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LEGISLATIVE RESEARCH AGENCY REPORTS

- 1) Memo: 06/17/1985 To: Senator Bennett From: Carol Berryhill,
enclosures
- 2) Memo: 03/15/1989 To: Rep. Goll From: Hayden Kayden, enclosures
- 3) Memo: 04/18/1989 To: Rep. Goll From: Hayden Kayden
- 4) Memo: 03/13/1989 From: Karen Oakley, enclosures
- 5) Memo: 06/06/1988 To: Rep. Boyer From: Ed Flanagan, enclosures
- 6) Memo: 06/06/1988 To: Senator Jones From: Becky Penrose
- 7) Memo: 12/16/1987 To: Rep. Boyer From: Karen Oakley, enclosures
- 8) Colorado Chapter
- 9) Minnesota Chapter 604
- 10) North Dakota Judicial Remedies
- 11) South Dakota Non-Profit Corporation Members
- 12) State of New Jersey Assembly No. 2398
- 13) Memo: 05/28/1987 To: Rep. Swackhammer From: Gretchen Keiser,
enclosures
- 14) Report: Workmen's Compensation Committee
- 15) Memo: 01/30/1987 To: Rep. Sund From: Penelope Weyrauch,
enclosures
- 16) Memo: 11/06/1985 To: Rep. Koponen From: Mark Torgerson, enclosures

American Bar Association Journal

American Insurance Association Studies

- 1) Annual Report

Insurance Services Office, Inc.

- 1) Report: Coming Capacity Shortage

Liabilities of Municipalities 1983

- 1) Report: NIMLO 1983

Information From the National Insurance Consumer Organization

- 1) Letter: 08/14/1985 To: Rick Rule From: Ron Landsman, enclosures

United States General Accounting Office Report - 1985

California Draft Legislation - 1985

Colorado - 1985 Self-Insurance for State

Connecticut - 1895 Discussion of Sovereign Immunity Doctrine

Illinois Governmental Tort Immunity - 1985

Louisiana - 1985 Legislation on Self-Insurance Liability of Public Entities

Maine Study - 1980

Maryland 1985 Tort Claims Act Amendments

New York Draft Legislation

New York Tort Reform Article

New York Tort Reform Article

North Dakota 84 Collateral Source Rule

Ohio Legislative Alternatives 1983

Ohio Municipal Liability 1979

Oregon 1980 Self-Insurance for State Tort Liability

South Carolina 1985 Amendments to Tort Claims Act

- 1) Memo: 06/17/1985 To: Sen. Bennett From: Carol Berryhill
- 2) Memo: 09/17/1985 To: Sen. Bennett From: Carol Berryhill,
enclosures
- 3) Memo: 04/24/1985 To: Sen. Zharoff From: Elizabeth Hickerson
- 4) Memo: 03/28/1985 From: Rob Nauheim, enclosure
- 5) Memo: 03/01/1985 To: Sen. Zharoff From: Rob Nauheim, enclosures
- 6) Memo: 04/03/1985 To: Rep. Szymanski From: Jonathan Sherwood,
enclosures

LEGISLATIVE RESEARCH AGENCY REPORTS



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box 1, State Capitol
Juneau, Alaska 99811-1100
Mail Stop 1100
(907) 465-1991

March 15, 1989

MEMORANDUM

TO: Representative Peter Goll

ATTN: Hayden Kaden

FROM: Karen Oakley *VO*
Legislative Analyst

RE: Medical Malpractice Premiums Paid by Alaska Doctors
Research Request 89.297

You asked how many doctors are in private practice in rural Alaska communities, and whether these doctors pay more for medical malpractice insurance than do other doctors. You also asked if the federal government pays medical malpractice premiums for the doctors it employs in Alaska.

In summary, there are only a handful of doctors in private practice living in rural Alaska communities. Medical malpractice premiums paid by Alaska doctors depend on the type of medicine practiced and the limits of liability chosen; the location of the practice does not directly affect premium cost. Liability for malpractice by federally-employed doctors is assumed by the federal government.

Geographic Distribution of Alaska Doctors

Currently, there are approximately 825 physicians working in Alaska. The Alaska State Medical Association (ASMA) Directory listed 827 doctors in Alaska in 1987. The Division of Occupational Licensing reported a similar number--833 doctors--with current licenses in August 1988.

Nearly 75 percent of doctors working in Alaska are in private practice. The major government employers of doctors in Alaska are the military, which employs 97 doctors, and the U.S. Public Health Service (PHS) (including the Indian Health Service), which employs 111 doctors. At least some of the PHS doctors are itinerants based in larger communities who travel to remote communities.

In Table 1, the number of doctors in private practice residing in each house election district is presented. We were not able to determine to what extent doctors in private practice provide services to communities other than the community in which the doctor resides. Conceivably, some private doctors living in urban areas travel to rural areas to provide services.

TABLE 1
NUMBER OF PRIVATE PHYSICIANS OF VARIOUS SPECIALTIES RESIDING IN EACH HOUSE ELECTION DISTRICT
(LIST RANKED BY THE NUMBER OF PRIVATE PHYSICIANS IN THE SPECIALTY)

SPECIALTY	TOTAL	HOUSE ELECTION DISTRICT															
		1	2	3	4	5	6	7-15	16	17	18-21	22	23	24	25	26	27
Family & General Practice	151	6		4	10	14	2	77	13		15				1	2	7
Internal Medicine	80	3		3	5	1		53			13						2
Pediatrics	44	2			2	1		26	2		10						1
Surgery	44	2		2	3	2		22	2		9						2
Obstetrics-Gynecology	42	1				1		29	3		8						
Orthopedic Surgery	41	2			2	1		24	1		10						1
Emergency Medicine	37				3	5		19	4		6						
Psychiatry	34	1			2			26			5						
Radiology	25	1			2	1		14	1		6						
Anesthesiology	25	1				1		18	1		4						
Ophthalmology	18				1	1		12			4						
Otolaryngology	14				1			9	1		3						
Pathology	12							8	1		3						
Cardiology	8							8									
Urology	7					1		4			2						
Neurology & Neurology Surgery	7							6			1						
Neonatal & Perinatal Medicine	7							7									
Dermatology	6				1			4			1						
Physical Medicine & Rehabilitation	4							4									
Occupational Medicine	4							4									
Acupuncture	2							2									
Sports Medicine	2							1			1						
Gastroenterology	2							2									
Family Therapy	2							1		1							
Public Health & Preventive Medicine	1							1									
Aerospace Medicine	0																
Primary Care	0																
TOTAL PRIVATE PHYSICIANS	619	19	0	9	32	29	2	381	29	1	101	0	0	0	1	2	13
TOTAL PHYSICIANS	827	24	1	19	36	29	2	496	29	3	138	4	6	0	17	7	16
PERCENT IN PRIVATE PRACTICE	74.8	79.2	0.0	47.4	88.9	100.0	100.0	76.8	100.0	33.3	73.2	0.0	0.0	0.0	5.9	28.6	81.3
PERCENT OF TOTAL IN PRIVATE PRACTICE		3.1	0.0	1.5	5.2	4.7	0.3	61.6	4.7	0.2	16.3	0.0	0.0	0.0	0.2	0.3	2.1

SOURCE: ALASKA STATE MEDICAL ASSOCIATION DIRECTORY (1987).

Prepared by the House Research Agency, March 1989 (89.297A).

These data indicate that very few doctors in private practice reside in rural areas. Four election districts that are generally considered to be rural (2, 22, 23, and 24) have no resident doctors in private practice.¹ The majority of doctors in private practice reside in Anchorage and Fairbanks (78 percent).

Twenty-four percent of all private doctors are in Family and General Practice. In those election districts with few resident private doctors, those doctors are typically in family practice. Most of the private specialists reside in Anchorage or Fairbanks.

For further information on the geographic distribution of doctors and other health care providers in Alaska, see House Research Memorandum 89.004, which is provided as Attachment A.

Medical Malpractice Premiums Paid by Alaska Doctors

Doctors employed by the federal government are not covered by medical malpractice insurance; instead, the federal government assumes liability for malpractice by its doctors. An individual who is injured by a federal government doctor in the normal course of the doctor's job may sue the federal government under the Federal Tort Claims Act. When the injured individual is successful in their claim against the government, damages are paid from a fund administered by the U.S. Department of Justice. Further information on medical malpractice coverage of federal government doctors is found in House Research Memorandum 87.097 (Attachment B).

Doctors in private practice obtain medical malpractice insurance from insurance companies.² According to the Alaska Division of Insurance Annual Report for FY 88, 22 insurance companies wrote medical malpractice insurance policies for doctors practicing in Alaska in that year. Attachment C, from the report, shows the percent of market share written by each company. A total of \$14.4 million in direct premiums written was reported. Three companies accounted for 92.5 percent of the total dollar value of premiums written. These companies were the Medical Indemnity Corporation of Alaska (MICA), Medical Insurance Exchange of California (MIEC), and the Continental Casualty Company.

¹One election district, Election District 24, has no resident doctors.

²The state does not require proof of insurance from doctors licensed to practice medicine in Alaska, and it is possible that some doctors do not have medical malpractice insurance.

The MICA had 48.3 percent of the medical malpractice market in Alaska in FY 88. The MICA was established by the Alaska Legislature in 1976 in response to the liability insurance crisis occurring at that time which severely reduced the availability of medical malpractice insurance in Alaska and elsewhere.³ The current premium schedule of the MICA is provided in Attachment D. The premium paid by a doctor depends upon the type of medicine the doctor practices and the limits of liability the doctor chooses. The MICA does not take the location of a doctor's practice into consideration in determining the premium.

The second largest provider of medical malpractice insurance to Alaska doctors is the MIEC. The MIEC is doctor-owned. The Alaska State Medical Association brought MIEC to Alaska around 1979 to provide doctors with a choice of insurance coverage. The current premium schedule of the MIEC is provided in Attachment E. As for the MICA, the premium schedule depends upon the doctor's specialty and limits of liability; the location of the doctor's practice is not taken into consideration.

In FY 88, the Continental Casualty Company, which is based in Chicago, wrote \$1.6 million in direct medical malpractice premiums, for an 11 percent market share. According to Renee Smith, of the company, Continental uses the standard ISO rates in determining the premiums to charge Alaska doctors that insure with them.⁴ She could not provide a premium schedule and was not sure how their rates compared with those of MICA or MIEC.

Premiums charged by both MICA and MIEC are based on actual Alaska loss experience data. Although none of the companies takes the precise location of the doctor's practice within Alaska into account when determining the premium, the doctor's location and the type of medicine practiced are often related; thus, the doctor's location may indirectly affect the doctor's medical malpractice insurance costs. Doctors practicing in rural areas are more likely to be generalists, rather than specialists. Rural doctors would therefore be more likely to be placed in the lower risk classifications and consequently pay less for medical malpractice insurance than specialized practitioners.

* * *

I hope you find this information useful. If I can provide any further information, please let me know.

Attachments

³For further information on the Medical Indemnity Corporation of Alaska, see House Research Memorandum 81.010.

⁴The ISO is one of the major ratings organizations.

ATTACHMENT A
House Research Memorandum 89.004

ATTACHMENT B
House Research Memorandum 87.097

ATTACHMENT C
Alaska Division of Insurance Annual Report FY 88
Companies Writing Medical Malpractice Insurance
Policies for Alaska Doctors

From Division of Insurance Annual Report for FY 88

PROPERTY AND CASUALTY MARKET SHARE
11 - MEDICAL MALPRACTICE

RANK	COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
1	MEDICAL INDEMNITY CORP OF AK	48.32	6,937
2	MEDICAL INS EXCHANGE OF CALIFORNIA	33.27	4,777
3	CONTINENTAL CASUALTY CO	10.93	1,570
4	NATIONAL UNION FIRE INS CO OF PITTSB	3.04	437
5	ST PAUL FIRE & MARINE INS CO	1.13	163
6	AETNA CASUALTY & SURETY CO	.90	130
7	NATIONAL CHIROPRACTIC MUTUAL INS CO	.59	85
8	CHICAGO INS CO	.45	65
9	AMERICAN CASUALTY CO OF READING	.45	65
10	TRAVELERS INDEMNITY CO	.41	59
11	NATIONAL FIRE INS CO OF HARTFORD	.24	35
12	INS CO OF THE STATE OF PA	.07	11
13	RLI INS CO	.06	9
14	AMERICAN CONTINENTAL INS CO	.03	5
15	ALASKA PACIFIC ASR CO	.03	5
16	PACIFIC EMPLOYERS INS CO	.02	4
17	HARTFORD FIRE INS CO	.01	2
18	INTERSTATE INDEMNITY CO	.00	1
19	JEFFERSON INS CO OF NY	.00	1
20	ST PAUL MERCURY INS CO	.00	-1
TOTAL FOR TOP 20 RANKED INSURERS		99.95	14,360
TOTAL FOR ALL 22 INSURERS WRITING THIS LINE		99.93	14,356

ATTACHMENT D
Medical Indemnity Corporation of Alaska
1989 Premium Schedule

BOARD OF GOVERNORS:

William G. Brock, Chairman
David J. Frazier, 1st Vice-Chairman
Frederick R. Hood, M.D., 2nd Vice-Chairman
David S. Grauman, M.D., Member At Large
Ronald W. Keller, M.D.
Renee Murray
Kim C. Smith, M.D.
C. Keith Campbell
Patricia L. Miles

ADMINISTRATIVE SERVICES:

Mary Pierce, Executive Director
Janet Sloan Johnston, Claim Manager
Penny Chmielewski, Risk Management Coordinator
Art Stanford, Underwriting Manager
Vickie Powell, Policyholder Services

MICA Medical Indemnity
Corporation of Alaska
ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1989

**Physician's and Surgeon's
Professional Liability Coverages and Premium Schedules**

Death or Total and Permanent Disability:

A Reporting Endorsement (tail coverage) will be issued at no extra cost because of death or permanent and total disability.

New Doctor Rule:

For physicians entering private practice for the first time following completion of medical school, residency training, military or public health service, premiums will be discounted 25 % for the first year of coverage.

Claims Free Premium Discount:

A 20 % premium discount will be provided to our insured physicians for a five year claims free history. This policyholder benefit will be provided upon renewal following the completion of the fifth year in which a claims free record has been demonstrated.

Claims Experience Premium Surcharges:

Claims experience premium surcharges may be imposed upon insureds with two or more claims in the last three years in which some elements of negligence or other contributing adverse factors are involved.

Employee Coverages:

Unlike many policies, most employees are provided coverage under the MICA policy.

Employee surcharges are limited to (1) Advanced Nurse Practitioners or Physician's Assistants added to a physician's or clinic's policy subject to 50 % of Class 1 premium (shares policy limits with employer, sponsor or supervising physician). (2) Physician's Assistants or Nurse Practitioners on policies providing separate limits of liability from sponsoring/supervising physician, subject to higher premium based upon specialty and practice situation; (3) employed Nurse Midwives or directly supervised Certified Registered Nurse Anesthetists (CRNAs) are subject to 100 % Class 3 annual premium; (4) unsupervised CRNAs or Nurse Midwives are subject to 100 % of Class 4 and Class 4A premium respectively.

No additional premium charges are incurred for other employees.

Locum Tenens:

MICA provides up to 60 days of coverage annually for a temporary substitute physician - locum tenens - for surgical and non-surgical specialties. Completion of application and prior approval of MICA is required.

This coverage is limited to 6 separate periods per year (except for illness or family emergencies of the insured physician) and any additional periods will involve customary premium charges.

Part Time Practitioners:

Class 1, 2, 2-A and 2-B: 35 % of the scheduled annual premiums for 10 hours or less per week practice; 65 % of the scheduled annual premium for 20 hours or less per week practice.

Short Term Practice Situations:

Pro-rated amount of annual premium computed on short rate tables subject to \$250 minimum premium.

Comprehensive General Liability Coverages:

This optional coverage is available at \$50 per physician covered, subject to the same limits of liability carried for professional liability. This coverage extends to bodily injury and property damage liability protection for those injuries accidentally sustained on the office premises by the general public.

This coverage is limited to only those premises actually occupied by our insured in rendering professional services. For example, if an insured occupied only one suite of a building, coverage would be limited to only that suite and not the entire building and parking lots. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. Limits of each physician's coverage must be equal to that carried by the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provided negligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule in an amount equal to the limits of liability stated on the declarations page of the policy except these limits shall not be concurrent nor excess to the corporate limits of liability as stated in the previous paragraph.

Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (See discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. The combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured. Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability		
# Doctors on Policy	\$500,000	\$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

PHYSICIAN'S RATE CLASSIFICATIONS

Class 1

Neurology

Psychiatry - excluding ECT;

Physicians - no surgery. Applies to general practitioners and physician specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia) who do not ordinarily assist in surgical procedures.

Class 2

Neonatology

Ophthalmology (Excluding Radial Keratotomy)

Physicians - minor surgery or assisting in major surgery. * Applies to general practitioners and physician specialists who perform minor surgery (including catheterization) or assist in major surgery.

Class 2-A

Emergency Medicine

Class 3

Physicians who include obstetrical procedures as any part of their practice. (May still be indicated as class 2-B on policy:)

Physicians - major surgery *

Proctology

Otorhinolaryngology

Abdominal Surgery

General Surgery

Pediatric Surgery

Thoracic Surgery

Traumatic Surgery

Plastic and Reconstructive Surgery, excluding cosmetic surgery

Urology

Gynecology (No Obstetrics)

Installments - Deferred Payments:

Initial policy issuance subject to deposit of \$1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25%, 25% and 15% quarterly or 60% and 40% semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10% annual simple interest on the unpaid balance.

Class 4

Anesthesiology

Class 4-A

Physicians - major surgery

Therapeutic Radiology

Obstetrics - Gynecology

Cardiovascular Surgery

Hand Surgery

Plastic and Reconstructive Surgery, including cosmetic surgery

Vascular Surgery

Orthopedic Surgery, excluding total joint procedures, spinal surgery and insertion of prosthetic devices.

Class 5

Physicians - major surgery

Neurosurgery

Orthopedic Surgery, including total joint procedures, spinal surgery and insertion of prosthetic devices.

* Major Surgery - involves operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the length or circumstances of an operation. It also includes removal of tumors (except skin tumors), open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery and any operations using general anesthesia.

NOTE: IF A PORTION OF THE PHYSICIAN'S PRACTICE IS IN A SPECIALTY WITH A HIGHER CLASS THAN HIS NORMAL SPECIALTY, HE OR SHE WILL BE PLACED IN THE HIGHER SPECIALTY FOR RATING PURPOSES.

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

The Claims-Made Policy extends professional liability protection to the physician, clinic or employee for claims reported in a single year, regardless of when service is rendered as long as the incident occurred while continuously insured under Claims-Made with MICA. Thus, claims reported this year are covered by this year's policy; claims reported next year by next year's policy and so on.

MICA's premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 19 % of the total claims resulting from professional services are reported; the second 39 %; the third 78 %; the fourth 93 %; the fifth and subsequent years, about 100 %.

Cost:

In keeping with the "stair step" development of claims, the rates charged for the Claims-Made policy mature at the fifth year. Subsequent renewal policies are charged at the mature rates. The specific cost of coverage is shown within our table entitled CLAIMS-MADE PREMIUM SCHEDULE.

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1985, your annual renewal premium on January 1, 1989 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

Limits of Liability:

MICA's professional and optional comprehensive general liability coverages are available with policy limits of:

\$200,000 per occurrence/\$600,000
aggregate per calendar year.
\$500,000 per occurrence/\$1,000,000
aggregate per calendar year.
\$1,000,000 per occurrence/\$2,000,000
aggregate per calendar year.
\$1,000,000 per occurrence/\$3,000,000
aggregate per calendar year.

Tail Coverages:

Should you stop practicing or change to another insurance company, MICA guarantees availability of a limited or unlimited Reporting Endorsement known as "tail" coverage to cover subsequently reported claims.* Tail coverage must be purchased by the insured within 30 days of termination of coverage, by cancellation or non-renewal; or by termination of employment or association with the physicians insured under a master group policy.

"Tail" coverage must also be recognized when a physician reduces rating classification to offset reduced premium charges while subsequently reported claims from the higher specialty continues to occur. This is currently being accomplished on a pro-rata basis when the policy is ultimately terminated, but depends on the company's rules, rates and rating plans in effect at the time the physician's class reduction is made.

Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA, and will be subject to the company's rules, rates, and rating plans in effect at the time the unlimited reporting endorsement is requested.

The tail premium is quoted as a one time cost but may be paid in installments. Refer to paragraph INSTALLMENTS.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month period if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

Retirement Benefit:

An Unlimited Reporting Endorsement (tail coverage) will be issued at no extra cost to any physician who has attained the age and years in the MICA program (as per the schedule below) and having completed five consecutive years as a MICA insured just prior to retirement:

Age	Years as MICA Insured
60	5
59	6
58	7
57	8
56	9
55	10

* The policy limits in effect at the time the Unlimited Reporting Endorsement is purchased will be applicable just as if the policy had not been cancelled or terminated and the claim had been reported during the last policy year.

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1989 **

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	\$200,000/\$400,000	\$500,000/\$1,000,000	\$1,000,000/\$2,000,000 \$1,000,000/\$3,000,000 *
CLASS 1				
1st year rates	Jan. 1, 1989	3,087	3,598	4,364
• 2nd year renewal rates	Jan. 1, 1988	4,532	5,644	7,269
• 3rd year renewal rates	Jan. 1, 1987	7,141	9,275	12,374
• 4th year renewal rates	Jan. 1, 1986	8,027	10,504	14,098
• 5th year renewal rates	Jan. 1, 1985	8,082	10,581	14,206
CLASS 2				
1st year rates	Jan. 1, 1989	4,477	5,396	6,740
• 2nd year renewal rates	Jan. 1, 1988	7,031	8,950	11,736
• 3rd year renewal rates	Jan. 1, 1987	11,515	15,161	20,441
• 4th year renewal rates	Jan. 1, 1986	13,029	17,256	23,376
• 5th year renewal rates	Jan. 1, 1985	13,125	17,387	23,560
CLASS 2-A *				
1st year rates	Jan. 1, 1989	6,066	7,451	9,454
• 2nd year renewal rates	Jan. 1, 1988	9,886	12,728	16,840
• 3rd year renewal rates	Jan. 1, 1987	16,514	21,887	29,661
• 4th year renewal rates	Jan. 1, 1986	18,747	24,972	33,980
• 5th year renewal rates	Jan. 1, 1985	18,887	25,166	34,251
CLASS 2-B/3				
1st year rates	Jan. 1, 1989	7,655	9,506	12,168
• 2nd year renewal rates	Jan. 1, 1988	12,742	16,506	21,944
• 3rd year renewal rates	Jan. 1, 1987	21,514	28,613	38,880
• 4th year renewal rates	Jan. 1, 1986	24,465	32,688	44,584
• 5th year renewal rates	Jan. 1, 1985	24,650	32,944	44,942
CLASS 4				
1st year rates	Jan. 1, 1989	11,032	13,873	17,936
• 2nd year renewal rates	Jan. 1, 1988	18,810	24,535	32,790
• 3rd year renewal rates	Jan. 1, 1987	32,138	42,906	58,472
• 4th year renewal rates	Jan. 1, 1986	36,615	49,085	67,117
• 5th year renewal rates	Jan. 1, 1985	36,895	49,473	67,659
CLASS 4-A				
1st year rates	Jan. 1, 1989	12,422	15,671	20,311
• 2nd year renewal rates	Jan. 1, 1988	21,309	27,841	37,256
• 3rd year renewal rates	Jan. 1, 1987	36,512	48,791	66,539
• 4th year renewal rates	Jan. 1, 1986	41,617	55,837	76,395
• 5th year renewal rates	Jan. 1, 1985	41,938	56,279	77,013
CLASS 5				
1st year rates	Jan. 1, 1989	16,991	21,578	28,115
• 2nd year renewal rates	Jan. 1, 1988	29,519	38,703	51,931
• 3rd year renewal rates	Jan. 1, 1987	50,886	68,129	93,046
• 4th year renewal rates	Jan. 1, 1986	58,056	78,021	106,881
• 5th year renewal rates	Jan. 1, 1985	58,505	78,641	107,749

* PREMIUM COST IS 4 % ABOVE \$1,000,000/\$2,000,000 LIMITS.

CLAIMS-MADE PREMIUMS PREPARED BY MILLMAN & ROBERTSON INC., CONSULTING ACTUARIES FOR THE MEDICAL INDEMNITY CORPORATION OF ALASKA, ARE BASED ON A FIVE YEAR PRICING STEP FOR REPORTED CLAIMS ADJUSTED ANNUALLY FOR CLAIMS EXPERIENCE.

* RETROACTIVE DATES AND RENEWAL PREMIUMS APPLY TO 2ND THROUGH 5TH YEAR ANNUAL RENEWAL. FIRST YEAR PHYSICIANS ARE SUBJECT TO FIRST YEAR RATES. ALL POLICIES ARE RENEWED EACH YEAR ON JANUARY 1. ALL 1ST AND RENEWAL PREMIUMS ARE PRORATED SUBJECT TO THE FIRST DAY OF COVERAGE UNDER THE ORIGINAL POLICY.

** SUBJECT TO 12.6 % INCREASE (RETROACTIVE TO 1/1/89) IF MICA'S FEDERAL TAX LIABILITY HAS NOT BEEN LEGISLATIVELY RESOLVED BY 7/1/89.

