 23, 1986

Mr. Norman Figon
Rate Analyst
Washington Insurance Department
Insurance Building
Olympia, WA 98504

Re: American National Fire Insurance Company
Select Driver I Program
Select Driver II Program
Private Passenger Automobile
Rate and Rule Revision

Dear Mr. Figon:

In your letter of March 25, 1986, you indicated that we need to place a provision in our ratemaking to reflect the impact of the "tort reform" law. As an attempt to quantify, we reviewed twenty-four claim files, which represented all of our Private Passenger Automobile claims over $50,000 in the state of Washington since 1983. Of these twenty-four claims, we believe that the new law could have an impact on three claims. One claim involved a driver that was intoxicated. We estimate that we would not have paid $20,000 of the claim. On the other hand, there were two claims in which American National Fire would see an increase in its loss liability. These are contributory negligence cases in which our percent of the entire loss liability would increase. The impact of the law on these two is at least $100,000 on each of them.

From the above study, it does not appear that the "tort reform" law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the "tort reform" law.

We request, therefore, that you reconsider the original filing of January 19, 1986, with an amended effective date rule of:

"For all policies written on or after June 2, 1986".

In our telephone conversation you mentioned a concern that we are selecting an increase less than our indications. Our plan of action is to take this increase, which we estimate to be slightly more than 14%, and to review the rates in the near future, such that we can effect a rate change six months after the effective date of this revision. We believe that this method will prove to be less disruptive on our book of business than other courses that we might have chosen.

We hope the above includes all the information that you need to expedite an approval of the filing.

Sincerely,

Kevin J. Kelley
Director of Actuarial

KK/nk

CHIEF EXECUTIVE
circular

Attachment 5

RECEIVED
OCT 14 1986
ISO DALLAS

DIR.
RAI.
KAS

October 3, 1986

ISO POLICY DECISION ON TORT REFORM ANNOUNCED

Chief Executive CE-86-31

BACKGROUND

Various tort reform measures have been enacted or are still under active consideration in many states. It is clear that meaningful tort reform will have a favorable, prospective impact on loss severity and/or frequency, variable by state and line of insurance which, ultimately, will be reflected in state loss experience.

However, in some jurisdictions, an immediate rate reflection in response to tort reform is being demanded. Statutes in Florida, New York and Hawaii mandate that insurers reflect tort reform legislation in their filings. The New York Insurance Department has already advised companies of its estimates of the cost reductive effects of tort reform. Florida has mandated a 1987 rollback to adjusted 1984 rates, unless companies file 1987 rates reflecting the impact of tort reform by October 15, 1986. Hawaii has mandated a 10% decrease in rates on October 1st to reflect tort reform, with further reductions required in future years. The Washington Insurance Department is requiring that future rate filings reflect enacted tort reform even without a specific statutory requirement.

Insurance Services Office, Inc., 160 Water Street, New York, New York 10038 (212) 487-5000

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ISO POSITION

ISO is unable to quantify, and to reflect in its filings with a reasonable degree of certainty, any immediate cost effects of tort reform. ISO believes that the reflection of any beneficial effect of tort reform on insurance pricing, where mandated, is a matter of individual insurer judgment and not a precise actuarial exercise. Such judgment is consequently more properly applied by individual insurers, rather than by ISO in its role of acting on behalf of those affiliated insurers which elect to use ISO's services.

Therefore, the ISO Board of Directors has established -- as ISO policy -- that, inasmuch as ISO cannot immediately reflect any cost effects of tort reform in its filings, any such effects are best determined by the judgment of each insurer, taking into account the distribution by coverage, class, and limits on its own book of business.

ISO ACTION

Consistent with this policy, ISO advisory rates will not reflect tort reform and each company must make its own assessment as to the immediate effect, if any, of tort reform on its book of business.

In New York, in order to assist companies in complying with the refiling requirements of the new law, ISO released Commercial Lines Circular CL-86-29 which contained revised manual rules utilizing the cost reductive effects promulgated by the Superintendent of Insurance, without commenting on their appropriateness.

In Florida, ISO has developed a filing procedure -- which has been approved by the Insurance Department -- whereby individual companies must supplement the ISO filing with their own individual estimates of the impact of tort reform. At the direction of the Insurance Department, ISO will collect these individual estimates and file them on behalf of each insurer. Refer to ISO Commercial Lines Circular CL-86-33 for specific details.

ADDITIONAL INFORMATION

ISO plans to shortly provide insurers with information which could be considered by each company in reflecting any effect of tort reform, including an analysis of the tort reform measures enacted in individual states.

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Within the next several days, ISO will release such information to insurers via Commercial Lines and Technical Services Circulars. In anticipating receipt of this material, each insurer should note ISO's strong belief that any beneficial effects of tort reform cannot be quantified with any degree of accuracy. Accordingly, providing any quantitative information does not imply that any actuarial precision can be applied to what is -- in effect -- an imprecise subject. However, the information may aid individual insurers in supplementing their judgment which, ultimately, will be the major factor in determining any beneficial pricing effect of tort reform.

CAUTION

In Circular CL-86-33 we detailed the Florida filing procedures which must be completed by October 15th. Since -- to avoid the rollback -- Florida rate filings require individual insurer estimates of the cost effects of tort reform and, since the judgment of each insurer will be the major component in arriving at these estimates, we urge individual insurers to promptly begin developing their own estimates, without waiting for the ISO material on tort reform which, as heretofore mentioned, will not produce precise results.

Daniel J. McNamara
President

cc: ISO Board of Directors
Actuarial Committee
Commercial Lines Committee
Personal Lines Committee

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Attachment 6

INSURANCE SERVICES OFFICE

160 WATER STREET NEW YORK, N. Y. 10038

TELEPHONE: (212) 487-5000

COMMERCIAL CASUALTY ACTUARIAL DIVISION
RICHARD S. BIONDI, ASSOCIATE ACTUARY & MANAGER

October 15, 1975

RECEIVED
AUTO & COMPENSATION
INSURANCE BUREAU

OCT 15 1975

INSURANCE DEPT.
STATE OF N. Y.

Mr. Stanley A. Dorf, Chief Actuary
New York Insurance Department
2 World Trade Center
New York, New York 10038

Re: Comparative/Contributory Negligence -
Automobile Liability Rate Change Proposal

Dear Mr. Dorf:

Because of the change in the New York law from contributory negligence to comparative negligence, I.S.O. proposes to increase Automobile Liability (including Uninsured Motorists) rates by 5%. This proposed increase is based on a study of closed Automobile Liability claims in California, comparing the actual settlement under the comparative negligence law with the estimate of what it would have been under the earlier contributory negligence law. Enclosed is Exhibit 1 displaying the indicated rate changes by line and coverage based on the survey, and also the proposed changes of 5% for the liability coverages and "no change" for Personal Injury Protection. Exhibit 2 details the results of the claim study survey, showing number of claims, losses under both negligence laws, and comparative/contributory ratios, by line and coverage.

We have also enclosed a copy of the "Call" letter used for this survey; in it can be found a sample copy of the questionnaire form and the general instructions for completing the form. The companies participating in the study write approximately 75% of the Automobile Liability premiums written by Insurance Services Office affiliated companies. All claims reported to us were settled very shortly after the changeover in negligence laws in California; thus, claims personnel completing these forms were in a good position to compare comparative vs. contributory settlements for their claims.

Very truly yours,

George Burger

GB:cm
Enc.

George Burger
Actuarial Assistant

New York

Automobile Liability Insurance

I.S.O. Proposed Rate Increases to Reflect the Change from Contributory to Comparative Negligence*

Coverage	Indicated Rate Change	Proposed Rate Change
Private Passenger		
Residual Bodily Injury	+ 4.1%	+ 5.0%
Personal Injury Protection	-	0.0
Property Damage	+ 4.6	+ 5.0
Uninsured Motorists	+13.0	+ 5.0
Total	+ 4.8	+ 4.4
Commercial		
Residual Bodily Injury	+ 6.8%	+ 5.0%
Personal Injury Protection	-	0.0
Property Damage	+ 6.9	+ 5.0
Uninsured Motorists	+ 0.1	+ 5.0
Total	+ 6.5	+ 4.7
Grand Total	+ 5.4%	+ 4.4%

*Note that all percent changes are weighted on New York's premium distribution.

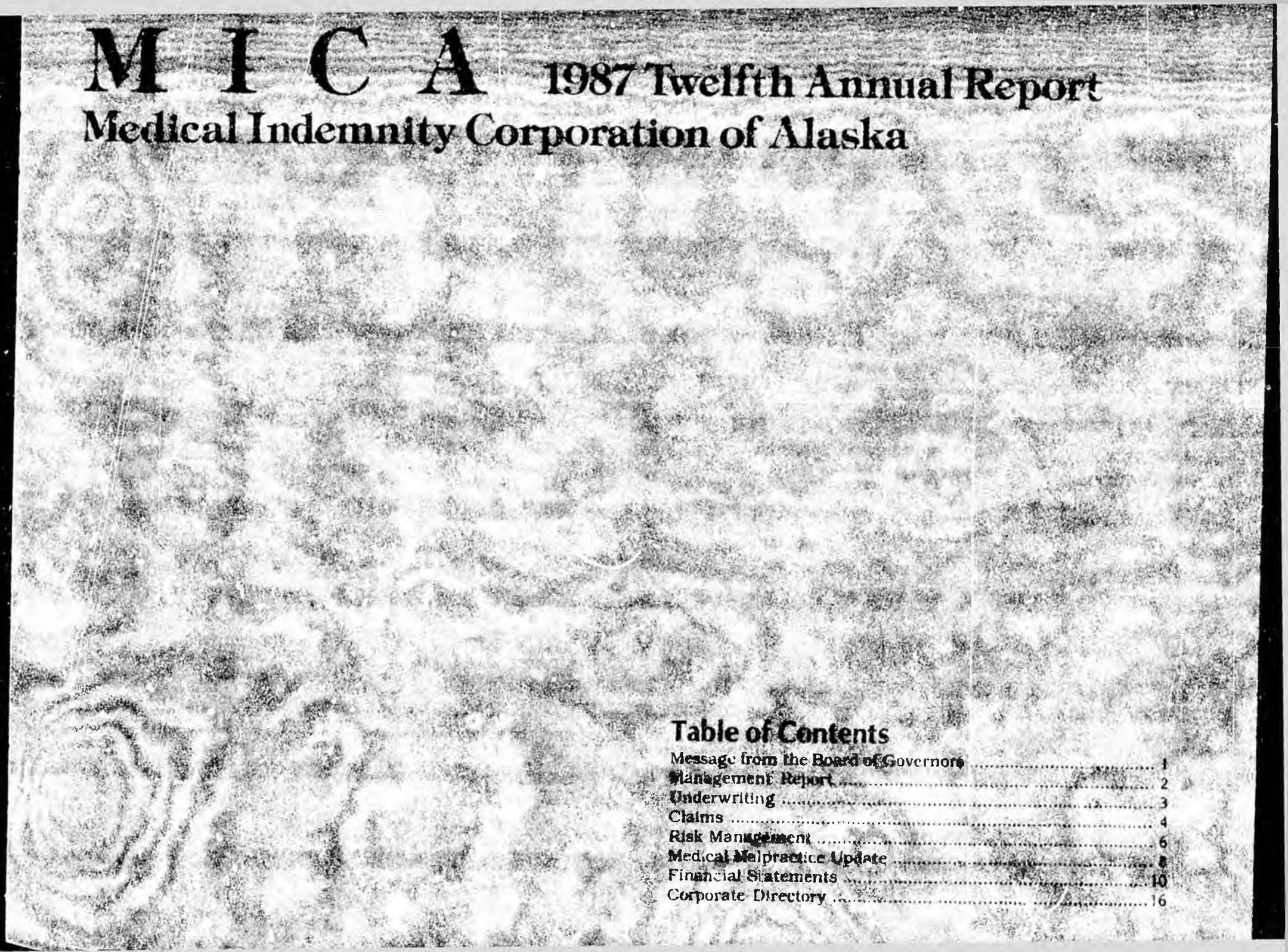
AUTOMOBILE LIABILITY INSURANCE
Effect of Change from Contributory to Comparative Negligence*

Coverage	(1) Number of claims	(2) Losses Under Contributory Negligence	(3) Losses Under Comparative Negligence	(4) Ratio ((3)÷(2))
Private Passenger Automobiles				
Bodily Injury	521	$1,098,811	$1,144,407	1.041
Property Damage	1,622	574,730	601,305	1.046
Uninsured Motorists	43	101,872	115,072	1.130
Total	2,186	$1,775,413	$1,860,784	1.048
Commercial Automobile				
Bodily Injury	318	517,285	552,522	1.068
Property Damage	1,018	361,123	386,135	1.069
Uninsured Motorists	9	48,305	48,339	1.001
Total	1,345	926,713	986,996	1.065
Grand Total	3,531	$2,702,126	$2,847,780	1.054

* NOTE: The above experience was taken from ISO's California Closed Claim Survey.

MICA 1987 Twelfth Annual Report

Medical Indemnity Corporation of Alaska



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Message from the BOARD OF GOVERNORS

1987 was a year of significant change in MICA's management structure. It was also a year of greatly improved operating results. As is often the case, the achievements of 1987 were the outgrowth of positive initiatives undertaken in earlier periods.

A major factor in the improvement of operating results was a substantial decline in both the frequency and severity of claims filed in 1987.

While it would be impossible to measure the contribution of any single cause of this result, we feel confident that stricter underwriting and aggressive risk management, including the Participatory Risk Management Program (PRMP), have played important roles. If this trend continues in 1988 and in future years, our continuing objective of stabilizing premium rates should, indeed, be achievable.

More disturbing is the 1987 court decision extending the liability of hospitals for treatment provided by physicians in the hospital emergency room. These developments will be discussed in more detail later in this report.

Particularly gratifying to MICA's Board of Governors was the successful transition in 1987 from contract management to self-administration. With the company's maturity, it has been possible to bring together a management staff with the skills and experience to operate the MICA program within its own organization.

MICA's Board appreciates the long and valuable support provided by Marsh and McLennan as contract administrator and the excellent cooperation provided by that organization in this transition which allowed the company to retain, in key positions, the former Marsh and McLennan employees most experienced in major functional areas of MICA's operation.

Heading up this management team is the company's new Executive Director Mary Pierce. Mary comes to MICA with a strong background in the insurance field and several years of service as a MICA board member, including chairmanship of its underwriting committee.

With these changes accomplished, we feel confident of your company's ability to deal with the opportunities and challenges of 1988 and beyond.

Respectfully submitted,

William G. Brock
Chairman

David J. Frazier
First Vice Chairman

Frederick R. Hood, M.D.
Second Vice Chairman

David S. Grauman, M.D.
At Large

MANAGEMENT REPORT

year of growth! In 1987 we completed our twelfth year offering professional liability protection to Alaska's medical providers — a year that challenged management but one in which we emerged with successful results.

In late 1986, the Board of Governors chose to discontinue the contract administration provided by Marsh & McLennan and move toward self administration. On April 1, 1987, MICA officially made the change, transferring experienced staff and hiring an executive director. The stage was set for MICA to develop into a full-service insurance company.

Reorganization played a key role in our growth. Greater functional definition was achieved by establishing departments — claims, underwriting, risk management/loss control, and finance — that separately service the needs of our policyholders and jointly function as a smooth-running, well-organized company.

Financially, MICA reached a new level of stability. We ended 1987 with a $3,975,476 policyholder surplus, the best in MICA's history. Several developments led to this financial growth.

Of direct impact was the decline in claims frequency and the level of severity of claims in 1987. We feel that our effective risk management program has led to our 1987 claims decrease.

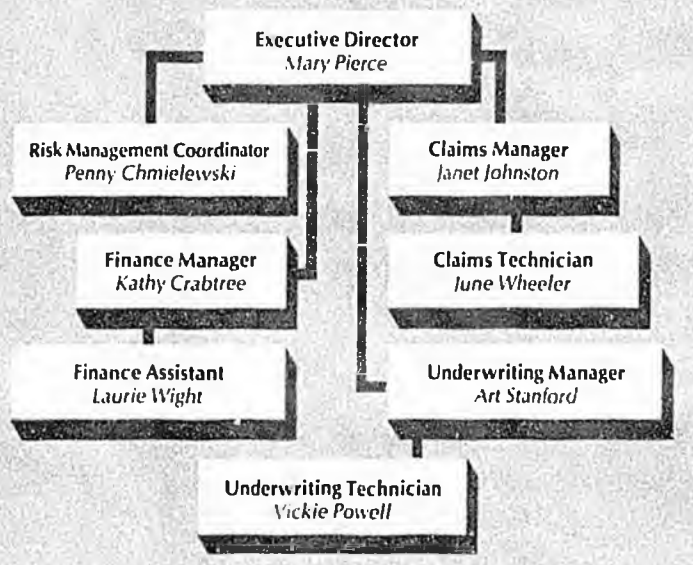
A significant contributor to favorable loss experience is successful claims management — controlling a claim after a loss has occurred. Immediate investigation may keep an incident from ever becoming a medical malpractice suit. MICA has the local talent and staff to offer immediate advice and assistance to a physician.

A further advantage for MICA is our unique position of having our own medical experts to assist in recognizing potential liability. We can therefore work toward a satisfactory resolution rather than participating in a costly discovery process. Our staff involvement means that much of the claims management work is done internally. This contributes to a cost reduction by selectively avoiding defense attorney involvement until an actual suit or other defense consideration makes it necessary.

An additional growth factor is our emphasis on prudent or equitable underwriting. We were mandated by the legislature to provide coverage to physicians at a time when insurance was unavailable. Our continuing commitment is to protect our entire policyholder population and to avoid exposing our good physicians to the financial consequences resulting from the poor loss experience of a few. Stable availability is achieved by maintaining consistent underwriting standards which were further refined in 1987.

The work done by our risk management department and committees has also led to MICA's growth and development into a mature insurance company. Criteria that had been established and were introduced in 1987 in the form of our Participatory Risk Management Program have already reaped beneficial results.

Our approach to claims, risk management criteria and underwriting philosophy provides the basis for a favorable, consistent analysis by our reinsurers. This allows MICA to continue to offer limits of liability which are both affordable and offer the medical providers necessary protection in our



MICA's management and staff is made up of individuals highly skilled and knowledgable in the fields of insurance and health care.

current litigious society.

