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CHANGES IN INSURANCE SERVICES**HOW THE PUBLIC IS TREATED**

- 1) Suggested Legislative Agenda for 1987 by: National Insurance
Consumer Organization

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CHANGES IN INSURANCE SERVICES
HOW THE PUBLIC IS TREATED



How To

**Tame the Insurance Industry Cycle
and
Make the Legal System More Efficient:**

A Suggested Legislative Agenda for 1987

by

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How to Tame The Insurance Cycle and Make the Legal
System More Efficient

I. Introduction and Background

Dramatic insurance premium increases and refusals of insurance companies to write certain types of insurance at any price are now old news. The debate over what is responsible for such price increases and refusals to deal -- an expanding legal system or insurance industry practices and privileges -- is also a familiar one.

Today, the insurance cycle has turned. First quarter 1986 profits for the industry were up 1227%; second quarter profits are likely to be even higher; and profits in 1987 and 1988 will be the highest in the history of the industry, according to Wall Street analysts. While prices will not fall to the same extent that profits have risen, insurers are already beginning to re-enter markets they had withdrawn from, and within six months prices should begin to fall. The insurance crisis thus is coming to an end.

However, the crisis, the legislation enacted in its wake, and insurers' reaction to that legislation has made one conclusion inescapable: limiting the ability of severely injured people to sue and be compensated for their injuries does not bring down insurance rates. For example, during the first half of 1986 a handful of states, notably Washington, Maryland, Colorado and West Virginia, enacted legislation

limiting damages for disfigurement, paralysis, and all other pain and suffering without requiring insurance companies to reduce their rates. After the enactment of such legislation, insurers did not reduce their rates but rather tried to increase them. After Washington enacted a \$117,000 to \$570,000 cap (depending on the age of the injured person) insurers sought substantial increases but were turned down by Insurance Commissioner Dick Marquardt; 1/ after Maryland enacted a \$350,000 cap, the major medical malpractice insurer sought a 50% rate increase, which was granted by Commissioner Ed Muhl; 2/ and after Colorado enacted a \$250,000 cap, the Hartford, one of the nation's largest insurance companies, announced that it would start cancelling current malpractice policies in November, 1987. This led Republican legislators to charge that "the insurance industry deceived the legislature when it pushed the reforms as dealing with the liability crisis." 3/

The most significant activity, however, occurred in West Virginia. There the legislature passed a bill in March, to take effect in June, that capped damages, required insurer data disclosure and prohibited arbitrary policy

1/ "The Shockwaves Begin," National Underwriter, May 30, 1986, at 14 (editorial) (characterizing Commissioner Marquardt as saying "You people have said that civil justice abuses have caused rates to soar. We believe you, and so we've acted to curb these abuses. Now its your turn to put up or shut up.")

2/ The Washington Post, July 3, 1986.

3/ Liability Week, Vol. 1, No. 13, July 28, 1986, at 3

cancellations. In May, the five West Virginia medical malpractice insurers notified all West Virginia doctors that their insurance would be cancelled effective May 31 unless the legislature repealed the disclosure and anti-cancellation provisions of the law. Although the West Virginia Supreme Court enjoined the insurers from leaving the state, the legislature came into special session, repealed the provisions the industry found objectionable, and threw in some additional "tort reform" for good measure. The insurance industry thus successfully blackmailed the West Virginia legislature. 4/

But the industry's West Virginia actions may have ensured that tort reform without insurance reform will never again be enacted. In June, for example, Florida limited damages for pain and suffering to \$450,000 but also required insurers to roll back their rates. Several companies promptly threatened to withdraw from Florida and have gone to court to prevent the law from taking effect. Nevertheless, the Governor signed the tort reform/insurance reform package, recognizing that the industry never carried out similar threats to leave the state when Florida rolled back auto and workmen's compensation insurance rates in the early 1970's.

Similarly, in July New York tied tort reform to insurance reform by requiring New York insurers to file new rates "appropriately modified to reflect the likely reductive

4/ See Business Insurance, May 19, 1986, at 1; Business Insurance, June 9, 1986, at 2.

cost effects reasonably attributable to any newly enacted statutory provisions of the civil practice law." And in Hawaii, the legislature enacted modest tort reform and mandated 10% to 15% cuts in insurance rates for each of the next three years.

States therefore seem to be beginning to learn that limiting compensation for disfigurement and paralysis will not bring down insurance rates, but that reforming the insurance industry and making the legal system more efficient will. NICO's recommendations in both areas follow.

II. Insurance Reforms

A. Requiring Disclosure

Most industry observers, including many insurance executives, acknowledge that the industry discloses little if any data on actual income and payouts on different types of insurance. ^{5/} For example, insurers disclose their payouts

^{5/} For example, John A. Bogardus, Chairman of Alexander & Alexander, the nation's second largest insurance brokerage, recently told the National Association of Insurance Brokers that "It is damaging to the industry's credibility when we respond with partial, self-serving answers or data that must later be corrected," that "more complete disclosure of claims data and the positive impact various reforms might produce must be forthcoming," and that "the industry gets nowhere by stonewalling these allegations [that profits are being hidden]." Journal of Commerce, May 14, 1986, at 2. Similarly, Kansas Insurance Commissioner Fletcher Bell has emphasized that "adequate, credible and useful statistical data and information is a problem of longstanding," and National Association of Insurance Commissioners President Josephine Driscoll has agreed that "the need for additional information has been more than amply demonstrated." The NAIC News, Vol. III, No. 7, June 1986, at 1.

for a category called "other liability" but not for the specific types of insurance that constitute "other liability," such as day-care, municipal, liquor, nurse-midwife, directors and officers, non-profit organizations, and pollution liability.