ATTACHMENT E
Medical Insurance Exchange of California
1989 Premium Schedule

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	Class	Specialty
2	Administrative Medicine	4	Neurology, Excluding Invasive Procedures
2	Allergy	5	Neurology, Including Invasive Procedures
8	Anesthesiology	10	Neurological Surgery
5	Assisting at Surgery	3	Nuclear Medicine*
4	Cardiology*	10	OB-GYN
9	Cardiovascular Surgery	3	Occupational Medicine (Not Industrial)
8	Colon & Rectal Surgery	4	Ophthalmology, Excluding Radial Keratotomy
3	Dermatology, Excluding Hair Transplants	7	Ophthalmology, Including Radial Keratotomy or 5% or more from cosmetic surgery
5	Dermatology, Including Hair Transplants	9	Orthopedics, Excluding Spinal Surgery and use of Chymopapain
7	Dermatology—liposuction	10	Orthopedics, Including Spinal Surgery and use of Chymopapain
8	Emergency Medicine	8	Otolaryngology
3	Endocrinology*	9	Otolaryngology—5% or more from Cosmetic Surgery
3	Family Practice—General Practice	2	Pathology
3	—No Surgery	3	Pediatrics
7	—Less than 5% of income from performance of Surgery	4	Pediatric Cardiology
8	—5% or more of income from performance of Surgery	8	Pediatric Surgery
10	—Including Obstetrics	3	Physical Medicine and Rehabilitation
9	—Including 5% or more income from any combination of Orthopedics, Gynecology, ENT Surgery	8	Plastic Surgery
3	Gastroenterology*	1	Psychiatry**
3	General Preventive Medicine	1	Psychiatry, Child**
8	General Surgery	2	Public Health
8	Gynecology (Only)	3	Pulmonary Diseases*
8	Hand Surgery	7	Radiology, Diagnostic and Therapeutic
8	Head & Neck Surgery	4	Radiology, Diagnostic Only*
3	Hematology*	7	Radiology, Therapeutic Only*
6	Industrial Medicine	3	Rheumatology*
3	Infectious Diseases*	8	Thoracic Surgery, Excluding Cardiovascular
3	Internal Medicine*	4	Urgent Care Medicine
4	Neonatology*	7	Urology
3	Neoplastic Diseases*		
3	Nephrology*		

*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 per 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, \$1,500 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.

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	107
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

The Retroactive Date is the original date of your first MIEC policy.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527



Medical Insurance Exchange of California

ALASKA

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	8,232	2,058
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	13,664	3,416
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

The Retroactive Date is the original date of your first MIEC policy.

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Telephone (415) 428-9411 / From outside California (800) 227-4527

MIEC**Medical Insurance Exchange of California****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	11,714	2,928
2. COVERAGE CLASS 2	3,408	852	6,704	1,676	8,520	2,130	9,210	2,302	13,990	3,497
3. COVERAGE CLASS 3	4,868	1,217	9,576	2,394	12,168	3,042	13,144	3,286	19,420	4,855
4. COVERAGE CLASS 4	5,600	1,400	11,008	2,752	13,996	3,499	15,116	3,779	21,400	5,350
5. COVERAGE CLASS 5	8,520	2,130	16,752	4,188	21,296	5,324	23,000	5,750	29,996	7,499
6. COVERAGE CLASS 6	9,492	2,373	18,668	4,667	23,728	5,932	25,628	6,407	32,944	8,236
7. COVERAGE CLASS 7	12,676	3,169	24,928	6,232	31,688	7,922	34,224	8,556	37,164	9,291
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	71,164	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	1,408	352

The Retroactive Date is the original date of your first MIEC policy.

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Telephone (415) 428-9411 / From outside California (800) 227-4527

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	96,666	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	592	148	752	188
12. PHYSIOTHERAPIST	512	128	1,008	252	1,280	320	1,384	346	1,500	375
13. PHYS ASST/NURSE PRAC	512	153	1,200	300	1,524	381	1,644	411	1,766	442

6250 Claremont Avenue, Oakland, California 94618-1324

Telephone (415) 428-9411 / From outside California (800) 227-4527

The Retroactive Date is the original date of your first MIEC policy.

MIEC**Medical Insurance Exchange of California****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.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box 5, State Capitol
Juneau, Alaska 99811-1100
Mail Stop 1100
(907) 165-1991

April 18, 1989

MEMORANDUM

TO: Representative Peter Goll

ATTN: Hayden Kaden

FROM: Karen Oakley *ko*
Legislative Analyst

RE: Medical Malpractice Premiums Paid by Alaska Doctors
Research Request 89.297 (Supplemental Information)

You requested further information concerning medical malpractice insurance in Alaska. Specifically, you wanted to know how many private doctors are covered by the Medical Indemnity Corporation of Alaska (MICA) and how many are covered by other insurance companies or are without insurance. You also asked about reinsurance purchased by MICA.

According to Art Stanford, with the MICA underwriting department, MICA currently covers about 250 individual physicians, ten hospitals and ten to 12 "related health care facilities." The latter include clinics, such as the Alaska Kidney Center, which are staffed primarily by technicians.

There are just over 600 doctors in private practice in Alaska, thus, 40 percent of the private doctors in Alaska are insured with MICA. I was unable to obtain estimates of the number of doctors insured by each of the 22 other companies writing medical malpractice insurance in Alaska. In 1988, MICA had 48 percent of the medical malpractice market in Alaska, so these other companies together probably insure a similar number of doctors, leaving some 100 to 125 private doctors without insurance. This estimate of the number of uninsured doctors is consistent with the observations of Mary Pierce, executive director of MICA; she estimates that from 15 to 20 percent of Alaska's private doctors are currently "going bare".

Ms. Pierce provided information on reinsurance purchased by MICA. She indicated that MICA pays about \$1.2 million for reinsurance annually. The primary reinsurer is Lloyd's of London, but a number of other companies, including at least one domestic hospital reinsurance company, sign on the policy. The MICA's retention (i.e., deductible portion) is \$250,000 per claim, however, the retention is indexed and increases by about 10 percent per year between the time the claim is made and the time the claim is settled.

Representative Goll
April 18, 1989
Page 2

The MICA is an associate member of the Physicians' Insurance Association of America (PIAA). Because MICA is not a physician-owned company, MICA cannot be a full member of the PIAA. The MICA has broached the idea of putting together a reinsurance pool with the other members of PIAA, but the idea has not generated much interest. Compared with the other companies in the association, MICA is small, and the other companies have nothing to gain from joining with MICA. For further information on MICA's reinsurance situation, please contact Ms. Pierce at 563-3414.

I hope this information is useful. Please let me know if I can provide any further information.



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Box V, State Capitol
Juneau, Alaska 99811-1100
Mail Stop 1100
(907) 461-1991

March 13, 1989

MEMORANDUM

TO: House Finance Fiscal Policy Subcommittee

FROM: Karen Oakley *VO*
Legislative Analyst

RE: Insurance Taxes in Alaska
Research Request 89.256

You asked for information on insurance taxes in Alaska. This memorandum provides background information on regulation and taxation of the insurance industry; a description of the current tax structure; a history of Alaska's insurance taxes; past, present and future revenues from insurance taxes; a comparison with other states; and current issues.

In summary:

- Premium taxes and fees paid by insurance companies generated \$25.6 million in FY 88, representing slightly more than one percent of the state's total unrestricted general fund revenues.
- Although the state must expend money to regulate the insurance industry, the premium tax is a net revenue producer for the state.
- Except for the tax rate on wet marine and transportation premiums, which is one of the lowest in the nation, Alaska's premium tax rate of 2.7 percent is average; however, Alaska has the highest per capita insurance tax revenue of any state.
- Current issues are the low tax rate applied to wet marine and transportation premiums and a pattern of nonpayment of taxes by foreign insurers.
- Due to slower population growth, premium tax revenues have probably peaked; any increased revenues in the foreseeable future will be due to increased enforcement.

Background

The insurance industry occupies the unique position of being the only form of interstate commerce regulated by the states.¹ Due to the difficulty of taxing the net income of insurance companies, states have instead levied taxes on gross premium income. Currently, all states levy taxes on insurance premiums. The tax is essentially a sales tax on insurance sold which is ultimately paid by insurance consumers. The tax rates are fairly uniform, most in the range of two to three percent. Prior to 1985, most states, including Alaska, employed a retaliatory system of taxing insurers--taxing insurance companies domiciled in other states (foreign insurers) at higher rates than domestic insurers. The U.S. Supreme Court found this practice violated the equal protection clause of the constitution in 1985 in Metropolitan v. Ward, a case involving Alabama's retaliatory taxation of foreign insurers.²

Insurance premium taxes generate considerably more revenue than is required to operate the agencies that regulate the insurance industry. In recent years, states have collectively spent less than \$200 million to regulate the insurance industry, whereas state taxes on insurance companies have totalled approximately \$4 billion.

Current Tax Structure

Table 1 summarizes the current taxes levied in Alaska on insurance premiums. The relevant statutes are provided in Attachment A.

In addition to premium taxes, the state also collects various fees from insurance companies and their agents. These fees were set in statute until 1985, when the relevant statute (AS 21.06.250) was amended to provide that the Division of Insurance shall adopt regulations setting the fees. The fees are to be set in an amount sufficient to reimburse the state for the expenses of the state in regulating the insurance industry. Current fees are found in 3 AAC 31.010 through 3 AAC 31.090; these regulations are included in Attachment A.

¹See House Research Agency Memorandum 88.122 for further information on state regulation of the insurance industry.

²Metropolitan Life Insurance Co. et. al. v. W.G. Ward et al. 105 S. Ct. 1676.

TABLE 1
INSURANCE TAXES IN ALASKA

INSURANCE TYPE	TAX RATE (%)	WHAT IS TAXED	STATUTE
ADMITTED LINES			
Domestic and Foreign Insurers (see Note 1)	2.7	total direct premiums after certain deductions (see Note 2)	AS 29.09.210(b)(1)
Hospital and Medical Service Corporations	6.0	gross premiums less claims paid	AS 29.09.210(b)(2)
Wet Marine and Transportation Insurers	0.075	gross underwriting profit (see Note 3)	AS 29.09.210(d)
Title Insurers	1.0	gross premium income (no deductions)	AS 21.66.110
SURPLUS LINES			
Casualty Insurance	2.7	total direct premiums after certain deductions (see Note 2)	AS 21.34.180
Marine Insurance (except Wet Marine)	2.7	total direct premiums after certain deductions (see Note 2)	AS 21.34.180
Wet Marine Insurance	0.075	gross underwriting profit (see Note 3)	AS 21.34.180
All Surplus Lines (see Note 4)	1.0	gross returned premiums	AS 21.34.190
UNAUTHORIZED LINES			
Casualty Insurance	3.0	gross premiums	AS 21.33.055
Marine, Wet Marine, and Transportation Insurance	0.075	gross premiums	AS 21.33.055
SELF-PROCURED LINES			
Marine, Wet Marine, and Transportation Insurance	0.075	gross premiums	AS 23.33.061
All other lines	3.0	gross premiums	AS 23.33.061

NOTES:

1. Domestic insurers are companies formed under the laws of the state of Alaska. Foreign insurers are companies formed under the laws of other states or countries. Until 1985, most states, including Alaska, taxed foreign insurers at a higher rate than domestic insurers. This practice of retaliatory taxation on the insurance industry was found unconstitutional in *Metropolitan v. Ward*, 105 S. Ct. 1676.
2. The tax is paid on total direct premium income less the following: applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums returned to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders.
3. Gross underwriting profit is computed by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance) the net losses paid (i.e., gross losses paid, less salvage and recoveries on reinsurance ceded).
4. This tax is a "filing fee" required to be paid by all surplus lines brokers.

Prepared by the House Research Agency, March 1989 (89.256A).

History of Alaska's Premium Taxes

A premium tax was first levied in Alaska in 1915. In addition to premium taxes, insurance companies were also charged various fees for filing, licensing and examinations. Shortly after statehood, the legislature undertook studies of all the territorial taxes to determine what revisions were necessary. Several problems with the insurance tax were identified at that time. Insurance companies were subject to the corporate net income tax, in addition to the premium tax, but due to the difficulty of identifying net income and of applying allocation factors, almost no income tax revenue was produced by insurance companies. The insurance tax law also favored domestic companies--which were not required to pay the premium tax for a five year period following incorporation and were taxed at one-half the rate at which foreign companies were taxed--and nonprofit fraternal associations--which were exempt from the premium tax.

In 1966, the Insurance Code (Title 21) was adopted (1 ch 120 SLA 1966). The select treatment of domestic companies and fraternal organizations was retained, but insurance companies were exempted from the corporate net income tax. The state also preempted the field of taxing insurance; thus, local governments are prohibited from taxing the sale of insurance within their bounds. (Local governments are, however, allowed to tax the property of insurance companies located within their bounds.)

The taxation provisions of the insurance code have been amended infrequently since they were adopted. In 1982, the statutes were amended to exempt premiums paid by the state for insurance policies and contracts from the premium tax. In 1986, following the Metropolitan v. Ward ruling, the tax rate was equalized for foreign and domestic insurers.³ The most recent amendment was made in 1987, when a sunset date of 1989 for the provision granting the five year exemption from premium taxes for newly incorporated domestic companies was set.

Revenues from Insurance Taxes and Fees

Revenues from insurance taxes and fees were \$25.6 million in FY 88. Total premiums written reached the \$1 billion mark in FY 86. Table 2 presents the amount of revenue generated by insurance premium taxes and fees each year since FY 60; the table also shows the gross premium income generated by the insurance of risks located in Alaska. Figure 1 shows annual tax revenues, and Figure 2 shows annual premiums written.

³The tax rate for domestic companies had been 1.5 percent, and the tax rate for foreign companies had been 3.0 percent. The 1986 amendment established the tax rate at 2.7 percent for both types of insurers.

TABLE 2
REVENUES FROM INSURANCE TAXES AND FEES IN ALASKA: FY 60-FY 88

FISCAL YEAR	INSURANCE TAX REVENUES				TOTAL PREMIUMS WRITTEN (\$1,000s)	INSURANCE TAX REVENUES AS A PERCENT OF:	
	FEES	TAXES	TOTAL	PER CAPITA		TOTAL PREMIUMS	UNRESTRICTED REVENUES
60	880,204	8857,211	8937,415	94.1	834,154	2.7	
61	70,250	963,784	1,034,034	4.4	36,881	2.8	
62	73,561	1,031,274	1,104,835	4.6	40,075	2.8	
63	75,726	1,135,279	1,211,005	4.8	42,900	2.8	
64	75,572	1,197,018	1,272,590	5.0	47,567	2.7	
65	78,974	1,321,067	1,400,041	5.3	58,628	2.4	
66	88,474	1,646,703	1,735,177	6.4	64,727	2.7	
67	123,560	1,802,721	1,926,281	6.9	70,159	2.7	
68	142,354	1,946,854	2,089,208	7.3	79,785	2.6	
69	152,651	2,200,987	2,353,638	8.0	93,859	2.5	
70	171,114	2,561,761	2,732,875	8.9	113,193	2.4	
71	208,599	3,018,206	3,226,805	10.1	131,519	2.5	
72	210,427	3,475,954	3,686,381	11.2	146,033	2.5	
73	242,761	3,729,747	3,972,508	11.8	155,738	2.6	1.9
74	246,213	3,765,090	4,011,303	11.5	189,880	2.1	1.6
75	265,570	4,419,887	4,685,457	12.2	264,829	1.8	1.4
76	329,210	6,078,744	6,407,954	15.6	356,048	1.8	0.9
77	404,654	8,063,205	8,467,859	20.3	452,564	1.9	1.0
78	511,667	10,001,963	10,513,630	25.5	473,711	2.2	1.4
79	500,078	10,772,179	11,272,257	27.2	459,467	2.5	1.0
80	536,297	10,435,773	10,972,070	26.1	478,688	2.3	0.4
81	654,757	10,618,190	11,272,947	26.0	578,457	1.9	0.3
82	868,689	12,530,175	13,398,864	28.8	648,723	2.1	0.3
83	801,034	13,842,732	14,643,766	29.4	760,143	1.9	0.4
84	833,710	16,172,775	17,006,485	32.6	829,606	2.0	0.5
85	876,059	17,504,733	18,380,792	34.1	956,125	1.9	0.6
86	1,641,244	21,283,325	22,926,569	41.9	1,041,981	2.2	0.7
87	1,411,122	23,659,248	25,070,370	46.6	944,922	2.7	1.4
88	1,763,499	23,847,174	25,611,073	47.6			1.1

Source: Annual Reports of the Alaska Division of Insurance

Prepared by the House Research Agency, March 1989 (89.256C).

FIGURE 1

INSURANCE TAX REVENUES IN ALASKA

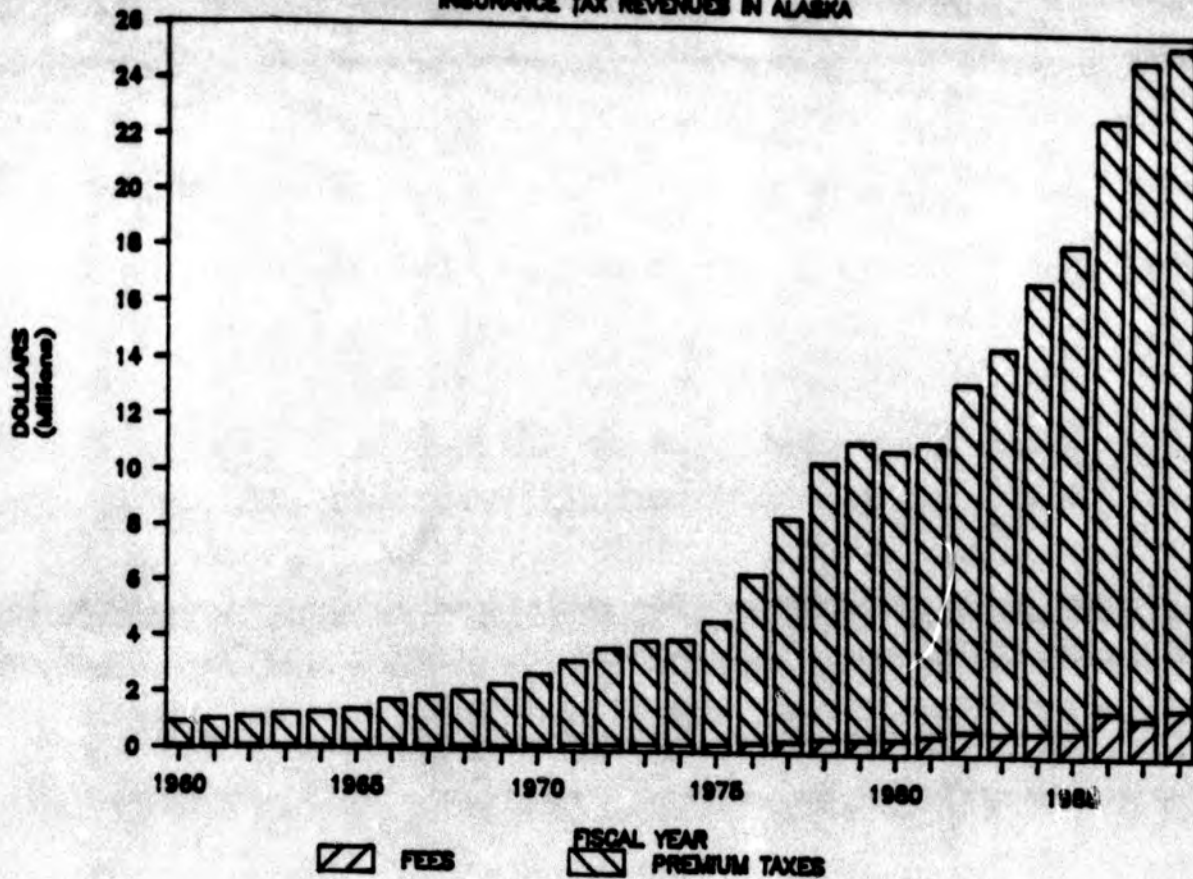
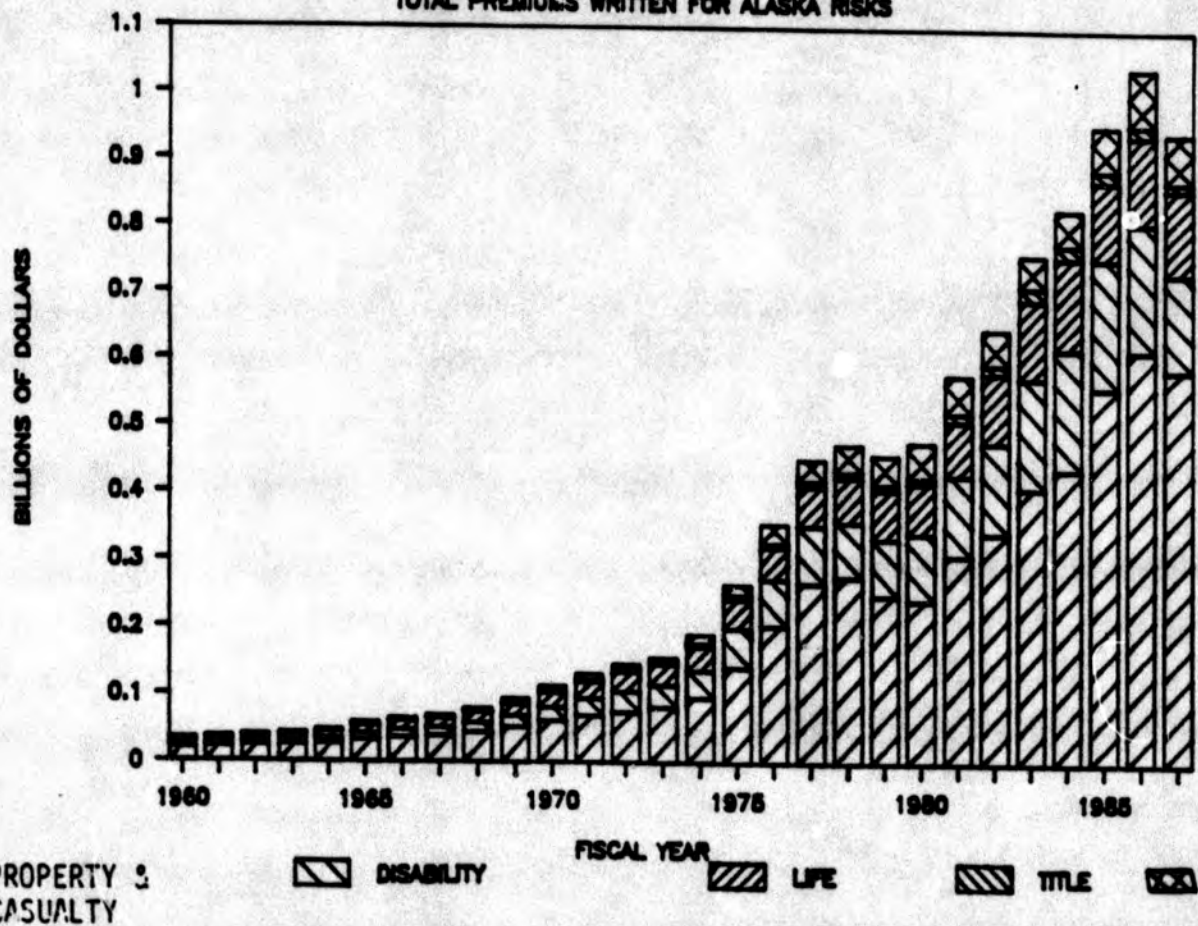


FIGURE 2

TOTAL PREMIUMS WRITTEN FOR ALASKA RISKS



The majority of revenues are generated by premiums for property and casualty insurance. Premium income for these types of insurance typically accounts for 50 to 60 percent of all premium income. Figure 3 shows the percentage of total premium income from each of the major types of insurance; there has been relatively little change during the past 29 years.

The majority of insurance companies insuring Alaska risks are domiciled in other states. Ninety-eight percent of all admitted insurers are foreign. Thus, the majority of insurance revenues are attributable to foreign insurers.

Revenues from insurance taxes and fees increased from \$11 million in FY 80 to over \$25 million in FY 89. Population appears to be the driving force behind the amount of premiums paid and therefore the amount of revenue generated. Population growth has slackened in the past two years due to the regression of the Alaska economy, and growth in insurance premium income and premium tax revenues has also slowed. According to Joan Brown, Division of Insurance, insurance tax and fee revenues have probably peaked, at least for the next few years. For the foreseeable future, any increased revenues will probably be due to increased enforcement (see below). Revenue from insurance taxes and fees has typically represented about one percent of total unrestricted general fund revenues.

Comparison to Other States

Attachment B provides a summary of the basic premium tax rates levied by each state. Most states levy a tax of two to three percent on gross premiums. The highest tax rate is four percent (West Virginia); the lowest tax rate appears to be found in Louisiana which charges 0.025 percent plus a flat annual license tax which varies depending on the line and gross premiums. Alaska's basic rate of 2.7 percent is average.

Table 3 compares the FY 85 per capita insurance tax revenues of the 50 states. Alaska, which collected \$33 per capita, had the highest per capita revenues from insurance taxes in that year. Illinois, with per capita revenues of \$10, had the lowest per capita insurance tax revenues.