External and internal occurrences have affected MICA's growth in 1987. We have always maintained a strong investment policy, sensitive to the liquidity issue of insurance regulations. Hence, the stock market dive in 1987 did not have an impact on MICA. Our investment holdings are long-term money market and bond issuances.

Internally, the choice to computerize MICA's claims, underwriting and risk management programs has been one that adds sophistication and credibility to MICA's information system.

We believe MICA is stronger today than at any time in its twelve-year history. We are grateful for dedicated committee members and advisors, for competent and loyal staff members and for the confidence you have shown in our past management of this company. It is within the framework of those components working together that the promise for a solid future will be continually renewed.

UNDERWRITING

As a public, non-profit corporation, MICA exists to maintain stable, available professional liability insurance coverage balanced with affordable premium levels consistent with fiscally sound business practices.

Prudent and equitable underwriting remains the most important function of the company in fulfilling our statutory responsibility to the Alaskan health care community.

Stable availability of coverage at affordable cost is not effortlessly achieved nor easily maintained, but involves substantial and continuing attention by your corporation's Board of Governors.

There are states where this balance is not being achieved, and one of the most striking examples appeared in the Wall Street Journal's January 11, 1988 edition. It reports that the St. Paul Insurance Company, once the largest medical malpractice insurer in Florida, is phasing out all physicians' and surgeons' professional liability coverages in that state as a result of being granted only a portion of the rate increases requested from the Florida Division of Insurance. This "pull out," purportedly due to inadequate rates, is coupled with current burdensome rates such as those charged in two Florida counties: $200,000 for OB/GYN and $250,000 for neurosurgeons just beginning practices!

The foundation of MICA's broad-based program for achieving its premium stabilization goals involves stringent underwriting standards guided by the premise that the corporation cannot insure any health care provider with a loss or claims history of a magnitude that might jeopardize the corporation's financial structure. Application of these standards includes rejecting new applications for cause, cancellation, nonrenewal or other restrictive or modifying coverage endorsements to new or existing policies. Further, we believe that the majority of policyholders — representing only the normal exposure to loss — should not share the burden of cost disproportionately as a consequence of inordinate loss histories of the few. This philosophy is further enhanced by equitable considerations such as claims-free premium discounts as well as adverse claims experience surcharges.

However, the corporation's efforts are of little value without our policyholders' cooperation and active participation in our loss and expense containment measures. We will continue to solidify this partnership between MICA and our policyholders. With that commitment, we believe Alaska will not face the professional liability insurance crisis — coverage unavailable and unaffordable — experienced by Florida physicians or by Alaska physicians in 1976.

UNDERWRITING COMMITTEE

Ronald Keller, M.D., Chairman
David S. Grauman, M.D.
C. Keith Campbell
David J. Frazier
Renee Murray

CLAIMS

1987 was an encouraging year from a claims standpoint. Frequency reached a four-year low, with claims and suits reported in 1987 approximating 1983 levels (chart 1). Even more encouraging, the reported injuries were far less severe, tending to be of a temporary and minor nature compared to the catastrophic disability and death injuries seen in recent years.

1987 was a year of superlatives and precedents. Several of the catastrophic damage cases of earlier years came to final resolution. Two were settled and the settlements were the largest that MICA has ever made. One was taken to trial and the resultant verdict was adverse to the defense and constituted the largest verdict ever awarded in a malpractice case in this state.

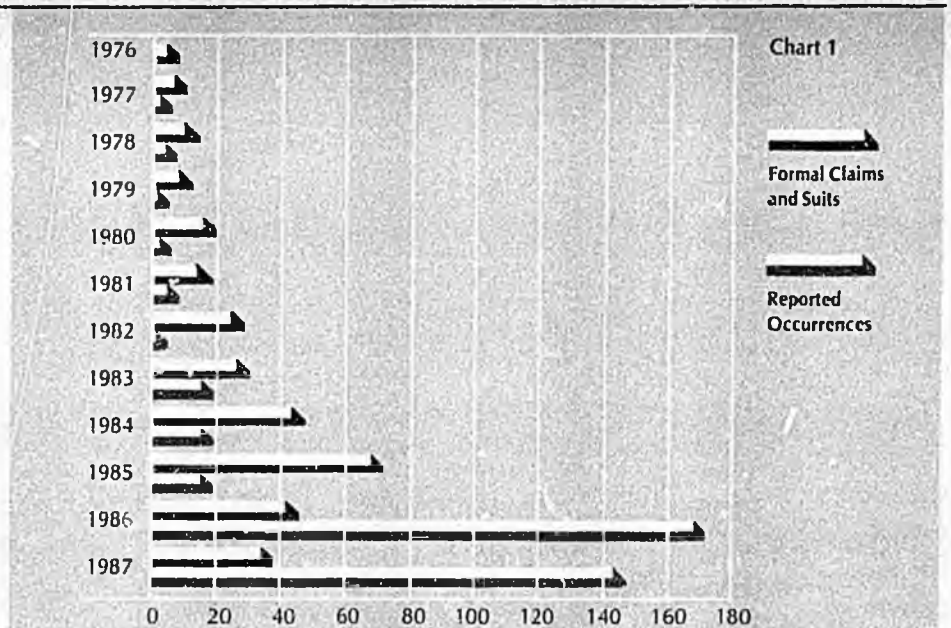
The accompanying article by corporate attorney Roger Holmes expands more fully on 1987 Supreme Court decisions which impact the investigation and defense of alleged claims of medical negligence. Each decision can reaffirm or change radically the rules of the game and have a major impact, not only on this company, but on the whole health care delivery system in Alaska.

To date three out of every four MICA files involve physicians (chart 2). This may change significantly if hospitals are increasingly held liable for doctors. As the state's major insurer of both physicians and hospitals, MICA is studying the recent court decision's implications from the various aspects of underwriting, claims management and loss prevention.

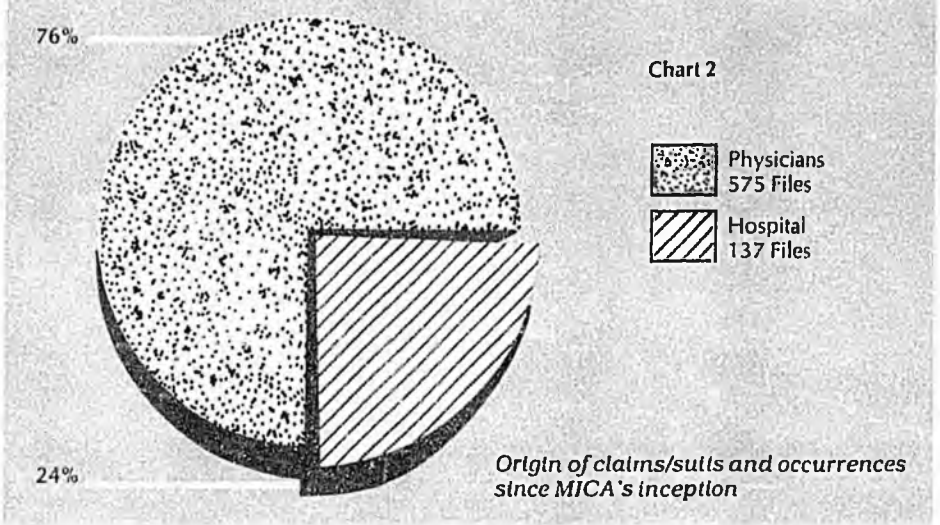
The 1987 year ended with 199 pending open files These files were from report years 1984-1987, all files for prior years having been closed. In general, the older a file is, the greater the likelihood that it is in suit.

For example, all the 1984 reported cases still pending are in suit with most of them calendared for trial during 1988. In contrast, the vast majority of files reported in 1987 involve occurrence reports on recent patient care situations with untoward outcomes. Relatively few of the 1987 files involve an actual claim or suit (chart 1). The introduction and implementation of MICA's participatory risk management program has resulted in a mushrooming of reported occurrences as required by the criteria. In contrast to actual claims and suits, these reported occurrences do not factor in underwriting considerations for premium surcharges or reductions. Most physician insureds have been diligent in their cooperation with these reporting requirements. This has necessitated an increase in staff since the investigation of reported occurrences is time and labor intensive.

A major strength for MICA — still the only professional liability carrier maintaining a local claim office — is its local expertise and local service, which allows claims to be managed in a manner unique to the insurance industry. All who are involved in processing



Report by years since MICA's inception of both formal claims/suits & reported occurrences totaling 712 files opened.



Origin of claims/suits and occurrences since MICA's inception

current litigious society.

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UNDERWRITING COMMITTEE

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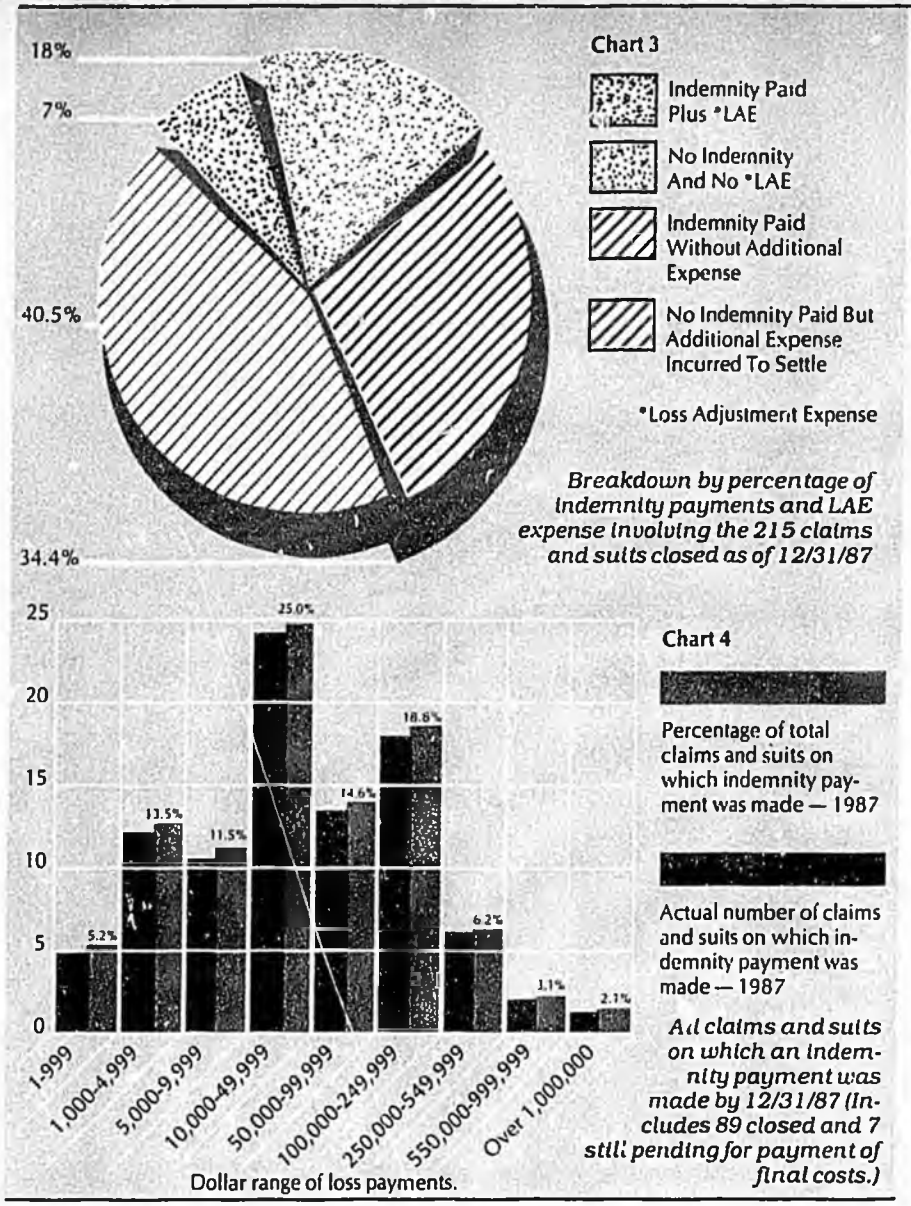


and final disposition of a claim against a MICA insured are readily available.

In looking at the overall cost of a claim, it is necessary to consider not only indemnity paid on behalf of the insured, but the cost of adjusting and defending the claim.

Loss adjustment expense (LAE) refers to money spent on defense of a claim and usually reflects defense attorney fees and other costs generated outside the company (Chart 3). Staff salary and much of our internal medical review process is accomplished without any LAE attributed to the file.

One out of every four claim files closed by year end was entirely managed by claims staff with no LAE charged to the file. Of those staff-managed cases, 72 percent closed with no indemnity payment. One of every five suits and three of every four active claims pending at year-end were being managed by MICA's claims staff. This takes on increasing importance as MICA's underwriting department begins implementing a premium surcharge and premium reduction plan related to both indemnity and LAE on claims.

When a file is opened, the local adjuster turns immediately to Alaskan physicians currently practicing in the specialty involved in the case. Claims staff and defense attorneys rely heavily on the input of these local medical experts in determining questions of liability.

Cases that our physician consultants feel to be without merit are vigorously resisted by claims staff who deal directly with patients and attorneys and attempt to educate them on the medical facts of the case. Frequently such cases are abandoned by the patient.

Some cases involve identifiable injury resulting from breaches in the standard of care as identified by our local physician reviewers. In these instances, we move in the direction of prompt and equitable settlement of the case if possible.

According to MICA policy, *no* settlement can be made without the express and written consent of the insured. Not uncommonly the "request" is a "demand" for settlement within policy limits by an insured anxious to avoid potential exposure in excess of his or her policy limits.

MICA has taken more cases to trial in the last twelve years than all other malpractice carriers writing in this state combined. Our track record has been remarkably good with only two adverse verdicts in our history.

Final authority for settlement or trial resides in the Claims Committee and the MICA Board of Governors. The local presence of decision makers, knowledgeable about the facts of each case and the idiosyncrasies of the legal jurisdiction, obviates the need for costly discovery proceedings designed to justify settlement and/or verdict values.

The improved experience of the last two years is the result of both claim prevention and claim management. The obvious challenge of the future is to work together to prevent and manage claims and to continue what appears to be a reversal of the escalating trend of recent years.

CLAIMS COMMITTEE
Renee Murray, Chairman
Frederick R. Hood, M.D.
Ron Keller, M.D.
C. Keith Campbell

RISK MANAGEMENT

1987 marked the fifth year for MICA's risk management emphasis — a year that brought to fruition much of our planning and effort for that program over the past four years. Good risk management has been recognized as a significant factor in cost and claims containment. Therefore, 1987 also saw MICA strengthening its focus in that area and continuing to expand its risk management educational outreach.

A major goal of the program during the year just past was implementation of the Participatory Risk Management Program (PRMP), which became effective with the beginning of the 1987 policy year. Along with it came a dramatic increase in the number of occurrences reported as required by the criteria — any incident with the potential to develop into a claim must be reported at the earliest opportunity. Such early reporting has enabled MICA's staff to evaluate potential problems and provide support to insured physicians by advising them about containment measures that could either remove the threat of a lawsuit or would put the physician in a better position later if a claim should occur. It is hoped that early reporting would give our claims staff and actuaries a more precise picture of the claims to be anticipated for the year.

Through PRMP, MICA-insured physicians have become aware that they are responsible for their own risk management and that participation in the program is a direct benefit to them.

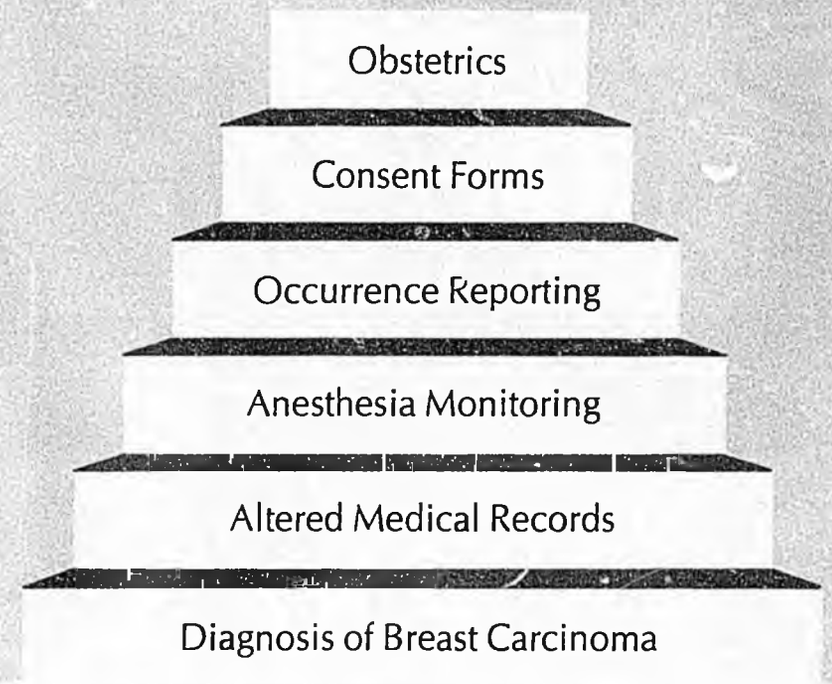
A recent survey of Physician Insurance Association of America (PIAA) companies has shown that over 50 percent of those companies either now have, or are in the process of implementing, a participatory-type of program like MICA's PRMP.

The Risk Management Committee, which continues to meet monthly, has been augmented by formation of the subcommittee on obstetrics. This committee, comprised of both obstetrical specialists and family practitioners performing obstetrics, as well as neonatalogists, has been helpful in responding to the many risk management issues involved in the practice of obstetrics in Alaska.

An important function of the risk management program has been to provide educational opportunities for our insureds and for non-insureds across the state. In early 1987, risk management completed a hospital audit program. Two consultants from Practice Management and Liability Consultant Group of California, with the assistance of MICA Risk Management Committee members and staff, visited each of our insured hospitals. In addition, a couple of physicians' office practices were also surveyed as a part of our baseline risk assessment program. Once the initial anxiety surrounding the risk management audits was dispelled, the program proved to be very successful and provided a positive educational experience by which each facility was able to implement changes incorporating good risk management principles and adding to overall quality care.

During the year, three additional hospitals have chosen to be insured by MICA and are to

Participatory risk management — six steps...