Insurers also do not disclose how much they pay out for economic damages - i.e., actual out-of-pocket loss, such as medical expenses and lost wages; for compensatory non-economic damages, such as compensation for paralysis, for the loss of a limb, for the loss of the ability to bear children or for brain damage; and for punitive damages - damages not to compensate the injured person but to punish the defendant and deter similar conduct in the future. And insurers do not disclose how much they pay out after a verdict is rendered (as opposed to the amount of the verdict, which is often dramatically greater than the amount paid out) and the amount they pay out in settlements, the amount they pay to injured people and the amount they pay to their own lawyers and for expenses, and the time that elapses between the insurance company receiving notice of a claim and the company actually paying the claim.

Finally, insurers do not disclose how often they pay claims in cases involving multiple defendants, nor the amount by which their payments in such cases exceed the amount proportional to the fault of their insureds.

Yet the disclosure and analysis of the above information is essential to determine the true condition of the insurance

industry, as well as the likely effect on both injured people and insurance rates of the various "tort reforms" that are today being considered -- such as limitations on damages for disfigurement and paralysis and punitive damages, and the elimination of joint and several liability. States should therefore require insurers to disclose certain information each year for major classes of liability insurance, including day-care center, products, municipal, medical malpractice, liquor, officers and directors, errors and omissions, and commercial auto. The information disclosed should include the following:

1. the amount paid out in economic damages, compensatory non-economic damages, and punitive damages, tabulated by size of economic damage;
2. the number of claims paid and the amount paid in claims pursuant to (a) verdicts (allocated separately for judge and jury verdicts); (b) settlements after a complaint is filed but before verdict; (c) settlements before a complaint is filed;
3. the total amount rendered in verdicts, and the total amount actually paid out pursuant to verdicts;
4. the average time elapsed between receiving notice of a claim and payment of the claim, by size of claim paid;
5. the investment income earned on the amount ultimately paid between receiving notice of the claim and paying the claim, by size of claim paid;
6. the total amount paid in defense lawyer's fees in connection with claims paid (a) pursuant to verdict; (b)

pursuant to settlements after a complaint is filed but before verdict; (c) pursuant to settlement before a complaint is filed;

7. the total amount paid in defense lawyer's fees in connection with (a) defense verdicts; (b) claims resolved prior to verdict pursuant to which no indemnity was paid;

8. the total amount of all other loss adjustment expenses paid in connection with:

- (a) claims paid pursuant to verdict;
- (b) claims paid pursuant to settlements after a complaint is filed but before verdict;
- (c) claims paid pursuant to settlements before a complaint is filed;
- (d) defense verdicts;
- (e) claims resolved prior to verdicts pursuant to which no indemnity was paid.

9. the total amount of premiums written;

10. the total amount of premiums earned;

11. in cases involving multiple defendants, (a) the number of claims paid, and the total amount paid; and (b) the amount by which the amount paid exceeded the amount proportional to the insurance company's insured's percentage of responsibility for the injury, as determined by the jury (in cases tried to verdict) or as estimated by the insurer (in cases that are settled).

Data similar to the above on auto accident cases was collected by the U.S. Department of Transportation in the

1970's. The data showed that people who were severely injured in auto accidents received only 50% of their economic loss, while those who were only slightly injured received several times their economic loss. ^{6/} Based on this study, DOT recommended a no-fault system for small claims: eliminating the right of people with limited damages to sue but in exchange guaranteeing them prompt payment of their economic damages. It did not recommend limiting the amount severely injured people could recover, since they were already being undercompensated. By undertaking studies similar to the DOT study in other areas of tort law, states could intelligently decide what, if any, reforms of the legal and insurance systems make sense.

States therefore should enact legislation requiring the disclosure of the above information (numbers 1 through 11). They may also wish to undertake so called "closed claim" studies which require the disclosure of similar information on a case-by-case basis for claims that have been resolved. Questions that could be included in such a study are attached as Exhibit A.

B. Increasing Competition

1. Repeal anti-group laws

For decades most states have had anti-group laws: laws that prohibit businesses or individuals from banding together

^{6/} See U. S. Department of Transportation, Automobile Insurance and Compensation Study, "Economic Consequences of Automobile Accident Injuries," Vols. I and II (April 1970).

to buy insurance as a group or to form a self-insurance group. Members of a self-insurance group, also known as a risk retention group, each contribute money to a pool out of which claims against them are paid.

Anti-group laws were passed at the behest of insurance agents, who earn more money by selling insurance policies one-by-one than by selling a smaller number of group policies (or, of course, by not selling any policies to those who choose to self-insure). As a result, today we have group life and health insurance, but in most states group homeowners and most group commercial liability policies are illegal.

Recognizing the obvious injustice of such laws, Congress in 1981 passed the Risk Retention Act, which pre-empts state anti-group laws and thus allows group purchase and self-insurance, but only for product manufacturers. A bill expanding the Risk Retention Act to apply to all commercial risks was approved in July by the Senate by a vote of 96 to 1 and may be enacted this year. In addition, several states, including Florida and New York, substantially repealed their anti-group laws this year. Because there is no legitimate policy justification for such laws, and because allowing commercial risks to self-insure or form purchasing groups would provide private insurance companies with some much-needed competition, the states should repeal their anti-group laws.

A bill effectively repealing an anti-group law and

permitting commercial risks to buy group insurance is attached as Exhibit B1. A bill expressly permitting self-insurance is attached as Exhibit B2.

2. Allow banks in insurance

A combination of state and federal laws effectively prevents banks in most states from writing liability insurance or even investing in insurance or reinsurance companies. There is a legitimate policy justification for such laws: the fear that a bank would refuse to make loans or provide other services to its customers unless they also purchased insurance from the bank. For example, a bank might refuse to issue a mortgage unless the borrower agreed to purchase homeowners insurance from it. Or it could refuse to make an auto loan unless the borrower agreed to purchase credit life insurance from it.

However, safeguards can be provided to prevent such practices. Given the current state of the insurance market, and the likelihood of similar markets in the future given today's inadequate state regulatory framework, allowing banks to write insurance or at least establish some presence in the insurance industry makes a great deal of sense. Banks are substantially more efficient than insurance companies, have the necessary capital base to write insurance, and want to enter many of the markets from which insurers have withdrawn or in which insurers have raised their rates dramatically. Moreover, even if banks concentrated on personal lines of insurance, such as homeowners and auto, insurance capacity is

fungible, and thus could be redirected toward commercial lines. States should therefore allow banks to enter the insurance industry.