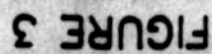


TABLE 3
1985 REVENUES FROM INSURANCE PREMIUM TAXES IN ALASKA AND OTHER STATES
(List sorted in descending order by per capita revenues)

STATE	INSURANCE TAX REVENUES (1,000s)	POPULATION (1,000s)	PER CAPITA REVENUES
ALASKA	817,557	521	833.7
NEVADA	28,420	936	30.4
KANSAS	73,666	2,450	30.1
OKLAHOMA	97,681	3,301	29.6
CONNECTICUT	92,840	3,174	29.3
NEW MEXICO	42,297	1,450	29.2
KENTUCKY	107,457	3,726	28.8
MASSACHUSETTS	163,684	5,822	28.1
DELAWARE	17,378	622	27.9
HAWAII	29,417	1,054	27.9
LOUISIANA	124,311	4,481	27.7
MONTANA	20,798	826	25.2
CALIFORNIA	654,557	26,365	24.8
TEXAS	378,649	16,370	23.1
SOUTH DAKOTA	16,279	708	23.0
WEST VIRGINIA	44,092	1,936	22.8
ALABAMA	90,046	4,021	22.4
MISSISSIPPI	54,084	2,613	20.7
IDaho	20,546	1,005	20.4
MISSOURI	99,088	5,029	19.7
IOWA	55,632	2,884	19.3
NEW HAMPSHIRE	19,080	998	19.1
TENNESSEE	90,994	4,762	19.1
VIRGINIA	108,633	5,706	19.0
MARYLAND	82,248	4,392	18.7
NORTH DAKOTA	12,635	685	18.4
NEBRASKA	29,540	1,606	18.4
NORTH CAROLINA	115,030	6,255	18.4
MINNESOTA	76,525	4,193	18.3
RHODE ISLAND	17,308	968	17.9
ARIZONA	55,436	3,187	17.4
PENNSYLVANIA	204,758	11,853	17.3
ARKANSAS	40,181	2,359	17.0
VERMONT	8,853	535	16.5
FLORIDA	187,634	11,366	16.5
NEW YORK	292,962	17,783	16.5
MAINE	19,023	1,164	16.3
UTAH	26,554	1,645	16.1
WYOMING	8,192	509	16.1
OHIO	170,805	10,744	15.9
OREGON	41,414	2,687	15.4
GEORGIA	91,310	5,976	15.3
WASHINGTON	61,396	4,409	13.9
COLORADO	43,647	3,231	13.5
NEW JERSEY	102,004	7,562	13.5
MICHIGAN	116,994	9,088	12.9
INDIANA	70,558	5,499	12.8
SOUTH CAROLINA	42,438	3,347	12.7
WISCONSIN	53,315	4,775	11.2
ILLINOIS	116,027	11,535	10.1
OVERALL	4,533,973	238,113	19.0

Source: U.S. Department of Commerce, Bureau of the Census, State Government Tax Collections in 1985, Series GF85, No. 1.

Prepared by the House Research Agency, March 1989 (89.2560).

Current Issues

Two issues are of concern at the present time with regard to Alaska's taxation of the insurance industry. These issues are 1) the lower tax rate applied to wet marine and transportation insurance, and 2) collection of taxes owed by foreign insurers.

Tax Rate on Wet Marine and Transportation Premiums. The tax levied on wet marine and transportation insurance premiums is 0.075 percent of gross underwriting profits--considerably lower than the tax rate of 2.7 percent of total direct premiums applied to most other types of insurance. The rate for wet marine and transportation insurance was set in 1966 and has not been changed since. Apparently, that rate (0.075 percent) was the typical rate applied to wet marine insurance at that time. Although 16 states do give preferential tax treatment to wet marine and transportation insurance, Alaska is one of only four states that taxes wet marine insurance at such a low rate. According to the Division of Insurance, insurance carriers in Alaska paid \$29,000 in taxes on wet marine and transportation insurance in 1986; if taxed at the standard rate at that time, these insurers would have paid \$229,000.⁴

Collection of Taxes Owed by Foreign Insurers. In their Annual Report for FY 88, the Division of Insurance noted the following about premium taxes:

A primary area where the division believes that additional revenue should be forthcoming is in the area of out-of-state insurance brokers who have failed to pay the premium taxes due and owing the State of Alaska for insurance written on Alaska risks and Alaska residents. Those additional revenues are in the process of being determined, but it is anticipated that the evaluation will show that substantial sums of tax revenues have gone uncollected. A pattern of nonpayment has been in existence for a period of time.

According to Joan Brown, Division of Insurance, many of the foreign insurers who have failed to pay premium taxes are firms located in Washington that underwrite wet marine risks (i.e. fishing boats) in Alaska. The division has performed a number of audits of such companies, and they plan to do more. The division has not yet completed their analysis of the amount of uncollected revenue. You may wish to contact Paul Roller, director, Division of Insurance, for further information on this topic (465-2515).

I hope this information is useful. If I can provide any further information, please let me know.

Attachments

⁴For further information on this topic, see House Research Memorandum 87.269.

ATTACHMENT A
Alaska Statutes and Regulations Concerning
Tax and Fees Collected from Insurance Companies

Sec. 21.66.050. Title insurance unearned premium reserve fund. (a) Every title insurance company, either foreign or domestic, operating in this state under the provisions of this chapter, shall annually set apart, establish, segregate and maintain at the end of each year into an account to be known as Title Insurance Unearned Premium Reserve Fund, a sum equal to three per cent of its gross premiums on title insurance policies issued during the year then ending covering property in this state. The reserve fund shall be in addition to the deposit with the director. There shall be no other reserve requirements. The reserve must be maintained separately and apart from the capital of the company, and shall be invested in the securities which are authorized for investment by domestic insurance companies under the laws of this state. Funds accumulated under this provision shall never be used for the payment of an obligation other than those incurred in connection with title insurance, and, in the event of the insolvency of a company, this fund shall be used to pay losses and to purchase reinsurance to protect title insurance policyholders even though there are no accrued title insurance claims. The reserve fund shall be considered and shall constitute unearned portions of the original premiums and shall be charged as a reserve liability of the company in determining its financial condition.

(b) The reserve funds shall be maintained in the treasury of the insurer as additional security to holders of title insurance policies issued by the insurer. When, on account of losses or otherwise, the amount of the reserve fund of an insurer is less than the amount required by this chapter no further insurance policies shall be issued by the insurer until the deficiency below the amount required is restored. The net income and profits derived from the fund shall be transferred to the general assets of the company. The company shall also at all times keep a separate record of the cash and securities of the reserve fund, giving complete identification of the assets belonging to the fund and showing full particulars as to withdrawals and additions. After the expiration of 120 months from the date of the first annual deposit in the unearned premium reserve fund made by a corporation now or hereafter qualified, that portion of the reserve fund established more than 120 months earlier shall be released and shall no longer constitute a part of the reserve fund and may be used for a corporate purpose. (§ 1 ch 120 SLA 1966, am § 5 ch 120 SLA 1974)

Sec. 21.66.060. Dividends. The corporation may not pay dividends except from net profits remaining on hand after retaining unimpaired

(1) the subscribed capital stock;
(2) the amount required to be set aside as unearned premium reserve fund;

(3) a sum sufficient to pay current liabilities for operating expenses and taxes, and losses established or in process of settlement, without impairment of the unearned premium reserve fund. (§ 1 ch 120 SLA 1966)

Sec. 21.66.070. Filing schedule of rates and policy forms. (Repealed. § 8 ch 120 SLA 1974)

Sec. 21.66.080. Annual statement. Every corporation, before March 2 of each year, shall furnish the director a sworn statement of assets and liabilities, and of all title premiums received by it during the preceding calendar year, setting out among other things that three per cent of all gross premiums on title insurance policies issued by it during the year covering property in this state have been set aside and held by it in an account known as the Title Insurance Unearned Premium Reserve Fund as provided in this chapter. The statement shall also show in the form which may be prescribed by the director all unpaid losses and claims upon title insurance policies of which the corporation has received due notice in writing from or on behalf of the insured. With the filing of the statement the corporation shall pay a filing fee of \$15 to be placed in the general fund. (§ 1 ch 120 SLA 1966)

Sec. 21.66.090. Application for certificate of authority. (a) Every company, before engaging in a title insurance business in this state, shall apply to the director for a certificate of authority to transact business. The company shall submit with the application a statement sworn to by the proper officers of the company showing its assets and liabilities and that it has complied with the capital requirements and initial guarantee fund deposit prescribed by this chapter.

(b) With the filing of the application the corporation shall pay a fee of \$50 to be deposited in the general fund and in addition shall pay all traveling expenses of the director or an authorized representative of the director and per diem of \$21 a day incurred in examining the applicant's title plant or plants. (§ 1 ch 120 SLA 1966)

Sec. 21.66.100. Issuance of certificate of authority by director. If satisfied that the applicant has fully complied with the provisions of this chapter the director shall issue a certificate of authority. A company that has heretofore qualified in this state as a trust company with title insurance powers under the banking act and is in good standing under existing law shall be entitled to a certificate of authority upon its filing the application and furnishing the information required in the preceding section. (§ 1 ch 120 SLA 1966)

Sec. 21.66.110. Annual tax on title insurance premiums. Annually each title insurance company shall pay before April 1, a tax of one per cent of the amount of gross title insurance premiums received by it including as premium income received from guaranteed certificates of title and other guarantees of title during the preceding calendar year covering property in this state, as shown by its annual statement to the director. (§ 1 ch 120 SLA 1966)

Sec. 21.66.120. Examination by director. (a) The director is authorized to examine the books, accounts, assets and title plants of a

Effect of amendments. — The 1984 amendment inserted "nonadmitted" in the first sentence.

Sec. 21.33.037. Acting for or aiding nonadmitted insurers prohibited. (a) A person may not directly or indirectly act as agent for, or otherwise represent, assist, or aid on behalf of another, a nonadmitted insurer in the transaction of insurance in this state.

(b) This section does not apply to

- (1) matters authorized to be done by the director,
- (2) surplus lines insurance effected and written under AS 21.34,
- (3) transactions for which a certificate of authority is not required under this title,
- (4) reinsurance,
- (5) the property and operations of railroads or aircraft engaged in interstate or foreign commerce and wet marine and transportation insurance,
- (6) life insurance, disability insurance and annuity contracts when solicited solely by mail or when not solicited, negotiated or procured in this state;

(7) transactions subsequent to issuance of a policy not covering domestic risks at time of issuance, and lawfully solicited, written or delivered outside this state.

(c) A person who represents or aids a nonadmitted insurer in violation of this section is subject to the penalties provided in AS 21.33.065. An insurance contract entered into in violation of this section shall not preclude the insured from enforcing the insured's rights in accordance with the terms and provisions of the contract and the laws of this state.

(d) If the nonadmitted insurer fails to pay a claim or loss within the provisions of the insurance contract, a person who assisted or in any manner aided directly or indirectly in the procurement of the insurance contract, shall be liable to the insured for the full amount under the provisions of the insurance contract. (5 10 ch 117 SLA 1984)

Sec. 21.33.040. Service of process. [Repealed, 5 2 ch 234 SLA 1968.]

Sec. 21.33.041. Contract validity. [Repealed, 5 26 ch 117 SLA 1984.]

Sec. 21.33.042. Suits by nonadmitted insurers. A nonadmitted insurer may not commence or maintain an action in law or equity in this state to enforce a right arising out of a transaction of insurance in this state except with respect to

- (1) claims under policies lawfully written in this state,
- (2) liquidation of assets and liabilities, other than the collection of new premiums, resulting from its former admitted operations in this state,

(3) transactions subsequent to issuance of a policy not covering domestic risks at time of issuance, and lawfully solicited, written or delivered outside this state.

(4) surplus lines insurance coverage exported in accordance with AS 21.34;

(5) reinsurance;

(6) the continuation and servicing of life insurance, disability insurance policies or annuity contracts remaining in force as to residents of this state where the insurer has withdrawn from the state and is not transacting new insurance;

(7) servicing of policies written by an admitted insurer in a state to which the insured has moved but in which the insured is not licensed, until the term of the policy expires.

(8) claims under policies covering wet marine and transportation insurance, including vessels of 50 displacement tons or less (5 11 ch 117 SLA 1984)

Sec. 21.33.045. Investigation and disclosure of insurance contracts. (a) When the director has reason to believe that insurance has been effectuated by or for a person in this state with a nonadmitted insurer the director shall in writing order the person to produce for examination all insurance contracts and other documents evidencing insurance with nonadmitted insurers and to disclose to the director the amount of insurance, name and address of each insurer, gross amount of premium paid or to be paid and the name and address of the person or persons assisting or aiding in the solicitation, negotiation or effectuation of the insurance.

(b) [Repealed, 5 26 ch 117 SLA 1984.]

(c) In case of a failure of any person to comply with the director's order under (a) of this section, the superior court, on application of the director, may issue an order requiring the production of the records and information sought by the director.

(d) This section does not apply to life insurance, disability insurance or annuity contracts (5 1 ch 234 SLA 1968, am 59 12, 13, 26 ch 117 SLA 1984)

Effect of amendments. — The 1984 amendment added subsections (c) and (d); in subsection (a), substituted "a nonadmitted" for "both authorized and unauthorized," and repealed former subsection (b) relating to violations of this section.

Sec. 21.33.050. Exemptions from service of process provisions. [Repealed, 5 2 ch 234 SLA 1968.]

Sec. 21.33.051. Reporting of unauthorized insurance. [Repealed, 5 26 ch 117 SLA 1984.]

Sec. 21.33.055. Unauthorized insurance premium tax. (a) Except as to premiums on lawfully procured surplus lines insurance

of insurance in this state may be suspended by the director if the annual statement has not been filed by March 1. (1 ch 120 SLA 1966; am § 1 ch 149 SLA 1984; am § 7 ch 26 SLA 1986)

Effect of amendments. — The 1985 "set under" for "as prescribed in" and amendment in subsection (d) substituted made other minor changes

Sec. 21.09.210. Tax. (a) Each authorized insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall file with the director, before March 2 in each year, a report of all insurance business written or contracted in the state (with proper proportionate allocation of premium for the property, subjects, or risks in the state insured under policies or contracts covering property, subjects, or risks located or resident in more than one state) during the preceding year ending December 31. The report shall show

(1) the amounts paid policyholders on losses,

(2) the total direct premium income including policy membership and other fees, premiums paid by application of dividends, refunds, savings coupon, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance whether designated a premium or otherwise;

(3) the amounts paid policyholders as returned premiums;

(4) the amounts paid policyholders as dividends.

(b) Each insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall pay a tax on the total direct premium income received during the year ending on the preceding December 31 and paid for the insurance of property or risks resident or located in the state other than wet marine and transportation insurance, after deducting from the total direct premium income the applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. No deductions may be made of cash surrender value of policies. Considerations received on annuity contracts are not included in the direct premium income and are not subject to tax. The tax shall be paid to the director annually before April 1, and is computed at the rate of

(1) for domestic and foreign insurers, except hospital and medical service corporations, 2.7 per cent,

(2) for hospital and medical service corporations, six per cent of their gross premiums less claims paid

(c) [Repealed effective July 1, 1989] A domestic company that has filed with the director, before July 1, 1987, for approval to orga-

nize is exempt from taxation under this section for a period of not more than five years from the date of its organization or until June 30, 1989, whichever occurs first

(d) An authorized insurer shall, with respect to all wet marine and transportation contracts written in this state during the preceding calendar year, before April 1 of each year, pay to the director a tax of three-quarters of one per cent on its gross underwriting profit. The gross underwriting profit is computed by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance), on wet marine and transportation insurance contracts, the net losses paid (i.e., gross losses paid, less salvage and recoveries on reinsurance ceded) during the calendar year under the contracts. In the case of an insurer issuing participating contracts, the gross underwriting profit shall not include, for computation of the tax prescribed by this section, the amounts refunded or paid as participation dividends by the insurers to the holders of the contracts

(e) Payment to the director by an insurer of the tax upon its premiums required by this section shall be in lieu of all other taxes imposed by the state upon premiums, franchises, privilege or other taxes measured by income of the insurer commencing with the taxable year beginning January 1, 1967

(f) The state hereby pre-empt the field of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses, and fees upon insurers and their general agents, agents and representatives as such, and on the intangible property of insurers or agents; and all political subdivisions of agencies in the state, including home rule boroughs or cities, are prohibited from imposing or levying upon insurers, or upon their general agents, agents and representatives as such, any tax, license, or fee. Provided that this subsection shall not be construed as prohibiting the imposition by political subdivisions of taxes upon real and tangible personal property of insurers and their general agents, agents and representatives.

(g) The director may suspend or revoke the certificate of authority of an insurer which fails to pay its taxes as required under this section.

(h) The provisions of this section do not apply to title insurance companies. A premium tax on title insurance companies shall be levied in accordance with the provisions of AS 21.66.110

(i) Premiums paid by the state for insurance policies and contracts purchased under the provisions of AS 39.30 are exempt from taxation under this section. Claims for exemption shall be made on forms provided by the division of insurance (1 ch 120 SLA 1966; am § 29 ch 137 SLA 1982; am § 1 ch 118 SLA 1986; am § 41 ch 14 SLA 1987; am §§ 1, 48 ch 29 SLA 1987)

Effect of amendments. - The 1986 amendment in subsection (b) in the third sentence substituted "are" for "shall" in two places and deleted "be" following "not" in two places. In paragraph (1) substituted "and foreign insurers, except hospital and medical service corporations, 2.7" for "companies, 1 1/2," in paragraph (2) substituted "six" for "8," and repealed paragraph (3), which read "for companies other than domestic and hospital and medical service corporations, 3 percent." The first 1987 amendment, effective May 30, 1987, deleted "except as provided in AS 21.09.250(c)" preceding "in computed at the rate" near the introductory language of subsection (b).

Sec. 21.09.250. Prohibited acts. An insurer doing business in this state may not make, write, place, or cause to be made, written, or placed in this state a policy, duplicate policy, or contract of insurance of any kind or character, or general or floating policy upon persons or property resident, situated, or located in this state, from or through a broker, agent, general agent, surplus line broker, or person who has not secured a license in this state. An insurer may not pay a commission or any form of remuneration to a person, firm, or organization for the writing or placing of insurance coverage in this state unless that person, firm, or organization holds a license issued by the director. (1 ch 120 SLA 1966, am § 2 ch 29 SLA 1987)

Effect of amendments. The 1987 amendment inserted "general agent" in the first sentence and made minor punctuation changes throughout the section.

Sec. 21.09.280. General agents. (a) An insurer appointing a person as its general agent to represent it in this state shall file notice of the appointment with the director on forms prescribed and furnished by the director.

(b) A general agent has the authority, consistent with this title, that may be conferred by the insurer. A general agent, resident or nonresident, qualified in AS 21.27.090, licensed as provided in this section in the same manner as is provided for agents in AS 21.27, may exercise the powers conferred by this title upon agents licensed for the kinds of insurance that the general agent is authorized to transact for the insurer appointing the agent.

(c) The appointment of a resident or nonresident general agent is not effective unless the person appointed is licensed as the general agent of the insurer by the director upon application and payment of a fee set under AS 21.06.250.

The second 1987 amendment in subsection (c) inserted "that has filed with the director, before July 1, 1987, for approval to organize" and "not more than" preceding "five years" and added "or until June 30, 1987, whichever occurs first" at the end of the subsection and repealed subsection (c), July 1, 1987.

Editor's notes. Section 2, ch 118, SLA 1986 provides that the tax rates in (b) of this section, as amended by § 1, ch 118, SLA 1986, apply "to the tax due by April 1, 1987 for the tax year beginning January 1, 1986 and to the tax due for subsequent tax years."

(d) Every licensee is subject to the payment of an annual fee set under AS 21.06.250 and payable on or before the close of business on the 30th day of June of each year.

(e) The director may deny, suspend, or revoke a license for any cause specified in AS 21.27.410 in the manner provided in AS 21.27.420.

(f) Persons employed on salary by an insurer, including officers and salaried employees performing the same services as general agents, are considered to be service representatives and are not required to be licensed.

(g) For purposes of this section, a person, firm, or corporation that performs management services for an insurer is not considered a general agent if

(1) the person, firm, or corporation is a wholly-owned subsidiary of the insurer;

(2) the person, firm, or corporation wholly owns the insurer; or

(3) the person, firm, or corporation is a wholly-owned subsidiary of the insurance holding company that owns or controls the insurer. (1 ch 120 SLA 1966, am § 7 ch 113 SLA 1974, am § 6 ch 26 SLA 1985, am §§ 3, 4 ch 29 SLA 1987)

Effect of amendments. - The 1985 amendment substituted "a" for "the" preceding "set under" for "as provided in."

Chapter 21. Investments.

Section 600. Definition of domestic insurer

Sec. 21.21.600. Definition of domestic insurer. In this chapter, unless the context requires otherwise, "domestic insurer" has the meaning given in AS 21.90.900 and, in addition, for the purposes of this chapter, includes an insurer which has been authorized to do business in this state and which, during its three preceding fiscal years taken together, or during any lesser period of time if it has been licensed to transact its business in the State of Alaska only for such lesser periods of time, has written an average of more gross premiums in the State of Alaska than it has written in its state of domicile during the same period, and the gross premiums written constitute 33 percent or more of its total gross premiums written everywhere in the United States for the three year or lesser period, as reported in its three most recent annual statements. (1 ch 206 SLA 1976)

Editor's notes. - This section is set out above to correct a minor error in the main pamphlet.

and premiums on independently procured insurance on which a tax has been paid under AS 21.33.061, every nonadmitted insurer shall pay to the director before April 1 following the calendar year in which the insurance was so effectuated, continued or renewed a premium-receipts tax of three percent of gross premiums charged for the insurance other than marine insurance and a premium-receipts tax of three-fourths of one percent of gross premiums charged for the marine insurance on subjects resident, located or to be performed in this state. The insurance on subjects resident, located or to be performed in this state procured through negotiations or an application, in whole or in part occurring or made in or from in or out of this state, or for which premiums in whole or in part are remitted directly or indirectly from in or out of this state, shall be considered to be insurance procured, or continued or renewed in this state. The term "premium" includes all premiums, membership fees, assessments, dues and any other consideration for insurance. The tax is in lieu of all taxes and fire department dues. On default of a nonadmitted insurer in the payment of the tax the insured shall pay the tax. If the tax prescribed by this section is not paid within the time stated, the tax shall be increased by a penalty of 25 percent and by the amount of an additional penalty not to exceed \$100 a day from the date the payment was due to the date paid.

(b) If a policy covers risks or exposures only partially in this state, the tax payable shall be computed on the portions of the premium which are properly allocable to the risks or exposures located in this state. In determining the amount of premiums taxable in this state, all premiums written, procured, or received in this state and all premiums on policies negotiated in this state shall be considered written on property or risks located or resident in this state, except premiums which are properly allocated or apportioned and reported as taxable premiums of another state. (S 1 ch 234 SLA 1968, am § 14 ch 117 SLA 1984)

Effect of amendments. - The 1984 amendment, in subsection (a), in the first sentence, substituted "nonadmitted" for "unauthorized", "a nonadmitted" for "an unauthorized" in the next-to-last sentence,

and "not to exceed \$100 a day" for "computed at the rate of one percent per month or any part of a month" in the last sentence.

Sec. 21.33.060. Defense of action by unauthorized insurer. (Repealed, § 2 ch 234 SLA 1968)

Sec. 21.33.061. Independently procured insurance; premium tax. (a) Every insured who procures or causes to be procured or continues or renews insurance with a nonadmitted insurer, or an insured or self-insurer who so procures or continues excess loss, catastrophe or other insurance, upon a subject of insurance resident, located or to be performed in this state, other than insurance procured through a sur-

plus lines broker under AS 21.34 shall, within 30 days after the date the insurance was procured, continued, or renewed, file a report with the director in writing and upon forms designated by the director and furnished to the insured upon request. The report shall show the name and address of the insured, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged, and additional pertinent information which is reasonably requested by the director.

(b) Insurance in a nonadmitted insurer of a subject of insurance resident, located or to be performed in this state procured through negotiations or an application, in whole or in part occurring or made in or from in or out of this state, or for which premiums in whole or in part are remitted directly or indirectly from in or out of this state, is considered to be insurance procured, or continued or renewed in this state within the intent of (a) of this section.

(c) There is levied upon the obligation, chose in action, or right represented by the premium charged for the insurance, a premium receipts tax of three per cent of gross premiums charged for the insurance other than marine insurance and a premium receipts tax of three-fourths of one per cent of gross premiums charged for the marine insurance. The term "premium" includes all premiums, membership fees, assessments, dues and any other consideration for insurance. The tax is in lieu of all taxes and fire department dues. The insured shall, before April 1 following the calendar year in which the insurance was procured, continued or renewed, pay the amount of the tax to the director. In event of cancellation and rewriting of the insurance contract the additional premium for premium receipts tax purposes is the premium in excess of the unearned premium of the canceled insurance contract.

(d) If a policy covers risks or exposures only partially in this state, the tax payable shall be computed on the portions of the premium which are properly allocable to the risks or exposures located in this state. In determining the amount of premiums taxable in this state, all premiums written, procured or received in this state and all premiums on policies negotiated in this state shall be considered written on property or risks located or resident in this state, except premiums which are properly allocated or apportioned and reported as taxable premiums of another state.

(e) If the insured fails to withhold from the premium the amount of tax levied, the insured is liable for the amount and shall pay the tax to the director within the time stated in (c) of this section. If the tax prescribed by this section is not paid within the time stated in (c) of this section, the tax shall be increased by a penalty of 25 percent and by the amount of an additional penalty not to exceed \$100 per day from the date the payment was due to the date paid.

(f) The attorney general, upon request of the director, shall proceed in the courts of this or another state or in a federal court or agency to recover the tax not paid within the time prescribed in this section.

(g) This section does not apply to individual life or individual disability insurance.

(h) This section does not abrogate or modify, and may not be construed or considered to abrogate or modify a provision of AS 21.33.037 or 21.33.042 or another provision of this chapter.

(i) This section does not apply to life insurance, disability insurance, annuity contracts, or insurance for aircraft regularly engaged in interstate or foreign commerce. (S 1 ch 234 SLA 1968; am §§ 15--18 ch 117 SLA 1984)

Effect of amendments. - The 1984 amendment added subsections (h) and (i) and, in subsection (a), substituted "a nonadmitted" for "an unauthorized" and "broker under AS 21.34 shall, within 30" for "agent under the surplus line law of this state shall, within 60" in the first sentence and deleted "or insureds" following

"insured" in the second sentence, in subsection (b), substituted "a nonadmitted" for "an unauthorized" and "is" for "shall be", and, in subsection (c), substituted "not to exceed \$100 per day" for "computed at the rate of one percent per month or any part of a month" in the second sentence.