MICA AV Lending Library Tapes

Anatomy of a Malpractice Case

Billing as a Risk Management Tool

Communications: The Best Medicine

Early Reporting of Incidents

Failure to Diagnose Cancer

Informed Consent

Jousting

Management of Risk in OB

The Quality of Medical Care

The Quality of the Medical Record

Risk Management Issues — E.R. Medicine

Risk Management Issues in the E.R.

Risk Management Issues — General Surgery and Anesthesiology

Risk Management Issues — Internal Medicine

Risk Management Issues — Perinatalogy

Risk Management Seminar (four-tape set)

Time of Trial

All tapes are available in both VHS and on ¾" tape.

be surveyed at the request of the Underwriting Department. The Risk Management Committee will continue to monitor these facilities and to assist them with their risk management programs.

In May 1987, MICA presented a Risk Management Seminar for medical office assistants using the two consultants who had participated in the hospital audits. This was given both in Anchorage and in Juneau and was well attended by office personnel of both MICA and non-MICA insured physicians. Results were extremely encouraging and, immediately following the seminar, the Risk Management Department experienced a marked increase in requests by insured staffs for risk management information.

Our library of risk management audio-video tapes is another educational service that continues to grow. Tapes are available upon request by our insureds.

We look ahead to the coming year with anticipation. Plans are underway for a seminar in the spring for hospital administrators and board members which will focus on effective credentialing systems and quality review. Another seminar on communications for physicians is scheduled for early summer.

We of MICA are truly pleased with the risk management program which has evolved over the past five years and realize that this has been made possible by the joint efforts of MICA's staff, its Board of Governors, physician and committee members, and physicians over the state who have participated in the program with us. In recognition of this, the following resolution was approved by the Board of Governors of the Medical Indemnity Corporation of Alaska at its annual meeting on August 14, 1987:

> Be it resolved that the Board of Governors of MICA mandates that the present risk management program be continued in an effective form and be refined, expanded and implemented at the direction of the Risk Management Committee, and that the Executive Director of MICA be instructed to devote his utmost attention and effort to that purpose.

RISK MANAGEMENT COMMITTEE

Frederick R. Hood, M.D.
Chairman

Roger Holmes, Esq.

Kitchner Head, M.D.

William Compton, M.D.

Burton Janis, M.D.

Ron Keller, M.D.

Theodore Shohl, M.D.

David Werner, M.D.

Steve Sitter, M.D.

George Pfaltzgraff, M.D.

RISK MANAGEMENT SUBCOMMITTEE ON OB

William Compton, M.D.,
Chairman

Theodore Barton, M.D.

Clarice Dukeminier, M.D.

Sarah Isto, M.D.

Jack Jacob, M.D.

Rodney Vaught, M.D.

Cathy Baldwin-Johnson, M.D.

Lydia Eastburn, M.D.

Frederick R. Hood, M.D.
(Ex Officio Member)

1987 MEDICAL MALP

By Roger F. Holmes, Esq.

1987 proved to be a very important year in Alaska for those concerned with medical malpractice. The Alaska Supreme Court rendered two opinions relevant to this area. The United States District Court issued a significant medical malpractice opinion and the first truly significant plaintiff's verdict was obtained in the medical malpractice area.

The United States District Court in Alaska ruled that drug manufacturers must provide warnings for physicians giving adequate notice of possible complications. It ruled further that how the physician communicated the medicine's dangers to the patient was the physician's own decision, and his or her independent duty. This reaffirmed a long-standing doctrine that the physician has total responsibility to notify the patient concerning possible drug complications.

In a separate issue, the Alaska Supreme Court previously had ruled that when a claimant put in issue his or her physical condition, the physician/patient privilege, as relates to that particular condition, is waived. This is the generally accepted law everywhere in the United States. Recently plaintiffs' attorneys have successfully narrowed this ruling, claiming that, although the privilege is waived, this means only that the defendant can obtain the medical records. Plaintiffs have claimed that treating physicians have no right to discuss the plaintiff's condition with defense attorneys or defendants without the plaintiff or plaintiff's attorney(s) being an actual participant in the discussion. Plaintiffs in several states have successfully convinced their Supreme Courts to narrow the physician/patient privilege waiver to require the presence of the plaintiff or plaintiff's attorney at all conferences.

This position was carried to its illogical extreme in a recent Alaska case. A health corporation was being sued for the alleged negligence of two of its physicians. The plaintiff received treatment from yet another physician employed by the health corporation. The plaintiff's attorney took the position that the health corporation, the two doctors being sued and their lawyer were not entitled to discuss the plaintiff's condition with the physician who was presently treating the plaintiff without the plaintiff's attorney being in attendance. This meant that the health corporation, which employed the physician, could not talk to its own employee about his treatment of a patient of the health corporation. Nor could the health corporation's lawyer talk to an employee of his client about the case.

The Alaska Supreme Court, rejecting what was a growing trend in the Lower 48, ruled that treating physicians may, but are not required to, consult exparte with defense counsel. Our Supreme Court has made it clear that any treating physician may consult with whomever he or she wishes once plaintiff's medical condition has been put at issue. This ruling clarifies the issue for all treating physicians. Many physicians were being threatened with a lawsuit if they discussed a plaintiff's medical condition exparte with a workers' compensation carrier, an adjuster, an attorney, etc. This ruling makes it easier for medical malpractice defendants to gather information with which to evaluate cases which are brought against them.

In *Jackson v. Fairbanks Memorial Hospital*, the Alaska Supreme Court leaped to the forefront in expanding the rights of hospital patients by holding, as a matter of law, that the hospital is responsible for the actions of all emergency room physicians. Prior to this ruling it was generally held that a plaintiff might be able to sue the hospital for the actions of an emergency room physician if the plaintiff could show that he or she reasonably believed the emergency room physician was an authorized agent of the hospital. In *Jackson* the Supreme Court held that hospitals had a nondelegable duty to provide emergency room services. The Supreme Court held that hospitals are, as a matter of law, responsible for the actions of all emergency room physicians. There are several ramifications of this decision.

The ink was hardly dry on the *Jackson* opinion before it was put to test in the case of *Justice v. Humana*. The plaintiff's attorneys dismissed the two individual emergency room physicians on the eve of trial and went to trial only against the hospital. Jury verdict studies show that plaintiffs, in medical malpractice cases, are more likely to win a verdict against a hospital than a doctor and that a verdict against a hospital is more likely to be higher than it would be against a doctor. In this case the jury awarded $1,450,000 in damages against Humana reduced by 10 percent comparative negligence — more than ten times higher than any previous

medical malpractice verdict in Alaska. Without the *Jackson* decision, the plaintiff would have had to keep the physicians involved in the case.

Possibly even more disquieting than the result in *Justice v. Humana* is additional language in the *Jackson* opinion. One of the plaintiff's claims on appeal was that the hospital should be liable for everything that goes on inside the hospital on the basis of enterprise liability. The argument is that if an enterprise impacts society and the negligent act occurred during the activity performed for the benefit or in the interest of the enterprise, the enterprise is liable. Rather than rejecting outright this theory, the Supreme Court rejected it by choosing the following language: "In short, *Jackson's* theory of enterprise liability is not *yet* the law in Alaska." (emphasis added)

Finally, the *Jackson* decision that a hospital has a nondelegable duty to provide emergency room services and is therefore liable for any negligence arising out of those services was based upon a state regulation designed to promote "safe and adequate treatment of individuals in hospitals and in the interest of public health, safety and welfare." That regulation stated, at the time the *Jackson* case arose, that an acute care hospital *shall* "ensure that a physician is available to respond to an emergency at all times." It now reads: "A general acute care hospital *must* provide surgical, anesthesia, perinatal, medical, nursing, pharmaceutical, dietetic, laundry, medical records, radiological, laboratory, and emergency care services." 7AAC12.105 (emphasis added)

The *Jackson* court specifically stated that its ruling did not extend to situations where a patient is treated by his or her own doctor in an emergency room provided for the doctor's convenience. On the other hand, plaintiffs' attorneys will no doubt now argue that *Jackson* stands for the proposition that hospitals are liable for the actions of *all* emergency room physicians, anesthesiologists, neonatalogists, radiologists, and pathologists. In short, an attempt will be made to hold the hospital responsible for the actions of every hospital-based physician, or to extend the decision to private physicians called into the hospital by emergency room physicians to consult on difficult cases.

There has been a trend in the Lower 48 and Alaska to attempt to make all physicians practicing in a hospital carry malpractice insurance. The *Jackson* case virtually guarantees that this trend in Alaska will continue. To hold hospital privileges in the future, a doctor may have to satisfy not only the hospital credentials committee, but also the hospital insuror's underwriting department.

This trend of requiring insurance to practice in a hospital has recently been taken a step further in Alaska. The second leading writer of medical malpractice insurance in Alaska now requires all obstetricians insured by it to share a call schedule only with those carrying insurance.

For many years it was felt that a willingness by juries to return big medical malpractice verdicts depended primarily on the degree of urban sophistication. Most early severe problems arose in New York, Florida, Illinois and California. Alaska, as a smaller state, has generally been one of the better places in which to try these cases. The verdict in *Justice v. Humana* may indicate that Alaskan juries are joining their counterparts "outside" in an increased willingness to award large sums of money against health care providers. Alaska's low population means that there will never be enough cases tried here to show an actual trend, but the *Justice* case may give us an indication that we are joining the ranks of urban areas where any well-prepared plaintiff's case has at least a 50 percent chance of winning.

Significant tort reform in California and Indiana has led to a substantially postive effect on the professional liability climate in those states. A look at the *Justice v. Humana* case provides insight on this.

In *Justice* the patient was seen in Anchorage with an apparent head injury. The physicians decided not to do a CAT scan. The patient was seen 48 hours later in California with increasing symptoms. A CAT scan was done in California but was misread by the physicians. Several weeks later the California physicians discovered an aneurysm. A claim was made against the Anchorage-based physicians and Humana as well as the California-based physicians. In California, where there is a meaningful cap on damages and other significant reforms, the California physicians settled for approximately $600,000. That settlement provides for repayment of half that amount out of what is recovered in Alaska. Although the total amount of the judgment against Humana has not yet been determined by the court, it is possible that the Anchorage-based defendants will end up paying almost two million dollars in this case. A large portion of that disparity can only be attributed to California's malpractice reform package.

In light of cases like *Justice* and absent significant tort reform in Alaska, we can look forward to more of the same in 1988.

FINANCIAL STATEMENTS

Medical Indemnity Corporation of Alaska

Board of Governors
Medical Indemnity Corporation of Alaska
Anchorage, Alaska

We have examined the balance sheets of Medical Indemnity Corporation of Alaska (MICA) as of December 31, 1987 and 1986, and the related statements of income and changes in policyholders' surplus, and cash flows for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As discussed in Note B to the financial statements, various factors may cause the ultimate settlement of unpaid losses and loss adjustment expenses to vary significantly from the estimated amounts included in the financial statements.

In our opinion, subject to the effects on the financial statements of such adjustments, if any, as might have been required had the outcome of the uncertainty referred to in the preceding paragraph been known, the financial statements referred to above present fairly the financial position of Medical Indemnity Corporation of Alaska at December 31, 1987 and 1986, and the results of its operations and cash flows for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Ernst & Whinney

Anchorage, Alaska
March 1, 1988

Balance Sheets

	December 31 1987	1986
ASSETS		
Investments — Note C		
Designated for retirement of notes payable	$ 2,344,563	$ 2,675,567
Undesignated	13,858,420	10,724,498
	16,202,983	13,400,065
Cash	509,275	533,338
Premiums receivable, less allowance for doubtful accounts of $2,000	63,275	132,402
Accrued interest receivable	312,230	246,188
Note receivable	11,331	23,112
Prepaid expenses	3,693	
Reinsurance recoverable		163,254
Furniture and equipment, less accumulated depreciation of $28,001 in 1987 and $11,288 in 1986	92,624	20,428
	$17,195,411	$14,518,787
LIABILITIES AND POLICYHOLDERS' SURPLUS		
Liabilities		
Reserve for loss and loss adjustment expenses	$ 6,838,481	$ 8,913,133
Advance premiums	1,064,261	322,596
Liability to reinsurers	486,390	14,020
Accounts payable and accrued expenses	230,803	227,034
	8,619,935	9,476,783
Notes payable to State of Alaska — Note E	4,600,000	5,000,000
Policyholders' surplus	3,975,476	42,004
	8,575,476	5,042,004
	$17,195,411	$14,518,787

See notes to financial statements.

Statements of Income and Changes in Policyholders' Surplus

	Year Ended December 31 1987	1986
REVENUE		
Premiums earned		
Physicians	$ 5,001,683	$ 4,422,990
Hospitals	1,706,513	1,283,528
Related health care	228,352	219,558
	6,936,548	5,926,076
Deduct		
Reinsurance ceded — Note D	1,343,352	1,045,000
	5,593,196	4,881,076
Investment income, less investment expenses of $59,551 in 1987 and $62,619 in 1986	1,601,914	1,196,065
Total Revenue	7,195,110	6,077,141
LOSSES AND EXPENSES		
Loss and loss adjustment expenses	1,917,786	4,993,655
Other underwriting expenses	1,015,002	726,353
Interest expense on notes payable to State of Alaska	328,850	210,000
Total Losses and Expenses	3,261,638	5,930,008
Net Income	3,933,472	147,133
POLICYHOLDERS' SURPLUS (DEFICIT) AT BEGINNING OF YEAR	42,004	(105,129)
Policyholders' Surplus At End Of Year	$ 3,975,476	$ 42,004

See notes to financial statements.

Statements of Cash Flows

	Year Ended December 31 1987	1986
OPERATING ACTIVITIES		
Net Income	$ 3,933,472	$ 147,133
Adjustments to reconcile net income to net cash provided by operating activities:		
Change in premiums receivable, advance premiums, and deferred premiums	810,792	(621,999)
Increase in accrued interest receivable	(66,042)	(17,152)
Change in reserve for loss and loss adjustment expenses, and reinsurance recoverable	(1,911,398)	2,205,941
Increase (decrease) in liability to reinsurers	472,370	(47,980)
Change in note receivable, prepaid expenses and accounts payable and accrued expenses	11,857	83,544
Provision for depreciation	16,713	3,870
Amortization of bond discount and premium	(101,018)	(93,774)
Net realized gains on investments	(63,100)	(3,063)
Net Cash Provided By Operating Activities	3,103,646	1,656,520
INVESTING ACTIVITIES		
Purchases of investments	(6,221,273)	(3,225,618)
Sales or maturities of investments	2,187,366	1,400,000
Purchase of furniture and equipment	(88,909)	(12,365)
Net Cash Used By Investing Activities	(4,122,816)	(1,837,983)
FINANCING ACTIVITIES		
Change in short-term investments and money market investments	1,395,107	(1,394,152)
Repayment of note to State of Alaska	(400,000)	
Receipt of note from State of Alaska		2,000,000
Net Cash Provided By Financing Activities	995,107	605,848
Increase (Decrease) In Cash	(24,063)	424,385
Cash at beginning of year	533,338	108,953
Cash At End of Year	$ 509,275	$ 533,338

See notes to financial statements.

Notes to Financial Statements

NOTE A — ORGANIZATION AND OPERATIONS

Medical Indemnity Corporation of Alaska (MICA) is an insurance company created by the State of Alaska legislature to provide professional liability insurance to Alaskan physicians and surgeons, hospitals, and related health care organizations. MICA commenced business on June 28, 1976.

Prior to January 1, 1979, MICA issued "occurrence" basis policies which provide coverage for the policyholder for claims incurred during the policy year regardless of when the claims are reported to MICA. Since January 1, 1979, MICA has issued only "claims-made" policies which provide coverage for the policyholder for claims reported during the policy year to MICA, regardless of when the claims were incurred. MICA also offers policyholders who terminate their policy the option of purchasing a "tail" (occurrence) policy which will indemnify the policyholder against future claims that occurred while a MICA policyholder.

MICA was capitalized with a note payable to the State of Alaska (see Note E).

NOTE B — SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation: The accompanying financial statements are presented in conformity with generally accepted accounting principles. Variances in the accompanying financial statements that would occur had the statements been prepared in accordance with statutory accounting practices are not material.

Premiums: Premiums are earned ratably over the policy period to which they apply. Policies are written on a calendar year basis. MICA utilizes the services of an independent consulting actuary in the development of its premium structure.

Reserve for Loss and Loss Adjustment Expenses: The liability for loss and loss adjustment expenses represents an estimate of the ultimate net cost of reported and incurred but not reported claims at the balance sheet dates. The liability for reported claims has been determined using case basis estimates and reduced for amounts ceded to reinsurers. The liability for incurred but not reported claims has been determined by independent consulting actuaries using MICA's own historical loss data, giving effect to estimates of trends in claim frequency and severity. These estimated liabilities are continually reviewed and, as adjustments become necessary, such adjustments are reflected in current operations.

Due to the inherent difficulty in estimating the reserve for loss and loss adjustment expenses for medical malpractice business and the stability of statistical information used in setting reserves, actual development of the ultimate reserves may be significantly different than the amount recorded in these financial statements.

Depreciation: Furniture and equipment are recorded at cost and depreciated over the estimated useful lives of the assets using the straight-line method.

Income Taxes: MICA has received a ruling from the State of Alaska that as a public corporation created by the State of Alaska, it is exempt from state income taxes. MICA is considered exempt from federal income taxes under Section 115 of the Internal Revenue Code. Federal tax law changes and their interpretation could result in changes to the tax status of MICA.

Reclassification: Amounts included in the 1986 statement of changes in financial position have been reclassified to conform to the 1987 presentation.

NOTE C — CASH AND INVESTMENTS

Cash: At December 31, 1987, the carrying amount of MICA's demand deposits is $509,275 and the bank balance is $182,058. Of the bank balance, $136,540 is covered by federal depository insurance.

Investments: Investments in government and corporate notes and bonds are carried at amortized cost. Short-term demand notes and money market investments are carried at cost. The Board of Governors has designated various investments for retirement of the notes payable to the State of Alaska. Investments at December 31, 1987 and 1986 are as follows:

	1987		1986	
	Carrying Amount	Market Value	Carrying Amount	Market Value
U.S. Govt. notes & bonds				
Designated bonds	$ 749,776	$ 749,776	$ 675,567	$ 675,567
Undesignated	7,573,715	7,871,941	6,771,532	7,630,198
Canadian govt. note — undesignated	248,047	285,938	247,734	310,938
Corporate notes				
Designated	1,594,787	1,537,248		
Undesignated	4,924,422	4,905,555	3,197,889	3,377,545
Short-term demand notes and money market investments				
Designated			2,000,000	2,000,000
Undesignated	1,112,236	1,112,236	507,343	507,343
	$16,202,983	$16,462,694	$13,400,065	$14,501,591

Realized gains and losses, which are not material to the financial statements, are determined on the basis of specific identification and are

included in interest income for presentation purposes.