A bill enabling banks to invest in reinsurance companies is attached as Exhibit C.

3. Establish Joint Underwriting Associations

By law, all drivers must have liability insurance, since the states have made the policy judgment that victims of auto accidents should not go uncompensated. Therefore, states have required that an insurer writing auto insurance must agree to insure, at actuarially sound rates, a small percentage of the high risks who can't get insurance in the normal, voluntary market. Such agreements are called assigned risk plans.

Arrangements similar to assigned risk plans, called joint underwriting associations, or JUA's, were created for medical malpractice insurance during the last trough in the insurance cycle in 1975-76. JUA's, like assigned risk plans, provide insurance at actuarially sound rates to those who can't get insurance in the voluntary market. The difference between the two structures is that the JUA itself collects premiums and pays claims, distributing its profits to its members if it makes money and assessing its members if it loses money. The JUA is in effect an insurance company. An assigned risk plan, on the other hand, is simply a mechanism through which high risk applicants apply and are assigned to private insurers who write the policies.

During the troughs of the insurance cycle, when interest rates are low, JUA's for some professional and commercial risks are as essential as assigned risk plans for drivers, since during those troughs insurers cancel certain classes regardless of risk. During the peaks of the insurance cycle, on the other hand, some insurers insure all commercial applicants regardless of risk. In 1981 for example, with interest rates at 20%, insurers wrote liability coverage for the Las Vegas MGM Grand Hotel fire after it occurred, reasoning that they could take in more by investing the premiums they collected than they would pay out in claims.

Thus, while JUA's are probably unnecessary during cycle peaks, states should have the ability to quickly establish them during cycle bottoms. Like state-run insurance companies, they can both deter West Virginia-style blackmail and provide an alternative insurance source if private insurers attempt such blackmail.

A bill giving the Insurance Department authority to establish a JUA is attached as Exhibit D.

4. Establish state re-insurance programs

Reinsurance is insurance for insurance companies: the insurance company pays the reinsurer a premium, in exchange for which the reinsurer agrees to pay all claims above a certain amount, or agrees to pay a portion of claims according to some formula. For example, in Alabama the major medical malpractice insurer pays all claims of up to \$200,000, and a reinsurer, to whom the primary insurer has

paid a premium, pays any amount above \$200,000. Reinsurance thus can insure insurance companies against very large claims.

Small businesses and others who decide to form groups to self-insure may find it relatively easy to set aside an amount sufficient to pay typical claims, but quite difficult to set aside enough to pay the unlikely but possible extremely large claim. They will therefore need to buy reinsurance. During the peaks of the insurance cycle, this presents no problem; during cycle bottoms, on the other hand, reinsurance is often even harder to find than primary insurance. This is especially true today, with Lloyds of London and Weavers of London, the dominant reinsurers, blanketly refusing to insure many U.S. risks. Many explanations for such refusals have been offered, including unprecedented embezzlements by Lloyd's insiders, the drop in the value of the pound from \$2.80 in 1965 to \$1.05 in early 1985 which made payments in dollars to U.S. insureds much more costly for British companies, and pressure from American insurers to reinforce their efforts to pressure legislatures into limiting liability. ^{7/}

To ensure that businesses and others who self-insure will be able to purchase re-insurance even during insurance cycle bottoms, states should establish their own

^{7/} See, e.g., Business Insurance, July 21, 1986, at 2; Chicago Tribune, October 20, 1985, at 5; Business Week, August 5, 1985, at 57; Journal of Commerce, July 26-27, 1985.

reinsurance programs. Self-insureds would pay the state a premium, in return for which the state would agree to pay all claims above a specified amount. If efficiently run, government-run reinsurance programs can make money. An example is the federal riot insurance program, which Congress established in 1968 to reinsure insurers of riot-caused damages. This program made a profit of \$125 million while keeping insurance available in inner cities.

A bill establishing a state reinsurance program for self-insureds is attached as Exhibit E.

5. Establish state-run insurance companies

Many states currently run successful insurance programs themselves. In some cases, the state-run company has a monopoly, as it does in five states with workmen's compensation insurance. In others, the state-run company competes with private insurers, as do 13 state-run workmen's compensation carriers. ^{8/}

All state funds, whether monopolistic or competitive, have two advantages over private insurance companies: they need not make a profit but need only break even, and they do not pay state taxes. In addition, a monopolistic state fund can spread the risk over all policyholders in the state. And a monopolistic state fund can operate on a "pay-as-you-

^{8/} U. S. Chamber of Commerce, Analysis of Workers' Compensation Laws at 39 (1980).

go" plus safety margin basis. By law, an insurance company must have sufficient capital to immediately pay not only all claims it knows of but also all claims it predicts it will pay in the future - over several years or even decades - on current policies. The company must also have sufficient capital to pay the amount it would owe all its policyholders on the unexpired portions of their policies if all policyholders cancelled their policies immediately. And the company must have an additional amount - typically a few million dollars - set aside as surplus.

For private insurance companies, these requirements make sense: if a private insurer becomes insolvent claimants may well go uncompensated, because most state insolvency funds are so undependable. A state-run insurance company with a monopoly, on the other hand, has a guaranteed market and guaranteed source of funding. Such a company need not characterize the entire amount it estimates it will pay out in the future on current policies as a liability, as private insurance companies do, and consequently it can charge lower rates.