Sec. 21.33.065. Penalties. (a) A person other than an insured, who in this state represents or aids a nonadmitted insurer in violation of AS 21.33.037, is subject to a civil penalty of not more than \$5,000 in addition to applicable criminal penalties and other penalties prescribed in this chapter.

(b) In addition to any other penalty provided, a person who violates a provision of this chapter shall be subject to a civil penalty of not more than \$1,000 for the first offense and not more than \$2,000 for each succeeding violation.

(c) An additional penalty of not more than \$1,000 may be levied for each month that a violation under this chapter continues. (S 1 ch 234 SLA 1968; am § 19 ch 117 SLA 1984)

Effect of amendments. - The 1984 amendment rewrote this section.

Sec. 21.33.068. Venue. (Repealed, § 26 ch 117 SLA 1984)

Sec. 21.33.070. Attorney fees. (Repealed, § 2 ch 234 SLA 1968)

Sec. 21.33.071. Insurer and insurance business defined. (Repealed, § 26 ch 117 SLA 1984)

Sec. 21.33.075. Exceptions. (Repealed, § 26 ch 117 SLA 1984)

Article 2. Surplus Lines.

Section

310 Exemptions from surplus line law

330 Surplus line broker defined

Secs. 21.33.080 - 21.33.300. Surplus Lines Insurance Law. (Repealed, § 26 ch 117 SLA 1984)

Sec. 21.33.310. Exemptions from surplus line law. The provisions of the surplus line insurance law controlling the placing of insurance with unauthorized insurers do not apply to reinsurance or to the following insurances when placed by licensed insurance agents of this state:

(1) wet marine and transportation insurance, except insurance covering risk or exposure of a marine vessel engaged in commercial fishing or fish processing in the state for a period of 30 or more consecutive days in a year;

(2) insurance on subjects located, resident, or to be performed wholly outside of this state, or on vehicles or aircraft owned and principally garaged outside this state;

(3) insurance on property or operations of railroads engaged in interstate commerce;

(4) insurance of aircraft operated in scheduled interstate flight, or cargo of such aircraft, or insurance against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance or use of the aircraft. (S 1 ch 120 SLA 1966; am § 2 ch 156 SLA 1970; am § 8 ch 206 SLA 1976)

Sec. 21.33.320. (Renumbered as AS 21.33.900)

Sec. 21.33.330. Surplus line broker defined. A surplus line broker is an individual licensed to transact business in the state or on risks in the state for an unadmitted insurer. (S 1 ch 120 SLA 1966)

Reviser's notes. - This section is about "broker" is found at AS 21.33.910. A new definition of surplus lines enacted in 1984.

Article 3. General Provisions.

Section

900 Records of insureds

910 Definitions

Sec. 21.33.900. Records of insureds. In order that the director may effectively administer this chapter, each person who has placed insurance with an unauthorized insurer shall, upon the director's order, produce for the examination of the director all policies and other documents evidencing the insurance and shall disclose to the director

license before December 2 shall pay a penalty of \$100. A surplus lines broker who fails to apply for renewal of the license before December 31 shall pay a penalty of \$250 and any other penalties provided in this title before the license may be renewed. (§ 21 ch 117 SLA 1984)

Sec. 21.34.150. Surplus lines brokers may accept business from other brokers. A surplus lines broker may originate surplus lines insurance or accept surplus lines insurance from another broker or surplus lines broker licensed in this state as to the kind of insurance involved. The surplus lines broker may compensate the licensed broker or surplus lines broker for the insurance. (§ 21 ch 117 SLA 1984)

Sec. 21.34.160. Records of surplus lines broker. (a) Each surplus lines broker shall keep in the office a full and true record of each surplus lines insurance contract placed by or through the surplus lines broker, including a copy of the policy, certificate, cover note, or other evidence of insurance showing the following items as may be applicable:

- (1) amount of insurance and perils insured;
- (2) brief description of property insured and its location;
- (3) gross premium charged;
- (4) any return premium paid;
- (5) rate of premium charged upon the several items of property;
- (6) effective date of the contract, and the terms of the contract;
- (7) name and address of the insured;
- (8) name and address of the insurer;
- (9) amount of tax and other sums to be collected from the insured;
- (10) any evidence of insurance issued in compliance with AS 21.34.160;
- (11) identity of the producing broker;
- (12) any confirming correspondence from the insurer or its representative; and
- (13) the application.

(b) The record of each contract shall be kept open at all reasonable times to examination by the director without notice for a period of not less than five years following termination of the contract. (§ 21 ch 117 SLA 1984)

Sec. 21.34.170. Monthly reports, summary of exported business. On or before the end of each month, each surplus lines broker shall file with the director, on forms prescribed by the director, a verified report in duplicate of all surplus lines insurance transacted during the preceding calendar month showing aggregate gross premiums written and aggregate return premiums by kind of insurance. (§ 21 ch 117 SLA 1984)

Sec. 21.34.180. Surplus lines tax. (a) Gross premiums charged, less any return premium, for surplus lines insurance are subject to a

premium receipts tax as outlined in AS 21.09.210, which shall be collected by the surplus lines broker as specified by the director, in addition to the full amount of the gross premium charged by the insurer for the insurance. The tax on any portion of the premium unearned at termination of insurance having been credited by the state to the surplus lines broker shall be returned to the policy holder directly by the surplus lines broker or through the producing broker, if any. The surplus lines broker may not absorb the tax or any part of it, and may not rebate for any reason the tax or any part of it.

(b) The surplus lines tax is due on the second day of March following the calendar year in which the premium is written. The tax shall be paid to and reported on forms prescribed by the director, or upon the director's order paid to and reported on forms prescribed by the surplus lines association.

(c) If a surplus lines policy procured through a surplus lines broker covers risks or exposures only partially located or to be performed in this state, the tax payable shall be computed on the portions of the premium properly attributable to the risks or exposures located or to be performed in this state as follows:

(1) if the risk insured is real or personal property, the percentage of the entire tax that is due to this state is the same as the percentage of the entire risk that is located in this state, computed on the same basis as was employed to calculate the insurable value of the risk;

(2) if the risk insured is business operations, general liability or employee benefits, the percentage of the entire tax that is due to this state is the same as the percentage of the insured business operations or employees that are located in this state.

(d) This section does not apply to insurance of risks of state government or its political subdivision, to an agency of state government or its political subdivision, or to insurance of aircraft regularly engaged in interstate or foreign commerce.

(e) If a multi-state risk has a portion of that risk located within this state, the surplus lines broker will remit payment of taxes collected in this state in accordance with the provisions of (c) of this section. (§ 21 ch 117 SLA 1984)

Sec. 21.34.190. Filing fee. The fee for filing the statement under AS 21.34.180(b) is an amount equal to one percent on gross premium charged less any return premiums during the preceding calendar year. The surplus lines broker shall pay the fee at the time of filing of the statement. (§ 21 ch 117 SLA 1984)

Sec. 21.34.200. Collection of taxes and fees. (a) If the tax collectible under AS 21.34.180 or the fee collectible under AS 21.34.190 by a surplus lines broker is not paid within the time prescribed, the tax, fee or both along with appropriate penalties may be collected by distraint or by an action in court, against the surplus lines licensee and the surety on the bond filed under AS 21.34.140(b)(4).

1.06.040

§ 21.06.090

INSURANCE

§ 21.06.260

88.210,

Sec. 21.06.090. Regulations. (a) The director may adopt reasonable regulations to effectuate this title. A regulation may not extend, modify, or conflict with any law of this state or the reasonable implications thereof. Except for regulations adopted under AS 21.06.250, a regulation affecting a person or matter other than the personnel or the internal affairs of the director's office shall be adopted or amended only after a hearing, of which notice was given as required by AS 21.06.200. If reasonably possible the director shall set out the proposed regulation or amendment in or with the notice of hearing. A regulation or amendment as to which a hearing is required is not effective until it has been on file as a public record in the director's office for at least 10 days.

(b) In addition to any other penalty provided, wilful violation of a regulation subjects the violator to the administrative penalty prescribed for that violation. (§ 1 ch 120 SLA 1966; am § 1 ch 26 SLA 1985)

Effect of amendments. — The 1985 amendment in subsection (a) inserted "Except for regulations adopted under AS 21.06.250" at the beginning of the third sentence and made other minor word changes.

Sec. 21.06.250. Fees and licenses. The director shall collect in advance a fee for each license and for services performed by the division of insurance. Fees may be collected for but are not limited to applications, examinations, licenses and license renewals, certificates of authority, service of process, printed or photocopied material, and postage. The director shall adopt regulations setting the fees in an amount the director determines to be sufficient to reimburse the state for the actual expense incurred in providing a service. (§ 1 ch 120 SLA 1966; am §§ 1 — 6 ch 113 SLA 1974; am § 1 ch 206 SLA 1976; am § 2 ch 26 SLA 1985)

Effect of amendments. — The 1985 amendment rewrote this section.

Sec. 21.06.260. Accounting and disposition of fees. The commissioner of administration shall separately account for fees collected under this chapter that the division deposits in the general fund. The annual estimated balance in the account may be used by the legislature to make appropriations to the Department of Commerce and Economic Development to carry out the operations of the division. (§ 42 ch 138 SLA 1986)

(3) "Voluntary pool" means the workers' compensation insurance assigned risk pool in which participation by insurers is voluntary. (Eff. 1/1/77, Register 61)

Authority: AN 21 06 090
AN 21 30 155-b1

CHAPTER 31. MISCELLANEOUS

Section

- 10 General requirements
- 20 Agent, general agent, and adjuster fees
- 30 Broker fees

Section

- 40 Surplus lines broker fees
- 50 Insurer fees
- 60 Miscellaneous fees
- 90 Definitions

3 AAC 31.010. GENERAL REQUIREMENTS. (a) The applicable nonrefundable fee established by the division of insurance, under 3 AAC 31.020 -- 3 AAC 31.090, must be paid to the director in advance of the action requested.

(b) The director will promptly remit to the commissioner of revenue, for deposit in the general fund, all fees received under this section. (Eff. 8/30/86, Register 99; am. 6/2/88, Register 106)

Authority: AS 21 06 090
AS 21 06 250

3 AAC 31.020. AGENT, GENERAL AGENT, AND ADJUSTER FEES. The following fees are established for resident or nonresident licensees, permanent or temporary, for insurance agents, general agents, and adjusters:

(1) application for an original license for all lines, including issuance of the license, if issued,

(A) for a resident individual not acting on behalf of a firm, \$120;

(B) for a nonresident individual not acting on behalf of a firm, \$220;

(C) for any individual acting on behalf of a licensed firm, \$45;

(D) for a resident firm, including the principal or manager, \$220; and

(E) for a nonresident firm, including the principal or manager, \$120;

(2) application for an original license for property casualty lines only or for life lines only, including issuance of the license, if issued,

(A) for a resident individual not acting on behalf of a firm, \$70;

(B) for a nonresident individual not acting on behalf of a firm, \$120;

(C) for any individual acting on behalf of a licensed firm, \$45;

(D) for a resident firm, including the principal or manager, \$120; and

(E) for a nonresident firm, including the principal or manager, \$220.

(3) annual continuation of a license for all lines,

(A) for a resident individual not acting on behalf of a firm, \$100;

(B) for a nonresident individual not acting on behalf of a firm, \$200;

(C) for any individual acting on behalf of a licensed firm, \$25;

(D) for a resident firm, including the principal or manager, \$200; and

(E) for a nonresident firm, including the principal or manager, \$400.

(4) annual continuation of a license for property casualty lines only or for life lines only,

(A) for a resident individual not acting on behalf of a firm, \$50;

(B) for a nonresident individual not acting on behalf of a firm, \$100;

(C) for any individual acting on behalf of a licensed firm, \$25;

(D) for a resident firm, including the principal or manager, \$100; and

(E) for a nonresident firm, including the principal or manager, \$200.

(5) application for an original resident trainee adjuster license and for issuance of the license, if issued, \$70;

(6) annual continuation of a resident trainee adjuster license, \$50;

(7) application for an original firm limited license for a travel insurance agent, including the principal or manager, \$70; and

(8) annual continuation of a firm limited license for a travel insurance agent, including the principal or manager, \$50. (Eff. 8/30/86, Register 99; am. 6/2/88, Register 106)

Authority: AS 21 06 090
AS 21 06 250

3 AAC 31.030. BROKER FEES. The following fees are established for licensees for insurance brokers:

(1) application for an original license for all lines, including issuance of the license, if issued,

(A) for a resident individual not acting on behalf of a firm, or a resident firm, including the principal or manager, \$220;

(B) for a nonresident individual not acting on behalf of a firm, or a nonresident firm, including the principal or manager, \$520; and

- (C) for any individual acting on behalf of a licensed firm, \$45.
- (2) application for an original license for property/casualty lines only or for life lines only, including issuance of the license, if issued,
 - (A) for a resident individual not acting on behalf of a firm, or a resident firm, including the principal or manager, \$170;
 - (B) for a nonresident individual not acting on behalf of a firm, or a nonresident firm, including the principal or manager, \$320; and
- (C) for any individual acting on behalf of a licensed firm, \$45.
- (3) annual continuation of a license for all lines,
 - (A) for a resident individual not acting on behalf of a firm, or a resident firm, including the principal or manager, \$200;
 - (B) for a nonresident individual not acting on behalf of a firm, or a nonresident firm, including the principal or manager, \$500; and
- (C) for any individual acting on behalf of a licensed firm, \$25.
- (4) annual continuation of a license for property/casualty lines only or for life lines only,
 - (A) for a resident individual not acting on behalf of a firm, or a resident firm, including the principal or manager, \$150;
 - (B) for a nonresident individual not acting on behalf of a firm, or a nonresident firm, including the principal or manager, \$300; and
- (C) for any individual acting on behalf of a licensed firm, \$25. (Eff. 6/2/88, Register 106)

Authority: AS 21.06.090
AS 21.06.250

3 AAC 31.040. SURPLUS LINES BROKER FEES. The following fees are established for licenses for surplus lines insurance brokers.

- (1) application for an original license, including issuance of the license, if issued,
 - (A) for a resident individual not acting on behalf of a firm, or a resident firm, including the principal or manager, \$220;
 - (B) for a nonresident individual not acting on behalf of a firm, or a nonresident firm, including the principal or manager, \$620; and
- (C) for any individual acting on behalf of a licensed firm, \$45.
- (2) annual continuation of a license,
 - (A) for a resident individual not acting on behalf of a firm, or a resident firm, including the principal or manager, \$200;
 - (B) for a nonresident individual not acting on behalf of a firm, or a nonresident firm, including the principal or manager, \$600; and

- (C) for any individual acting on behalf of a licensed firm, \$25. (Eff. 6/2/88, Register 106)

Authority: AS 21.06.090
AS 21.06.250

3 AAC 31.050. INSURER FEES. The following fees are established for insurers:

- (1) application for a certificate of authority, including a solicitation permit and issuance of the certificate, if issued, a one-time fee of \$1,000;
- (2) annual continuation of a certificate of authority, \$100;
- (3) amendment to a certificate of authority, \$100;
- (4) amendment to the articles of incorporation, \$100;
- (5) revised bylaws or amendment to bylaws, \$100;
- (6) filing an annual statement, \$100;
- (7) solicitation permit for subsequent financing, for domestic insurers, \$100;
- (8) insurer appointment of a general agent or agent, \$10;
- (9) annual continuation of an insurer appointment of a general agent or agent, \$10; and
- (10) reinstatement of a certificate of authority, \$500. (Eff. 6/2/88, Register 106)

Authority: AS 21.06.090
AS 21.06.250

3 AAC 31.060. MISCELLANEOUS FEES. (a) The following fees are established:

- (1) application for an original resident solicitor license, including issuance of the license, if issued, for an individual soliciting on behalf of a licensed individual or firm, \$70;
- (2) annual continuation of a resident solicitor license for an individual soliciting on behalf of a licensed individual or firm, \$50;
- (3) amendment to an insurance license, \$20;
- (4) insurance vending machine license, each machine, each year, \$70;
- (5) for issuing a certification, \$25;
- (6) for accepting service of process, \$25;
- (7) for a copy of an insurance report, \$25;
- (8) for a three-year rating bureau license, \$300; and
- (9) with respect to a license other than surplus lines broker, which has not been revoked, a surcharge for late payment of an annual license continuation fee, if payment is overdue by
 - (A) 1 to 60 days, \$100; or
 - (B) over 60 days, \$200.

3 AAC 31.090 ALASKA ADMINISTRATIVE CODE 3 AAC 31.090

(b) For any printed material furnished by the director and not otherwise described in this section, the director will, in his or her discretion, charge the actual cost of printing plus handling and postage (Eff. 6/2/88, Register 106)

Authority: AS 21.06.090
AS 21.06.250

3 AAC 31.090. DEFINITIONS. In this chapter,

- (1) "all lines" means both life lines and property/casualty lines;
- (2) "life lines" means life, disability, annuities, credit life and disability, and, if qualified, variable products insurance; and
- (3) "property casualty lines" means property, casualty, surety, marine, title, mortgage guaranty, and, if qualified, disability insurance (Eff. 6/2/88, Register 106)

Authority: AS 21.06.090
AS 21.06.250

PART 3. SECTION OF WEIGHTS AND MEASURES

Chapter

- 32 Specifications, Tolerances, and Regulations for Weighing and Measuring Devices (3 AAC 32.010 3 AAC 32.610)
- 33 Commodities (3 AAC 33.010 3 AAC 33.600)
- 34 Method of Sale and Delivery of Commodities (3 AAC 34.010 3 AAC 34.140)
- 35 Overweight and Overweight Vehicles (3 AAC 35.110 3 AAC 35.900)
- 36 Deleted

CHAPTER 32. SPECIFICATIONS, TOLERANCES, AND REGULATIONS FOR WEIGHING AND MEASURING DEVICES

Article

- 1 Repealed
- 2 Household Scales (3 AAC 32.050 3 AAC 32.070)
- 3 Testing and Inspecting of Commercial Devices (3 AAC 32.090)
- 4 Inspection of Incorrect Apparatus (3 AAC 32.090 3 AAC 32.110)
- 5 Gas Measuring Devices (3 AAC 32.120 3 AAC 32.150)
- 6 Specifications: Positive Displacement and Turbine Gas Measuring Devices (3 AAC 32.160 3 AAC 32.280)
- 7 Testing of Positive Displacement and Turbine Gas Measuring Devices (3 AAC 32.210 3 AAC 32.270)
- 8 Specifications and Requirements: Thrift Meters (3 AAC 32.280 3 AAC 32.290)
- 9 User Requirements: Gas Measuring Devices: General (3 AAC 32.300 3 AAC 32.370)
- 10 Corrections for Altitude: Applicable to All Gas Meters (3 AAC 32.380 3 AAC 32.400)
- 11 Electric Meters (3 AAC 32.410 3 AAC 32.610)

3 AAC 32.050 COMMERCE AND ECON DEV 3 AAC 32.070

Article 1. Hanging Scales

Repealed 7/17/82

Article 2. Household Scales

Section

50 Commercial use of household scales
60 Sale of household scales

Section

70 Prima facie evidence

3 AAC 32.050. COMMERCIAL USE OF HOUSEHOLD SCALES. No overload type of spring scale or balances commonly known as "household" scales shall be used or employed in any commercial establishment in the State of Alaska for the weighing of any commodity sold to the purchasing public (Eff. 7/24/70, Register 35)

Authority: AS 45.75.050
AS 47.75.120

3 AAC 32.060. SALE OF HOUSEHOLD SCALES. No "household" scale shall be sold or offered for sale by any manufacturer, vendor or vendors of such devices, for use or service whatsoever unless the dial or reading face is plainly and conspicuously marked with the wording, "Not legal for use in trade," it being provided that such scales may be sold or offered for household or noncommercial use only (Eff. 7/24/70, Register 35)

Authority: AS 45.75.050
AS 45.75.120

3 AAC 32.070. PRIMA FACIE EVIDENCE. Any such scale found in commercial use at any store, stand, business establishment, or on any vehicle from which commodities are sold or offered for sale, is prima facie evidence of commercial use, and shall be subject to immediate condemnation and confiscation (Eff. 7/24/70, Register 35)

Authority: AS 45.75.050
AS 45.75.120

Article 3. Testing and Inspecting of Commercial Devices

Section

80 Assistance in testing operations

ATTACHMENT B
Basic Premium Taxes in the 50 States

BASIC PREMIUM TAXES ON
FOREIGN AND DOMESTIC INSURANCE COMPANIES

Note: Does not include other applicable taxes such as fire marshal, fire department, firemen's pension, police pension, workers compensation administration, automobile financial responsibility administration, security fund and other miscellaneous levies. Does not cover offsets for real estate taxes, local investments, property taxes, etc. For taxes and assessments based on workers compensation premiums, please refer to each state, Section III.

<u>State</u>	<u>Domestic Companies</u>	<u>Foreign Companies</u>
Alabama	1%	4%
Alaska	Tax free for 5 years after organization; 3% (86)	3%
Arizona	1.9% for fire insurance 1.7% for all other lines .4312% assessment on all auto insurance premiums (85)	same as domestics (85)
Arkansas	2.5% (81)	2.5%
California	2.33% (82)	2.33% (82)
Colorado	2.25% (except companies having home or regional office in Colo., including captives--1%)	2.25% (except companies having home or regional office in Colo., including captives--1%)
Connecticut	2% plus 2.625% on interest and dividends	2%
Delaware	2%	2%
District of Columbia	2%	2%
Florida	none	2%
Georgia	2.25%	2.25%
Hawaii	2.9647% (79)	4.2824% (79)
Idaho	3%	3%
Illinois	2% for certain domestics (see II-C-3). (Subject to 4% income tax)	2% (4% income tax is deductible)

Basic Premium Taxes - 2

<u>State</u>	<u>Domestic Companies</u>	<u>Foreign Companies</u>
Indiana	2% (may elect corporate income tax)	2%
Iowa	2%	2%
Kansas	1%	2%
Kentucky	Domestic mutuals exempt but domestic stock same as foreign	2%
Louisiana	(Domestic and Foreign) 1/4 of 1% plus: Flat annual license tax by lines, based on gross (84) premiums of \$6,000 or less: \$140 life, A&H (gross annual premiums of \$7,000 or less); \$180 fire, marine, vehicle, WC, and all other. Additional license tax for each additional \$10,000 or fraction, by lines: \$66.67 boiler inspection, plate glass; \$170 life, A&H; \$300 fire, marine extended coverage, vehicle, WC, all other. (Reduction of tax allowed if assets invested in Louisiana securities.)	
Maine	2% (86)	2%
Maryland	2%	2%
Massachusetts	2%: 14% surtax	2%: 14% surtax
Michigan	5 mills per dollar of paid-up capital & surplus. 7.8% corporate income tax.	Fire--3%: casualty--2%
Minnesota	2% (except domestic mutuals which are exempt from premium tax other than fire premiums in protected areas.)	2%
Mississippi	3% (85)	3%
Missouri	2%	2%
Montana	2.75%	2.75%
Nebraska	0.6% for 1985, 0.7% for 1986, 0.8% for 1987, 1.0% for 1988 and thereafter (86)	same as domestic (86)
Nevada	3% (35)	Same as domestic (83)
New Hampshire	2%	2%

Basic Premium Taxes - 2

<u>State</u>	<u>Domestic Companies</u>	<u>Foreign Companies</u>
Indiana	2% (may elect corporate income tax)	2%
Iowa	2%	2%
Kansas	1%	2%
Kentucky	Domestic mutuals exempt but domestic stock same as foreign	2%
Louisiana	(Domestic and Foreign) 1/4 of 1% plus: Flat annual license tax by lines, based on gross (84) premiums of \$6,000 or less: \$140 life, A&H (gross annual premiums of \$7,000 or less); \$180 fire, marine, vehicle, WC, and all other. Additional license tax for each additional \$10,000 or fraction, by lines: \$66.67 boiler inspection, plate glass; \$170 life, A&H; \$300 fire, marine extended coverage, vehicle, WC, all other. (Reduction of tax allowed if assets invested in Louisiana securities.)	
Maine	2% (86)	2%
Maryland	2%	2%
Massachusetts	2%: 14% surtax	2%: 14% surtax
Michigan	5 mills per dollar of paid-up capital & surplus. 7.8% corporate income tax.	Fire--3%: casualty--2%
Minnesota	2% (except domestic mutuals which are exempt from premium tax other than fire premiums in protected areas.)	2%
Mississippi	3% (85)	3%
Missouri	2%	2%
Montana	2.75%	2.75%
Nebraska	0.6% for 1985, 0.7% for 1986, 0.8% for 1987, 1.0% for 1988 and thereafter (86)	same as domestics (86)
Nevada	3% (85)	Same as domestics (83)
New Hampshire	2%	2%

Basic Premium Taxes - 3

<u>State</u>	<u>Domestic Companies</u>		<u>Foreign Companies</u>	
New Jersey	2%		2%	
New Mexico	3%		3%	
New York	Combination of franchise and premium tax, not to exceed 2.65%.			
North Carolina	1.75%	(86)	1.75%	(86)
North Dakota	1%		1%	(83)
Ohio	franchise tax		2.5%	
Oklahoma	4%	(85)	4%	
Oregon	none, except foreign-controlled domestics organized after 1971; (corporate excise tax) 2.25%		2.25%	
Pennsylvania	2%		2%	
Rhode Island	2%		2%	
South Carolina	1.25%		1.25%	(86)
South Dakota	2.5%	(82)	2.5%	
Tennessee	2.5%	(84)	2.5%	(84)
Texas	3.50%	(81)	3.50%	(81)
Utah	2.25%		2.25%	
Vermont	2%		2%	
Virginia	2.75%		2.75%	
Washington	2%	(86)	2.0%	(86)
West Virginia	4% (3% on non-fire and casualty policies)	(81)	4% (3% on non-fire and casualty policies)	(81)
Wisconsin	none (corporate income tax)		Reciprocal fire tax minimum--3/8 of 1%, plus 2% fire department tax; casualty--2%	
Wyoming	2.5%	(86)	2.5%	(86)

Alaska State Legislature

Senate Advisory Council



PO Box V
State Capitol
Juneau, Alaska 99811
Phone (907) 465-3114

MEMORANDUM

TO: Senator Lloyd Jones
Alaska State Senate

FROM: Becky S. Penrose
Senate Advisory Council

DATE: June 6, 1988

SUBJECT: Status of Bills Addressing Tort Reform, Ophthalmologists, and Optometrists; IR# 88-003285

The information which you requested regarding Ophthalmologists, and Optometrists has been summarized as follows:

1. The number of bills introduced
2. The bill ID number, title, and sponsor
3. A summary of the bill
4. The status and votes

The information which you requested regarding Tort Reform; HB 85, is attached.