State of Alaska statutes define the eligible investments that MICA can own. At December 31, 1987 and 1986, MICA is in compliance with the respective statutes. MICA's investments are held by a custodial bank. The investments are uninsured and not registered in MICA's name.

NOTE D — REINSURANCE

MICA has purchased reinsurance to indemnify itself against losses in excess of certain limits. The terms of the various reinsurance agreements are as follows:

- Claims applicable to the 1987 policy period in excess of $250,000 up to $2,000,000 (policy limits) per occurrence are 100% recoverable from reinsurers subsequent to MICA's retention of approximately the first $1,000,000 of excess losses. MICA's reinsurance policy for 1987 is based on participation through January 1, 1990. The reinsurance company's participation is generally subject to a $25,000,000 aggregate recovery if the reinsurance policy remains in force for the three year period. Termination of the reinsurance policy prior to January 1, 1990 would result in an adjustment of the $25,000,000 aggregate recovery.
- Claims applicable to the 1986 policy period in excess of $250,000 up to $2,000,000 (policy limits) per occurrence are 100% recoverable from reinsurers subsequent to MICA's retention of the first $1,000,000 of excess losses. The reinsurance company's participation is subject to a $4,500,000 aggregate recovery.
- Claims applicable to the 1985 policy period in excess of $250,000 up to $2,000,000 (policy limits) per occurrence are 83.5% recoverable from reinsurers subsequent to MICA's retention of the first $831,000 of excess losses. MICA remains liable for 16.5% of the excess losses not covered by reinsurance.
- Claims applicable to 1984 and prior policy years in excess of $200,000 up to $5,000,000 (policy limits) per occurrence are 100% covered by reinsurance agreements for the first $1,750,000 of excess losses. MICA retains the liability for the next $750,000 of excess loss. Excess losses subsequent to MICA's $750,000 retention are 100% recoverable from reinsurers.

MICA remains liable to the extent reinsurance companies are unable to meet their obligations.

Amounts which have been deducted from liability, income and expense accounts in connection with all ceded reinsurance placed with other insurance companies at December 31, 1987 and 1986 are as follows:

	1987	1986
Estimated loss and loss adjustment expenses to be recovered from reinsurer	$5,830,000	$6,219,000
Reinsurance premiums	1,343,352	1,045,000
Loss and loss adjustment expense paid by reinsurer	3,050,873	197,785

NOTE E — NOTES PAYABLE TO THE STATE OF ALASKA

The Act which created MICA provided for its initial capitalization through loans up to $6,000,000 from the State of Alaska Medical Malpractice Revolving Loan Fund. At December 31, 1987, MICA had the following notes payable to the State of Alaska:

Amount	Interest Rate	Terms
$3,000,000	7%	Repayment of this loan is to be made in installments based upon underwriting earnings computed as specified in the Act. Repayment of $597,714 is due on March 1, 1988. No repayment was due at December 31, 1986. Interest is payable quarterly. This loan is subordinated to all other obligations of MICA.
$1,600,000	6%	Repayment of this loan is to be made in four annual installments of $400,000 each December. Interest is payable quarterly. This loan is subordinated only to the obligations of policyholders and claimants.

The remaining $1,400,000 provided under the provisions of the Act can be drawn on if operations demand.

NOTE F — LEASES

MICA leases office space. Rental expense was $37,290 in 1987 and $30,500 in 1986.

NOTE G — PENSION PLAN

In 1987, MICA established a defined contribution pension plan covering substantially all employees. Plan participants are required to contribute a percentage of their respective gross compensation (not to exceed 5%) to the plan. Matching contributions are made by MICA equal to 50% of the participant's contribution. Participants are fully vested in both participant and matching contributions at all times.

The Board of Governors may make additional contributions to the plan to be allocated to participants based upon participant compensation. Participant vesting in these additional contributions is based upon the participant's years of service. Pension costs are funded as they accrue. Pension expense for 1987 is $10,620.

CORPORATE DIRECTORY

Board of Governors

William G. Brock *Chairman of the Board*
David J. Frazier *First Vice Chairman*
Frederick R. Hood, M.D. *Second Vice Chairman*
David S. Grauman, M.D. *At Large*
Ronald W. Keller, M.D.
Renee Murray
Kim C. Smith, M.D.
C. Keith Campbell

Board of Governors Committees

Executive Committee

William G. Brock *Chairman*
David J. Frazier *First Vice Chairman*
Frederick R. Hood, M.D. *Second Vice Chairman*
David S. Grauman, M.D. *At Large*

Audit Committee

Kim C. Smith, M.D. *Chairman*
David S. Grauman
Renee Murray

Finance & Investment Committee

C. Keith Campbell *Chairman*
David Grauman, M.D.
William G. Brock

Legislative Committee

Kim C. Smith, M.D. *Chairman*
William G. Brock

Actuaries

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6-1316A
Ford
4/21/89

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to medical malpractice advisory panels."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 09.55.536(a) is amended to read:

(a) In an action for damages due to personal injury or death based upon the provision of professional services by a health care provider when the parties have not agreed to arbitration of the claim under AS 09.55.535, the court shall appoint within 20 days after filing of answer to a summons and complaint a five-person [THREE-PERSON] expert advisory panel unless the court decides that an expert advisory opinion is not necessary for a decision in the case. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel, giving the parties the opportunity to object or make suggestions. Three members of the panel shall be persons who are not health care providers.

* Sec. 2. AS 09.55.536(b) is repealed and reenacted to read:

(b) The expert advisory panel shall consider only evidence presented by the parties. Under the applicable rules of the Alaska Rules of Civil Procedure, a party may perform discovery, obtain the attendance of witnesses, examine or cross-examine witnesses, obtain a physical examination of the injured person if alive, and obtain the production of all relevant hospital, medical, or other records or materials relating to the health care provided to the injured person.

The parties may attend all hearings of the panel. The panel shall maintain a record of testimony or oral statements of witnesses, and shall keep copies of all written statements it receives.

* Sec. 3. AS 09.55.536(f) is amended to read:

(f) Discovery [NO DISCOVERY] may be undertaken in a case before [UNTIL] the report of the expert advisory panel is received. [HOWEVER, THE COURT MAY RELAX THIS PROHIBITION UPON A SHOWING OF GOOD CAUSE BY ANY PARTY.] If the panel has not completed its report within the 30-day period prescribed in (c) of this section, the court may, upon application, grant it an additional 30 days.

Appendix "A"

A Comparative Analysis of Various Medical Malpractice Screening Panel Statutes

STATE	Parties Control Pres. of Evidence	Cross-Exam. Permit	Pre-Trial Disc. Permit	Parties Attend Hearing	Non-Physician Members	Report Admissible as Evidence at Trial	Statute Number
ALABAMA	YES	YES	YES	YES	YES	YES	§6-5-480
ALASKA	NO	NO	NO	NO	NO	YES	§09.55.560
ARIZONA	YES	YES	YES	YES	YES	YES	§12-566
CONNECTICUT	YES	YES	NO	YES	YES	YES	§38.19a
DELAWARE	YES	YES	YES	YES	YES	YES	18§6903
FLORIDA	YES	YES	YES	YES	YES	NO	TIT45§768.57
HAWAII	YES	YES	NO	YES	YES	NO	§671
IDAHO	YES	YES	NO	YES	YES	NO	§6-1001
INDIANA	YES	YES	YES	YES	YES	YES	§16-9.5-9-1
KANSAS	NO	NO	NO	NO	YES	NO **	§65-4901
LOUISANA	YES	YES	YES	YES	YES	YES	§1299.47
MAINE	YES	YES	YES	YES	YES	NO	§2801
MARYLAND	YES	YES	YES	YES	YES	YES	§3-2A-02
MASS	YES	YES	YES	YES	YES	YES	TIT.231§60B
MICHIGAN	YES	YES	YES	YES	YES	NO	§600.5040
MONTANA	YES	YES	NO	YES	YES	NO	§27-6-101
NEBRASKA	YES	YES	YES	YES	YES	YES	§44-2840
NEVADA	NO	NO	NO	NO	YES	YES	§41A.003
NEW HAMP.	YES	YES	YES	YES	YES	YES	§519-A:1
NEW JERSEY	YES	YES	YES	YES	YES	YES	§4:21-1
NEW MEXICO	YES	YES	NO	YES	YES	NO	§41-5-14
NEW YORK	YES	YES	YES	YES	YES	YES	§148-a
OHIO	YES	YES	YES	YES	YES	YES	§2711.22
PENN.	YES	YES	YES	YES	YES	YES	40P.S.§1264
TENNESSEE	YES	YES	YES	YES	YES	YES	§29-26-101
UTAH	YES	YES	NO	YES	YES	NO	§78-14-12
VERMONT	YES	YES	YES	YES	YES	NO	§7001
VIRGINIA	YES	YES	YES	YES	YES	YES	§8.01-581.1
WISCONSIN	YES	YES	YES	YES	YES	YES	§655.02
WYOMING	YES	YES	NO	YES	YES	NO	§9-2-1501
PUERTO RICO	YES	YES	YES	YES	YES	BINDING	T.26§4110

6-1317A
Ford
4/24/89

Reg. Dorley

BY THE LABOR AND
COMMERCE COMMITTEE

IN THE HOUSE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act requiring certain persons who are in a regulated occupation or profession to obtain malpractice insurance."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.02 is amended by adding a new section to read:

Sec. 08.02.030. MALPRACTICE INSURANCE REQUIRED. (a) A person in an occupation or profession regulated under this title, shall obtain malpractice insurance from an insurer authorized to do business in this state, if judgment has been entered against the person for civil damages and the civil damages resulted from an act or omission arising out of the person's occupation or profession. Malpractice insurance required under this section must provide coverage in an amount of not less than $100,000 for negligent acts or omissions arising out of the occupation or profession of the insured, and must be maintained in effect until the judgment is satisfied or the parties to the judgment have entered into a settlement agreement.

(b) This section does not apply to a person who is no longer employed in the occupation or profession that resulted in an award of civil damages, or to an occupation or profession regulated under this title that is unrelated to the occupation or profession that resulted in an award of civil damages.

(c) In this section, "malpractice insurance" has the meaning given in AS 21.12.070(a)(10).

6-1322A
Ford
4/24/89

Donley

BY THE LABOR AND COMMERCE COMMITTEE

IN THE HOUSE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to malpractice insurance for health care providers."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 21.42 is amended by adding a new section to read:

Sec. 21.42.375. REQUIRED PROVISION FOR HEALTH CARE PROVIDER LIABILITY INSURANCE. (a) A malpractice insurance policy issued in this state to a health care provider must include coverage for any hospital at which the health care provider practices, as an insured under the policy.

(b) In this section, "health care provider" means an audiologist licensed under AS 08.11; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist, or a psychological associate licensed under AS 08.86.

6-1321E
Chenoweth
4/25/89

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act amending Rule 68 of the Alaska Rules of Civil Procedure relating to the award of costs and attorney fees and to the payment of prejudgment interest."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. Rule 68(b) of the Alaska Rules of Civil Procedure is repealed and reenacted to read:

(b) If the judgment finally rendered by the court is

(1) more favorable to the offeree than the offer, and the offeree is the party defending against the claim, the court may require the offeree to pay the offeror's actual reasonable costs incurred after the making of the offer and the greater of

(A) the actual reasonable attorney's fees incurred by the offeror after the making of the offer; or

(B) the attorney's fees payable to the offeror as determined under Rule 82(a);

(2) not more favorable to the offeree than the offer, the offeree is the party making the claim, and the offeree prevails, the offeree shall pay the actual reasonable costs and the actual reasonable attorney's fees incurred by the offeror after the making of the offer and may not be awarded costs or attorney's fees incurred after the making of the offer.

* Sec. 2. Rule 68 of the Alaska Rules of Civil Procedure is amended by adding a new subsection to read:

(d) If the judgment finally rendered by the court is not more

favorable to the offeree than the offer, the prejudgment interest accrued before judgment is entered shall be adjusted as follows:

(1) if the offeree is the party making the claim, the interest rate will be reduced by the amount specified in AS 09.30.065;

(2) if the offeree is the party defending against the claim, the interest rate will be increased by the amount specified in AS 09.30.065.

6-1319A
Ford
4/25/89

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to civil actions against insurers for unfair or deceptive acts."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 21.36 is amended by adding a new section to read:

Sec. 21.36.025. DAMAGES RESULTING FROM AN UNFAIR OR DECEPTIVE ACT. An insurer who commits an unfair or deceptive act against an insured, is liable for the actual damages resulting from the unfair or deceptive act. Damages awarded to an insured under this section are not subject to a limitation on liability contained in an insurance policy, if the policy is issued by the insurer who engages in the unfair or deceptive act.

6-0628J
Ford
4/25/89

Original sponsors: Cotten, Larson, Hoffman, et al.

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 166 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to civil actions; amending Alaska Rule of Civil Procedure 68; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS AND PURPOSE. (a) Tort law in this state has generally been developed by the courts on a case-by-case basis. While this process has resulted in some significant changes in the law, including amelioration of the harshness of many common law doctrines, the legislature has periodically intervened in order to bring about needed reforms. The purpose of this Act is to enact further reforms in order to create a more equitable distribution of the cost and risk of injury and increase the availability and affordability of insurance.

(b) The legislature also finds comparable cost increases in professional liability insurance. Escalating malpractice insurance premiums discourage physicians and other health care providers from initiating or continuing their practice or offering needed services to the public. Other professionals, such as architects and engineers, face similar difficult choices, financial instability, and unlimited risk in providing services to the public.

(c) The legislature also finds that citizens should be encouraged to serve as board members and officers of electric or telephone cooperatives. These organizations serve important governmental functions, and their vitality and effectiveness depend upon the willingness of experienced individuals to seek leadership and decision-making roles within them.

Accordingly, these board members and officers should be protected from liability arising from an act or omission within the scope of their duties, unless the act or omission constitutes gross negligence.

(d) It is the intent of the legislature to reduce costs associated with the tort system, while ensuring that adequate and appropriate compensation for persons injured through the fault of others is available.

(e) The legislature wishes to help match losses with compensation by helping to

(1) ensure that money paid to an injured person is available when anticipated expenses or losses occur;

(2) ensure that a claimant with substantial injury requiring long-term treatment will have money available for future medical care;

(3) reduce medical reparation system costs by eliminating those portions of awards that are not needed to compensate the claimant;

(4) eliminate duplicate recoveries; and

(5) reduce the costs of litigation.

(f) The legislature wishes to accumulate additional information about the costs to society of the tort, health care, and insurance systems as they are presently constituted. This information is necessary to determine whether the tort, health care, and insurance systems as they are presently constituted are fairly serving victims and whether a disproportionate amount of compensation dollars are absorbed by the system.

(g) The legislature finds that it is extremely difficult to defend against a claim that has become stale after information and witnesses have disappeared. The legislature finds that on the whole society is better served by a reasonable statute of repose even though in a few limited instances injuries may go without compensation.

* Sec. 2. AS 09.10.055(a) is repealed and reenacted to read:

(a) Notwithstanding AS 09.10.140, a person may not bring an

action for personal injury, death, property damage, contribution or indemnity arising from a deficiency in the construction or the design, planning, supervision, or observation of construction, of an improvement to real property, unless the action is brought within 10 years of the date of substantial completion of the improvement to real property.

Sec. 3. AS 09.10 is amended by adding a new section to read:

Sec. 09.10.065. LIMITATION ON ACTIONS INVOLVING A HEALTH CARE PROVIDER. (a) Notwithstanding AS 09.10.140, an action based on professional negligence may not be brought against a health care provider by a person who is, on the date of the alleged negligent act or omission

(1) 10 years of age or older, unless the action is brought within three years of the date of injury, or one year after accrual of the action, whichever period is shorter;

(2) less than 10 years of age, unless the action is brought within three years of the date of injury, or before the person's 11th birthday, whichever period is longer.

(b) The limitation imposed under (a) of this section is tolled during any period in which there exists

(1) fraud, including fraud or collusion between a parent or guardian and an insurer or health care provider, resulting in the failure to bring on action on behalf of an injured minor;

(2) intentional concealment; or

(3) the undiscovered presence of a foreign body, that has no therapeutic or diagnostic purpose or effect, in the body of the injured person and the action is based on the presence of the foreign body.

(c) In this section,

(1) "health care provider" has the meaning given in AS 18.-23.070;

(2) "professional negligence" means a negligent act or omission by a health care provider in rendering professional services;

(3) "professional services" means services provided by a health care provider that are within the scope of services for which the person is licensed, and that are not prohibited under the person's license or by a hospital in which the services are provided.

* Sec. 4. AS 09.10.070 is amended to read:

Sec. 09.10.070. ACTIONS TO BE BROUGHT IN TWO YEARS. A [NO] person may not bring an action (1) for libel, slander, assault, battery, seduction, or false imprisonment [, OR FOR ANY INJURY TO THE PERSON OR RIGHTS OF ANOTHER NOT ARISING ON CONTRACT AND NOT SPECIFICALLY PROVIDED OTHERWISE]; (2) upon a statute for a forfeiture or penalty to the state; or (3) upon a liability created by statute, other than a penalty or forfeiture; unless commenced within two years.

* Sec. 5. AS 09.10 is amended by adding a new section to read:

Sec. 09.10.075. LIMITATION ON ACTIONS INVOLVING INJURY TO PERSON OR PROPERTY. (a) Notwithstanding AS 09.10.140, a person may not bring an action for personal injury, death, or property damage unless the action is brought within two years of the accrual of the action.

(b) This section does not apply if a shorter period of time for bringing the action is imposed under another provision of law.

(c) In this section, "accrual" means the date that the person discovers or should have discovered the person's right to bring an action.

* Sec. 6. AS 09.17.020 is amended to read:

Sec. 09.17.020. PUNITIVE DAMAGES. Punitive damages may not be awarded in an action, whether in tort, contract, or otherwise, unless

supported by clear and convincing evidence of malice, bad motive, or reckless indifference to the interests of another.