Finally, state-run insurance companies, whether monopolistic or competitive, should be able to run much more efficiently than many private insurers. For example, according to data recently submitted by the Insurance Services Office to House Judiciary Committee Chairman Peter Rodino (D-N.J.), for each dollar businesses pay in premiums for product liability insurance, insurance companies pay out

\$.29 in claims and defense costs. 9/ The states have proved they can do a better job. In Ohio, for example, the state-run workmen's compensation fund takes in only \$.84 for every dollar it pays to injured workers, while privately-run workmen's compensation carriers take in as much as \$1.45 for every dollar they pay in benefits. 10/

Perhaps most important, state insurance programs may be the most effective response to insurers who threaten to withdraw from states in order to pressure legislators to repeal legislation insurers find objectionable, as occurred in West Virginia and as is occurring in Florida. The existence of such programs both makes it less likely that private insurers will withdraw and ensures that policyholders have an alternative insurance source if private insurers do withdraw.

A statute authorizing a state-run insurance company is attached as Exhibit F.

6. Establish interstate compacts

What occurred in West Virginia highlighted the gross disparity of bargaining power between a small state and the insurance industry. West Virginia is a very small market for malpractice insurers, with West Virginia doctors accounting

9/ See House Judiciary Committee press release, June 9, 1986 (data "undermines the companies' claims of massive losses and raises the specter of price-gouging." according to Chairman Rodino).

10/ A. Tobias, The Invisible Bankers, 168 (1982)

for a tiny fraction of U.S. malpractice premiums; malpractice insurers therefore would lose very little by withdrawing from West Virginia. For West Virginia doctors, on the other hand, malpractice insurance is essential. Both the malpractice insurers and the legislature recognized this, which is why the malpractice insurers won.

West Virginia could have fought back by starting its own insurance company. West Virginia also could have fought back by establishing an interstate joint underwriting association together with several other larger states -- say Ohio, Pennsylvania and New York. Under such a plan, as a condition of writing insurance in any of the member states an insurer would have to agree to insure a certain percentage of the risks in each state. Thus, if an insurer wished to withdraw from West Virginia it could do so -- but it could then no longer write insurance in New York, Pennsylvania or Ohio either, each of which is a huge insurance market. Insurer blackmail would therefore be much less likely.

States could also establish joint re-insurance programs. For example, if New York, Pennsylvania, Ohio and West Virginia established such a program, as a condition of doing business in any of those states an insurance company would be required to contribute a small percentage of its premiums -- say, 1/4 of 1% -- to fund a joint program that would write reinsurance in all four states, under underwriting and other standards established jointly by the member states.

A draft bill establishing an interstate re-insurance program is attached as Exhibit G.

C. Regulating More Effectively

1. Prohibit arbitrary cancellations

Under current law, insurance companies may cancel a policy at any time, without notice, for any reason or for no reason. During the peaks of the insurance cycle - when interest rates are high and insurers are therefore earning substantial investment income - they rarely, if ever, arbitrarily cancel policies. During the troughs of the insurance cycle, on the other hand, when interest rates and therefore insurers' earnings on their investments are low, insurers cancel even excellent risks, arbitrarily and without notice. This is the case today, and was the case 10 years ago.

The states should enact legislation that would prohibit midterm cancellations unless the policyholder has engaged in fraud or has failed to pay his premiums or there has been a change in the underlying risk. It is fundamentally unfair for a policyholder, who has entered into an insurance contract for a specified term, to suddenly find that contract cancelled before that term runs.

Nonrenewals, on the other hand, should be permitted, but only if the insurer gives the policyholder adequate notice of its intent not to renew, and a statement of reasons for not renewing.

Bills restricting cancellations and nonrenewals are

attached as Exhibits H1 and H2.

2. Require experience rating

Good drivers pay less than bad drivers for auto insurance, and homeowners who are good risks pay less than those who are bad risks. In contrast, in most states, good doctors and bad doctors pay the same rate: a doctor who has been successfully sued for malpractice several times pays the same rate as a doctor who has never had a claim against him. Many other professionals and small businesses also pay a set rate regardless of their individual claims experience, i.e., they are not experience-rated.

By requiring insurance companies to experience-rate all professional and commercial risks, just as they experience-rate drivers and homeowners, states could reduce insurance rates for most insureds. This is particularly true for medical malpractice insurance, since studies have consistently shown that a very small percentage of doctors is responsible for a very large amount of the malpractice. 11/ Absent experience rating, therefore, the majority of doctors, who rarely if ever engage in malpractice, subsidize the small minority of doctors who are frequent malpractitioners.

11/ See, e.g., Michigan Report on the Liability Crisis at 11 (1985) (19.3% of doctors accounted for 72.2% of claims; 58.1% had no claims); Florida Insurance Commissioner, Closed Claims Study of Medical Malpractice Insurance, 1975-82 (1983) (0.7% of doctors accounted for 24% of claims; one doctor for 31 claims); S. Ferber & B. Sheridan, "Six Cherished Malpractice Myths Put To Rest," 52 Medical Economics 150 (1975) (0.6% of Los Angeles doctors accounted for 30% of all payments).

A bill requiring experience rating is attached as Exhibit I1. Regulations specifying how doctors can be experience rated are attached as Exhibit I2.

3. Establish flex-rating

If insurance companies were fully subject to the antitrust laws, then rate regulation might be unnecessary; the market would determine the proper level of rates. However, because under the McCarran-Ferguson Act insurers may legally fix prices and engage in other anticompetitive activity, regulation of insurance rates is essential.

To allow the market to work as competitively as possible despite McCarran-Ferguson, insurance companies should be permitted to raise or cut their rates without approval by the insurance commissioner within a "zone of reasonableness" - say, 15% above and 15% below the existing rate. Above or below that rate, however, states should not permit a rate to take effect unless and until the insurance commissioner approves the rate. Requiring such prior approval of rates except those within the zone of reasonableness should both smooth out the insurance industry cycle and enhance competition in the industry.

A bill requiring prior approval of insurance rates except those within a zone of reasonableness - so called "flex-rating" - is attached as Exhibit J.

4. Beef up enforcement

It is well-established that state insurance departments

are understaffed and underfunded. According to the 1986 Yearbook of the American Academy of Actuaries, for example, 26 states have no actuaries - people who have been professionally trained to determine the adequacy of present rates on the basis of past claims experience. Moreover, of the 8,000 actuaries in the United States, only 64 are employed by state insurance departments; Aetna alone has twice as many actuaries as all the states combined.