OPTOMETRY BILLS

In the 1987 and 1988 legislature there were four bills introduced regarding Optometry. Those were HB 291, HB 532, HB 534, and SB 226.

The prime sponsor of HB 291, an act relating to the regulation of optometry was the Health, Education and Social Services Committee (HESS). It had referrals to the HESS and Finance Committees. Since May 1, 1987 it has been in the House Finance Committee. At the end of the 1988 session it became a dead bill.

The prime sponsor of HB 532, an act relating to the regulation of Optometrists, extending the termination date of the board of examiners in optometry was the Labor and Commerce Committee (L&C). It had referrals to the L&C, HESS, and Finance Committees. On 5/8/88 it was transmitted to the Governor. It was signed into law on 5/25/88 Chapter 50 SLA 88. The effective date of law was 5/26/88.

Senator Jones
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The prime sponsor of HB 534, an act relating to regulation of dispensing opticians and dispensing optician apprentices; extending the termination date of the board of dispensing opticians was the L&C Committee. It had referrals to the L&C, HESS, and Finance Committees. On 5/6/88 it was transmitted to the Governor. It was signed into law on 5/25/88 Chapter 51 SLA 88. The effective date of law was 5/26/88.

The prime sponsor of SB 226, an act relating to the regulation of Optometry was the HESS Committee. It had referrals to the HESS, and L&C Committees. Zero Fiscal Note. On 5/4/88 it was transmitted to the Governor. It was signed into law on 5/25/88 Chapter 49 SLA 88. The effective date of law is 8/23/88.

HB 532, (CH 50 SLA 88) will extend the Board of Examiners in Optometry until June 30, 1992 (would have expired June 30, 1988).

Under the bill, the board will be responsible for licensing of optometrists (currently the board adopts regulations for the registration of optometrists). A person could not practice, attempt to practice, or offer to practice optometry without first obtaining a license from the board. The board would also be responsible for licensing branch officers of Alaskan licensee's.

Repeals AS 08.72.120, "A person may not practice, or attempt, or offer to practice, optometry without first obtaining a certificate of registration from the board." Provides act takes effect immediately.

Introduced February 17, 1988 and referred to L&C, HESS, and Finance.

Reported back to House March 2, 1988 by L&C recommending it do pass. Concurring: Donley (Chair), Ellis, Furnace, Menard, Koponen. To HESS.

Reported back to the House March 17, 1988 by Hess recommending it do pass. Concurring: Ellis and Koponen (Co-Chairs), Hanley, Phillips and Gruenberg. To Finance.

Passed the House April 5, 1988, 36-0-3-1. Excused: Davis, Hermann, Wallis. Absent: Pettyjohn. The effective date clause was adopted.

Reported back to the Senate April 14, 1988 by L&C recommending it do pass. Concurring: Kelly (Chair), Szymanski and Fahrenkamp. To Finance.

On May 6 the Finance Committee referral was waived at the request of Senator Halford. The bill passed the Senate May 6, 1988 with a vote of 19-0-1. Absent: Szymanski. The effective date clause was adopted.

HB 532 passed both houses and was transmitted to the Governor 5/8/88.

HB 534, (CH 51 SLA 88) will extend the Board of Dispensing Opticians until June 30, 1992 (would have expired June 30, 1988).

Senator Jones
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Under the bill, the board will require an apprentice to register with the Department of Commerce and Economic Development before beginning employment or service as an apprentice. Provides act takes effect immediately.

A person would be entitled to take an exam to be licensed as a dispensing optician"... who (1) has had education equivalent to four years attendance at high school; (2) has either (A) completed at least 6,000 hours of training as an apprentice after registering with the department as an apprentice; or been engaged for at least 6,000 hours as a practicing optician in good standing in a state, territory, district, or possession of the United States; and has paid the required fee." (underlined language added by the bill to existing law). Under section relating to a dispensing optician's apprentice, language is added requiring an apprentice to register with the Department of Commerce and Economic Development before beginning employment or service as an apprentice. Also says "no more than two apprentices may be under the direct supervision of one licensed dispensing optician at the same time. (underlined language added).

Removes the requirement in current law that a licensee must submit evidence of 30 hours of continuing competence in optical dispensing as prescribed by regulation of the board before renewing a license. The licensee would now have to submit evidence of continuing competence in optical dispensing as prescribed by regulations of the board.

Introduced February 17, 1988 and referred to L&C, HESS, and the Finance Committes.

Reported back to House March 4, 1988 by L&C recommending it be replaced with a L&C substitute and that it do pass. Concurring: Donley (Chair), Boucher Menard, Koponen. To Finance.

Reported back to the House March 17, 1988 by HESS recommending it do pass. Concurring: Ellis and Koponen (Co-Chairs), Hanley, Phillips and Gruenberg. To Finance.

Reported back to the House March 31, 1988 by Finance recommending it do pass. Concurring: Adams (Chair), Pourchot, Larson, Swackhammer, Boyer, Rieger, Frank, Wallis, Brown, Davis and Goll. To Rules.

Passed the House April 5, 1988, 36-0-2. Excused: Hermann, Wallis. The effective date clause was adopted. Rep. Furnace gave notice of reconsideration, but it was not taken up and the bill was transmitted to the Senate for its consideration on April 6.

Reported back to the Senate April 14, 1988 by L&C recommending it do pass. Concurring: Kelly (Chair), Szymanski and Fahrenkamp. To Health, Education & Social Services.

Passed the Senate May 4, 1988 with a vote of 19-0-1. Absent:

Szymanski. The effective date clause was adopted.

HB 534 passed both houses and was transmitted to the Governor 5/6/88.

SB 226. (CH 49 SLA 88) relates to the practice of optometry.

This bill will:

1. Allow the Board of Examiners in Optometry to issue a license endorsement authorizing a licensee who completes an examination and other requirements established by regulation to administer drugs, except those prohibited by law. The endorsement would expire at the same time as the license to which it attaches, and it would be renewed upon satisfactory completion of continuing education requirements established by the board by regulation.
2. Allow the board to impose disciplinary sanctions when it finds after a hearing that a licensee has failed to refer a patient to a physician after ascertaining the presence of ocular or systemic conditions requiring management by a physician (current law allow sanctions when a licensee has failed to refer a patient to "the appropriate health care practitioner after ascertaining the possible presence of ocular disease").
3. Add a new section to optometry law (AS 08.72) prohibiting licensed optometrists from using drugs in the practice of optometry unless (1) the drug is a (A) nonprescription drug; (B) a drug, used for examination purposes only, within the categories of topically applied ocular anesthetics, but not including cocaine; cycloplegics or mydriatics, but not including atropine, homatropine, scopolamine, epinephrine, and 10 percent phenylephrine; (C) or a drug, within the category of miotics used, after consultation with an ophthalmologist, for the treatment of an inadvertently induced angle closure; and (2) the person holds a license endorsement issued by the board authorizing the use of drugs.
4. Rewrite the definition section under optometry law.
5. Does not provide an effective date (bill becomes law 90 days after being signed by the governor.).

Introduced April 1 and referred to HESS, L&C.

Reported back to the Senate April 13 by HESS recommending it do pass with an amendment. Concurring: Fischer (Chair), Jones, and Halford, To L&C. The HESS amendment would insert the following new section:

AS 08.72.160 is amended to read:

Sec. 08.72.160. EXAMINATION. (a) The examination shall be written, practical, and oral in nature. The [NATIONAL BOARD OF

EXAMINERS IN OPTOMETRY EXAMINATION, PARTS 1 AND 2 SHALL COMPRISE THE] written portion of the Alaska examination shall be comprised of all or part of a national or international examination as designated by the board in regulations. The oral portion of the examination shall be recorded and retained for two years.

[(b) AN APPLICANT WHO FAILS THE PRACTICAL OR THE ORAL PORTION OF THE EXAMINATION MAY TAKE A RE-EXAMINATION IN THAT PORTION WITHOUT PAYING AN ADDITIONAL EXAMINATION FEE.]

(b) [(c)] An applicant who fails one [THE WRITTEN] portion of the examination may take a re-examination in the portion failed [THE WRITTEN PORTION] upon payment of a re-examination [AN ADDITIONAL EXAMINATION] fee established under AS 08.01.065.

(c) [(d)] An applicant who fails more than one portion of the examination must retake the entire examination and pay the [FULL] examination fee.

Reported back to the Senate April 23 by L&C recommending it be replaced with a L&C substitute and that it do pass. Concurring: Eliason (Chair) and Uehling. Not concurring: Szymanski had no recommendation. To Rules.

The L&C substitute would require the examination for applications to consist of all or part of a national or international examination designated by regulation by the board (currently the national board of examiners in optometry examination, parts 1 and 2, have to compromise the written portion of the Alaska examination). An applicant who fails a portion of the exam could take a re-examination in the portion failed (currently an applicant who fails the written portion of the exam can take a reexam in the written portion).

L&C also repeals AS 08.72.160(b), "(b) An applicant who fails the practical or the oral portion of the examination may take a re-examination in that portion without paying an additional examination fee."

Reported back to the Senate May 4, 1987 by Rules recommended it be replaced with a Rules substitute and that it be calendared May 5. Concurring: Eliason (Chair), Faiks, Bennett, Hensley and Binkley.

The Rules substitute adds a new section stating the chapter and regulations adopted under it do not limit the practice of an optician licensed under AS 08.71 (Dispensing Opticians).

On May 5, 1987 the Rules substitute was adopted, and the bill passed the Senate, 20-0. Received in the House May 6, 1987 and referred to Finance.

Reported back to the House April 27, 1988 by Finance recommending it be replaced with a House Finance substitute, and that it do pass.

Concurring: Adams (Chair), Pourchot, Goll, Boyer, Frank, Brown, Davis, Senator Jones
June 6, 1988
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Wallis, Swackhammer, Larson. Not concurring: Rieger has no recommendation.

The House Finance substitute:

1. Adds a new "Findings and Intent" section. The section says it is the intent of the legislature that "...optometrists (1) abide by the scope of practice of optometry as provided by law; (2) not treat ocular diseases or disorders except as provided by law; and (3) refer patients with ocular diseases to appropriate health care providers."
2. Changes the language amending AS 08.72.175 (License endorsement) to read: "(a) The board may issue a license endorsement authorizing a licensee to use the pharmaceutical agents described in AS 08.72.272, if the licensee or applicant for a license passes the written and practical portions of an examination on ocular pharmacology, approved by the board, that tests the licensee's or the applicant's knowledge of the characteristics, pharmacological effects, indications, contraindications, and emergency care associated with the use of pharmaceutical agents..."

Also adds language that allows a pharmacist or pharmaceutical supplier to supply an optometrist with pharmaceutical agents as provided by law upon presentation of evidence that the licensee holds a license endorsement.

3. Adds subsections to AS 08.72.272 (Use of Pharmaceutical Agents) by adding language that says a licensee may not use pharmaceutical agents for treatment of an eye disease or disorder or for any other therapeutic purpose. The licensee is not allowed to purchase, possess, or administer a pharmaceutical agent unless he/she has obtained a license endorsement.

On April 29, 1988 the House finance substitute was adopted and the bill passed the House, 37-1-1-1. Nay: Taylor. Excused: Pettyjohn. Absent: Navarre. Rep. Taylor gave notice of reconsideration.

Reconsideration was taken up the same day, and the bill again passed the House, 38-0-2. Excused: Cato, Pettyjohn.

On April 30, 1988 the Senate concurred in House amendments (final action), 18-0-1-1. Excused: Sturgulewski. Absent: Kerttula.

SB 226 was transmitted to the Governor on 5/4/88.

Please let me know if I can be of any further help.

BP:bsp

Attachments

**SOURCE SUMMARY OF SCS CS HB 85 (RULES)
"AN ACT RELATING TO CIVIL LIABILITY"**

SCS CSHB 85 (Rules) combines civil liability measures from six different House and Senate bills, as follows:

1. CSSB 211 (Fin) am "An Act relating to civil liability; and providing for an effective date."

Passed the Senate on March 30, 1988 by a vote of 13 to 7. HCS CSSB 211 (L&C) is currently (5/7) in House Judiciary.

CSSB 211 (Fin) am is incorporated in sections 1 through 9, 11, 12, 15, 19, and 20. There are, however, two changes. First, the limit on noneconomic damages is raised from \$100,000 to \$250,000. Second, "economic damages" is defined to include the value of contributions from non-wage earning roles such as homemakers, retired persons and persons living a subsistence lifestyle.

2. HCS SB 223 (L&C) "An Act relating to civil liability of zoos and zoo operators."

SB 223 passed the Senate on April 29, 1987 by a vote of 19 to 0. HCS SB 223 (L&C) is currently (5/7) in House Judiciary.

HCS SB 223 (L&C) is incorporated in its entirety in section 10. This bill provides that zoos and zoo operators are not strictly liable for injuries suffered by visitors to a zoo. There must be actual negligence on the part of the zoo operator for the injured party to recover damages.

3. CSSB 346 (Jud) "An Act granting immunity from civil liability for providing volunteer emergency services."

Currently in Senate Rules.

CSSB 346 (Jud) is incorporated in its entirety in section 13. This bill provides that a volunteer member of an organization that exists to provide emergency services is not liable for an act or omission in providing those services, unless the person was grossly negligent.

4. CSSB 461 (Jud) "An Act relating to the liability of hospitals for the actions of certain nonemployees."

CSSB 461 (Jud) passed the Senate on March 14, 1988 by a vote of 13 to 6. It is currently (5/7) in House Labor and Commerce.

CSSB 461 (Jud) is incorporated in its entirety in section 14. The bill provides that a hospital's duty to provide certain services is not, by itself, enough to find the hospital liable for the negligence of its non-employees.

5. CSHB 459 (Res) "An Act relating to liability for releases of hazardous substances."

CSHB 459 (Res) passed the House on April 14, 1988 by a vote of 30 to 4. It is currently (5/7) in the Senate Labor and Commerce Committee.

CSHB 459 (Res) is incorporated in its entirety in sections 16 and 17. It provides that with certain exceptions, a person is strictly liable for damages cause by the person's creation, transportation, storage and disposal of hazardous substances.

6. CSHB 406 (HESS) "An Act relating to the responsibility for the treatment and care of intoxicated and incapacitated persons taken into protective custody; and providing for an effective date."

CSHB 406 (HESS) is currently (5/7) in the House Judiciary Committee.

CSHB 406 (HESS) is incorporated in section 18 with one deletion. This bill provides that a person may not take civil or criminal action against a police officer or emergency service patrol member for a non-malicious decision to take or not to take an intoxicated or incapacitated person into protective custody. Since relief from criminal liability may not be put into HB 85 because of the single subject rule, section 20 only deals with civil liability.



**ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
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February 11, 1988

MEMORANDUM

TO: Representative Mark Boyer
ATTN: Ed Flanagan
FROM: Karen Oakley *VO*
Legislative Analyst
RE: State Regulation of Insurance Rates
Research Request 88.122

You asked how states regulate insurance rates and whether other states employ actuaries to review insurance company requests to change rates.

In this memorandum, we discuss: 1) state regulation of the insurance industry in general; 2) the primary methods by which states regulate insurance rates and the use of actuaries by states; and 3) how insurance rates are currently regulated in Alaska.

In summary, we found:

- States regulate insurance rates as one of several means to ensure that insurance companies remain solvent and can therefore pay future claims.
- The methods by which states regulate insurance rates are of two general types. The prior approval and open competition methods differ in the degree to which competition is allowed to determine rates.
- Alaska regulate insurance rates via prior approval.

About half of the states have actuaries on staff, and the remaining states, including Alaska, contract for actuarial analysis of rate filings that are expected to have major impacts. Government actuaries are generally employed to evaluate the data and assumptions that insurance company and rating bureau actuaries used to devise rates. Only two states use actuaries to generate rates independently.

The Alaska Division of Insurance is currently recruiting for four positions that were authorized in the FY 88 budget. Although the legislature intended that one of these positions be filled by an actuary, experienced actuaries can expect to earn about twice as much working for an insurance company, and it is unlikely that an actuary will be found for any of the positions.

BACKGROUND

Rates and Rate-making

The insurance rate is the number of dollars charged per unit of exposure to a type of risk.¹ An insurance rate has two components: the portion that covers the pure loss cost per unit of exposure and the portion, called loading, that covers the sales expense, overhead and profit of the insurer. In devising insurance rates, rates should:

- 1) be adequate to meet loss burdens, but not excessive;
- 2) allocate costs among insureds equitably;
- 3) be revised reasonably often to reflect as current a degree of loss experience as is feasible; and
- 4) encourage loss-prevention efforts among insureds.

Rate-making presents one of the more difficult problems in the insurance business because the rate must be set before all costs are known. In setting rates, past loss experience is necessary to estimate future costs. Laws that would prohibit insurance companies from pooling loss data have been abandoned because of the recognition that cooperation in rate-making is an essential part of sound rating and that unrestricted competition often leads to rates that are too low. Rates that are too low are just as undesirable, if not worse, than rates that are too high, because, above all, the insureds are seeking assurance that losses will be paid.

¹The insurance premium is the product of the insurance rate and the number of units of exposure.

To provide the kind of loss experience data that insurance companies need to set sound rates, rating bureaus or organizations have been formed to pool and analyze loss information on various lines of insurance. Most states authorize rating organizations to file rate changes on behalf of member insurance companies. For example, the National Council of Compensation Insurance (NCCI), a rating organization that analyzes loss data and trends in the workers' compensation field on a nationwide basis, applied in 1986 for approval of significant increases in Alaska rates on behalf of Alaska insurers.

Why States Regulate Insurance Rates

States regulate insurance rates to ensure that rates are neither too high nor too low and that rates do not unfairly discriminate among the various classes of insureds. The insurance industry is akin to utility industries, whose rates are also regulated by government. Like a utility, an insurance company must remain solvent if the company is to perform the service that it sells. States regulate insurance rates as one of several means of ensuring the future solvency of the insurance companies doing business within their bounds.

That the several states, rather than the federal government, regulate the insurance industry is due to the McCarran-Ferguson Act, enacted in 1945. A Supreme Court ruling in 1944, in a case involving cooperation among insurance companies in rate-making, held that insurance was "commerce" and that when conducted across state lines, insurance was "interstate commerce." Under this ruling, insurance was therefore subject to federal laws governing trade practices, including the Sherman Anti-Trust Act and other acts dealing with the control of business activities in restraint of trade. The McCarran-Ferguson Act declared that state regulation of insurance should continue and that federal anti-trust acts would be applicable to insurance but only to the extent that the individual states did not regulate insurance. In other words, as long as the states attempted to regulate the insurance industry, the industry would be exempt from the normal restrictions on interstate trade. Thus, insurance has the unusual distinction of being a form of interstate commerce that is regulated by the states. Further information on the history of state regulation of insurance is provided in Attachment A.

Rate Regulation and the Insurance "Crisis"

In 1985, insurance rates for many types of insurance skyrocketed and some forms of insurance became unavailable at any price. This "crisis" was precipitated by the practice of cash flow underwriting, which is the practice of charging inadequate premiums to generate cash for investment and then relying upon investment returns to offset underwriting deficits. During the period of high interest rates that occurred in the late 1970s and early 1980s, insurance companies underpriced premiums to generate cash for investment. When interest rates began to decline in 1984, insurance companies began to increase premiums and to select the risks they would underwrite with greater caution, thereby precipitating the "crisis."

Many legislatures attempted to address the insurance crisis and the problems were assaulted on three fronts: 1) tort reform; 2) establishing new insurance mechanisms and strategies; and 3) regulatory reform. A variety of regulatory reforms have been considered, including expanding data submitted by insurers, permitting policy cancellation only with cause, and requiring mandatory notice of nonrenewals and cancellations, but rating laws have received the most attention. According to the National Conference of State Legislatures, 23 state legislatures considered bills during their 1987 sessions addressing rate-setting and review.

House Research Memorandum 87.080 provides an overview of the approaches to solving the insurance crisis excluding tort reform (Attachment B). See pages 8 - 10 of this memorandum and its Attachment F for information on regulatory reforms, including reforms affecting the regulation of rates.

STATE REGULATION OF INSURANCE RATES

Methods of Rate Regulation

State approaches to regulation of insurance rates vary along a spectrum that ranges between the extremes of no regulation of rates (Illinois) to the imposition of state-made rates (Texas). Although as many as ten different approaches have been defined, the approaches can be categorized into two groups, commonly referred to as prior approval and open competition. The approaches differ by the degree to which competition is relied upon to set adequate and fair rates. Prior approval laws are the more conservative approach because rates must be reviewed and approved (or not denied) by the state prior to their use. Open competition laws allow insurance companies much greater freedom to change rates and allow the changes to be effective immediately. Roughly half the states have adopted prior approval laws, and half have adopted open competition laws.

Prior approval laws generally have the following provisions:

- Rates and supporting data must be filed with the state insurance commissioner;
- Rate changes do not become effective until: 1) a specified waiting period expires (during which time the filing is reviewed by the department); or 2) the insurance commissioner gives an affirmative approval;
- Insurers may cooperate in making rates with other insurers through rating bureaus or they may file rates independently. Bureau members may deviate from bureau rates upon application.

Alaska regulates insurance rates under a prior approval law; the relevant statute is attached (Attachment C).

There are several types of open competition laws. The most common are: 1) file and use; 2) use and file; and 3) no file.

- Under file and use laws, rates become effective immediately upon filing with no affirmative action by the insurance commissioner required. Rates may be subsequently disapproved, however. File and use provisions may apply to all lines of insurance or to just casualty lines. In some states, adherence to bureau rates is required. In other states, bureau rates are advisory only.
- Under use and file laws, rates may take effect immediately, and a filing need not take place until some specified future time.
- Under no file laws, there is no requirement that rates be filed or affirmatively approved by the insurance commissioner. Rate changes by an insurer become effective immediately. Rating bureaus are advisory only, and they are specifically prohibited from requiring that any member adhere to their rates. Both insurers and bureaus must maintain adequate information about their rates and must make this information available to the commissioner upon request. Under a no file law, the primary means that the commissioner has to ensure that rates are adequate and not discriminatory is through rating and underwriting examinations of insurance companies.

Florida employs an open competition law that uses both the file and use and the use and file approaches. The relevant statute is attached as an example of an open competition law (Attachment D).

A new method of rate regulation, referred to as flex rating, has recently been developed. Flex rating combines the prior approval and the file and use methods by allowing insurance companies or rating bureaus to raise or cut their rates without the approval of the insurance commissioner as long as the change is within a "zone of reasonableness," generally within 15 percent of the existing rate. Prior approval is required if the rate change falls outside of the zone of reasonableness. Flex rating is meant to enhance competition, while maintaining a degree of control, and to smooth the cyclical nature of insurance rates.

Only two states--Oregon and New York--have adopted flex rating; the relevant statutes are found in Attachment E. Flex rating is too new to judge its effects.

Whether the method a state uses to regulate rates (or the degree of scrutiny applied to rate filings) has a significant impact on rates is an arguable question. The General Accounting Office (GAO) published a major study of state insurance regulation practices in 1979. This study included an analysis of the effect of the method of rate regulation on rates for automobile insurance. The GAO found that there was little difference in the price of automobile insurance between states that regulated rates through prior approval and those that relied on open competition. They concluded that the automobile insurance market was competitive enough that price regulation was not warranted. While the GAO study is almost ten years old, its general conclusions about rate regulation seem relevant today: All states, regardless of the method of rate regulation, were affected by the most recent insurance crisis. Relevant portions of the GAO report are attached (Attachment F).

Use of Actuaries in Rate Regulation

An actuary is professionally trained to make projections about future financial events based on statistically valid analysis of data. Within the insurance field, actuaries are most often employed to determine rates and reserve levels.

According to the 1986 yearbook of the American Academy of Actuaries, 24 states employ actuaries in their insurance departments. The 1979 GAO study of state insurance departments reported that of the 8,000 certified actuaries in the United States at that time, only 64 were employed directly by state insurance departments (see Attachment F).

Of the 26 states that do not have an actuary on staff, almost all contract for actuarial services when such services are needed. In prior approval states, an actuarial consultant would likely be hired only to analyze rate filings that would have major effects on rates. In open competition states, where systematic analysis of rates is not done, actuarial services would be more likely to be hired for other purposes, such as analysis of the sufficiency of insurance company reserves.

In reviewing rate filings, most departments judge the actuarial work of the companies or rating bureaus and the assumptions on which the work is based. Departments typically do not have independent data against which to judge the adequacy of the rates. According to the GAO study, only Texas and Massachusetts employ actuaries to make an independent analysis of rates. In Texas, the State sets rates for certain lines, and in Massachusetts, the commissioner may choose between rates recommended by the State Rating Bureau and rates recommended by insurance companies.