* Sec. 7. AS 09.17.030 is amended to read:

Sec. 09.17.030. DAMAGES RESULTING FROM COMMISSION OF A CRIME. A person who suffers personal injury or death may not recover damages for the personal injury or death if the injuries or death occurred while the person was engaged in the commission of a crime [FELONY], the person has been convicted of the crime [FELONY], including conviction based on a guilty plea or plea of nolo contendere, and the crime [FELONY] substantially contributed to the injury or death. [THIS SECTION DOES NOT AFFECT A RIGHT OF ACTION UNDER 42 U.S.C. 1983.]

* Sec. 8. AS 09.17.030 is amended by adding new subsections to read:

(b) This section does not apply to a person who suffers personal injury or death if the person liable for the damages

(1) was engaged in the commission of a crime at the time the personal injury or death occurred; and

(2) has been convicted of the crime, including conviction based on a guilty plea or plea of nolo contendere.

(c) In this section "crime" has the meaning given in AS 11.81.-900(b).

* Sec. 9. AS 09.17.040(d) is amended to read:

(d) In an action to recover damages, the court shall, at the request of a [AN INJURED] party, enter judgment ordering that amounts awarded a judgment creditor for future damages be paid to the maximum extent feasible by periodic payments rather than by a lump-sum payment, if the amount awarded for future damages equals or exceeds $50,000. If a portion of the judgment awarded is owed to an attorney under a contingent fee agreement, that portion of the judgment shall be reduced to present value.

* Sec. 10. AS 09.17.040(e) is amended to read:

(e) The court shall [MAY] require security be posted, in order to ensure that funds are available as periodic payments become due, unless the court determines that the debt is adequately secured. The court may not require security to be posted if an authorized insurer, as defined in AS 21.90.900, acknowledges to the court its obligation to discharge the judgment.

* Sec. 11. AS 09.17.040(f) is amended to read:

(f) A judgment ordering payment of future damages by periodic payment shall specify the recipient, the dollar amount of the payments, the interval between payments, [AND] the number of payments or the period of time over which payments shall be made, and shall include an amount representing future payments for anticipated inflation. Payments may be modified only in the event of the death of the judgment creditor, in which case payments may not be reduced or terminated, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before death. In the event the judgment creditor owed no duty of support to dependents at the time of the judgment creditor's death, the money remaining shall be distributed in accordance with a will of the deceased judgment creditor accepted into probate or under the intestate laws of the state if the deceased had no will.

* Sec. 12. AS 09.17.050(a) is amended to read:

(a) Unless the act or omission constituted gross negligence, a person may not recover tort damages for personal injury, death, or damage to property for an act or omission to act in the course and scope of official duties, from [ONE OF] the following:

(1) a member of the board of directors or an officer of a nonprofit corporation;

(2) a member of the board of directors of a public or nonprofit hospital, or a member of a citizen's advisory board of any hospital;

(3) a member of a school board of a school district;

(4) a member of the governing body, a commission, or a citizen's advisory committee of a municipality of the state;

(5) a member of the board of directors or an officer of an electric or telephone cooperative organized under AS 10.25.

* Sec. 13. AS 09.17.070 is repealed and reenacted to read:

Sec. 09.17.070. COLLATERAL BENEFITS. (a) A party defending against a claim may introduce evidence of amounts received or to be received by the claimant as compensation for the same injury from the following collateral sources:

(1) 42 U.S.C. 301 - 1397 (Social Security Act);

(2) state or federal income disability or worker's compensation benefits;

(3) health, sickness, accident, or income insurance; or

(4) a contract or agreement to pay medical, hospital, dental, or other health care services.

(b) If the party defending against the claim elects to introduce evidence under (a) of this section, the claimant may introduce evidence of the amount that the claimant has paid or contributed to secure the right to an insurance benefit, contract, or agreement introduced by the party defending against the claim as evidence.

(c) A source of collateral benefits introduced under (a) of this section may not recover from the claimant an amount paid as compensation for the injury, and may not be subrogated to the rights of the claimant against the party defending against the claim.

* Sec. 14. AS 09.30.070(a) is amended to read:

(a) The rate of interest on judgments and decrees for the payment of money is that rate of interest paid by member banks of the 12th Federal Reserve District on six-month treasury bills averaged over the year prior to the entry of the judgment or decree [10.5 PERCENT A YEAR], except that a judgment or decree founded on a contract in writing, providing for the payment of interest until paid at a specified rate not exceeding the legal rate of interest for that type of contract, bears interest at the rate specified in the contract if the interest rate is set out in the judgment or decree.

* Sec. 15. AS 09.30.070 is amended by adding a new subsection to read:

(c) Prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 16. AS 09.55.580(a) is amended to read:

(a) Except as provided under (f) of this section, when the death of a person is caused by the wrongful act or omission of another, the personal representatives of the former may maintain an action therefor against the latter, if the former might have maintained an action, had the person lived, against the latter for an injury done by the same act or omission. The action shall be commenced within two years after the death, and the damages therein shall be the damages the court or jury may consider fair and just. The amount recovered, if any, shall be exclusively for the benefit of the decedent's spouse and children when the decedent is survived by a spouse or children, or other dependents. When the decedent is not survived by a [NO] spouse, [OR] children, or other dependents, the amount recovered shall be administered as other personal property of the decedent but shall be limited to pecuniary loss and may not exceed $100,000, except for damages awarded under (c)(6) of this section. When the plaintiff prevails, the trial court shall determine the allowable costs and expenses of

the action and may, in its discretion, require notice and hearing thereon. The amount recovered shall be distributed only after payment of all costs and expenses of suit and debts and expenses of administration.

* Sec. 17. AS 21.06.110 is amended to read:

Sec. 21.06.110. DIRECTOR'S ANNUAL REPORT. As early in each calendar year as is reasonably possible the director shall prepare and deliver an annual report to the legislature and the commissioner, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in Alaska, with such summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose business was closed during the year, the cause of the closing, and the amount of ascertainable assets and liabilities of each closed business;

(3) the name of each insurer against which delinquency or similar proceedings were instituted, and a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipts and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance, or the office of director;

(7) other pertinent information and matters the director considers proper;

(8) an analysis of medical malpractice insurance rate changes occurring as a result of court decisions in the state

involving personal injury or death.

* Sec. 18. AS 09.10.055(b), AS 09.17.010(c), 09.17.040(c), and AS 09.-55.548 are repealed.

* Sec. 19. REPORT. The Department of Commerce and Economic Development, with the cooperation of all state agencies, shall report to the legislature by the 30th day of the Second Session of the Seventeenth Alaska State Legislature on closed insurance claims and insurance company finances. The report must consist of

(1) a study of closed insurance claims to identify

(A) the extent to which the legal system has or has not been the cause of dramatic liability insurance increases or decreases and coverage reduction in crisis lines in the state;

(B) how victims are faring under the present system;

(C) what the various specific tort reform measures have actually accomplished; and

(D) if the passage of this Act has resulted in a measurable decrease in insurance rates in the state;

(2) a study of insurance company finances to determine the extent to which

(A) dramatic liability insurance rate increases and coverage limitations in the state are, or are not, cost-justified in relation to awards, settlements, and relevant court decisions in the state involving personal injury, death, or property damage based on fault; and

(B) legislative or regulatory actions affecting the tort system in the state are necessary to resolve the state's liability insurance rate increases.

* Sec. 20. AS 09.30.070(c), as added by sec. 15 of this Act, has the effect of amending Alaska Rule of Civil Procedure 68 by providing that

prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 21. APPLICABILITY. This Act applies to all causes of action accruing on or after the effective date of this Act.

* Sec. 22. This Act takes effect immediately under AS 01.10.070(c).

6-1321E
Chenoweth
4/25/89

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act amending Rule 68 of the Alaska Rules of Civil Procedure relating to the award of costs and attorney fees and to the payment of prejudgment interest."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. Rule 68(b) of the Alaska Rules of Civil Procedure is repealed and reenacted to read:

(b) If the judgment finally rendered by the court is

(1) more favorable to the offeree than the offer, and the offeree is the party defending against the claim, the court may require the offeree to pay the offeror's actual reasonable costs incurred after the making of the offer and the greater of

(A) the actual reasonable attorney's fees incurred by the offeror after the making of the offer; or

(B) the attorney's fees payable to the offeror as determined under Rule 82(a);

(2) not more favorable to the offeree than the offer, the offeree is the party making the claim, and the offeree prevails, the offeree shall pay the actual reasonable costs and the actual reasonable attorney's fees incurred by the offeror after the making of the offer and may not be awarded costs or attorney's fees incurred after the making of the offer.

* Sec. 2. Rule 68 of the Alaska Rules of Civil Procedure is amended by adding a new subsection to read:

(d) If the judgment finally rendered by the court is not more

favorable to the offeree than the offer, the prejudgment interest accrued before judgment is entered shall be adjusted as follows:

(1) if the offeree is the party making the claim, the interest rate will be reduced by the amount specified in AS 09.30.065;

(2) if the offeree is the party defending against the claim, the interest rate will be increased by the amount specified in AS 09.30.065.

6-0628D
Ford
5/6/89

Original sponsors: Cotten, Larson,
Hoffman, et al.

IN THE HOUSE

BY THE LABOR AND
COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 166 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to civil actions; amending Alaska Rule of Civil Procedure 68; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS AND PURPOSE. (a) Civil justice in this state has generally been developed by the courts on a case-by-case basis. This process has resulted in some significant changes in the law, and the legislature has periodically intervened to bring about needed reforms. The purpose of this Act is to enact further reforms that create a more equitable distribution of the cost and risk of injury.

(b) The legislature also finds that unnecessarily high malpractice insurance premiums discourage physicians and other health care providers from initiating or continuing their practice or offering needed services to the public. Other professionals, such as architects and engineers, face similar difficult choices, financial instability, and risk in providing services to the public.

(c) The legislature also finds that citizens should be encouraged to serve as board members of electric or telephone cooperatives. These organizations serve important governmental functions, and their vitality and effectiveness depend upon the willingness of experienced individuals to seek leadership and decision-making roles within them. Accordingly, these board members should be given some protection from liability arising from an act or omission within the scope of their duties.

(d) It is the intent of the legislature to reduce costs associated

with the civil justice system, while ensuring that adequate and appropriate compensation for persons injured through the fault of others is available.

(e) The legislature wishes to help match losses with compensation by helping to

(1) ensure that money paid to an injured person is available when anticipated expenses or losses occur;

(2) ensure that a claimant with substantial injury requiring long-term treatment will have money available for future medical care;

(3) reduce medical reparation system costs by eliminating those portions of awards that are not needed to compensate the claimant;

(4) eliminate duplicate recoveries; and

(5) reduce the costs of litigation.

(f) The legislature wishes to accumulate additional information about the costs to society of the civil justice, health care, and insurance systems as they are presently constituted. This information is necessary to determine whether the civil justice, health care, and insurance systems as they are presently constituted are fairly serving victims and whether a disproportionate amount of compensation dollars are absorbed by the system.

(g) The legislature finds that it is extremely difficult to defend against a claim that has become stale after information and witnesses have disappeared. The legislature finds that on the whole society is better served by a reasonable statute of repose even though in a few limited instances injuries may go without compensation.

* Sec. 2. AS 09.10.055(a) is repealed and reenacted to read:

(a) Notwithstanding AS 09.10.140, a person may not bring an action for personal injury, death, property damage, or indemnity arising from a deficiency in the construction or the design, planning, supervision, or observation of construction, of an improvement to real property, unless the action is brought within 10 years of the date of

substantial completion of the improvement to real property.

* Sec. 3. AS 09.10 is amended by adding a new section to read:

Sec. 09.10.065. LIMITATION ON ACTIONS INVOLVING A HEALTH CARE PROVIDER. (a) Notwithstanding AS 09.10.140, an action based on professional negligence may not be brought against a health care provider by a person who is, on the date of the alleged negligent act or omission

(1) 10 years of age or older, unless the action is brought within five years of the date of injury, or one year after accrual of the action, whichever period is shorter;

(2) less than 10 years of age, unless the action is brought within five years of the date of injury, or before the person's 12th birthday, whichever period is longer.

(b) The limitation imposed under (a) of this section is tolled during any period in which there exists

(1) fraud, including fraud or collusion by a parent, guardian, insurer, or health care provider, resulting in the failure to bring on action on behalf of an injured minor;

(2) intentional concealment; or

(3) the undiscovered presence of a foreign body, that has no therapeutic or diagnostic purpose or effect, in the body of the injured person and the action is based on the presence of the foreign body.

(c) In this section,

(1) "accrual" has the meaning given in AS 09.10.070(d);

(2) "health care provider" has the meaning given in AS 18.-23.070;

(3) "professional negligence" means a negligent act or omission by a health care provider in rendering professional services;

(4) "professional services" means services provided by a health care provider that are within the scope of services for which the person is licensed, and that are not prohibited under the person's license or by a hospital in which the services are provided.

* Sec. 4. AS 09.10.070 is amended to read:

Sec. 09.10.070. ACTIONS TO BE BROUGHT IN TWO YEARS. A [NO] person may not bring an action (1) for libel, slander, assault, battery, seduction, or false imprisonment, or for any injury to the person or rights of another not arising on contract and not specifically provided otherwise; (2) upon a statute for a forfeiture or penalty to the state; or (3) upon a liability created by statute, other than a penalty or forfeiture; unless commenced within two years of the accrual of the action.

* Sec. 5. AS 09.10.070 is amended by adding new subsections to read:

(b) Notwithstanding AS 09.10.140, the period of time within which a person may bring an action under (a)(1) of this section may not be extended for a disability described under AS 09.10.140, for more than 20 years after the date of the injury. This subsection does not apply if the injury is caused by an intentional act.

(c) The limitation of (a) of this section does not apply to an action described in (a)(1) of this section if the period of limitation imposed under AS 09.10.065 applies, or if a shorter period of time for bringing the action is imposed under another provision of law.

(d) In this section, "accrual" means the date that the person discovers or should have discovered the person's right to bring an action.

* Sec. 6. AS 09.17.030 is amended to read:

Sec. 09.17.030. DAMAGES RESULTING FROM COMMISSION OF A CRIME. A person who suffers personal injury or death may not recover damages

for the personal injury or death if the injuries or death occurred while the person was engaged in the commission of a crime [FELONY], the person has been convicted of the crime [FELONY], including conviction based on a guilty plea or plea of nolo contendere, and the crime [FELONY] substantially contributed to the injury or death. [THIS SECTION DOES NOT AFFECT A RIGHT OF ACTION UNDER 42 U.S.C. 1983.]

* Sec. 7. AS 09.17.030 is amended by adding new subsections to read:

(b) This section does not apply to a person who suffers personal injury or death if the person liable for the damages

(1) was engaged in the commission of a crime at the time the personal injury or death occurred; and

(2) has been convicted of the crime, including conviction based on a guilty plea or plea of nolo contendere.

(c) In this section "crime" has the meaning given in AS 11.81.-900(b).

* Sec. 8. AS 09.17.040(f) is amended to read:

(f) A judgment ordering payment of future damages by periodic payment shall specify the recipient, the dollar amount of the payments, the interval between payments, [AND] the number of payments or the period of time over which payments shall be made, and shall include an amount representing future payments for anticipated inflation. Payments may be modified only in the event of the death of the judgment creditor, in which case payments may not be reduced or terminated, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before death. In the event the judgment creditor owed no duty of support to dependents at the time of the judgment creditor's death, the money remaining shall be distributed in accordance with a will of the deceased judgment creditor accepted into probate or under the intestate laws of the

state if the deceased had no will.

* Sec. 9. AS 09.17.050(a) is amended to read:

(a) Unless the act or omission constituted gross negligence, a person may not recover tort damages for personal injury, death, or damage to property for an act or omission to act in the course and scope of official duties, from [ONE OF] the following:

(1) a member of the board of directors or an officer of a nonprofit corporation;

(2) a member of the board of directors of a public or nonprofit hospital, or a member of a citizen's advisory board of any hospital;

(3) a member of a school board of a school district;

(4) a member of the governing body, a commission, or a citizen's advisory committee of a municipality of the state;

(5) a member of the board of directors of an electric or telephone cooperative organized under AS 10.25.

* Sec. 10. AS 09.17.070 is repealed and reenacted to read:

Sec. 09.17.070. COLLATERAL BENEFITS. (a) A party defending against a claim may introduce evidence of amounts received or to be received by the claimant as compensation for the same injury from the following collateral sources:

(1) 42 U.S.C. 301 - 1397 (Social Security Act);

(2) state or federal income disability or worker's compensation benefits;

(3) health, sickness, accident, or income insurance; or

(4) a contract or agreement to pay medical, hospital, dental, or other health care services.

(b) If the party defending against the claim elects to introduce evidence under (a) of this section, the claimant may introduce

evidence of the amount that the claimant has paid or contributed to secure the right to an insurance benefit, contract, or agreement introduced as evidence by the party defending against the claim.

(c) A source of collateral benefits introduced under (a) of this section may not recover from the claimant an amount paid as compensation for the injury, and may not be subrogated to the rights of the claimant against the party defending against the claim.

* Sec. 11. AS 09.30.070 is amended by adding a new subsection to read:

(c) Prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 12. AS 21.06.110 is amended to read:

Sec. 21.06.110. DIRECTOR'S ANNUAL REPORT. As early in each calendar year as is reasonably possible the director shall prepare and deliver an annual report to the legislature and the commissioner, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in Alaska, with such summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose business was closed during the year, the cause of the closing, and the amount of ascertainable assets and liabilities of each closed business;

(3) the name of each insurer against which delinquency or similar proceedings were instituted, and a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipts and expenses of the division for the year;

(6) recommendations of the director as to amendments or

supplementation of laws affecting insurance, or the office of director;

(7) other pertinent information and matters the director considers proper;

(8) an analysis of medical malpractice insurance rate changes occurring as a result of court decisions in the state involving personal injury or death;

(9) an analysis of liability insurance claims that were closed following a civil action, that

(A) establishes a statistical data base for comparing the annual percentage change in the number and amount of claims;

(B) determines the number and dollar amount of claims closed, by year incurred; and

(C) compares the percentage change in direct premiums written;

(10) an analysis of changes in the incomes of physicians licensed under AS 08.64 occurring as a result of court decisions in the state involving personal injury or death.

* Sec. 13. AS 09.10.055(b), 09.17.040(c), and AS 09.55.548 are repealed.