The result is that insurance departments, no matter how dedicated, can not meaningfully scrutinize insurance company requests for rate increases; as Ken Merin, New Jersey's new insurance commissioner, has said, insurance departments often are simply "out-manned and out-gunned." ^{12/} Often, therefore, rate increase requests are effectively rubberstamped.

State insurance departments are similarly lacking in investigators, auditors and other professionals, as the U. S. General Accounting Office has found. ^{13/} Specifically, the GAO found that "most states do not have specialized examiners and few states have the capacity to do computerized audits," that "the authority of departments to order corrective action is very limited," and that only two of the 17 states it examined "conducted an original actuarial analysis enabling

^{12/} Journal of Commerce, July 8, 1986, at 1.

^{13/} See U.S. General Accounting Office, Issues and Needed Improvements in State Regulation of the Insurance Business (October 1979).

them to independently recommend the appropriate level of insurance rates."

The states should pass legislation requiring insurance departments to have on staff a specified number of actuaries auditors, investigators and other professionals, and appropriating adequate funding for such positions.

5. Close the "revolving door"

While some insurance commissioners are dedicated to the public interest and do yeoman work with limited resources, others lack the will to stand up to the insurance industry. For example, the GAO study found that most regulators do not have an "arms-length relationship" with the industry, and that about half of all insurance regulators come from and return to the insurance industry.

Clearly, prior experience in the insurance industry yields expertise helpful in regulating the industry. Conversely, one can learn much about the industry from regulating it, and can use that knowledge productively within the industry after leaving the insurance department.

Yet regulators must always hold uppermost the broad public interest, not the narrow, albeit legitimate, private interests of insurance companies, and an insurance commissioner must never allow his vigilance in guarding the public interest to be compromised by his looking toward a future job within the industry. Therefore, to eliminate the appearance of any conflict of interest, states should pass

legislation that would require state insurance commissioners to wait five years before going to work for any company they had regulated.

States should also seriously consider as candidates for insurance commissioner qualified individuals who have not worked in the insurance industry.

A bill that has gathered substantial support in Congress in the wake of the Michael Deaver scandal, which can be adapted to apply to state insurance commissioners and the insurance industry, is attached as Exhibit K.

6. Establish an Office of Insurance Consumer Advocate

Perhaps because insurance is such an arcane and seemingly boring issue, the consumer is rarely if ever represented in insurance rate hearings. This lack of consumer presence is compounded by the lack of an "arms-length relationship", as the GAO study put it, between the insurance industry and insurance regulators.

An insurance consumer advocate would represent the consumer point of view at rate hearings and ensure that the insurance department does not rubber stamp insurance company rate requests. An insurance consumer advocate might also cause insurance companies to moderate their requests for rate increases. A handful of states (South Carolina, Maine, Oklahoma and New Jersey) have already established such offices. New Jersey's is particularly effective: the cost of the consumer advocate's intervening is billed back to the insurance company seeking the rate increase, thus creating an

incentive for the insurer to keep its rates down in hopes that the consumer advocate will not intervene.

The New Jersey statute creating such a system is attached as Exhibit L.

7. Prohibit the pass-through of lobbying expenses

Like other industries, the insurance industry engages in expensive lobbying and public relations campaigns on controversial issues. For example, since December, 1984 the industry has been engaged in a "massive effort to market the idea that there is something wrong with the civil justice system in the United States," as the Insurance Information Institute has put it. ^{14/} And in January of this year, the industry embarked on a \$6.5 million advertising campaign designed, again in the III's words, to "change the widely-held perception that there is an insurance crisis to a perception of a lawsuit crisis." ^{15/}

While insurance companies clearly have the right to seek to manipulate public opinion, whether they have the right to charge their policyholders for the cost of such manipulation is less clear. To ensure that the insurance industry does not charge its policyholders for lobbying/public relation efforts that many of those policyholders may not agree with, may be adversely affected by, and may believe to be false and misleading, states should enact legislation prohibiting the

^{14/} National Underwriter, December 21, 1984, at 2.

^{15/} Journal of Commerce, March 19, 1986, at 1, 20.

insurance commissioner from approving any rate increase to the extent that it includes expenses for public relations and lobbying. Under such statutes, insurance companies' first amendment rights to conduct expensive lobbying and public relations campaigns -- even false and misleading ones -- would be preserved; their policyholders would simply not have to pay for them.

Passing through the cost of lobbying and public relations to consumers is a particularly stark example of a larger problem: insurers blanketly passing through to policyholders all their expenses, rather than allocating those expenses by type of expense and by state. Policyholders thus end up paying for expenditures -- from charitable contributions to executive compensation -- that should more appropriately be borne by stockholders, and policyholders in low expense states end up subsidizing policyholders in high expense states.

Recently, the Supreme Court of Oklahoma ruled that insurance companies must provide "detailed evidence" of their expenses when seeking rate increases. 16/ If other states follow this decision, or legislatures codify it, rates should fall somewhat - perhaps substantially - and should more accurately reflect insurers' activities in each state.

16/ State of Oklahoma v. Oklahoma State Board for Property & Casualty Rates, No. 65,430, slip. op. at 13 (Oklahoma Supreme Court, decided July 24, 1986).

D. Require risk management

Many insurance buyers have not established risk management programs - i.e., they have not set up procedures intended to eliminate, to the greatest extent possible, dangerous aspects of their operation. Perversely, insurance companies and agents also have limited incentives to encourage insurance buyers to set up risk management programs, since the greater the risk the greater the premium, and thus the greater the profit to both the company and the agent, whose profits are calculated as a percentage of the premium.

However, states can pass laws requiring insurance purchasers and self insureds to set up risk management programs. For example, hazardous waste insurers wrote even bad risks at very low rates in the early 1980's, and refused to write even good risks - at any price - during the last year or so. However, if insurers try to control risk through careful, ongoing risk monitoring and control, rather than merely collecting and investing premiums and paying out claims, insurers can make money by writing even hazardous waste insurance.