REGULATION OF INSURANCE RATES IN ALASKA

Alaska regulates insurance rates using the prior approval method. The rating law, AS 21.39, is Attachment C.

The Division of Insurance within the Department of Commerce and Economic Development is responsible for regulation of the insurance industry. Review of rate filings is one of the responsibilities of the Market Conduct Surveillance section.² Don Koch currently heads this four-person section, and I spoke with him about rate review and the need for a staff actuary.

The division estimates that they review from 10,000 to 15,000 rate and form filings each year. (A form filing is a request to change the insurance contract and is often a request to change what is covered by a specific policy.) Each filing is reviewed, but some filings receive more attention than others. Rate changes that will have a larger total effect receive the most attention.

The division does not currently have a staff actuary. The division does contract for actuarial services in some circumstances. Most recently, the division contracted for an evaluation of the filing of the National Council of Compensation Insurance for a major increase in workers' compensation insurance rates.

²The Market Conduct Surveillance Section also has responsibility for performing market conduct examinations of insurance companies and for developing a public education program and a market access program.

Representative Boyer
February 11, 1988
Page 8

In the FY 88 budget, the legislature authorized four new positions for the Division of Insurance, raising the total number of division employees from 19 to 23. In authorizing these new positions, the legislature expressed their intent that one of the positions be filled by an insurance actuary (Attachment G). Of these new positions, the most likely position to be filled by an actuary would be the Insurance Financial Examiner II, which is a Range 21 position (approximately \$46,000 annual salary). The class specification for this position is attached (Attachment H). The person in this position would work in the Market Conduct Surveillance section and assist in review of rate filings; this person would also go into the field to perform market conduct examinations.

According to both Mr. Koch and John George, the division director, the likelihood that they will be able to find an actuary to fill this position is remote. Experienced actuaries employed by insurance companies can expect a salary twice that paid to a Range 21 position. Thus, the division does not expect to find an actuary for the position.

In fact, the division is having difficulty finding anyone to fill the positions. Authorized last July, none of the positions have yet been filled. The division was not able to find anyone within Alaska that was qualified and interested in the positions, and they are now searching outside the state. The positions are highly technical, and almost any person hired would have to be trained to perform some of the required tasks. Finding applicants with the necessary minimum qualifications and an interest in a government position in Alaska has been difficult.

I hope you find this information useful. Also attached are two documents sent by the National Conference of State Legislatures on insurance regulation reform (Attachments I and J). If we can provide any further information, please let us know.

Attachments

Attachments are numerous, they may be seen in our office.



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

February 11, 1988

MEMORANDUM

TO: Representative Mark Boyer
ATTN: Ed Flanagan
FROM: Karen Oakley *VO*
Legislative Analyst
RE: State Regulation of Insurance Rates
Research Request 88.122

You asked how states regulate insurance rates and whether other states employ actuaries to review insurance company requests to change rates.

In this memorandum, we discuss: 1) state regulation of the insurance industry in general; 2) the primary methods by which states regulate insurance rates and the use of actuaries by states; and 3) how insurance rates are currently regulated in Alaska.

In summary, we found:

- States regulate insurance rates as one of several means to ensure that insurance companies remain solvent and can therefore pay future claims.
- The methods by which states regulate insurance rates are of two general types. The prior approval and open competition methods differ in the degree to which competition is allowed to determine rates.
- Alaska regulates insurance rates via prior approval.

- About half of the states have actuaries on staff, and the remaining states, including Alaska, contract for actuarial analysis of rate filings that are expected to have major impacts. Government actuaries are generally employed to evaluate the data and assumptions that insurance company and rating bureau actuaries used to devise rates. Only two states use actuaries to generate rates independently.
- The Alaska Division of Insurance is currently recruiting for four positions that were authorized in the FY 88 budget. Although the legislature intended that one of these positions be filled by an actuary, experienced actuaries can expect to earn about twice as much working for an insurance company, and it is unlikely that an actuary will be found for any of the positions.

BACKGROUND

Rates and Rate-making

The insurance rate is the number of dollars charged per unit of exposure to a type of risk.¹ An insurance rate has two components: the portion that covers the pure loss cost per unit of exposure and the portion, called loading, that covers the sales expense, overhead and profit of the insurer. In devising insurance rates, rates should:

- 1) be adequate to meet loss burdens, but not excessive;
- 2) allocate costs among insureds equitably;
- 3) be revised reasonably often to reflect as current a degree of loss experience as is feasible; and
- 4) encourage loss-prevention efforts among insureds.

Rate-making presents one of the more difficult problems in the insurance business because the rate must be set before all costs are known. In setting rates, past loss experience is necessary to estimate future costs. Laws that would prohibit insurance companies from pooling loss data have been abandoned because of the recognition that cooperation in rate-making is an essential part of sound rating and that unrestricted competition often leads to rates that are too low. Rates that are too low are just as undesirable, if not worse, than rates that are too high, because, above all, the insureds are seeking assurance that losses will be paid.

¹The insurance premium is the product of the insurance rate and the number of units of exposure.

To provide the kind of loss experience data that insurance companies need to set sound rates, rating bureaus or organizations have been formed to pool and analyze loss information on various lines of insurance. Most states authorize rating organizations to file rate changes on behalf of member insurance companies. For example, the National Council of Compensation Insurance (NCCI), a rating organization that analyzes loss data and trends in the workers' compensation field on a nationwide basis, applied in 1986 for approval of significant increases in Alaska rates on behalf of Alaska insurers.

Why States Regulate Insurance Rates

States regulate insurance rates to ensure that rates are neither too high nor too low and that rates do not unfairly discriminate among the various classes of insureds. The insurance industry is akin to utility industries, whose rates are also regulated by government. Like a utility, an insurance company must remain solvent if the company is to perform the service that it sells. States regulate insurance rates as one of several means of ensuring the future solvency of the insurance companies doing business within their bounds.

That the several states, rather than the federal government, regulate the insurance industry is due to the McCarran-Ferguson Act, enacted in 1945. A Supreme Court ruling in 1944, in a case involving cooperation among insurance companies in rate-making, held that insurance was "commerce" and that when conducted across state lines, insurance was "interstate commerce." Under this ruling, insurance was therefore subject to federal laws governing trade practices, including the Sherman Anti-Trust Act and other acts dealing with the control of business activities in restraint of trade. The McCarran-Ferguson Act declared that state regulation of insurance should continue and that federal anti-trust acts would be applicable to insurance but only to the extent that the individual states did not regulate insurance. In other words, as long as the states attempted to regulate the insurance industry, the industry would be exempt from the normal restrictions on interstate trade. Thus, insurance has the unusual distinction of being a form of interstate commerce that is regulated by the states. Further information on the history of state regulation of insurance is provided in Attachment A.

Rate Regulation and the Insurance "Crisis"

In 1985, insurance rates for many types of insurance skyrocketed and some forms of insurance became unavailable at any price. This "crisis" was precipitated by the practice of cash flow underwriting, which is the practice of charging inadequate premiums to generate cash for investment and then relying upon investment returns to offset underwriting deficits. During the period of high interest rates that occurred in the late 1970s and early 1980s, insurance companies underpriced premiums to generate cash for investment. When interest rates began to decline in 1984, insurance companies began to increase premiums and to select the risks they would underwrite with greater caution, thereby precipitating the "crisis."

Many legislatures attempted to address the insurance crisis and the problems were assaulted on three fronts: 1) tort reform; 2) establishing new insurance mechanisms and strategies; and 3) regulatory reform. A variety of regulatory reforms have been considered, including expanding data submitted by insurers, permitting policy cancellation only with cause, and requiring mandatory notice of nonrenewals and cancellations, but rating laws have received the most attention. According to the National Conference of State Legislatures, 23 state legislatures considered bills during their 1987 sessions addressing rate-setting and review.

House Research Memorandum 87.080 provides an overview of the approaches to solving the insurance crisis excluding tort reform (Attachment B). See pages 8 - 10 of this memorandum and its Attachment F for information on regulatory reforms, including reforms affecting the regulation of rates.

STATE REGULATION OF INSURANCE RATES

Methods of Rate Regulation

State approaches to regulation of insurance rates vary along a spectrum that ranges between the extremes of no regulation of rates (Illinois) to the imposition of state-made rates (Texas). Although as many as ten different approaches have been defined, the approaches can be categorized into two groups, commonly referred to as prior approval and open competition. The approaches differ by the degree to which competition is relied upon to set adequate and fair rates. Prior approval laws are the more conservative approach because rates must be reviewed and approved (or not denied) by the state prior to their use. Open competition laws allow insurance companies much greater freedom to change rates and allow the changes to be effective immediately. Roughly half the states have adopted prior approval laws, and half have adopted open competition laws.

Prior approval laws generally have the following provisions:

- Rates and supporting data must be filed with the state insurance commissioner;
- Rate changes do not become effective until: 1) a specified waiting period expires (during which time the filing is reviewed by the department); or 2) the insurance commissioner gives an affirmative approval;
- Insurers may cooperate in making rates with other insurers through rating bureaus or they may file rates independently. Bureau members may deviate from bureau rates upon application.

Alaska regulates insurance rates under a prior approval law; the relevant statute is attached (Attachment C).

There are several types of open competition laws. The most common are: 1) file and use; 2) use and file; and 3) no file.

- Under file and use laws, rates become effective immediately upon filing with no affirmative action by the insurance commissioner required. Rates may be subsequently disapproved, however. File and use provisions may apply to all lines of insurance or to just casualty lines. In some states, adherence to bureau rates is required. In other states, bureau rates are advisory only.
- Under use and file laws, rates may take effect immediately, and a filing need not take place until some specified future time.
- Under no file laws, there is no requirement that rates be filed or affirmatively approved by the insurance commissioner. Rate changes by an insurer become effective immediately. Rating bureaus are advisory only, and they are specifically prohibited from requiring that any member adhere to their rates. Both insurers and bureaus must maintain adequate information about their rates and must make this information available to the commissioner upon request. Under a no file law, the primary means that the commissioner has to ensure that rates are adequate and not discriminatory is through rating and underwriting examinations of insurance companies.

Florida employs an open competition law that uses both the file and use and the use and file approaches. The relevant statute is attached as an example of an open competition law (Attachment D).

A new method of rate regulation, referred to as flex rating, has recently been developed. Flex rating combines the prior approval and the file and use methods by allowing insurance companies or rating bureaus to raise or cut their rates without the approval of the insurance commissioner as long as the change is within a "zone of reasonableness," generally within 15 percent of the existing rate. Prior approval is required if the rate change falls outside of the zone of reasonableness. Flex rating is meant to enhance competition, while maintaining a degree of control, and to smooth the cyclical nature of insurance rates.

Only two states--Oregon and New York--have adopted flex rating; the relevant statutes are found in Attachment E. Flex rating is too new to judge its effects.

Whether the method a state uses to regulate rates (or the degree of scrutiny applied to rate filings) has a significant impact on rates is an arguable question. The General Accounting Office (GAO) published a major study of state insurance regulation practices in 1979. This study included an analysis of the effect of the method of rate regulation on rates for automobile insurance. The GAO found that there was little difference in the price of automobile insurance between states that regulated rates through prior approval and those that relied on open competition. They concluded that the automobile insurance market was competitive enough that price regulation was not warranted. While the GAO study is almost ten years old, its general conclusions about rate regulation seem relevant today: All states, regardless of the method of rate regulation, were affected by the most recent insurance crisis. Relevant portions of the GAO report are attached (Attachment F).

Use of Actuaries in Rate Regulation

An actuary is professionally trained to make projections about future financial events based on statistically valid analysis of data. Within the insurance field, actuaries are most often employed to determine rates and reserve levels.

According to the 1986 yearbook of the American Academy of Actuaries, 24 states employ actuaries in their insurance departments. The 1979 GAO study of state insurance departments reported that of the 8,000 certified actuaries in the United States at that time, only 64 were employed directly by state insurance departments (see Attachment F).

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Representative Boyer
February 11, 1988
Page 8

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I hope you find this information useful. Also attached are two documents sent by the National Conference of State Legislatures on insurance regulation reform (Attachments I and J). If we can provide any further information, please let us know.

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**ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY**

December 16, 1987

MEMORANDUM

TO: Representative Mark Boyer
FROM: Karen Oakley *ko*
Legislative Analyst
RE: Civil Immunity for Referees
Research Request 88.087

You asked whether any states have laws making it a crime to assault a referee, and you asked what states have laws granting civil immunity to referees.

To the best of our knowledge, no state has a law specifically regarding assault on referees. Prosecutors could bring charges against a person assaulting a referee, as they may bring charges against any person assaulting another person. Presumably, a referee that had been assaulted could also seek civil damages against the perpetrator. Any such case, whether civil or criminal, would probably involve different standards than a case involving assault on a person simply walking down the street, particularly if the sport involved fighting, such as ice hockey or boxing. Referees in such sports undertake their duties with a knowledge of the potential for such an occurrence associated with the particular sport and thereby assume a degree of risk. Some sports, notably ice hockey, provide for sanctions against a participant that assaults an official, and assault of a referee in a sport that officially recognizes the possibility of assault would have to be egregious before it would warrant referral to the court system.

At least six states have passed laws granting civil immunity to volunteer referees involved with nonprofit organizations. New Jersey passed such a law in 1986, and Arkansas, Colorado, Minnesota, North Dakota and South Dakota passed laws in 1987. Copies of these laws are attached. In addition, 11 states considered passage of volunteer immunity laws during 1987. Table 1 lists these states and provides a brief description of each bill.

Representative Boyer
December 16, 1987
Page 2

Note that most of the laws and bills provide immunity only to volunteers. While most team managers and coaches serve without compensation, referees are generally paid for their services. In order to provide immunity to paid referees, immunity would have to be granted to the nonprofit organization sponsoring the athletic program and to its employees. The bills considered by Hawaii, Illinois, and Indiana grant immunity to volunteers and to the nonprofit organization and its employees.

I hope you find this information useful. If I can provide any additional information, please let me know.

Attachments

TABLE 1
STATES THAT CONSIDERED BILLS GRANTING IMMUNITY FROM CIVIL LIABILITY
TO REFEREES AND OTHER VOLUNTEERS WITH YOUTH SPORTS ORGANIZATIONS--1987

STATE	BILL NO.	BILL PROVISIONS
CONNECTICUT	HB 7369	Provides immunity to directors, officers and trustees of nonprofit organizations (qualifying under the Internal Revenue Code) and directors of common interest communities for actions performed within the scope of official function and duty and performed in good faith. The bill contains exceptions for willful and wanton misconduct.
HAWAII	HB 232	Provides that a volunteer manager, coach, instructor, umpire, referee, or assistant in a sports program of a nonprofit association shall not be civilly liable for damages. Provides immunity for the nonprofit association, and its officers and employees, in sponsoring the sports program. Provides exceptions to immunity and establishes standards of negligence. Defines nonprofit associations to include youth and athletic associations, volunteer fires, ambulance, religious, charitable, fraternal, veterans, civic county fair or agricultural associations and auxiliaries.
ILLINOIS	HB 210	Provides immunity from civil liability to volunteers who serve as managers, coaches, instructors, umpires or referees in sports programs of nonprofit organizations. Also extends civil immunity to the association itself and its officers and employees unless the conduct of the person or association falls substantially below the standard generally practiced in like circumstances by similar programs and and proof is made that the act or omission was a breach of a recognized duty.
INDIANA	HB 1102	Grants immunity from civil liability to volunteers, or persons under the control of the volunteers, for negligent acts or omissions, in sports or leisure activities conducted by nonprofit organizations. The immunity is extended to the organization itself and its employees. Conduct which is intentional, willful, wanton or reckless is excluded from the grant of immunity.
LOUISIANA	SB 229	Provides personal immunity to volunteer managers, coaches, instructors, umpires, referees, and their assistants involved with nonprofit sports programs. Defines "nonprofit sports program" and creates the usual exceptions.
MISSISSIPPI	HB 257	Provides that voluntary acts of assistance to protect a person's health or safety do not create a duty of care. The immunity extends to the board of directors of nonprofit corporations for actions taken, or omissions made, in performance of duty except where such acts are willful and wanton.
MISSOURI	HB 177	Provides for immunity of volunteers involved with sports programs.

TABLE 1 (Continued)

STATES THAT CONSIDERED BILLS GRANTING IMMUNITY FROM CIVIL LIABILITY
TO REFEREES AND OTHER VOLUNTEERS WITH YOUTH SPORTS ORGANIZATIONS--1987

STATE	BILL NO.	BILL PROVISIONS
NEBRASKA	LB 43	Grants immunity from civil liability to volunteers (coaches, managers, instructors, umpires or referees) absent willful or wanton misconduct or intentionally tortious conduct. Immunity extends to nonprofit corporations which conduct or sponsor the sports programs.
NEW HAMPSHIRE	HB 301	Grants civil immunity from liability to volunteer coaches and officials of nonprofit associations which conduct athletic programs formally recognized by the Amateur Athletic Union or the National Collegiate Athletic Association. Programs conducted for the benefit of, and participation of minors, (under 18 years of age) would be the only ones covered under the specific language of the bill. The immunity extends to formal competitions as well as practice and instructional sessions but excludes conduct which is willful, wanton or grossly negligent.
RHODE ISLAND	87-H-5196	Grants civil immunity to persons acting as athletic coaches, managers or officials for sports teams conducted under a nonprofit organization's charter. Would extend to organized events and practice sessions but would not excuse acts or omissions which constitute willful, wanton or gross negligence or acts by an official who has not participated in a safety orientation and training program. The bill specifically excludes any act resulting from the negligent operation of a motor vehicle and those coming within a public or private school's athletic program.
VERMONT	HB 13	Provides immunity from civil liability for damages as a result of acts or omissions arising out of service as a volunteer, athletic coach, manager or official except in cases of gross negligence.

SOURCE: National Conference of State Legislatures, State Legislative Summary:
Liability Insurance, July 1987.

Prepared by House Research Agency, December 1987 (88.087; 100287-05).

NO. 970

ARKANSAS 1987 ACTS

State of Arkansas
76th General Assembly

ACT 970 1987
A BILL

Regular Session, 1987 AS ENGROSSED 2/2/87

HOUSE BILL 1077

By: Representative Hinchaw AS ENGROSSED 1/6/87

For An Act To Be Entitled

1 "AN ACT GRANTING LIMITED TORT IMMUNITY TO DIRECTORS OF
2 NONPROFIT CORPORATIONS AND MEMBERS OF BOARDS, COMMISSIONS,
3 AGENCIES, AUTHORITIES, AND OTHER GOVERNING BODIES OF ANY
4 GOVERNMENTAL ENTITY; AND FOR OTHER PURPOSES."
5

6 BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:
7

8 SECTION 1. The General Assembly has determined that nonprofit cor-
9 porations serve important functions in providing services and assistance to
10 persons in the State and that in order for these nonprofit corporations to
11 function effectively, persons serving on the board of directors should not
12 subject to vicarious liability for the negligence of corporate employees or
13 other directors. The General Assembly has further determined that potential
14 exposure to vicarious liability has a detrimental effect on the participation
15 of persons as directors of nonprofit corporations and that providing immunity
16 to directors of such corporations for certain types of liability will be in
17 the best interest of the State and that the same immunity should be extended
18 to members of governing bodies of governmental entities.
19

20 SECTION 2. Except as otherwise provided by this Act, no member of any
21 board, commission, agency, authority, or other governing body of any govern-
22 mental entity and no member of the board of directors of a nonprofit cor-
23 poration that holds a valid federal income tax exemption issued by the
24 Internal Revenue Service shall be held personally liable for damages resulting
25 from:
26

27 (a) any negligent act or omission of an employee of the nonprofit
28 corporation or governmental entity; or

29 (b) any negligent act or omission of another director or member of the
30 governing body of the governmental entity.

BBK078

ARKANSAS 1987 ACTS

NO. 970

AS ENGROSSED 2/2/87 AS ENGROSSED 4/6/87

H.B. 1077

1 SECTION 3. The same immunity provided by this Act shall be extended to
2 any athletic official during the officiating of an interscholastic, inter-
3 collegiate, or any other amateur athletic contest being conducted under the
4 auspices of a nonprofit or governmental entity. No official shall be held
5 personally liable in any civil action for damages to a player, participant, or
6 spectator as a result of his acts of commission or omission arising out of
7 officiating duties and activities. Nothing in this Section shall be deemed to
8 grant immunity to any person causing damage by his malicious, willful, wanton,
9 or grossly negligent act.

10
11 SECTION 4. The immunity provided by this Act shall not extend to acts or
12 omissions of directors of nonprofit corporations or members of boards, com-
13 missions, agencies, authorities or other governing bodies of any governmental
14 entity which constitute ordinary or gross negligence personal to the direc-
15 tor or member or to intentional torts committed by a director or member.
16 Provided further that the immunity provided by this Act shall not extend to
17 acts or omissions of directors of nonprofit corporations which are licensed or
18 permitted by the Arkansas Alcoholic Beverage Control to dispense alcoholic
19 beverages, beer or wine.

20
21 SECTION 5. If a nonprofit corporation transfers assets to a member of
22 the board of directors of such corporation or to another nonprofit corporation
23 in order to avoid claims against corporate assets resulting from a judgment
24 rendered as a result of a suit to recover damages for the negligence of the
25 corporation, a corporate employee or a director, the director to whom the
26 asset is transferred or any director of the corporation from which assets are
27 transferred to avoid such claims may be held personally liable for any such
28 judgment rendered and the immunity provided by this Act shall be of no force
29 or effect.

30
31 SECTION 6. This Act shall only apply to suits for recovery of damages
32 based upon causes of action that accrue after August 1, 1987.

33
34 SECTION 7. Nothing herein shall be construed to limit the liability of a
35 nonprofit corporate entity itself for damages resulting from any negligent act,
36 or omission of an employee of the nonprofit corporation.

BBK078

NO. 970

ARKANSAS 1987 ACTS

AS ENCLOSED 4/6/87

H.B. 1077

1 SECTION 8. All laws and parts of laws in conflict with this Act are
2 hereby repealed.
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26 /s/ Jerry E. Hinshaw

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4/14/87
APPROVED BY Paula
GOVERNOR

BBK078

COLORADO**CHAPTER 103****COURTS AND COURT PROCEDURE****DAMAGES — GENERAL PROVISIONS**

SENATE BILL NO. 80. BY SENATORS Bishop, DeNier, Donley, Allard, Durham, Fenlon, Fowler, Hopper, Rizzuto, Sandoval, Simcikland, Traylor, Wells, Winkler, Gallagher, Groff, Martinez, Mendez, P. Powers, R. Powers, Schroeder, and Trujillo, also REPRESENTATIVES Schauer, Carpenter, Tebedo, Armstrong, Green, McInnis, Reeves, Swenson, Taylor-Little, Anderson, Berger, Bond, Dambman, Fish, Fleming, Lawson, Masson, Mutzebaugh, Norton, Pankey, Philips, Ruddick, Rupert, Tucker, L'ivang, and S. Williams.

AN ACT

CONCERNING THE IMMUNITY FROM LIABILITY OF VOLUNTEERS WHO ASSIST ORGANIZATIONS RELATING TO YOUNG PERSONS.

Be it enacted by the General Assembly of the State of Colorado:

Section 1. 13-21-116, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

13-21-116. Actions not constituting an assumption of duty - immunity for volunteers assisting organizations for young persons. (2.5) (a) No person who performs a service or an act of assistance, without compensation or expectation of compensation, as a leader, assistant, teacher, coach, or trainer for any program, organization, association, service group, educational, social, or recreational group, or nonprofit corporation serving young persons or providing sporting programs or activities for young persons shall be held liable for actions taken or omissions made in the performance of his duties except for wanton and willful acts or omissions; except that such immunity from liability shall not extend to protect such person from liability for acts or omissions which harm third persons.

(b) For the purposes of this subsection (2.5), "young persons" means persons who are eighteen years of age or younger.

Section 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Approved: April 30, 1987

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

MINNESOTA

604.06 ACTIONS INVOLVING NEGLIGENCE

92

CHAPTER 604

ACTIONS INVOLVING NEGLIGENCE

604.06 Fireman's rule.

604.08 Volunteer athletic coaches and officials; immunity from liability.

604.06 FIREMAN'S RULE.

The common law doctrine known as the fireman's rule shall not operate to deny any peace officer, as defined in section 626.84, subdivision 1, clause (c), or 176B.01, subdivision 2, a recovery in any action at law or authorized by statute.

History: 1987 c 384 art 1 s 45

604.08 VOLUNTEER ATHLETIC COACHES AND OFFICIALS; IMMUNITY FROM LIABILITY.

Subdivision 1. Grant. No individual who provides services or assistance without compensation as an athletic coach, manager, or official for a sports team that is organized or performing under a nonprofit charter, and no community-based, voluntary nonprofit athletic association, or any volunteer of the nonprofit athletic association, is liable for money damages to a player or participant as a result of an individual's acts or omissions in the providing of that service or assistance.

This section applies to organized sports competitions and practice and instruction in that sport.

For purposes of this section, "compensation" does not include reimbursement for expenses.

Subd. 2. Limitation. Subdivision 1 does not apply:

(1) to the extent that the acts or omissions are covered under an insurance policy issued to the entity for whom the coach, manager, or official serves;

(2) if the individual acts in a willful and wanton or reckless manner in providing the services or assistance;

(3) if the acts or omissions arise out of the operation, maintenance, or use of a motor vehicle;

(4) to an athletic coach, manager, or official who provides services or assistance as part of a public or private educational institution's athletic program; and

(5) if the individual acts in violation of federal, state, or local law.

The limitation in clause (1) constitutes a waiver of the defense of immunity to the extent of the liability stated in the policy, but has no effect on the liability of the individual beyond the coverage provided.