* Sec. 14. REPORT. The Department of Commerce and Economic Development, with the cooperation of all state agencies, shall report to the legislature by the 30th day of the Second Session of the Seventeenth Alaska State Legislature on closed insurance claims and insurance company finances. The report must consist of

(1) a study of closed insurance claims to identify

(A) the extent to which the legal system has or has not been the cause of dramatic liability insurance increases or decreases and coverage reduction in crisis lines in the state;

(B) how victims are faring under the present system;

(C) what the various specific tort reform measures have actually accomplished; and

(D) if the passage of this Act has resulted in a measurable decrease in insurance rates in the state;

(2) a study of insurance company finances to determine the extent to which

(A) dramatic liability insurance rate increases and coverage limitations in the state are, or are not, cost-justified in relation to awards, settlements, and relevant court decisions in the state involving personal injury, death, or property damage based on fault; and

(B) legislative or regulatory actions affecting the tort system in the state are necessary to resolve the state's liability insurance rate increases.

* Sec. 15. AS 09.30.070(c), as added by sec. 11 of this Act, has the effect of amending Alaska Rule of Civil Procedure 68 by providing that prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 16. APPLICABILITY. (a) This Act applies to all causes of action for damages resulting from an act or omission occurring on or after the effective date of this Act.

(b) AS 09.17.070(c), as added by sec. 10 of this Act, applies to a contract or agreement entered into on or after the effective date of this Act.

* Sec. 17. This Act takes effect immediately under AS 01.10.070(c).

6-0628D
Ford
5/2/89

Original sponsors: Cotten, Larson, Hoffman, et al.

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

C[illegible]R HOUSE BILL NO. 166 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to civil actions; amending Alaska Rule of Civil Procedure 68; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS AND PURPOSE. (a) Civil justice in this state has generally been developed by the courts on a case-by-case basis. This process has resulted in some significant changes in the law, and the legislature has periodically intervened to bring about needed reforms. The purpose of this Act is to enact further reforms that create a more equitable distribution of the cost and risk of injury.

(b) The legislature also finds that unnecessarily high malpractice insurance premiums discourage physicians and other health care providers from initiating or continuing their practice or offering needed services to the public. Other professionals, such as architects and engineers, face similar difficult choices, financial instability, and risk in providing services to the public.

(c) The legislature also finds that citizens should be encouraged to serve as board members and officers of electric or telephone cooperatives. These organizations serve important governmental functions, and their vitality and effectiveness depend upon the willingness of experienced individuals to seek leadership and decision-making roles within them. Accordingly, these board members and officers should be given some protection from liability arising from an act or omission within the scope of their duties.

(d) It is the intent of the legislature to reduce costs associated with the civil justice system, while ensuring that adequate and appropriate compensation for persons injured through the fault of others is available.

(e) The legislature wishes to help match losses with compensation by helping to

(1) ensure that money paid to an injured person is available when anticipated expenses or losses occur;

(2) ensure that a claimant with substantial injury requiring long-term treatment will have money available for future medical care;

(3) reduce medical reparation system costs by eliminating those portions of awards that are not needed to compensate the claimant;

(4) eliminate duplicate recoveries; and

(5) reduce the costs of litigation.

(f) The legislature wishes to accumulate additional information about the costs to society of the civil justice, health care, and insurance systems as they are presently constituted. This information is necessary to determine whether the civil justice, health care, and insurance systems as they are presently constituted are fairly serving victims and whether a disproportionate amount of compensation dollars are absorbed by the system.

(g) The legislature finds that it is extremely difficult to defend against a claim that has become stale after information and witnesses have disappeared. The legislature finds that on the whole society is better served by a reasonable statute of repose even though in a few limited instances injuries may go without compensation.

* Sec. 2. AS 09.10.055(a) is repealed and reenacted to read:

(a) Notwithstanding AS 09.10.140, a person may not bring an action for personal injury, death, property damage, or indemnity arising from a deficiency in the construction or the design, planning, supervision, or observation of construction, of an improvement to real

property, unless the action is brought within 10 years of the date of substantial completion of the improvement to real property.

* Sec. 3. AS 09.10 is amended by adding a new section to read:

Sec. 09.10.065. LIMITATION ON ACTIONS INVOLVING A HEALTH CARE PROVIDER. (a) Notwithstanding AS 09.10.140, an action based on professional negligence may not be brought against a health care provider by a person who is, on the date of the alleged negligent act or omission

(1) 10 years of age or older, unless the action is brought within three years of the date of injury, or one year after accrual of the action, whichever period is shorter;

(2) less than 10 years of age, unless the action is brought within three years of the date of injury, or before the person's 11th birthday, whichever period is longer.

(b) The limitation imposed under (a) of this section is tolled during any period in which there exists

(1) fraud, including fraud or collusion by a parent, guardian, insurer, or health care provider, resulting in the failure to bring on action on behalf of an injured minor;

(2) intentional concealment; or

(3) the undiscovered presence of a foreign body, that has no therapeutic or diagnostic purpose or effect, in the body of the injured person and the action is based on the presence of the foreign body.

(c) In this section,

(1) "accrual" has the meaning given in AS 09.10.070(d);

(2) "health care provider" has the meaning given in AS 18.-23.070;

(3) "professional negligence" means a negligent act or

omission by a health care provider in rendering professional services;

(4) "professional services" means services provided by a health care provider that are within the scope of services for which the person is licensed, and that are not prohibited under the person's license or by a hospital in which the services are provided.

* Sec. 4. AS 09.10.070 is amended to read:

Sec. 09.10.070. ACTIONS TO BE BROUGHT IN TWO YEARS. A [NO] person may not bring an action (1) for libel, slander, assault, battery, seduction, or false imprisonment, or for any injury to the person or rights of another not arising on contract and not specifically provided otherwise; (2) upon a statute for a forfeiture or penalty to the state; or (3) upon a liability created by statute, other than a penalty or forfeiture; unless commenced within two years of the accrual of the action.

* Sec. 5 AS 09.10.070 is amended by adding new subsections to read:

(b) Notwithstanding AS 09.10.140, the period of time within which a person may bring an action under (a)(1) of this section may not be extended for a disability described under AS 09.10.140, for more than 20 years after the date of the injury. This subsection does not apply if the injury is caused intentionally.

(c) The limitation of (a) of this section does not apply to an action described in (a)(1) of this section if the period of limitation imposed under AS 09.10.065 applies, or if a shorter period of time for bringing the action is imposed under another provision of law.

(d) In this section, "accrual" means the date that the person discovers or should have discovered the person's right to bring an action.

* Sec. 6. AS 09.17.030 is amended to read:

Sec. 09.17.030. DAMAGES RESULTING FROM COMMISSION OF A CRIME. A person who suffers personal injury or death may not recover damages for the personal injury or death if the injuries or death occurred while the person was engaged in the commission of a crime [FELONY], the person has been convicted of the crime [FELONY], including conviction based on a guilty plea or plea of nolo contendere, and the crime [FELONY] substantially contributed to the injury or death. [THIS SECTION DOES NOT AFFECT A RIGHT OF ACTION UNDER 42 U.S.C. 1983.]

* Sec. 7. AS 09.17.030 is amended by adding new subsections to read:

(b) This section does not apply to a person who suffers personal injury or death if the person liable for the damages

(1) was engaged in the commission of a crime at the time the personal injury or death occurred; and

(2) has been convicted of the crime, including conviction based on a guilty plea or plea of nolo contendere.

(c) In this section "crime" has the meaning given in AS 11.81.-900(b).

* Sec. 8. AS 09.17.040(f) is amended to read:

(f) A judgment ordering payment of future damages by periodic payment shall specify the recipient, the dollar amount of the payments, the interval between payments, [AND] the number of payments or the period of time over which payments shall be made, and shall include an amount representing future payments for anticipated inflation. Payments may be modified only in the event of the death of the judgment creditor, in which case payments may not be reduced or terminated, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before death. In the event the judgment creditor owed no duty of support to dependents at the time of the judgment creditor's death, the money remaining

shall be distributed in accordance with a will of the deceased judgment creditor accepted into probate or under the intestate laws of the state if the deceased had no will.

* Sec. 9. AS 09.17.050(a) is amended to read:

(a) Unless the act or omission constituted gross negligence, a person may not recover tort damages for personal injury, death, or damage to property for an act or omission to act in the course and scope of official duties, from [ONE OF] the following:

(1) a member of the board of directors or an officer of a nonprofit corporation;

(2) a member of the board of directors of a public or nonprofit hospital, or a member of a citizen's advisory board of any hospital;

(3) a member of a school board of a school district;

(4) a member of the governing body, a commission, or a citizen's advisory committee of a municipality of the state;

(5) a member of the board of directors or an officer of an electric or telephone cooperative organized under AS 10.25.

* Sec. 10. AS 09.17.070 is repealed and reenacted to read:

Sec. 09.17.070. COLLATERAL BENEFITS. (a) A party defending against a claim may introduce evidence of amounts received or to be received by the claimant as compensation for the same injury from the following collateral sources:

(1) 42 U.S.C. 301 - 1397 (Social Security Act);

(2) state or federal income disability or worker's compensation benefits;

(3) health, sickness, accident, or income insurance; or

(4) a contract or agreement to pay medical, hospital, dental, or other health care services.

(b) If the party defending against the claim elects to introduce evidence under (a) of this section, the claimant may introduce evidence of the amount that the claimant has paid or contributed to secure the right to an insurance benefit, contract, or agreement introduced as evidence by the party defending against the claim.

(c) A source of collateral benefits introduced under (a) of this section may not recover from the claimant an amount paid as compensation for the injury, and may not be subrogated to the rights of the claimant against the party defending against the claim.

* Sec. 11. AS 09.30.070 is amended by adding a new subsection to read:

(c) Prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 12. AS 21.06.110 is amended to read:

Sec. 21.06.110. DIRECTOR'S ANNUAL REPORT. As early in each calendar year as is reasonably possible the director shall prepare and deliver an annual report to the legislature and the commissioner, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in Alaska, with such summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose business was closed during the year, the cause of the closing, and the amount of ascertainable assets and liabilities of each closed business;

(3) the name of each insurer against which delinquency or similar proceedings were instituted, and a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipts and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance, or the office of director;

(7) other pertinent information and matters the director considers proper;

(8) an analysis of medical malpractice insurance rate changes occurring as a result of court decisions in the state involving personal injury or death;

(9) an analysis of liability insurance claims that were closed following a civil action, that

(A) establishes a statistical data base for comparing the annual percentage change in the number and amount of claims;

(B) determines the number and dollar amount of claims closed, by year incurred; and

(C) compares the percentage change in direct premiums written;

(10) an analysis of changes in the incomes of physicians licensed under AS 08.64 occurring as a result of court decisions in the state involving personal injury or death.

* Sec. 13. AS 09.10.055(b), , 09.17.040(c), and AS 09.-55.548 are repealed.

* Sec. 14. REPORT. The Department of Commerce and Economic Development, with the cooperation of all state agencies, shall report to the legislature by the 30th day of the Second Session of the Seventeenth Alaska State Legislature on closed insurance claims and insurance company finances. The report must consist of

(1) a study of closed insurance claims to identify

(A) the extent to which the legal system has or has not

been the cause of dramatic liability insurance increases or decreases and coverage reduction in crisis lines in the state;

(B) how victims are faring under the present system;

(C) what the various specific tort reform measures have actually accomplished; and

(D) if the passage of this Act has resulted in a measurable decrease in insurance rates in the state;

(2) a study of insurance company finances to determine the extent to which

(A) dramatic liability insurance rate increases and coverage limitations in the state are, or are not, cost-justified in relation to awards, settlements, and relevant court decisions in the state involving personal injury, death, or property damage based on fault; and

(B) legislative or regulatory actions affecting the tort system in the state are necessary to resolve the state's liability insurance rate increases.

* Sec. 15. AS 09.30.070(c), as added by sec. 11 of this Act, has the effect of amending Alaska Rule of Civil Procedure 68 by providing that prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 16. APPLICABILITY. (a) This Act applies to all causes of action for damages resulting from an act or omission occurring on or after the effective date of this Act.

(b) AS 09.17.070(c), as added by sec. 10 of this Act, applies to a contract or agreement entered into on or after the effective date of this Act.

* Sec. 17. This Act takes effect immediately under AS 01.10.070(c).

5-7-89

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 166 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to civil actions; amending Alaska Rule of Civil Procedure 68; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS AND PURPOSE. (a) Civil justice in this state has generally been developed by the courts on a case-by-case basis. This process has resulted in some significant changes in the law, and the legislature has periodically intervened to bring about needed reforms. The purpose of this Act is to enact further reforms that create a more equitable distribution of the cost and risk of injury.

(b) The legislature also finds that unnecessarily high malpractice insurance premiums discourage physicians and other health care providers from initiating or continuing their practice or offering needed services to the public. Other professionals, such as architects and engineers, face similar difficult choices, financial instability, and risk in providing services to the public.

(c) The legislature also finds that citizens should be encouraged to serve as board members of electric or telephone cooperatives. These organizations serve important governmental functions, and their vitality and effectiveness depend upon the willingness of experienced individuals to seek leadership and decision-making roles within them. Accordingly, these board members should be given some protection from liability arising from an act or omission within the scope of their duties.

(d) It is the intent of the legislature to reduce costs associated

with the civil justice system, while ensuring that adequate and appropriate compensation for persons injured through the fault of others is available.

(e) The legislature wishes to help match losses with compensation by helping to

(1) ensure that money paid to an injured person is available when anticipated expenses or losses occur;

(2) ensure that a claimant with substantial injury requiring long-term treatment will have money available for future medical care;

(3) reduce medical reparation system costs by eliminating those portions of awards that are not needed to compensate the claimant;

(4) eliminate duplicate recoveries; and

(5) reduce the costs of litigation.

(f) The legislature wishes to accumulate additional information about the costs to society of the civil justice, health care, and insurance systems as they are presently constituted. This information is necessary to determine whether the civil justice, health care, and insurance systems as they are presently constituted are fairly serving victims and whether a disproportionate amount of compensation dollars are absorbed by the system.

(g) The legislature finds that it is extremely difficult to defend against a claim that has become stale after information and witnesses have disappeared. The legislature finds that on the whole society is better served by a reasonable statute of repose even though in a few limited instances injuries may go without compensation.

* Sec. 2. AS 09.10.055(a) is repealed and reenacted to read:

(a) Notwithstanding AS 09.10.140, a person may not bring an action for personal injury, death, property damage, or indemnity arising from a deficiency in the construction or the design, planning, supervision, or observation of construction, of an improvement to real property, unless the action is brought within 10 years of the date of

substantial completion of the improvement to real property.

* Sec. 3. AS 09.10 is amended by adding a new section to read:

Sec. 09.10.065. LIMITATION ON ACTIONS INVOLVING A HEALTH CARE PROVIDER. (a) Notwithstanding AS 09.10.140, an action based on professional negligence may not be brought against a health care provider by a person who is, on the date of the alleged negligent act or omission

(1) 10 years of age or older, unless the action is brought within five years of the date of injury, or one year after accrual of the action, whichever period is shorter;

(2) less than 10 years of age, unless the action is brought within five years of the date of injury, or before the person's 12th birthday, whichever period is longer.

(b) The limitation imposed under (a) of this section is tolled during any period in which there exists

(1) fraud, including fraud or collusion by a parent, guardian, insurer, or health care provider, resulting in the failure to bring on action on behalf of an injured minor;

(2) intentional concealment; or

(3) the undiscovered presence of a foreign body, that has no therapeutic or diagnostic purpose or effect, in the body of the injured person and the action is based on the presence of the foreign body.

(c) In this section,

(1) "accrual" has the meaning given in AS 09.10.070(d);

(2) "health care provider" has the meaning given in AS 18.-23.070;

(3) "professional negligence" means a negligent act or omission by a health care provider in rendering professional services;

(4) "professional services" means services provided by a health care provider that are within the scope of services for which the person is licensed, and that are not prohibited under the person's license or by a hospital in which the services are provided.

* Sec. 4. AS 09.10.070 is amended to read:

Sec. 09.10.070. ACTIONS TO BE BROUGHT IN TWO YEARS. A [NO] person may not bring an action (1) for libel, slander, assault, battery, seduction, or false imprisonment, or for any injury to the person or rights of another not arising on contract and not specifically provided otherwise; (2) upon a statute for a forfeiture or penalty to the state; or (3) upon a liability created by statute, other than a penalty or forfeiture; unless commenced within two years of the accrual of the action.

* Sec. 5. AS 09.10.070 is amended by adding new subsections to read:

(b) Notwithstanding AS 09.10.140, the period of time within which a person may bring an action under (a)(1) of this section may not be extended for a disability described under AS 09.10.140, for more than 20 years after the date of the injury. This subsection does not apply if the injury is caused by an intentional act.

(c) The limitation of (a) of this section does not apply to an action described in (a)(1) of this section if the period of limitation imposed under AS 09.10.065 applies, or if a shorter period of time for bringing the action is imposed under another provision of law.

(d) In this section, "accrual" means the date that the person discovers or should have discovered the person's right to bring an action.

* Sec. 6. AS 09.17.030 is amended to read:

Sec. 09.17.030. DAMAGES RESULTING FROM COMMISSION OF A CRIME. A person who suffers personal injury or death may not recover damages

for the personal injury or death if the injuries or death occurred while the person was engaged in the commission of a crime [FELONY], the person has been convicted of the crime [FELONY], including conviction based on a guilty plea or plea of nolo contendere, and the crime [FELONY] substantially contributed to the injury or death. [THIS SECTION DOES NOT AFFECT A RIGHT OF ACTION UNDER 42 U.S.C. 1983.]

* Sec. 7. AS 09.17.030 is amended by adding new subsections to read:

(b) This section does not apply to a person who suffers personal injury or death if the person liable for the damages

(1) was engaged in the commission of a crime at the time the personal injury or death occurred; and

(2) has been convicted of the crime, including conviction based on a guilty plea or plea of nolo contendere.

(c) In this section "crime" has the meaning given in AS 11.81.-900(b).

* Sec. 8. AS 09.17.040(f) is amended to read:

(f) A judgment ordering payment of future damages by periodic payment shall specify the recipient, the dollar amount of the payments, the interval between payments, [AND] the number of payments or the period of time over which payments shall be made, and shall include an amount representing future payments for anticipated inflation. Payments may be modified only in the event of the death of the judgment creditor, in which case payments may not be reduced or terminated, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before death. In the event the judgment creditor owed no duty of support to dependents at the time of the judgment creditor's death, the money remaining shall be distributed in accordance with a will of the deceased judgment creditor accepted into probate or under the intestate laws of the

state if the deceased had no will.