Elevator and boiler and machinery insurance provides an instructive analogy. In their infancy, elevators and boilers were both quite dangerous, since elevator cables could break and boilers could explode. Insurers, however, insisted that those risks be managed - for example, that cables be strengthened and that boilers be monitored - before agreeing

to write elevator or boiler and machinery insurance. As a result, elevator and boiler accidents are today virtually unheard of. Insurers should spend more of their premium dollar on engineering, and insist that risks seeking hazardous waste insurance first obtain an "environmental audit" and take steps to minimize both the possibility that hazardous substances will be released and the extent of the harm should any such release occur. In that way insurers can both make money and encourage a safer environment.

A bill requiring municipalities which self-insure to set up risk management programs is attached as Exhibit M.

E. Allocate medical malpractice insurance costs more equitably

The problem with medical malpractice insurance is not its total cost -- \$3.4 billion ^{17/} or 8/10 of 1% of the \$425 billion ^{18/} spent on medical care in 1985 -- but its allocation.

The costs of the system are misallocated in four major ways. First, doctors in high-risk specialties pay for risk that should be shared by others. The medical profession may be viewed as a pyramid, with a base of thousands of general practitioners and an apex of relatively few high-risk specialists. The patient is pushed up the pyramid as his

^{17/} Best's Insurance Management Reports, Insurance Premium Distribution - 1985, Release No. 22, July 21, 1986.

^{18/} The Washington Post, July 30, 1986, at 6.

case and its treatment become more complex. As the case gets more difficult and slight error more devastating, fewer and fewer doctors are asked to bear the cost.

For example, a man may go to see his family doctor because he has blood in his urine. The G.P. may send him to a urologist, the urologist may order x-rays, on the basis of those x-rays the urologist and radiologist may determine that the man has kidney cancer, a surgeon may partially remove the cancer, and a radiation oncologist may then treat the patient with radiation. Assume that the radiation oncologist radiates the wrong kidney and the patient dies. Under the current medical malpractice insurance system radiation oncologists must bear the cost of that mistake. Were it not for the diagnosis and treatment of many other doctors at different levels of the pyramid, however, the radiation oncologist would never have treated the patient. If doctors on lower levels of the pyramid bore a small portion of the cost of a mistake by doctors on higher levels -- on the rationale that all doctors benefit economically by treating patients on whom specialists undertake high-risk procedures -- the cost of malpractice insurance for high-risk specialists would go down. In addition, such a system would give all doctors a greater incentive to exercise due care in referring patients.

Second, doctors are broken down by insurance companies into too many categories, with too few doctors in some categories. In Wisconsin, for example, the few dozen

neurosurgeons in the state traditionally have constituted one category. Thus, if an insurance company pays a major claim against one neurosurgeon it must raise rates substantially to all neurosurgeons -- there are simply too few doctors in the category among whom to spread the risk. If insurers were required to put all doctors into three or four categories rather than the dozen or so they do today, an adequate spread of risk would exist in all categories. Doctors who are today paying exorbitant premiums would pay substantially less, while doctors paying very little today would find their premiums rising slightly. The statute recently enacted in Wisconsin requiring that doctors be grouped into no more than four categories is attached as Exhibit N1. A chart showing the effect on premiums of collapsing nine doctor classifications into three is attached as Exhibit N2.

Third, today doctors pay for malpractice that could more easily be borne by hospitals. Whenever a doctor makes a mistake, whether in making a diagnosis in his office or conducting a procedure in a hospital, the doctor pays. Charging hospitals for part of the cost of malpractice occurring in hospitals would have two positive effects. Because hospitals have a very large number of beds over which to spread risk, hospitals could bear the cost of malpractice occurring in hospitals better than doctors. And requiring hospitals to pay for malpractice occurring there would encourage them to make sure that the doctors to whom they grant privileges are competent.

Fourth, doctors, unlike drivers and homeowners, are not

experience rated, so that the many doctors who are rarely if ever negligent subsidize the few doctors who are frequently negligent. If doctors were experience rated, so that those frequently involved in malpractice paid more and those with good records paid less, this subsidization would stop and most doctors would pay less. Experience rating would thus increase each doctor's incentive to exercise due care. Regulations implementing experience-rating of doctors are attached as Exhibit I2.

In addition, of course, doctors do a notoriously bad job of disciplining their own. Insurance companies should disclose all payments they make in connection with malpractice claims, and the names of doctors involved in those claims, to the Department of Insurance, and the Department of Insurance should make such information available to medical licensing boards, hospitals, professional review organizations and the public. Such disclosure would enable doctors to weed out the "bad apples," thus reducing the incidence of malpractice and consequently reducing malpractice insurance rates. Moreover, such disclosure would be invaluable to the consumer in choosing a doctor.

A bill requiring disclosure of payments in medical malpractice cases is attached as Exhibit O.

III. How to Make the Legal System More Efficient

There is a difference between "tort reform" and true legal reform. "Tort reform," in the sense in which it is

used by insurers, simply means limiting liability: making it more difficult to sue and more difficult to win, and limiting compensation -- particularly for "non-economic" injuries such as disfigurement and paralysis -- for people who do sue and win.

Limiting liability, however, does nothing to reduce the overall costs of the legal system by making it more efficient, e.g., by reducing delay, or increasing the proportion of the money flowing through the system that actually reaches the injured person. NICO's recommendations for making the legal system more efficient follow.

A. Limit lawyer's fees on both sides.

Should government limit legal fees? On the one hand, principled conservatives, including Senate Commerce Committee Chairman John Danforth (R.-MO), have forcefully argued that an administration which has sought to deregulate airlines, communications, banking and other endeavors ought not single out lawyers' fees for regulation.