History: 1987 c 337 s 126

North Dakota

32-03-43

JUDICIAL REMEDIES

Source: S.L. 1985, ch. 371, § 1.

32-03-43. Wrongful life action prohibited — Definition. No person may maintain a claim for relief or receive an award for damages on that person's own behalf based on the claim that, but for the act or omission of another, that person would have been aborted. As used in this section "abortion" means the termination of human pregnancy with an intention other than to produce a live birth or to remove a dead embryo or fetus.

Source: S.L. 1985, ch. 372, §§ 1, 2.

32-03-44. Immunity of officers, directors, and trustees of nonprofit organizations. Any person who serves as a director, officer, or trustee of a nonprofit organization that is, or would qualify as a nonprofit organization that is, described in paragraphs 3, 4, 5, 6, 7, 10, and 19 of section 501(c) of the Internal Revenue Code of 1954 as amended [26 U.S.C. 501(c)(3), (4), (5), (6), (7), (10), and (19)], is immune from civil liability for any act or omission resulting in damage or injury if at the time of the act or omission all of the following are met:

1. The officer, director, or trustee was acting in good faith and in the scope of that person's official duties as a director, officer, or trustee of the nonprofit organization.
2. The act or omission did not constitute willful misconduct or gross negligence on the part of the officer, director, or trustee.
3. The officer, director or trustee did not receive or expect to receive reimbursement for or payment of expenses in excess of two thousand dollars per year for expenses actually incurred as a result of providing services as a director, officer, or trustee of the nonprofit organization and did not receive or expect to receive compensation or anything in lieu of compensation as payment for services provided as a director, officer, or trustee of the nonprofit organization.

Source: S.L. 1987, ch. 401, § 1.

32-03-45. Immunity of volunteers providing services, for nonprofit organizations. Except as provided in section 32-03-46, any person who, on a volunteer basis, provides services or performs duties on behalf of a nonprofit organization is immune from civil liability for any act or omission resulting in damage or injury if at the time of the act or omission all of the following are met:

1. The person who caused the damage or injury was acting in good faith, in the exercise of reasonable and ordinary care, and in the scope of that person's duties as a volunteer for the nonprofit organization.
2. The act or omission did not constitute willful misconduct or gross negligence.

This section does not grant immunity to any person causing damage as the result of the negligent operation of a motor vehicle.

GOOD SAM

Source: S.L. 1987, ch. 402, § 1.

32-03-46. Immunity of volunteers

1. Any person who provides service for reimbursement of expenses, such as a coach, manager, or official for a sports team which is a nonprofit or similar charter is immune from civil liability for any act or omission resulting in damage or injury if at the time of the act or omission all of the following are met:
 - a. The person who caused the damage or injury was acting in good faith, in the exercise of reasonable and ordinary care, and in the scope of that person's duties as a coach, manager, or official.
 - b. The act or omission did not constitute willful misconduct or gross negligence.
 - c. The coach, manager, or official was acting in the scope of the training program with which the person is associated.
2. This section does not grant immunity to any person causing damage or injury as a result of the negligent operation of a motor vehicle.
 - a. Any person causing damage or injury as a result of the negligent operation of a motor vehicle.
 - b. Any person for any damage or injury as a result of sports competition or practice.
 - c. Any athletic coach, manager, or official of a public or private educational institution.

Source: S.L. 1987, ch. 402, § 2.

CHAPTER

GOOD SAM

Section

- 32-03.1-01. Definitions.
- 32-03.1-02. Actions barred.
- 32-03.1-03. Criminal immunity.
- 32-03.1-04. Physicians or surgeons.

32-03.1-01. Definitions. For the purposes of this chapter, the following terms shall have the designated meanings:

1. "Aid or assistance necessary or reasonable" means any actions which the aider reasonably believed would benefit the person in need of aid or assistance upon the aider's perception of the person's illness and the total emergency situation as reasonably believed he could succeed in providing aid or assistance.

Source: S.L. 1987, ch. 402, § 1.

Effective Date.

This section became effective April 2, 1987.

32-03-46. Immunity of volunteer athletic coaches and officials.

1. Any person who provides services or assistance free of charge, except for reimbursement of expenses, as an athletic coach, manager, or official for a sports team which is organized or performing pursuant to a nonprofit or similar charter is immune from civil liability for any act or omission resulting in damage or injury to a player or participant if at the time of the act or omission all the following are met:
 - a. The person who caused the damage or injury was acting in good faith, in the exercise of reasonable and ordinary care, and in the scope of that person's duties for the sports team.
 - b. The act or omission did not constitute willful misconduct or gross negligence.
 - c. The coach, manager, or official had participated in a safety orientation and training program established by the league or team with which the person is affiliated.
2. This section does not grant immunity to:
 - a. Any person causing damage as the result of the negligent operation of a motor vehicle.
 - b. Any person for any damage caused by that person permitting a sports competition or practice to be conducted without supervision.
 - c. Any athletic coach, manager, or official providing service as a part of a public or private educational institution's athletic program.

Source: S.L. 1987, ch. 402, § 2.

Effective Date.

This section became effective April 2, 1987.

CHAPTER 32-03.1

GOOD SAMARITAN ACT

Section

- 32-03.1-01. Definitions.
 32-03.1-02. Actions barred.
 32-03.1-03. Criminal immunity.
 32-03.1-04. Physicians or surgeons.

Section

- 32-03.1-05. Exceptions.
 32-03.1-06. Limited repealer.
 32-03.1-07. Costs and fees.
 32-03.1-08. Actions not barred.

32-03.1-01. Definitions. For the purposes of this chapter, the following terms shall have the designated meanings:

1. "Aid or assistance necessary or helpful in the circumstances" means any actions which the aider reasonably believed were required to prevent death or serious permanent injury, disability or handicap, or reasonably believed would benefit the injured or ill person, depending upon the aider's perception of the nature and severity of the injury or illness and the total emergency situation, and that the aider reasonably believed he could successfully undertake.

South Dakota

NONPROFIT CORPORATIONS — MEMBERS

47-23-28

Source: SL 1986, ch 388, § 9.

CHAPTER 47-23

NONPROFIT CORPORATIONS — MEMBERS, DIRECTORS, OFFICERS AND AGENTS

Section

47-23-2.1. Liability of director, trustee or officer serving without compensation.

47-23-28. Definition of terms.

47-23-29. Immunity of volunteers of nonprofit organizations, certain hospitals and governmental entities.

47-23-30. Person not immune where negligent operation of vehicle caused injury.

47-23-31. Effect on other statutes concerning immunity.

47-23-32. Waiver of immunity to extent of risk sharing pool or liability insurance coverage — Volunteer serving as director, officer or trustee exempt.

47-23-2.1. Liability of director, trustee or officer serving without compensation. No director, trustee or officer serving without compensation, other than reimbursement for actual expenses, of any corporation organized under this chapter, and which is exempt from taxation pursuant to Section 501(a) of the Internal Revenue Code, 26 U.S.C. Section 501(a) and is listed as an exempt organization in Section 501(c) of the Internal Revenue Code, 26 U.S.C. Section 501(c), as amended, or any hospital organized pursuant to chapters 34-8, 34-9, or 34-10 is liable, and no cause of action may be brought, for damages resulting from the exercise of judgment or discretion in connection with the duties or responsibilities of such director, trustee, or officer while acting in his official capacity as such director, trustee or officer, unless the act or omission involved willful or wanton misconduct.

Source: SL 1987, ch 343, § 1.

47-23-12. Bylaw provisions governing vote or quorum, etc.

Religious Societies.

There is a presumption of majority representation in the governance of churches; such presumption can be overcome by express provi-

sions in the articles of incorporation or bylaws, or the constitution of the general church. *Foss v. Dykstra* (1983) 342 NW 2d 220.

47-23-28. Definition of terms. Terms used in §§ 47-23-28 to 47-23-32 mean:

- (1) "Volunteer," an individual performing services for a nonprofit organization, a nonprofit corporation, a hospital organized pursuant to chapters 34-8, 34-9 or 34-10, or a governmental entity without compensation, other than reimbursement for actual expenses incurred. The term includes a volunteer serving as a director, officer, trustee or direct service volunteer;
- (2) "Nonprofit organization," any organization which is exempt from taxation pursuant to Section 501(c) of the Internal Revenue Code, 26 U.S.C. Section 501(c) as amended;
- (3) "Nonprofit corporation," any corporation organized under chapters 47-22 to 47-28, inclusive, and which is exempt from taxation pursu-

South Dakota

47-23-29

CORPORATIONS

NONPROFIT

ant to Section 501(a) of the Internal Revenue Code, 26 U.S.C. Section 501(a);

- (4) "Governmental entity," any county, municipality, township, school district, chartered governmental units, other special districts, or any association, authority, board, commission, division, office, officer, task force or other agency of the state of South Dakota.

Source: SL 1987, ch 344, § 1.

47-23-29. Immunity of volunteers of nonprofit organizations, certain hospitals and governmental entities. Any volunteer of a nonprofit organization, a nonprofit corporation, any hospital organized pursuant to chapters 34-8, 34-9 or 34-10, or a governmental entity shall be immune from civil liability in any action brought in any court in this state on the basis of any act or omission resulting in damage or injury if:

- (1) The individual was acting in good faith and within the scope of such individual's official functions and duties for the nonprofit organization, the nonprofit corporation, a hospital organized pursuant to chapters 34-8, 34-9 or 34-10, or a governmental entity; and
- (2) The damage or injury was not caused by willful and wanton misconduct by such individual.

Source: SL 1987, ch 344, § 2.

47-23-30. Person not immune where negligent operation of vehicle caused injury. No immunity provided in §§ 47-23-28 to 47-23-32 extends to any person causing personal injury or wrongful death resulting from the negligent operation of a motor vehicle.

Source: SL 1987, ch 344, § 3.

47-23-31. Effect on other statutes concerning immunity. Sections 47-23-28 to 47-23-32 shall not be construed to constitute a modification or repeal of §§ 33-15-18.1, 33-15-18.2, 20-9-3, 20-9-4 and 20-9-4.1.

Source: SL 1987, ch 344, § 4.

47-23-32. Waiver of immunity to extent of risk sharing pool or liability insurance coverage — Volunteer serving as director, officer or trustee exempt. To the extent that any volunteer, nonprofit corporation, nonprofit organization, governmental entity or hospital organized pursuant to chapters 34-8, 34-9 or 34-10 participates in a risk sharing pool or purchases liability insurance and to the extent that coverage is afforded thereunder, the immunity provided by § 47-23-29 is deemed to have been waived and may not be raised by way of affirmative defense. This section does not apply to a volunteer serving as a director, officer or trustee.

Source: SL 1987, ch 344, § 5.

NONPROFIT CORPORATION:

Section
47-24-7. Time of filing annual report of a corporation shall first day of the second month of each year. The first at the first day of the second corporation of the year next : cate of incorporation was issu tion of the secretary of state deposited in the United with postage prepaid, s. 11

47-24-7. Time of filing a report of a corporation shall first day of the second month of each year. The first at the first day of the second corporation of the year next : cate of incorporation was issu tion of the secretary of state deposited in the United with postage prepaid, s. 11

Source: SL 1978, ch 339, § 2; 19 § 8.

Commission Note.

Section 11 of Chapter 383, SL 1978, ch 339, § 2, is amended: "For the purpose of implementing the annual report required by Act for corporations existing prior 1, 1988, the annual report required 2, 4, 6, 8 and 10 (§§ 47-9-3, 47-9A-1, 47-24-7 and 47-27-19) of this Act shall be the period of time beginning January 1 through the close of business the day of the anniversary date of the corporation's incorporation in 1987. This section does not apply to corporations incorporated after 1987."

47-24-8. Report on other fiscal year. The state may grant to a corporation the right to report on other fiscal year and to file the report within the month following the anniversary of the fiscal year.

Source: SL 1978, ch 339, § 2; 19 § 9.

Amendments.

The 1986 amendment, at the end of the section, is amended to read:

Lab

[OFFICIAL COPY REPRINT]
ASSEMBLY, No. 2398

STATE OF NEW JERSEY

INTRODUCED MAY 5, 1966

By Assemblymen ARANGO, DARIO, Gargiulo, Penn, DiGaetano,
Castrillo, Assemblywoman Donovan, Assemblyman Kosco, Assem-
blywoman Crecco and Assemblyman Kavanaugh

**[An Act providing civil immunity from liability to certain volun-
teers and supplementing Title 2A of the New Jersey Statutes.]**

**AN ACT providing civil immunity from liability to certain volun-
teer athletic coaches and officials and supplementing Title 2A of
the New Jersey Statutes.**

1 Be it enacted by the Senate and General Assembly of the State
2 of New Jersey:

1 **[I. a. As used in this act:*

2 "Community or service organization" means any nonprofit cor-
3 poration, society or association as provided in P. L. 1959, c. 90
4 (C. 2A:53A-7 to 2A:53A-11) or nonprofit federation council or
5 affiliated group composed of the organizations which serves per-
6 sons in a community for recreational, educational, social, sports-
7 related, or other beneficial purposes. These organizations include,
8 but are not limited to scouting organizations, 4-H clubs, youth
9 organizations, and auxiliary groups.

10 b. Notwithstanding any provisions of law to the contrary, no
11 person who provides service or assistance free of charge, except
12 for reimbursement of expenses to a community or service organi-
13 zation shall be liable in any civil action for damages as a result
14 of his acts of commission or omission arising out of and in the
15 course of his rendering that service or assistance.

16 c. Nothing in this section shall be deemed to grant immunity
17 to any person causing damage by his willful, wanton, or grossly
18 negligent act of commission or omission.]*

EXPLANATION—Matter enclosed in bold-faced brackets [thus] in the above bill
is not enacted and is intended to be omitted in the law.

Matter printed in italics thus is new matter.

Matter enclosed in asterisks or stars has been adopted as follows:

*—Assembly committee amendments adopted May 8, 1966.

- 1 **1. a. Notwithstanding any provisions of law to the contrary, no*
 2 *person who provides services or assistance free of charge, except*
 3 *for reimbursement of expenses, as an athletic coach, manager, or*
 4 *official for a sports team which is organized or performing pursuant*
 5 *to a nonprofit or similar charter shall be liable in any civil action*
 6 *for damages to a player or participant as a result of his acts of*
 7 *commission or omission arising out of and in the course of his*
 8 *rendering that service or assistance.*
- 9 *b. The provisions of subsection a. of this section shall apply not*
 10 *only to organized sports competitions, but shall also apply to prac-*
 11 *tice and instruction in that sport.*
- 12 *c. Nothing in this section shall be deemed to grant immunity to*
 13 *any person causing damage by his willful, wanton, or grossly negli-*
 14 *gent act of commission or omission, nor to any coach, manager, or*
 15 *official who has not participated in a safety orientation and train-*
 16 *ing program established by the league or team with which he is*
 17 *affiliated.*
- 18 *d. Nothing in this section shall be deemed to grant immunity to*
 19 *any person causing damage as the result of his negligent operation*
 20 *of a motor vehicle.*
- 21 *e. Nothing in this section shall be deemed to grant immunity to*
 22 *any person for any damage caused by that person permitting a*
 23 *sport competition or practice to be conducted without supervision.*
- 24 *f. Nothing in this act shall apply to an athletic coach, manager, or*
 25 *official who provides services or assistance as part of a public or*
 26 *private educational institution's athletic program.**
- 1 2. This act will take effect immediately.

TORT LIABILITY AND MALPRACTICE

Exempts volunteers to nonprofit community and service organiza-
 tions from civil liability for damages.



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

May 28, 1987

MEMORANDUM

TO: Representative C. E. Swackhammer
ATTN: Tom Wright
FROM: Gretchen Keiser *G. Keiser*
Legislative Analyst
RE: Insurance Reform
Research Request 87.300

You requested this agency to obtain a report about liability insurance and tort reform prepared by a New Mexico legislative committee. We were asked to review the report to determine if any recommendations might be applicable to Alaska.

The report in question is titled: Report of the Interim Legislative Workmen's Compensation Committee on Liability Insurance and Tort Law Reform (December 1986) and was submitted to the New Mexico Legislature (Attachment A). The report findings and recommendations include:

- 1) Despite the passage of several tort reform measures--some dating from 1976--New Mexico has experienced sharp increases in liability insurance premiums. The report concludes that there has been no demonstrable evidence that enacting tort reforms results in insurance rate relief.
- 2) The insurance premium crisis in New Mexico is unrelated to the amount or quality of tort litigation in the state. Jury awards have remained constant (after adjustments for inflation) and the number of lawsuits filed per capita has remained constant since 1959. Based on the ratio of insurance premiums earned to claims paid, New Mexico is one of the most profitable states in the nation for insurers. In effect, New Mexico premium payers are subsidizing claimants in other states.
- 3) Data suggest that the insurance industry appears to be raising rates in response to the downturn in investment profitability--as a result of interest rate declines during the 1985-87 period--not in response to casualty losses.

- 4) The report recommended that legislation be adopted to:
- a) establish a separate department of insurance;
 - b) require the department of insurance to undertake a substantive review of carrier rate increases;
 - c) give the department the power to approve/reject the rates prior to their implementation;
 - d) increase the budget and staff of the department of insurance;
 - e) require that the method of determining rates include claims experience within the state of New Mexico;
 - f) require insurance companies to provide detailed reports concerning New Mexico policies to the department of insurance; and
 - g) grant the department of insurance the authority to work with other states to address the problem of threatened withdrawal of insurance companies from any individual state.

You asked us to consider the applicability of these recommendations to Alaska. We talked with Mr. Don Koch, Chief of the Market Analysis Section in Alaska's Division of Insurance. Additional information on Alaska's insurance situation is taken from a recent memorandum on insurance reform issues prepared by the House Research Agency (Research Request 87.080; Attachment B).

Insurance regulation in Alaska is presently handled by the Division of Insurance in the Department of Commerce and Economic Development. To our knowledge, there is no strong push or need to establish a separate department of insurance in Alaska. Mr. Koch indicated that commissioners of Commerce and Economic Development have allowed the director of the division to fully exercise the powers embodied in Alaska's insurance statutes (Title 21). Furthermore, the division is currently quite small (19 persons).

Alaska conducts substantive reviews of all insurance rate filings and possesses the "prior approval" authority before a company can implement its new rates. The State has a 15-day period during which to review, accept or reject a proposed rate change. Typically, the division does not formally respond to the insurer if the filing is acceptable--thus allowing the rate change to automatically go into effect at the end of the 15-day period.¹

¹According to Mr. Koch, the division does not believe that House Bill 313--which would require the division to formally respond to filings of greater than five percent rate increase--is necessary.

The FY 88 authorized budget for the Division of Insurance stands at \$1.3 million--up from \$960,000 in FY 87. This will allow the division to add four new staff: 1 clerical; 1 financial examiner (to verify solvency of insurers, brokers and agents); and 2 market analysts (to review rates and reports as well as to conduct field audits to review underwriting and complaint files maintained by insurers). Funding for these positions comes from increased fees charged to insurance companies operating in the state. According to Mr. Koch, additional staffing may be warranted in the future to more adequately handle the consumer complaint function within the division.

Insurance rates in Alaska are established in accordance with AS 21.39.030 which allows for the consideration of past and prospective loss experience both inside and outside the state. Requiring insurers to base their rates solely on in-state experience could work to Alaskans' detriment because of the relatively low volume of insurance business in many industries. Poor in-state claims experience in a particular industry or one large claim in a heretofore claim-free industry could wreak havoc on rates. Typically, the division and insurers look at claims experience in Alaska, regionally and nationwide. In effect, the statutes allow insurers to "borrow" experience from national statistics; a rate, for example, may be weighted 75 percent Alaska claims experience and 25 percent national claims experience.

According to Mr. Koch, Alaska already requires fairly detailed reports from the insurance companies operating in the state. Furthermore, the division has access to an electronic data base maintained nationally by the National Association of Insurance Commissioners (NAIC). The division, in the past, has received more information than it could readily process and analyze. New staff to be added in FY 88 will enable the division to examine in greater detail the information currently received in insurer reports as well as to take fuller advantage of data compiled on a national basis.

The final recommendation in the New Mexico report suggested that their department of insurance be given the authority to work with other states to address threatened withdrawals of insurance companies from an individual state. Mr. Koch indicated that Alaska routinely works with other western state members of the NAIC to collectively apply pressure on insurance companies which attempt to pull out of a particular state. He did note that certain states with elected insurance commissioners (e.g., Washington, Louisiana and Florida) have on occasion raised issues for political purposes, and that other states have had to work around these individuals.

In summary, it appears that Alaska currently has in place several of the recommendations made in the New Mexico report: substantive review, prior approval, increased staff, detailed reporting requirements, and interstate cooperation. The remaining recommendations--department status and in-state rate determination--do not appear to be warranted in Alaska. For your

Representative Swackhammer
May 28, 1987
Page 4

information, the attached House Research Agency memorandum provides a broader discussion of insurance reform and summarizes additional proposals to change insurance marketing and regulation nationwide.

Please contact me if you have any questions regarding this information.

Attachments

ATTACHMENT A
New Mexico Legislative Council Report

STATE OF NEW MEXICO

NEW MEXICO LEGISLATIVE COUNCIL

334 STATE CAPITOL, SANTA FE, NEW MEXICO 87503

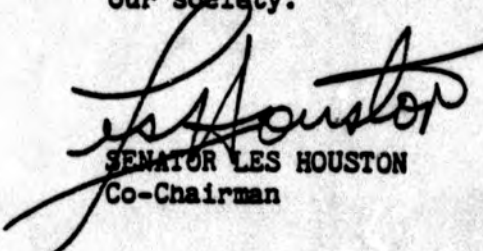
Telephone 505 827-3700

December 18, 1986

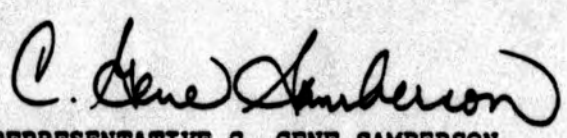
Enclosed is the final report of the interim legislative workmen's compensation committee to the first session of the thirty-eighth legislature.

The workmen's compensation committee was created by Laws 1986, Chapter 22, Section 104. The committee was instructed to, among other things, "study the entire personal injury . . . area of the law and recommend any changes in law to the first session of the thirty-eighth legislature."

Pursuant to that charge, the committee met regularly throughout the interim and heard testimony from the business community, insurance companies, lawyer groups and consumer interest groups. The focus of our concern was to examine the so-called "Insurance Crisis" and to examine whether changes in the laws governing the civil justice system would fix the problem of increased insurance premiums in all aspects of our society.



SENATOR LES HOUSTON
Co-Chairman



REPRESENTATIVE C. GENE SAMBERSON
Co-Chairman

REPORT
OF THE
INTERIM LEGISLATIVE
WORKMEN'S COMPENSATION COMMITTEE
ON LIABILITY INSURANCE AND TORT LAW REFORM

TO THE
THIRTY-EIGHTH LEGISLATURE, FIRST SESSION

December 18, 1986
File No. 205.111

BACKGROUND OF THE COMMITTEE

The interim workmen's compensation committee was created by Laws 1986, Chapter 22, Section 104. The committee was instructed to, among other things, "study the entire personal injury . . . area of the law and recommend any changes in law to the first session of the thirty-eighth legislature."

Pursuant to that charge, the committee met regularly throughout the interim and heard testimony from the business community, insurance companies, lawyer groups and consumer interest groups. The focus of our concern was to examine the so-called "Insurance Crisis" and to examine whether changes in the laws governing the civil justice system would fix the problem of increased insurance premiums in all aspects of our society.

FINDINGS

The testimony and evidence presented before the committee led us to make the following findings:

1. There is an insurance premium crisis in this state evidenced by massive increases in premiums in all areas of tort liability insurance.

2. New Mexico has already enacted the following changes which the advocates of tort reform have designated as the most important requirements to stem the tide of insurance premium increases:

A) Governmental Liability

With respect to governmental liability, New Mexico's Tort Claims Act, enacted in 1976, contains caps on liability (\$300,000 per person and \$500,000 per accident) which are among the most restrictive in the

nation. The statute of limitations under the act requires that a claim be brought within two years, rather than the usual period of three years, and, in addition, bars claims if the claimant has not notified the appropriate governmental agency within 90 days of the accident.

B) Medical Malpractice

In the medical malpractice area, New Mexico's Medical Malpractice Act, also enacted in 1976, limits liability to \$500,000 per accident for non-medical damages, and the three-year statute of limitations runs from the date of the accident rather than the date of discovery of the injury.

C) Dram Shop Liability

In 1986, New Mexico limited the judicially created cause of action against liquor dispensing establishments and precluded damages in excess of \$50,000 per person and \$100,000 per accident.

D) General Liability

General liability has been limited by the New Mexico supreme court's abolition of joint and several liability and subsequent institution of a system of comparative negligence requiring that responsibility for liability be shared in proportion to the fault of each party.

3. Despite the presence of all of these "tort reform" changes in law, New Mexico is experiencing the same skyrocketing insurance premiums that are currently being experienced throughout the nation.

A) For example, with respect to governmental liability during the last two years: the city of Roswell's insurance has jumped from \$87,000 per year to \$677,000 per year; the city of Socorro's insurance has jumped from \$70,000 per year to \$312,000 per year; and the city of Tatum's insurance has increased from \$17,000 per year to \$51,000 per year.

B) Similar examples abound for counties, school districts and other governmental entities.

C) New Mexico businesses are either unable to acquire liability insurance or have experienced dramatic premium increases in the category of general liability insurance.

4. New Mexico's experience parallels that of other jurisdictions which have enacted so-called "tort reforms" in an effort to stem the tide of rising insurance premiums. There has been no demonstrable evidence that enacting tort reforms will result in rate relief. In fact, the Province of Ontario, which for years has had more numerous and more stringent tort reforms than any other jurisdiction in North America has, like New Mexico, found that those so-called reforms have had no effect on the problem of ever-increasing insurance premiums.