* Sec. 9. AS 09.17.050(a) is amended to read:

(a) Unless the act or omission constituted gross negligence, a person may not recover tort damages for personal injury, death, or damage to property for an act or omission to act in the course and scope of official duties, from [ONE OF] the following:

(1) a member of the board of directors or an officer of a nonprofit corporation;

(2) a member of the board of directors of a public or nonprofit hospital, or a member of a citizen's advisory board of any hospital;

(3) a member of a school board of a school district;

(4) a member of the governing body, a commission, or a citizen's advisory committee of a municipality of the state;

(5) a member of the board of directors of an electric or telephone cooperative organized under AS 10.25.

* Sec. 10. AS 09.17.070 is repealed and reenacted to read:

Sec. 09.17.070. COLLATERAL BENEFITS. (a) A party defending against a claim may introduce evidence of amounts received or to be received by the claimant as compensation for the same injury from the following collateral sources:

(1) 42 U.S.C. 301 - 1397 (Social Security Act);

(2) state or federal income disability or worker's compensation benefits;

(3) health, sickness, accident, or income insurance; or

(4) a contract or agreement to pay medical, hospital, dental, or other health care services.

(b) If the party defending against the claim elects to introduce evidence under (a) of this section, the claimant may introduce

evidence of the amount that the claimant has paid or contributed to secure the right to an insurance benefit, contract, or agreement introduced as evidence by the party defending against the claim.

(c) A source of collateral benefits introduced under (a) of this section may not recover from the claimant an amount paid as compensation for the injury, and may not be subrogated to the rights of the claimant against the party defending against the claim.

* Sec 11. AS 09.30.070 is amended by adding a new subsection to read:

(c) Prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 12. AS 21.06.110 is amended to read:

Sec. 21.06.110. DIRECTOR'S ANNUAL REPORT. As early in each calendar year as is reasonably possible the director shall prepare and deliver an annual report to the legislature and the commissioner, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in Alaska, with such summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose business was closed during the year, the cause of the closing, and the amount of ascertainable assets and liabilities of each closed business;

(3) the name of each insurer against which delinquency or similar proceedings were instituted, and a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipts and expenses of the division for the year;

(6) recommendations of the director as to amendments or

supplementation of laws affecting insurance, or the office of director;

(7) other pertinent information and matters the director considers proper;

(8) an analysis of medical malpractice insurance rate changes occurring as a result of court decisions in the state involving personal injury or death;

(9) an analysis of liability insurance claims that were closed following a civil action, that

(A) establishes a statistical data base for comparing the annual percentage change in the number and amount of claims;

(B) determines the number and dollar amount of claims closed, by year incurred; and

(C) compares the percentage change in direct premiums written;

(10) an analysis of changes in the incomes of physicians licensed under AS 08.64 occurring as a result of court decisions in the state involving personal injury or death.

* Sec. 13. AS 09.10.055(b), 09.17.040(c), and AS 09.55.548 are repealed.

* Sec. 14. REPORT. The Department of Commerce and Economic Development, with the cooperation of all state agencies, shall report to the legislature by the 30th day of the Second Session of the Seventeenth Alaska State Legislature on closed insurance claims and insurance company finances. The report must consist of

(1) a study of closed insurance claims to identify

(A) the extent to which the legal system has or has not been the cause of dramatic liability insurance increases or decreases and coverage reduction in crisis lines in the state;

(B) how victims are faring under the present system;

(C) what the various specific tort reform measures have actually accomplished; and

(D) if the passage of this Act has resulted in a measurable decrease in insurance rates in the state;

(2) a study of insurance company finances to determine the extent to which

(A) dramatic liability insurance rate increases and coverage limitations in the state are, or are not, cost-justified in relation to awards, settlements, and relevant court decisions in the state involving personal injury, death, or property damage based on fault; and

(B) legislative or regulatory actions affecting the tort system in the state are necessary to resolve the state's liability insurance rate increases.

* Sec. 15. AS 09.30.070(c), as added by sec. 11 of this Act, has the effect of amending Alaska Rule of Civil Procedure 68 by providing that prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 16. APPLICABILITY. (a) This Act applies to all causes of action for damages resulting from an act or omission occurring on or after the effective date of this Act.

(b) AS 09.17.070(c), as added by sec. 10 of this Act, applies to a contract or agreement entered into on or after the effective date of this Act.

* Sec. 17. This Act takes effect immediately under AS 01.10.070(c).

6-0628D
Ford
5/8/89

Original sponsors: Cotten, Larson, Hoffman, et al.

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 166 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to civil actions; amending Alaska Rule of Civil Procedure 68; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. FINDINGS AND PURPOSE. (a) Civil justice in this state has generally been developed by the courts on a case-by-case basis. This process has resulted in some significant changes in the law, and the legislature has periodically intervened to bring about needed reforms. The purpose of this Act is to enact further reforms that create a more equitable distribution of the cost and risk of injury.

(b) The legislature also finds that unnecessarily high malpractice insurance premiums discourage physicians from initiating or continuing their practice or offering needed services to the public. Other professionals, such as architects and engineers, face similar difficult choices, financial instability, and risk in providing services to the public.

(c) The legislature also finds that citizens should be encouraged to serve as board members of electric or telephone cooperatives. These organizations serve important governmental functions, and their vitality and effectiveness depend upon the willingness of experienced individuals to seek leadership and decision-making roles within them. Accordingly, these board members should be given some protection from liability arising from an act or omission within the scope of their duties.

(d) It is the intent of the legislature to reduce costs associated with the civil justice system, while ensuring that adequate and appropriate

compensation for persons injured through the fault of others is available.

(e) The legislature wishes to help match losses with compensation by helping to

(1) ensure that money paid to an injured person is available when anticipated expenses or losses occur;

(2) ensure that a claimant with substantial injury requiring long-term treatment will have money available for future medical care;

(3) reduce medical reparation system costs by eliminating those portions of awards that are not needed to compensate the claimant;

(4) eliminate duplicate recoveries; and

(5) reduce the costs of litigation.

(f) The legislature wishes to accumulate additional information about the costs to society of the civil justice, health care, and insurance systems as they are presently constituted. This information is necessary to determine whether the civil justice, health care, and insurance systems as they are presently constituted are fairly serving victims and whether a disproportionate amount of compensation dollars are absorbed by the system.

(g) The legislature finds that it is extremely difficult to defend against a claim that has become stale after information and witnesses have disappeared. The legislature finds that on the whole society is better served by a reasonable statute of repose even though in a few limited instances injuries may go without compensation.

* Sec. 2. AS 09.10.055(a) is repealed and reenacted to read:

(a) Notwithstanding AS 09.10.140, a person may not bring an action for personal injury, death, property damage, or indemnity arising from a deficiency in the construction or the design, planning, supervision, or observation of construction, of an improvement to real property, unless the action is brought within 15 years of the date of substantial completion of the improvement to real property.

* Sec. 3. AS 09.10.055(d) is amended to read:

(d) The limitation prescribed by this section may [SHALL] not be asserted by way of defense by

(1) a person in actual possession or control, as owner, tenant, or otherwise of an improvement at the time a deficiency in an improvement is [CONSTITUTES] the proximate cause of the injury or death; or

(2) in an action for damages resulting from the design, planning, supervision, or observation of construction of a facility for the transportation or storage of hazardous materials [FOR WHICH IT IS PROPOSED TO BRING AN ACTION].

* Sec. 4. AS 09.10.055(e) is amended to read:

(e) In this section,

(1) "hazardous materials" means a material or substance that, when it enters into or on the surface or subsurface land, water, or atmosphere of the state, presents an imminent and substantial danger to the public health and welfare; "hazardous substance" includes oil; in this paragraph "oil" has the meaning given in AS 46.-08.900;

(2) "person" means an individual, corporation, partnership, business trust, unincorporated organization, association, or joint-stock company.

* Sec. 5. AS 09.10 is amended by adding a new section to read:

Sec. 09.10.065. LIMITATION ON ACTIONS INVOLVING A PHYSICIAN. (a) Notwithstanding AS 09.10.140, an action based on professional negligence may not be brought against a physician by a person who is, on the date of the alleged negligent act or omission

(1) 10 years of age or older, unless the action is brought within five years of the date of injury;

(2) less than 10 years of age, unless the action is brought within five years of the date of injury, or before the person's 12th birthday, whichever period is longer.

(b) The limitation imposed under (a) of this section is tolled during any period in which there exists

(1) fraud, including fraud or collusion by a parent, guardian, insurer, or physician, resulting in the failure to bring on action on behalf of an injured minor;

(2) intentional concealment; or

(3) the undiscovered presence of a foreign body, that has no therapeutic or diagnostic purpose or effect, in the body of the injured person and the action is based on the presence of the foreign body.

(c) In this section,

(1) "physician" means a person licensed under AS 08.64;

(2) "professional negligence" means a negligent act or omission by a physician in rendering professional services;

(3) "professional services" means services provided by a physician that are within the scope of services for which the physician is licensed, and that are not prohibited under the physician's license or by a hospital in which the physician practices.

* Sec. 6. AS 09.10.070 is amended to read:

Sec. 09.10.070. ACTIONS TO BE BROUGHT IN TWO YEARS. A [NO] person may not bring an action (1) for libel, slander, assault, battery, seduction, or false imprisonment, or for any injury to the person or rights of another not arising on contract and not specifically provided otherwise; (2) upon a statute for a forfeiture or penalty to the state; or (3) upon a liability created by statute, other than a penalty or forfeiture; unless commenced within two years

of the accrual of the action.

* Sec. 7. AS 09.10.070 is amended by adding new subsections to read:

(b) Notwithstanding AS 09.10.140, the period of time within which a person may bring an action under (a)(1) of this section may not be extended for a disability described under AS 09.10.140, for more than 20 years after the date of the injury. This subsection does not apply if the injury is caused by an intentional act.

(c) The limitation of (a) of this section does not apply to an action described in (a)(1) of this section if the period of limitation imposed under AS 09.10.065 applies, or if a shorter period of time for bringing the action is imposed under another provision of law.

(d) In this section, "accrual" means the date that the person discovers or should have discovered the person's right to bring an action.

* Sec. 8. AS 09.17.040(f) is amended to read:

(f) A judgment ordering payment of future damages by periodic payment shall specify the recipient, the dollar amount of the payments, the interval between payments, [AND] the number of payments or the period of time over which payments shall be made, and shall include an amount representing future payments for anticipated inflation. Payments may be modified only in the event of the death of the judgment creditor, in which case payments may not be reduced or terminated, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before death. In the event the judgment creditor owed no duty of support to dependents at the time of the judgment creditor's death, the money remaining shall be distributed in accordance with a will of the deceased judgment creditor accepted into probate or under the intestate laws of the state if the deceased had no will.

* Sec. 9. AS 09.17.050(a) is amended to read:

(a) Unless the act or omission constituted gross negligence, a person may not recover tort damages for personal injury, death, or damage to property for an act or omission to act in the course and scope of official duties, from [ONE OF] the following:

(1) a member of the board of directors or an officer of a nonprofit corporation;

(2) a member of the board of directors of a public or nonprofit hospital, or a member of a citizen's advisory board of any hospital;

(3) a member of a school board of a school district;

(4) a member of the governing body, a commission, or a citizen's advisory committee of a municipality of the state;

(5) a member of the board of directors of an electric or telephone cooperative organized under AS 10.25.

* Sec. 10. AS 09.17.070 is repealed and reenacted to read:

Sec. 09.17.070. COLLATERAL BENEFITS. (a) A party defending against a claim may introduce evidence of amounts received or to be received by the claimant as compensation for the same injury from the following collateral sources:

(1) 42 U.S.C. 301 - 1397 (Social Security Act);

(2) state or federal income disability or worker's compensation benefits;

(3) health, sickness, accident, or income insurance; or

(4) a contract or agreement to pay medical, hospital, dental, or other health care services.

(b) If the party defending against the claim elects to introduce evidence under (a) of this section, the claimant may introduce evidence of the amount that the claimant has

(1) incurred in actual attorney fees in pursuing the civil action; and

(2) paid or contributed to secure the right to an insurance benefit, contract, or agreement introduced as evidence by the party defending against the claim.

(c) A source of collateral benefits introduced under (a) of this section may not recover from the claimant an amount paid as compensation for the injury, and may not be subrogated to the rights of the claimant against the party defending against the claim.

* Sec. 11. AS 09.30.070 is amended by adding a new subsection to read:

(c) Prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 12. AS 21.06.110 is amended to read:

Sec. 21.06.110. DIRECTOR'S ANNUAL REPORT. As early in each calendar year as is reasonably possible the director shall prepare and deliver an annual report to the legislature and the commissioner, showing, with respect to the preceding calendar year,

(1) a list of the authorized insurers transacting insurance in Alaska, with such summary of their financial statement as the director considers appropriate;

(2) the name of each insurer whose business was closed during the year, the cause of the closing, and the amount of ascertainable assets and liabilities of each closed business;

(3) the name of each insurer against which delinquency or similar proceedings were instituted, and a concise statement of the facts with respect to each proceeding and its present status;

(4) a statement in regard to examination of rating organizations, advisory organizations, joint underwriters, and joint reinsurers as required by AS 21.39.120;

(5) the receipts and expenses of the division for the year;

(6) recommendations of the director as to amendments or supplementation of laws affecting insurance, or the office of director;

(7) other pertinent information and matters the director considers proper;

(8) an analysis of medical malpractice insurance rate changes occurring as a result of court decisions in the state involving personal injury or death;

(9) an analysis of liability insurance claims that were closed following a civil action, that

(A) establishes a statistical data base for comparing the annual percentage change in the number and amount of claims;

(B) determines the number and dollar amount of claims closed, by year incurred; and

(C) compares the percentage change in direct premiums written;

(10) an analysis of changes in the incomes of physicians licensed under AS 08.64 occurring as a result of court decisions in the state involving personal injury or death.

* Sec. 13. AS 09.10.055(b), 09.17.040(c), and AS 09.55.548 are repealed.

* Sec. 14. REPORT. The Department of Commerce and Economic Development, with the cooperation of all state agencies, shall report to the legislature by the 30th day of the Second Session of the Seventeenth Alaska State Legislature on closed insurance claims and insurance company finances. The report must consist of

(1) a study of closed insurance claims to identify

(A) the extent to which the legal system has or has not

been the cause of dramatic liability insurance increases or decreases and coverage reduction in crisis lines in the state;

(B) how victims are faring under the present system;

(C) what the various specific tort reform measures have actually accomplished; and

(D) if the passage of this Act has resulted in a measurable decrease in insurance rates in the state;

(2) a study of insurance company finances to determine the extent to which

(A) dramatic liability insurance rate increases and coverage limitations in the state are, or are not, cost-justified in relation to awards, settlements, and relevant court decisions in the state involving personal injury, death, or property damage based on fault; and

(B) legislative or regulatory actions affecting the tort system in the state are necessary to resolve the state's liability insurance rate increases.

* Sec. 15. AS 09.30.070(c), as added by sec. 11 of this Act, has the effect of amending Alaska Rule of Civil Procedure 68 by providing that prejudgment interest may not be awarded for future economic or noneconomic damages.

* Sec. 16. APPLICABILITY. (a) This Act applies to all causes of action for damages resulting from an act or omission occurring on or after the effective date of this Act.

(b) AS 09.17.070(c), as added by sec. 10 of this Act, applies to a contract or agreement entered into on or after the effective date of this Act.

* Sec. 17. This Act takes effect immediately under AS 01.10.070(c).

3-16-89

3:00 Work session

Donley ✓ Sprinkle ✓ Collins ✓
Grussendorf ✓ Boucher ✓ Leman ✓
Boyer ✓

Rep Pettyjohn Rep Cotton

Tape # 27 Side A HB 166 Tort Reform
000

Sen Cotten Intro HB166

AK. Statute of Repose negated because not broad enough.

363
450 Tina Tomsen Physician from Anch. Support HB 166

456 Art Tilgner Family Physician Support HB166
534

Support 535 Vivian Haneman Rep AK Society of Prof Engineer
577

Support 579 Charlie Aarons Family Physician
619 act Liability of Hosp. for non-employee

Support 621 Steve Smith Pres. Alaska Air Carriers Assoc.
635

Side B 000 }
to
033

Support

040 Karen Johnson Sisters of Providence

~~HB164~~

204

165 Roger Holmes Corp. Secretary Medical Indemnity Corp

206

~~Support~~ Roland Gower ~~General~~ Surgeon Anch.

304

Oppose

HB166 Al Gross AK Trial Lawyers

305

Sectional Analysis

Bill is Not about Lawyer - It's about Injured People

672 end tape 27 Side B

Tape #28

Side A 000 - 271

Al Gross

293

Roger Holmes Major Corp would be impacted by reducing litigation

442

HB41 Held till Tue.

HB155 " "

Bi-annual renewals

D— Fees set by regulations?
Burns— Yes

Burns Currently not able to collect all the fees now.

Burns Going to General Fund.

100 Bi-Annual Vets
400 Drs.

Donley: Put a packet together for Committee

Collins: recvd complaints about how the bd acts.
Power Grabbing

R— Hold Bill

D— Hold HB 41 till 3-23-89

238 Collins — Move 41 w/ Indef Rec.

D obj

Spoke against HB 166 3/21/89

250 — Teleconference Worksession
HB 166

Bernard Kelly
Attorney from Anch.

413
Boyer

439
Gruenberg

490
Leman

514
Colton

551
Dr. McGuire Orthopedic Surgeon
Statute of Limitations

Tape # Side B
000 –

000
Dr. McGuire Foreign Body
Fraudulent Concealment

239
Gall DCV. 2 Dec. of Repose
Dalcon Shield
Drug DES
Airplanes (older)
Concerns w/ HB 164

Sect 4 2 yr limits for minors
Sect 15 Wrongful Death - CAP
Sect 21 Expert

363 Collins

392 - Mr. Rogusca

448 - Mike Flannigan Attorney

587 - ~~Mr. Rice~~ Mr. Schneider Attorney
CAP - for not dependent

640 - Mr. Paul Coston Attorney

664

Tape # Side A

000 Paul Coston

128 - Mr. Bowman Dir of Interest Group

246 - Margaret Wolf - Mid Town Day Care

Justice Vs. Humane

292 - Mr. Tinnagi Nat'l Structure
376 Settlements & Trade
Assoc.