On the other hand, the Reagan Administration has sought to limit plaintiff's lawyer's fees -- to 25% of the first \$100,000 recovered, 20% of the next \$100,000, 15% of the next \$100,000 and 10% of anything above \$300,000. It has not sought to limit defense lawyers fees. Because the relationship between a defense lawyer and his corporate client is a roughly equal one, whereas the relationship between a plaintiff's lawyer and his client -- a scared, unsophisticated injured individual -- is grossly unequal,

plaintiffs arguably need protection by the government that defendants do not.

The Administration's sliding scale, however, would not protect plaintiffs from overreaching plaintiff's lawyers but rather would limit the ability to sue of those people who have been seriously injured by a defective product or a negligent doctor or hospital. For example, one law firm representing several women rendered infertile by the Dalkon Shield IUD had to spend \$800,000 before recovering a penny from A. H. Robins, the manufacturer of the Shield. 19/ Under the Administration's proposal it would not be economically feasible to bring such a case, since defense fees and defense tactics -- and therefore plaintiff's lawyers' costs -- remain unlimited, while the plaintiff's lawyer's reward for winning the case is sharply limited.

If lawyers fees are to be limited, they should be limited on both sides. The fastest growing expenditure in the legal system is not plaintiff's lawyer's fees - which are typically 1/3 of the recovery if they win and nothing if they lose - but defense lawyers fees. According to the Insurance Services Office, for each dollar insurers pay to injured people they pay \$.46 to defense lawyers -- double the amount they paid to defense lawyers just ten years ago. 20/ And

19/ Robins, Zelle, Larson & Kaplan, "The Bomb in the Boardroom," Nov. 15, 1984, Minneapolis, MN (seminar) (Statement of Robins, Zelle, attorney Roger P. Brosnahan).

20/ Insurance Services Office, Inc., The Rising Costs of General Liability Legal Defense, at 3 (May 1986).

since 1956, defense lawyers' fees have risen three times as fast as claims payments. 21/

The rise in defense costs is particularly alarming because each additional dollar spent on defense lawyers means an additional dollar that must be charged directly to policyholders; increasing defense costs thus directly increases insurance rates. The amount the plaintiff spends on his lawyers, on the other hand, has no effect on premium rates, since rates are based on the amount of the jury verdict or settlement, not the percentage of that verdict or settlement that goes to the plaintiff's lawyer.

States could limit defense fees by disapproving any rate that included within it more than a certain percentage -- say 25% -- for defense costs. Under such a plan, the amount spent on defense costs is limited, but the insurer has the ability to determine how best to allocate that amount. With lawyers fees limited, a greater percentage of the money flowing through the system would wind up in the hands of the injured person.

A bill taking an extremely modest first step toward controlling lawyers fees on both sides is attached as Exhibit P.

B. Penalize frivolous actions on both sides

Just as insurers have sought to limit plaintiff's but

21/ Insurance Services Office, Inc., and National Association of Independent Insurers, "1985: A Critical Year" (May 1985).

not defense lawyers' fees, they have sought to penalize frivolous actions by plaintiffs - frivolous suits -- but not frivolous actions by defendants - frivolous motions and objections.

In fact, however, much greater incentives exist for the latter than for the former: because they charge by the hour, defense lawyers have an incentive to "keep their meter running" by raising defenses, filing motions, interposing objections and briefing and rebriefing the same issue -- no matter how untenable their position -- even if settling the case quickly would actually be cheaper for their clients. Plaintiff's lawyers, in contrast, have no incentive to delay, since they work on a contingency fee basis, getting paid only if and when they win.

States should enact legislation establishing severe sanctions, or encouraging judges to impose such sanctions, for delaying tactics or actions taken in bad faith, whether by plaintiff or defense lawyers. Possibilities include:

1. The judge could order that the party found to be acting in bad faith pay the attorney's fees involved in opposing the action found to be in bad faith, perhaps with an additional penalty;
2. The judge could direct a verdict on the issue or issues dealt with in bad faith against the party found to be acting in bad faith;
3. The judge could direct a verdict in the entire case against the party acting in bad faith;

4. Lawyers found to be acting in bad faith could be suspended;

5. Lawyers found to be continually acting in bad faith could be disbarred.

Bills imposing modest penalties for frivolous actions are attached as Exhibits Q1, Q2 and Q3.

C. Prohibit secrecy agreements

What does a lawyer do when a defendant offers to settle his client's case for a generous amount, but only on condition that the settlement agreement remain sealed and that all material discovered during the case be returned or destroyed? The settlement is clearly in the individual client's best interest, but equally clearly can be contrary to the public interest: it may allow the manufacturer to continue to market a product it knows is defective, it causes more people to be killed and injured by that product, and it makes it more difficult for other people injured by the product, or the families of those killed by the product, to receive compensation.

Perhaps the most sordid and well-known example of a corporation insisting on secrecy agreements is that of A. H. Robins in Dalkon Shield cases; 22/ today, Honda and the other

22/ See Remarks of Miles Lord, Chief Judge, District Court for the District of Minnesota, to Messrs. Robins, Forrest and Lunsford of A.H. Robins Co., Feb. 29, 1984 ("In order that no group of plaintiffs might assert a sustained assault upon your system of evasion and avoidance, you time after time demand that able lawyers who have knowledge of the facts must, as a price of getting their cases, agree to never again take a Dalkon Shield case nor help any less experienced lawyers with their cases against your company.")

manufacturers of 3-wheel All Terrain Vehicles (ATV's), which have already been responsible for almost 200 deaths, are insisting on similar agreements.

To eliminate the conflict between the individual client's interest and the public interest, to reduce costs and to save lives, states should prohibit secrecy agreements.

A draft bill prohibiting such agreements and accompanying explanations are attached as Exhibit R.

D. Encourage offensive collateral estoppel

Under the doctrine of collateral estoppel, a party that has had a full and fair opportunity to litigate a fact at issue is not permitted to relitigate that issue in case after case; rather, the fact is established and can be used in future cases.

Judges have been hesitant to allow the use of collateral estoppel by plaintiffs, even though allowing such use would substantially speed up the resolution of cases. Taking the Dalkon Shield example again, in case after case A. H. Robins argued that the Dalkon Shield was not defective, even as court after court found that it was defective; had the defectiveness of the product been deemed established early in the litigation, with liability then depending on whether or not there was causation in each individual case, costs on all sides would have been substantially reduced. 23/

23/ See M. Mintz, At Any Cost: Corporate Greed, Women and the Dalkon Shield (1985).

E. Pass back collateral source benefits

Under current law in the majority of states, the jury is not permitted to hear evidence of any payments the plaintiff may receive for his injury from sources other than the defendant, e.g., workmen's compensation benefits, health insurance benefits, or social security benefits. In some states the jury may consider such evidence, and in a few states the jury verdict is automatically reduced by the amount of benefits from these "collateral sources."

The majority rule -- the so-called "collateral source rule" -- presents a difficult issue. On the one hand, a defendant who has negligently caused an injury certainly does not deserve a windfall because the plaintiff happens to have insurance or is eligible for other benefits. On the other hand, a plaintiff who receives compensation for medical expenses from both a jury verdict and another source receives double recovery to the extent medical expenses paid by the other source exceed the payment he has made to that source, such as premiums for health insurance.

To prevent both windfalls to defendants and double recovery for plaintiffs, the fairest solution is probably to require the defendant to pay the full amount of the verdict, but to excuse the source of the collateral benefits from paying such benefits to the extent that they are already included in the jury verdict. With the money thereby saved, the source of the collateral benefits would be required to reduce the cost of those benefits across the board. For

example, if the jury verdict included compensation for lost wages, and the plaintiff was eligible for workmen's compensation benefits, the defendant would pay the full amount of the verdict to the plaintiff and the plaintiff's workmen's compensation carrier would be excused from paying the plaintiff, but would be required to pass through the savings by reducing its rates across the board.

Under this rule, the cost of health insurance and workmen's compensation insurance should fall by 10-15%, and transaction costs would be reduced. And taxpayers, workers and purchasers of health insurance would not subsidize liability insurers, as they would if jury verdicts were reduced by collateral source benefits.

F. Create incentives to settle.

Because they're paid by the hour, defense lawyers have an incentive to keep their meters running by delaying the resolution of cases -- even those where liability is clear -- to the greatest extent possible.

Penalizing defendants for refusing to make reasonable offers, and penalizing plaintiffs for making unreasonable demands, would encourage both sides to be more reasonable more quickly in negotiating and thus to resolve cases more quickly.

A bill penalizing both the failure to accept a reasonable offer and the making of an unreasonable demand is attached as Exhibit S.

G. Establish alternatives to the tort system - including

no-fault systems, arbitration, mediation, mini-trials,
and other alternative dispute resolution systems

The tort system serves three important functions: compensation, deterrence and disclosure. Because no effective criminal penalties exist to deter corporations from acting irresponsibly, the tort system provides the only meaningful deterrent to such actions. And because government regulators can not be depended on to ferret out information that corporate defendants do not wish to disclose, the tort system is the only means to force disclosure of such information. The stories of A. H. Robins and the Dalkon Shield, 24/ Ford and the Pinto gas tank, 25/ Richardson-Merrell and MER-29, 26/ and Johns- Manville 27/ and asbestos are just a few of the scandals unearthed as a result of tort litigation. And it was only the fear of more litigation, and of large awards for both compensatory and punitive damages, which finally forced these and other dangerous products off the market and encouraged the development of less dangerous substitutes.

It is therefore essential that the common law continues to develop and that no limits be placed on either

24/ See id.

25/ See Grimshaw v. Ford Motor Co., 174 Cal. Rptr. 348 (1981)

26/ See Toole v. Richardson-Merrell, 251 Cal.App. 2 689 (1967).

27/ See P. Brodeur, Outrageous Misconduct: The Asbestos Industry on Trial (1985).

compensatory or punitive damages in cases involving defective products.

In other types of cases, on the other hand, factors other than the tort system may deter irresponsible conduct or force disclosure - or deterrence and disclosure may be less important - and another type of system might compensate people more efficiently than does the tort system. The classic example is no-fault auto insurance. Both criminal penalties and self-interest deter people from driving recklessly, and when the police arrive at the scene of an auto accident it becomes a matter of public record. A no-fault insurance system which neither deters reckless conduct nor forces disclosure but does compensate people more efficiently than does the tort system therefore makes sense for auto accidents. Up to 95% of each dollar flowing through such systems reaches the injured person, compared to less than 50 % of each dollar in the tort system.

For other types of uncomplicated cases involving relatively minor injuries, such as many slip-and-fall cases, no-fault systems may also be worth trying. For example, states may wish to consider a no-fault system with an add-on penalty for deterrence for all cases not involving death, disfigurement or permanent disability in which the plaintiff's economic loss was less than a certain amount. Under such a system, if the injured person sought payment of his economic loss from a defendant causing the injury, and the defendant failed to pay such economic losses within 30 days, the defendant would automatically be penalized heavily,

e.g., by being required to pay treble damages. Such a system might well provide a sufficient deterrent to run-of-the-mill negligence causing relatively minor injury, although it would not force any disclosure.

In addition, for parties with roughly equal bargaining power -- such as an asbestos manufacturer and its insurer or two major manufacturers -- other less costly alternatives to the tort system may make sense. Corporations that have frequent business dealings with each other, for example, can provide by contract that any disputes between them be resolved by binding arbitration, or by "mini-trials" that are much less formal and expensive than full blown trials.

Finally, in certain cases the tort system has worked exactly as it is supposed to: litigation and substantial damage judgments have not only compensated injured people but have also stopped irresponsible actions, or forced responsible ones, and have enabled the public to learn the truth about outrageous corporate misconduct. After the corporation and its officers are punished adequately, many still-uncompensated victims of the product might be more quickly and adequately compensated through an alternative dispute resolution system than through the tort system.

Bills establishing various types of alternative dispute resolution systems are attached as Exhibits T1, T2 and T3.