380 Mtg adjourned @ 5:20

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*                                                                    *
* DELIVER TO: LIOCJOA                                                *
*                                                                    *
*                                                                    *
* ORIGINAL                                                           *
* SENT:          30/03/89  TIME: 15:42                               *
* FROM:          LIOCINE                                             *
* SUBJECT:       (H)L&C;TORTE;3-30;ANC;PL#1                          *
* PRINT DATE:    30/03/89  TIME: 15:42                               *
*                                                                    *
**********************************************************************
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*** ANCHORAGE PARTICIPANT LIST ***

TO: ALL TELECONFERENCE SITES
FROM: INEZ ----> ANCHORAGE

DATE: __MARCH 30, 1989_____
TC #: __89-03-094_____
SPONSOR: __HOUSE LABOR AND COMMERCE_____
SUBJECT: __HB 166 - CIVIL LIABILITY_____

TO TESTIFY:

1.) BOB NESTEL
2.) FRANK THOMAS-MEARS
3.) DENNIS BOOKEY
4.) PEGGY BRADLEY
5.)
6.)

TO OBSERVE:

1.) DICK CATTANACH
2.) EARLENE CARESS
3.) GAIL GATTON
4.) SUZANNE BROWN
5.)
6.)

EMAIL ADDRESS IS: LIOCINE
BACKUP NUMBER IS: 561-1199

EOM ..... IW

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 3-23-89

PLACE: #17

SUBJECT OF MEETING:
HB 166
SB 149

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Mark Breed	Sen Rodey	-		-	-	(Y)	N	If needed / SB 149
Willis Kirkpatrick	Div Banking					(Y)	N	If Needed SB 149
Harvey Sullivan	NFIB	430 'C' St #201 Anch 99501		276-2246		(Y)	N	SB 166
Bob Kerttula	AGS	Box K Juneau		465 3771		Y	N	If needed HB 166
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 3-30-89

PLACE: C-17

SUBJECT OF MEETING:
HJR 37 HB 155
HCR 2 HB 166
HB 72

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Paula Haley	State Comm for Human Rights	800 "A" St. Suite 203 Anchorage AK 99501	→	907 279-3106	907 277-7674	(Y)	N	HB 155
Tom Lawson	DCED Indemnity	PO Box O Juneau	99811		465-2017	(Y)	N	HCR 2
Mary Pierce	MICA Corp	4000 Old Seward Hwy Suite 203 Anch, AK	99503	907 563-3414	n/c	Y	(N)	
DAVID JOHNSON	ASMA	3012 Tongass Ave Ketchikan AK	99901	907 225-6396	907 225-5149	Y	(N)	HB 166
Bob Bertel	AGO	Box K Juneau	99811	36[illegible] →		Y	(N)	HB 166
Dave Alexander	ASMA	9607 Prospect Anchorage AK	99516	5622423 →		Y	(N)	HB 166
Patrick Bradley	ASMA	2150 Belmont Dr Anchorage	99517	258-3[illegible]	561 1363	Y	(N)	166
Diane Kaplan	APRN	4640 Old Seward Anc. 99503		563 7733		(Y)	N	
						Y	N	
						Y	N	
						Y	N	

DELIVER TO: LIOCMAB

ORIGINAL
SENT: 04/01/89 TIME: 09:36
FROM: LIOCMAT
SUBJECT: PART LIST
PRINT DATE: 04/01/89 TIME: 09:36

T/C NO: 89-03--73

DATE: 4/01/89
SPONSOR: HOUSE L&C
SUBJECT: CIVIL LIABILITY
MODERATOR: JODI
SITE: MATSU

FINAL STATS

TESTIFIED

	NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1.	DANA OLSON	HC30 BOX 5438, WASILLA 99687	373-4612	
2.				
3.				
4.				
5.				

OBSERVED

	NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1.				
2.				
3.				
4.				
5.				

DELIVER TO: LIOCMAB

ORIGINAL
SENT: 04/01/89 TIME: 09:49
FROM: LIOCKOD
SUBJECT: H.L&C;PL#2;HB 166;4-1-89
PRINT DATE: 04/01/89 TIME: 09:49

T/C NO: 89-03-073

DATE: SATURDAY, APRIL 1, 1989
SPONSOR: HOUSE LABOR AND COMMERCE COMMITTEE
SUBJECT: HB 166 - CIVIL LIABILITY
MODERATOR: TINA WITTEVEEN
SITE: KODIAK L.I.O.

needs resources referral
• pollution recovery limited by value of ship

PARTICIPANT LIST #2

attorney Maritime Law

TESTIFIED

	NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1.	GERALD MARKHAM	BOX 806, KODIAK 99615	486-4194	HB 166
2.	DON WEE	1915 E. REZANOF, KODIAK	486-3201	HB 166
3.				
4.				
5.				

OBSERVED

	NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1.				
2.				
3.				
4.				
5.				

TESTIFIED:
UNABLE:
OBSERVED:
TOTAL:

START TIME: 9:35 AM END TIME:

LEGISLATIVE TELECONFERENCE NETWORK

SIGN-IN SHEET

SPONSOR: Labor & Commerce

SUBJECT: Comp Liability

START/END TIME: 9:30 - 12:00 DATE: April 1

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS	PHONE #	TESTIFY	OBSERVE	BILL #
1	DUANE HEYMAN ANCHORAGE CHAMBER OF COMM.	437 E. ST. SUITE 300 ANCH 99501	272-2401	X		
2	Leonard Hackett	P.O. Box 10-489 Anch-99511		X		
3	DAVE PARKHURST	5430 LANCELOT CIR ANCHORAGE AK 99502	333-5611	X		
4	Dolores Roguszka	P.O Box 100558 Anchorage AK 99510	346-1017		X	166
5	GENE ROGUSZKA	P.O. Box 100558 ANCH 99510			✓	✓
6	DAN ROWLEY	2550 DENALI ST. 8TH FLR ANCH, AK 99503	278-2551	✓		
7	John Crittenden	2451 Spurr Lane Anch. AK 99517	243-3738	✓	✓	166
8	Morry Holloway / Yukon Eq.	2020 E. 3rd Ave, Anchorage, AK 99501	277-1541	✓		166
9	JOHN ROSS	12840 Jeanne Pl. Anchorage AK 99516	345-2796	X		166
10	Cheri Jacobus	3739 LOCARNO DR Anch. AK 99508	561-8754	X		
11	Mike Schneider	880 D ST #202 Anch, AK 99501	277-4551		✓	
12	Howard Thomas	2611 Brittany Drive Anchorage, AK 99504	333-9101	✓		166
13	AL-TAMAGNI	7001 OAKWOOD DR ANCHORAGE. AK	349-1736	✓		
14	Mike Mordy	3800 Wintergreen Pl Anchorage, Ak 99508	563-6597		✓	166
15	Randall Weiner	215 Christensen #4 Anchorage 99501	276-4244	✓		
16						
17						
18						

LEGISLATIVE TELECONFERENCE NETWORK

SIGN-IN SHEET

SPONSOR: _____

SUBJECT: _____

START/END TIME: _____ DATE: _____

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS	PHONE #	TESTIFY	OBSERVE	BILL #
1	Terrie Gottstein	6201 West Tree Dr	346-3764	✓		
2	JOEL CHAMBERLAIN Joel Chamberlain	ANCH. 3031 BROOKLIEN ST	276-0900	✓		
3	~~John Gottstein~~					
4	Nancy Sheik	P.O. Box M73555 ER AK	694-1348	✓		
5	Karen Johnson	2618 glenwood	261-3101		✓	
6	ALAN COUTHARLL	3013 COTTONWOOD	279-398-7	✓		
7	Gail Gatton	540 L St, Suite 102	258-4042		✓	
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						

DELIVER TO: LIOCROG

ORIGINAL
SENT: 04/03/89 TIME: 15:21
FROM: LIOCINE
SUBJECT: (H)L&C;HB166;4-3;ANC;PL#2
PRINT DATE: 04/03/89 TIME: 15:21

*** ANCHORAGE PARTICIPANT LIST ***

TO: ALL TELECONFERENCE SITES
FROM: INEZ ----> ANCHORAGE

DATE: APRIL 3, 1989
TC #: 89-03-143
SPONSOR: HOUSE LABOR AND COMMERCE
SUBJECT: HB 166 - CIVIL LIABILITY

TO TESTIFY:

1.) DR. C.J. LITTLE HB 166
2.) DR. T.R. TOMSEN HB 166
3.) A.N. CORTHELL HB 166
4.) DR. J.S. SPENCER HB 166
5.) DR. JEFFERY LAWERENCE HB 166
6.)

TO OBSERVE:

1.) GAIL GATTON
2.) KAARON JOHNSON
3.) MR. GENE ROGUSZKA
4.)
5.)
6.)

EMAIL ADDRESS IS: LIOCINE
BACKUP NUMBER IS: 561-1199

FOM ..... TW

TELECONFERENCE PARTICIPATION

SPONSOR H LTC

DATE/TIME

SUBJECT HB146

LIO'S

(moderator)

	TESTIFY	OBSERVE		TESTIFY	OBSERVE
ANCHORAGE ( )	Dr. C.J. Little Dr. T.R. Thomson Dr. A.N. Corthell	to testify	PETERSBURG * ( )		
BARROW * ( )			SITKA ( )		
BETHEL ( )	1 to ~~observe~~ testify Donna Chris		SOLDOTNA ( )		
DELTA JUNCTION * ( )			VALDEZ * ( )		
DILLINGHAM * ( )			LTC'S		
FAIRBANKS (Anne)	1 to observe (may want to testify Marlene Leak		HOMER		
GLENNALLEN * ( )			WRANGELL		
JUNEAU ( )			OFFNETS		
KETCHIKAN ( )			OFF1 MTLC		William Sheuber, Pres Steve Stimel, Claims Mgr. Ron Newpaur, underwriter VP
KODIAK ( )			OFF2		
KOTZEBUE ( )			OFF3		
MAT-SU ( )			OFF4		
NOME ( )			OFF5		
			OFF6		

operating Co of METC

VTS'S ON BACK

* SESSION ONLY

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-3-89

PLACE: C-17

SUBJECT OF MEETING:
WORKSESSION
HB 166

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Dan Hensley	Alaska Action Trust	1015 W 7th	9950	277-7354	276-1191	Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-4-89

PLACE: C-17

SUBJECT OF MEETING:

HB 166 HB 155
HB 92
HB 72

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
GORDON EVANS	HIAA	318 4TH ST., JUNEAU	99801		586-3210	(Y)	N	HB92
MIKE COUGHLIN	RET/BEN	P.O. BOX CR JUNEAU 99811		4	465-4470	Y	N	HB 92 IF NEEDED
Paul Fuller	D.O.T.	Pouch D Juneau			465-2575	(Y)	N	HB92
Kip Lolett	Dept Admin				465-4430	(Y)	N	HB-155
Dennis Scholl, PhD	Alaska Mental Health Board	419 6th St, Suite 124 Juneau, AK 99801 →			465-3071	(Y)	N	HB-92
CONNIE J. SIPE	OAC				5-3500	Y	N	To answer questions/observe HB155
Mary Pierce	MICA	4000 Old Seward Anch AK 99503			563-3414	Y	N	HB-166
Clark Ervening	APA	217 Second Street Suite 204 Juneau				(Y)	N	If time
Ben Hartley	AGO	Juneau				Y	(N)	HB-166
						Y	N	
						Y	N	

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-6-89

PLACE: C #17

SUBJECT OF MEETING:
HB 155 HB 72
HB 235 HB 166

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
John Manning	HSS	Box H-Doc Juneau	99811		465-3027	Y	N	
Kim Smith	MICA	10301 Glacier Hwy Juneau	99801	789-0631	789-2910	Y	N	HB 166
Beth Kertulla	AG's	AGO				Y	N	HB 166
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

TELECOPY COVER SHEET

Anchorage Legislative Information Office

Office - (907) 561-7007 Fax - (907) 562-4376

TO: Colette Jensen - Rep. Pearley FAX: _____ PHONE: 465-3892

FROM: Inez - Anch LIO PHONE: 561-7007

INSTRUCTIONS: please call her & let her know it's arrived.

RECEIVED: Date _____ Time _____

SENT: Date 4-11-89 Time 9:40A

DISPOSAL OF ORIGINAL: Discard ____ Hold for Pickup X

NUMBER OF PAGES: 2 (counting cover sheet)

SENT BY: Inez

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* *
* DELIVER TO: LIOCMAB *
* *
* *
* ORIGINAL *
* SENT: 04/08/89 TIME: 11:39 *
* SUBJECT: FS(H)L+C;HB166;4-8;ANCH *
* PRINT DATE: 04/08/89 TIME: 11:39 *
* *
****

ANCHORAGE FINAL STATS

DATE: _____APRIL 8, 1989_____
SITE: _____ANCHORAGE, ALASKA_____
SPONSOR: _____HOUSE LABOR AND COMMERCE COMMITTEE_____
SUBJECT: _____HB 166, CIVIL LIABILITY_____
MODERATOR: ___MARYANN_____
TELECONFERENCE NO. 89-03-092_____
****

TESTIFIED:

NAME\REPRESENTING:	ADDRESS			PHONE
ROGER HOLMES,	705 CHRISTENSEN,	ANCH	99501	277-8564
STEVE VAN GOOR, AK BAR ASSOC.,	310 K ST., #602	ANCH	99501	272-7469

OBSERVED:

NAME\REPRESENTING	ADDRESS			PHONE #
BOB NESTEL,	16810 EASY ST. #2	EAGLE RIVER	99577	694-4372
GENE ROGUSZKA,	BOX 100558	ANCH	99510	346-1017

****

TESTIFIED: ___2_____
OBSERVED: ___2_____
TOTAL: ___4_____

START TIME: __10:00AM
END TIME: _____

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-8-89

PLACE: C#17

SUBJECT OF MEETING:

HB 166

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Paul Cossman	Alaska Academy of Trial Lawyers	12601 Atherton Anchorage	99516		276-3188	(Y)	N	request permission to testify @ end of hrg.
CHARLES W. COE	" "	814 W. 2nd ANCHORAGE AK	99501		276766	Y	N	GAME & F&G 8-7
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-11-89

PLACE: CH17

SUBJECT OF MEETING:
HB92
HJR40
HB166 – Hospital Liability for Actions of Non-employees

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
William G. Brock	MICA	P.O. Box 20709 Juneau, AK	99802	586-3763	586-3656	(Y)	N	HJR 40
PAUL ROLLER	D.O.T.	Pouch D Juneau		465-2515	→	(Y)	N	— " —
HARLAN HUDSON	Health Assoc.	319 Seward #11	99501		586-179	(Y)	N	HB166
Beth Kertulo	AGO	Box K JNO	99811			Y	(N)	HB 166
DAVID CROSBY	Health Assn	Juneau				(Y)	N	HB 166
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-18-89

PLACE: C#17

SUBJECT OF MEETING:

HB 96 HB 168 HB 166
HB 284 HB 13
SCR 21
SB 82 SJR 41

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
ED CRANG	CFAB	5260 LUPIN PL. ANC	99507	562-2552	276-2007	(Y)	N	SB82
Bob Bartholomew	DOTPF	P.O. Box Z Juneau		463-3239	465-3911	(Y)	N	HB 284
Tom Lawson	DCED	PO Box D Juno	99811		465-2017	Y	(N)	SCR21 Available for Questions
Paul Keller	D.O.T	Pouch D "	99811		465-2515	(Y)	N	SJR 41
MARTHA FISCHBACH	SELF	Box 34496, JNU	99803	364-2675	465-8828	(Y)	N	HB 96 - Vet Bd.
ROXANNA Horschel	Aang Force A.S.A	10360 Nigh Rd	99515	522-1155	5225289	(Y)	N	HB284
Karl Ohls	Sen. Zharoff	P.O. Box V, Juneau	99811		465-3473	(Y)	N	SB 82
Resa Ferrel	A.G.C. of Ak.	134 No. Franklin	99801	586-1760		(Y)	N	HB284
Randall Burns	Dept. of Commerce	P.O. Box D-21C Juneau, AK 99811			465-2535	(Y)	N	HB 96
Dean Paddock	Self	Box 20312 Juneau 99802		788-4231	463-1470	(Y)	N	SB82
Scott Burgess	AML	217 2nd St Suite 200 Juneau 99801			6-1325	(Y)	N	~~HB~~ HB 284

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-20-89

PLACE: GH 17

SUBJECT OF MEETING:
SB 82, SB 101, SJR 30, HB 284, HB 166, HB 278

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
PAULA TERRELL	SENATOR KERTTULA					(Y)	N	
ROSIE PETERSON	G/COVE	211 FOURTH ST. #101	99801		6-1736	[illegible]	(N)	SJR 30
Dave Gray	SEN. Kelly			3822		Y	N	SB 101
Guy Warren	JNU-DOUGLAS OFFICIAL ASSOC	4362 TAKU BLVD JUNEAU	99801		9-3852	(Y)	N	SB 107
KATE GRAHAM	UNITED FISHERMEN OF ALASKA	211 4TH ST. SUITE 106 JNU	99801		6.2820	IF NEEDED Y	N	SB 82 HB 166
(166) Dennis Mestas	Alaska Alaska OF Trial Lawyers	880 'N' St. Suite 202	99501	277-4	272-4551	(Y)	N	HB 166
166 Bob Kerttula	~~ADAG~~ Atty Gen	Juneau				Y	(N)	H.B. 166
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-24-89

PLACE: C#17

SUBJECT OF MEETING:

HB 146
HB 166
(Worksession)

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Randall Burns	Dept of Commerce	P.O. Box O-LC Juneau AK 99811	99811		465-2535	(Y)	N	HB 146
Kim Smith	MICA	10301 GLACIER JUNEAU AK	99801	789-0636	789-7910	(Y)	N	HB 166
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: 4-22-89

PLACE: C#17

SUBJECT OF MEETING:

HB 166

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
✓ RICHARD RITTER	Alaska Professional Design Council Chairman Leg Liaison Committee APDC	800 GLACIER AVE. JUNEAU	99801		6-1371	(Y)	N	HB 166
✓ DAVID CROSBY	HEALTH RESIN ARK	424 N. Franklin Juneau	99801		6-1786	(Y)	N	HB 166
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	