5. New Mexico's tort reforms have not reduced insurance rates for general liability insurance. Florida has enacted very comprehensive tort reform.

Aetna, one of the nation's largest commercial liability insurers, has been lobbying throughout the nation for the following reforms enacted by Florida:

- A) reducing compensation to injury victims by the amount of compensation from collateral sources;
- B) restricting the doctrine of joint and several liability;
- C) limiting compensation for paralysis, disfigurement and other types of non-economic damages to \$450,000;
- D) limiting punitive damages; and
- E) requiring periodic payments of future economic damages of more than \$250,000.

Aetna, in a rate filing proposed to take effect January 1, 1987, explained why each of these provisions would have little or no effect on insurance rates. Eliminating the collateral source rule, for example, would have a negligible effect on insurance rates because "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." Restricting joint and several liability would not reduce insurance rates "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." And limiting compensation for "non-economic" damages would not lower insurance costs, according to Aetna, "due to the impact of degree of disability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff."

Finally, Aetna concluded that limiting punitive damages would have "no impact" on Aetna's claim values, and requiring periodic payments of future economic damages over \$250,000 would yield "no net savings" because of the "interaction of policy limits, past economic losses, and future economic losses," the "settlement value of the case," and the "apparent implicit recognition of the periodic nature of future damages."

The St. Paul Insurance Company, the nation's largest medical malpractice insurer, conducted an analysis similar to Aetna's and reached similar conclusions. The St. Paul found that four of the 313 closed claims it analyzed would have been affected by the "tort reforms" enacted in Florida, "for a total effect of about 1% savings." The St. Paul further explained that the 1% savings estimate probably overstated the savings resulting from tort reform. The Aetna and St. Paul analyses appear to raise a presumption that "tort reform" will not bring about the desired results.

6. The committee found no evidence of a litigation explosion in New Mexico, nor was there any evidence of excessive judgments in tort cases. Indeed, the national studies presented to the committee suggest that the median jury award has remained constant after adjustments for

inflation and that the number of lawsuits filed per capita has remained constant since 1959.

7. New Mexico is the eighth most profitable state in the nation for insurance carriers as expressed in the ratio of insurance premiums earned by general liability carriers to claims paid by those carriers. New Mexico premium payers, therefore, are in the unenviable position of subsidizing claimants in other states.

8. Data presented to the committee indicates that during the early 1980's when interest rates were high, the insurance industry lowered premiums to sell more policies thereby increasing investment income. The data also shows that with the falling interest rates later in the decade, the industry found itself not realizing as great a return on its outside investments. (Other industries have found themselves in the same situation.)

9. The current data correlates with the historical data presented to the committee, demonstrating that the insurance industry as a whole has experienced historical cycles of increased premium rates which correlate to general decreases in interest rates.

10. Thus, what the insurance industry appears to be doing is attempting to keep its economic portfolio current by raising rates not in response to casualty losses, but rather in response to the downtrend in investment profitability.

CONCLUSIONS

1. There is no litigation crisis or "tort reform" crisis in New Mexico.

2. There is an insurance premium crisis in New Mexico which is unrelated to the amount or quality of tort litigation in this State.

RECOMMENDATIONS

Based on the testimony heard during the course of our study, the committee recommends that:

Tort Reform

New Mexico is and has been a national leader in tort reform. New Mexico has already enacted or judicially created the following reforms:

- A) the Tort Claims Act;
- B) dram shop legislation;
- C) joint and several liability; and
- D) laws relating to medical malpractice.

No relief has been realized except in medical malpractice. No further changes should be made in the current New Mexico laws governing personal injury unless evidence can be produced that will establish that a reduction in rates will occur if the proposed change is enacted.

Liability Insurance Reform

1. Legislation should be adopted establishing the department of insurance as an independent department of state government under the direction of a secretary of insurance appointed by the governor.
2. Legislation should be adopted requiring the department of insurance to undertake a substantive review of carrier rate increases, coupled with the power to approve or reject those rates, prior to their implementation.
3. Legislation should be adopted to increase the budget and staff of the department of insurance to a level commensurate with its important responsibilities to the people of this state.

4. Legislation should be adopted requiring that the method of determining rates include claims experience within the state of New Mexico.

5. Legislation should be adopted requiring insurance companies to provide detailed reports to the department of insurance concerning their New Mexico policies.

6. Legislation should be adopted granting to the department of insurance the authority to work with its counterparts in other states to address the problem of threatened withdrawal of insurance companies from any individual state.

skepticism of the workings of the legal system. You did not, for example, say that whatever the 2d U.S. Circuit Court of Appeals rules, only Dennis Levine will know if he was guilty of inside trading. Evidence is a tricky matter, but certainly our system — which occasionally goes so far as to impose the

those who deny the Holocaust to support their cause. The disheartening thing about the conclusion of this article is that it will help them to do the same thing if Mr. Demjanjuk is convicted.

Adam S. Cohen
Cambridge, Mass.

New Mexico Tort Reform Efforts Overlooked

THE ROUNDUP OF selected states and their tort reform efforts ("The States of Tort Reform") in the Feb. 16 issue failed to include information about activities in New Mexico. While many states have rushed to restrict the rights of victims, an interim committee of the New Mexico Legislature studied the problem during 1988 and basically concluded that legislative action must focus on insurance reform. Interestingly, the two chairmen of the interim committee — and several of its members — are categorized politically as staunch conservatives.

The committee concluded that an insurance-premium crisis existed in New Mexico and that New Mexico had suffered the same exorbitant insurance premiums and unavailability of insurance as "non-reformed" states, despite significant tort law changes occurring over the years. These changes include: caps on recoveries against the government, doctors and liquor businesses; pure comparative negligence; and abolition of joint and several liability.

Furthermore, studies from the Aetna Life & Casualty Co. and St. Paul Cos. Inc. indicated that rates were negligibly affected by the elimination of punitive damages, the collateral source rule and joint and several liability, or by limiting non-economic damages or requiring structured settlements. The report concluded that the insurance-premium crisis was caused by the in-

dustry's response to the downtrend in investment profitability not in response to underwriting losses.

Following the call of its interim committee, the 1987 Legislature changed the regulation of the insurance industry to require the superintendent of insurance to approve rates *before* their use in the state, instead of the discarded system of allowing insurers to use and then file their rate schedules. Also, all workers' compensation insurers were required to file separate rate schedules rather than the single schedule previously permitted.

A bill to prohibit anti-competitive activities (basically the federal antitrust laws), to regulate cancellation and non-renewal of coverage, to prohibit secrecy agreements concerning dangerous products and to require litigation-related disclosure of information, passed in the House 58-5 but died in the Senate, where the insurance industry had more influence.

Many of us speculate that states which have raced to alter tort laws will change direction over the next several years toward insurance reform to protect consumers, but not before thousands of victims are robbed of a full recovery for their injuries due to regressive tort laws.

Ron Morgan
Editor in Chief
Journal of New Mexico
Trial Lawyers' Association
Albuquerque, N.M.

ATTACHMENT B
House Research Memorandum 87.080



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P. O. Box Y, State Capitol
Juneau, Alaska 99811-3100
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April 21, 1987

MEMORANDUM

TO: Representative Fran Ulmer
ATTN: Judy Knight
FROM: Penelope Weyhrauch
Legislative Analyst
RE: State Tax on Insurance Carriers
Research Request 87.269

You requested a discussion of the State tax on insurance carriers, specifically those discussed in AS 21.09.210(d). This statute dictates that a tax of three-quarters of one percent be applied to the gross underwriting profits of insurance carriers for wet marine and transportation insurance that they carry. Wet marine and transportation insurance is defined in Alaska Statute 21.12.090(b). According to Don Koch, with the Division of Insurance, Department of Commerce and Economic Development, this definition includes marine vessels and their cargoes, although the definition could arguably include aircraft and aircraft cargoes.

Under AS 21.09.210(b), insurance carriers, other than wet marine and transportation insurance carriers, must pay a tax on net premiums received. The tax is 2.7 percent for domestic insurers, and six percent of gross premiums less claims paid for hospital and medical insurance corporations.

According to Mr. Koch, the current tax structure is beneficial for wet marine and transportation insurance carriers. He said that insurers can collect (from those insured) in excess of what will amount to three-quarters of one percent of their underwriting profit. This excess is retained by insurers as profits.

Mr. Koch does not know why the tax for wet marine and transportation insurance differs from the tax for other types of insurance, and believes insurance should all be taxed at the same rate. He said that there are sixteen states which give preferential tax treatment to wet marine and

transportation insurance carriers. Alaska is one of four states which taxes wet marine and transportation insurance at three-quarters of one percent of an insurer's gross profits; the lowest tax rate of all the states.¹ According to Mr. Koch, insurance carriers in Alaska paid \$29,000 in taxes on wet marine and transportation insurance in 1986; if taxed at the standard rate at that time--three percent of gross premiums--these insurers would have paid \$229,000 in taxes.²

The tax schedule appears to have been established in 1966, when the Alaska Insurance Code was adopted.³ There is very little information available from committee hearings and minutes on the tax differentiation between wet marine and transportation insurance and other types of insurance. A supplement to the House Journal on March 3, 1966 stated that Mr. Lingle (the Director of the Division of Insurance at that time) "...pointed out that the wet marine insurance tax is changed in the bill. In the bill, the amount is the usual one put on insurance of this type."⁴

I hope this information is useful to you. If you have any questions or would like additional information, please contact our agency.

Attachments: AS 21.09.210 (Insurance Tax)
AS 21.12.090 (Marine, Wet Marine and Transportation Defined)

¹Of the sixteen states which give preferential tax treatment for wet marine and transportation insurance, Alaska has one of the highest tax rates for other types of insurance--2.7 percent. Fourteen of these states apply a tax for insurance, other than wet marine and transportation insurance, of between two and 2.5 percent, while Hawaii's standard tax is 4.2 percent.

²The tax rate for domestic and foreign insurers was amended by Ch. 118 SLA 1986. This amendment changed tax rates for domestic insurers and for companies other than hospital and medical service corporations from 1.5 percent and three percent respectively, to 2.7 percent.

³Chapter 120, SLA 66.

⁴House Journal Supplement, March 3, 1966, No. 12, p. 25, paragraph 8.

Sec. 21.12.090. Marine, wet marine and transportation insurance defined. (a) "Marine insurance" includes

(1) insurance against any and all kinds of loss or damage to

(A) vessels, craft, aircraft, cars, automobiles and vehicles of every kind, as well as all goods, freights, cargoes, merchandise, effects, dis-

bursements, profits, money, bullion, precious stones, securities, choses in action, evidences of debt, valuable papers, bottomry and respondentia interests and all other kinds of property and interests therein, in respect to, appertaining to or in connection with any and all risks or perils of navigation, transit, or transportation, including war risks, on or under any seas or other waters, on land or in the air, or while being assembled, packed, crated, baled, compressed or similarly prepared for shipment or while awaiting shipment or during delays, storage, transshipment, or reshipment incident thereto, including marine builder's risks and all personal property floater risks;

(B) a person or to property in connection with or appertaining to a marine, inland marine, transit or transportation insurance, including liability for loss of or damage to either, arising out of or in connection with the construction, repair, operation, maintenance or use of the subject matter of the insurance (but not including life insurance or surety bonds or insurance against loss by reason of bodily injury to the person arising out of the ownership, maintenance or use of automobiles);

(C) precious stones, jewels, jewelry, gold, silver and other precious metals, whether used in business or trade or otherwise and whether in the course of transportation or otherwise;

(D) bridges, tunnels and other instrumentalities of transportation and communication (excluding buildings, their furniture and furnishings, fixed contents and supplies held in storage) unless fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion are the only hazards to be covered; piers, wharves, docks and slips, excluding the risks of fire, tornado, sprinkler leakage, hail, explosion, earthquake, riot and/or civil commotion; other aids to navigation and transportation, including dry docks and marine railways, against all risks;

(2) "marine protection and indemnity insurance", meaning insurance against, or against legal liability of the insured for loss, damage or expense arising out of, or incident to, the ownership, operation, chartering, maintenance, use, repair or construction of a vessel, craft or instrumentality in use in ocean or inland waterways, including liability of the insured for personal injury, illness or death or for loss of or damage to the property of another person.

(b) For the purposes of this title "wet marine and transportation" insurance is that part of marine insurance which includes only

(1) insurance upon vessels, crafts, hulls and of interests in or with relation to vessels, crafts, and hulls;

(2) insurance of marine builder's risks, marine war risks and contracts or marine protection and indemnity insurance;

(3) insurance of freights and disbursements pertaining to a subject of insurance coming within this section; and

(4) insurance of personal property and interests in personal property, in the course of exportation from or importation into any country, and in the course of transportation coastwise or on inland waters, including transportation by land, water, or air from point of origin to final destination, in respect to, appertaining to or in connection with, any and all risks or perils of navigation, transit or transportation, and while being prepared for and while awaiting shipment, and during delays, storage, transshipment or reshipment incident thereto. (§ 1 ch 120 SLA 1966)

Sec. 21.09.210. Tax. (a) Each authorized insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall file with the director, before March 2 in each year, a report of all insurance business written or contracted in the state (with proper proportionate allocation of premium for the property, subjects, or risks in the state insured under policies or contracts covering property, subjects, or risks located or resident in more than one state) during the preceding year ending December 31. The report shall show

(1) the amounts paid policyholders on losses;

(2) the total direct premium income including policy membership and other fees, premiums paid by application of dividends, refunds, savings coupons, and similar returns or credits to payment of premiums for new or additional or extended or renewed insurance, charges for payment of premium in installments, and all other consideration for insurance from all kinds and classes of insurance whether designated a premium or otherwise;

(3) the amounts paid policyholders as returned premiums;

(4) the amounts paid policyholders as dividends.

(b) Each insurer, and each formerly authorized insurer with respect to premiums received while an authorized insurer in this state, shall pay tax on the total direct premium income received during the year ending on the preceding December 31 and paid for the insurance of property or risks resident or located in the state other than wet marine and transportation insurance, after deducting from the total direct premium income the applicable cancellations, returned premiums, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. No deductions may be made of cash surrender value of policies. Considerations received on annuity contracts are not included in the direct premium income and are not subject to tax. The tax shall be paid to the director annually before April 1, and, except as provided in AS 21.69.390(c), is computed at the rate of

(1) for domestic and foreign insurers, except hospital and medical service corporations, 2.7 percent;

(2) for hospital and medical service corporations, six percent of their gross premiums less claims paid.

(c) A domestic company is exempt from taxation under this section for a period of five years from the date of its organization.

(d) An authorized insurer shall, with respect to all wet marine and transportation contracts written in this state during the preceding calendar year, before April 1 of each year, pay to the director a tax of three-quarters of one percent on its gross underwriting profit. The gross underwriting profit is computed by deducting from the net premiums (i.e., gross premiums less all return premiums and premiums for reinsurance) on wet marine and transportation insurance contracts, the net losses paid (i.e., gross losses paid, less salvage and recoveries on reinsurance ceded) during the calendar year under the contracts. In the case of an insurer issuing participating contracts, the gross underwriting profit shall not include, for computation of the tax prescribed by this section, the amounts refunded or paid as participation dividends by the insurers to the holders of the contracts.

(e) Payment to the director by an insurer of the tax upon its premiums required by this section shall be in lieu of all other taxes imposed by the state upon premiums, franchise, privilege or other taxes measured by income of the insurer commencing with the taxable year beginning January 1, 1967.

(f) The state hereby pre-empts the field of imposing excise, privilege, franchise, income, license, permit, registration, and similar taxes, licenses, and fees upon insurers and their general agents, agents and representatives as such; and on the intangible property of insurers or agents; and all political subdivisions of agencies in the state, including home rule boroughs or cities, are prohibited from imposing or levying upon insurers, or upon their general agents, agents and representatives as such, any tax, license, or fee. Provided that this subsection shall not be construed as prohibiting the imposition by political subdivisions of taxes upon real and tangible personal property of insurers and their general agents, agents and representatives.

(g) The director may suspend or revoke the certificate of authority of an insurer which fails to pay its taxes as required under this section.

(h) The provisions of this section do not apply to title insurance companies. A premium tax on title insurance companies shall be levied in accordance with the provisions of AS 21.66.110.

(i) Premiums paid by the state for insurance policies and contracts purchased under the provisions of AS 39.30 are exempt from taxation under this section. Claims for exemption shall be made on forms provided by the division of insurance. (§ 1 ch 120 SLA 1966; am § 29 ch 137 SLA 1982; am § 1 ch 118 SLA 1986)



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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February 5, 1987

MEMORANDUM

TO: Representative Mike Navarre

ATTN: Pat Malone

FROM: Penelope Weyhrauch
Legislative Analyst

RE: Insurance Agents and Brokers: Commingling of Funds
Research Request 87.087

You requested a discussion of the commingling of funds held by insurance agents and brokers in Alaska, and legislation in other states which address this issue.

The commingling of funds by insurance agents and brokers refers to a situation where premiums collected by the agent/broker are not kept in an account separate from personal or business funds. Premiums deposited in an account do not belong to an agent/broker. An agent/broker is acting as a fiduciary of the insurance company or the insured and by the nature of a fiduciary relationship is required to keep premiums in trust. In Alaska, premiums can be held in interest-bearing accounts, from which the agent/broker can periodically withdraw the interest.

Don Koch, of the Department of Commerce and Economic Development, Division of Insurance, said that most agents and brokers in Alaska have trust accounts set up for premiums but do not use them properly. He believes that there are agents and brokers who occasionally commingle premium and nonpremium funds, but that this commingling is often unintentional.

Mr. Koch said that within the last ten years, twelve cases of commingled funds have come to the division's attention. Four of the twelve cases were situations where commingling occurred and the agent/broker went bankrupt. In these four cases, commingling was proved and the agents'/brokers' licenses were revoked. The other eight cases are being investigated by the Alaska State Troopers. Mr. Koch said that he believes the Troopers have gathered enough evidence on three of these cases to suggest that commingling has occurred, and now the Division of Insurance can begin its investigation into these cases. The remaining five cases are still under investigation by the Troopers.

Mr. Koch believes that there are additional cases of commingling, but the division does not have the staff to pursue them. He said that he is able to perform some of the financial accounting required to keep insurance agents and brokers in compliance with Alaska's prohibition on the commingling of funds, but that a CPA is required to do a more complete audit.

Commingling of Funds by Insurance Agents and Brokers in Other States

I surveyed five states--California, Colorado, Idaho, Washington, and Wyoming--on state legislation and policy regarding the commingling of funds by insurance agents and brokers. Only one state, Idaho, allows insurance agents and brokers to commingle funds. The state of Idaho does however require agents and brokers to keep records and account for all premiums which they hold. The other four states listed above all require that insurance agents and brokers set up trust accounts for premiums, separate from personal and business funds. Copies of the statutes are attached. The discussion that follows addresses only the variations in the statutes.

California law allows agents and brokers to commingle enough funds to take care of contingencies, such as bounced premium checks. Paul Geary, Staff Counsel for the Insurance Compliance Bureau of the California Department of Insurance, said that most commingling that occurs in California occurs when an agent or broker is having financial difficulty. At that time, the agent or broker may take funds out of the premium trust account and use them for other purposes. An agent or broker who violates the law will be disciplined according to the magnitude of the offense. Discipline could include the revocation of an agent's or broker's license.

Colorado law relating to the commingling of funds is used by the Division of Insurance to suspend or revoke an agent's or broker's license. Bob Lord, Supervisor of Licensing and Investigations, Division of Insurance, said that commingling of funds is not much of a problem in Colorado. He said that the smaller companies which are just getting started might commingle, but this occurs mostly out of ignorance of the law.

Washington does not have much of a problem with the commingling of funds, according to Melody Bankers, Deputy Commissioner of the Consumer Protection Division, Washington Insurance Commissioner's Office. Ms. Bankers believes that the Washington statute relating to the commingling of funds requires excessive accounting measures of insurance agents and brokers. The Washington law requires that all premiums be kept in accounts separate from nonpremium funds. Ms. Bankers believes that this requirement is unnecessary for retail establishments which supply credit life insurance with purchases.

Representative Navarre
February 5, 1987
Page 3

Wyoming prosecutes violators of its law regarding the commingling of funds by agents and brokers. Violators may be found guilty of embezzlement, and convicted of a felony. Charles Hartman, Assistant Commissioner with the Department of Insurance, said that the department prosecuted three or four commingling cases last year.

* * *

I hope this information is helpful to you. If you have any questions or would like additional information, please contact our agency.

PW

Attachments

(1954) 43 C2d 476, 274 P2d 857.

In prosecution of insurance agent for grand theft by appropriation of money collected by him for payment of premiums under group insurance policies, there is no material variance between indictment alleging that defendant unlawfully took money belonging to insurer and proof that money belonged to trustees for whom defendant acted as agent in collecting such premiums, since such variance, if one exists, would be only in designation of person injured. *People v Hedderly* (1954) 43 C2d 476, 274 P2d 857.

Premiums received by general agent on insurance written by one insurer and paid over to second insurer are trust funds in hands of second insurer for benefit of insured, and second insurer and general agent are required to account for them in so far as they can be traced. *Mid-State Ins. Co. v American Fid. & Cas. Co.* (1956) 234 P2d 721.

An insurance broker may contract with an insurance company as to the payment of premiums negotiated by him for the benefit of the insured. He acts as a fiduciary both as to the insured and the insurer, and under Code Civ Proc, § 369 can recover the premiums from the insured in an

action in his own name without joining the insurer with him. *Warren (Walter J.) Ins. Agency v Surpur Timber Co.* (1967) 250 CA2d 99, 58 Cal Rptr 143.

Defendant who accepted money for an insurance premium from the purchaser of a truck and had failed to secure the insurance was properly convicted of grand theft under Ins. Code, § 1733, which provides that funds received "by any person acting as an insurance agent" as an insurance premium are received "in his fiduciary capacity," and that "any such person who diverts or appropriates such fiduciary funds to his own use is guilty of theft", where, though defendant was not a licensed insurance agent, the facts amply demonstrated that he was acting as an insurance agent. Though a predecessor statute used the words agent "whether licensed or unlicensed," the deletion of that language without the insertion of terminology limiting operation of the statute to either licensed or unlicensed persons alone resulted in coverage of persons in either status and subsequent legislative history demonstrated no definitive attempt to change the scope of the crime. *People v Hewitt* (1975) 53 CA3d 759, 126 Cal Rptr 20.

§ 1733.5. [Added by Stats 1957 ch 973 § 1 and repealed by Stats 1959 ch 4 § 1, effective February 27, 1959.]

See § 1744.

§ 1734. Fiduciary funds: Maintenance

This section applies to any person licensed, whether under a permanent license, restricted license, temporary license, or certificate of convenience, to act in any of the capacities specified in Section 1733. If fiduciary funds, as defined in Section 1733, are received by such person, he shall either:

- (a) Remit premiums, less commissions, and return premiums received or held by him to the insurer or the person entitled thereto, or
- (b) Maintain such fiduciary funds on California business at all times in a trustee bank account or depository in California separate from any other account or depository, in an amount at least equal to the premiums and return premiums, net of commissions, received by him and unpaid to the persons entitled thereto or, at their direction or pursuant to written contract, for the account of such persons. However, such person may commingle with such fiduciary funds in such account or depository such additional funds as he may deem prudent for the purpose of advancing premiums, establishing reserves for the paying of return commissions or for such contingencies as may arise

§ 1734

PRODUCTION AGENCIES

in his business of receiving and transmitting premium or return premium funds.

Added Stats 1959 ch 4 § 2, effective February 27, 1959; Amended Stats 1972 ch 553 § 1; Stats 1974 ch 594 § 1; Stats 1976 ch 845 § 1.

Prior Law: Former § 1730.5, as added by Stats 1951 ch 607 § 2 p 1769.

Amendments:

1972 Amendment: Amended subd (b) by (1) adding "trustee" after "times in a"; and (2) deleting the former third and fourth sentences which read: "Further, such person may commingle the funds of any principal with his own funds to an unlimited extent, if such principal in writing specifically waives the segregation requirements of this section. Commingling of funds as herein permitted shall not alter the fiduciary nature of such premium or return premium funds."

1974 Amendment: (1) Substituted "subdivision" for "subsection" wherever it appears in the introductory paragraph; and (2) added "on California business" and "in California" in subd (b).

1976 Amendment: (1) Substituted ", are received by such person, he shall either:" for "and held for one or more principals, are maintained in accordance with subdivision (b) hereof, such funds for other principals may be held and remitted in accordance with subdivision (a) hereof. Otherwise each such person who does not make immediate remittance of all funds received as premium to the insurer entitled thereto must elect and follow with respect to such funds, one of the following methods:" at the end of the introductory clause; and (2) substituted a comma for "within fifteen (15) days after the receipt thereof;" after "thereto" in subd (a).

Former Sections: Former § 1734, similar to present § 1743, was added by Stats 1953 ch 58 § 1 and repealed by Stats 1959 ch 4 § 1, effective February 27, 1959.

Original § 1734, relating to review of act of commissioner denying license, was added by Stats 1937 ch 652 § 22 and repealed by Stats 1945 ch 901 § 26.

Cross References:

Section applicable to bail license: § 1821.

Collateral References:

Law Review Articles:

Review of Selected 1972 Code Legislation. 4 Pacific LJ 528.

§ 1735. Fiduciary funds: Managing general agents

As used in this section a managing general agent is a licensed insurance agent who, (1) has a written management contract with one or more admitted insurers covering business transacted by the insurer in a substantial portion of the State of California; (2) under such contract manages the transaction of either all or one or more of the classes of insurance written by such insurers in that territory or the transactions therein by such insurers under a specified fictitious underwriter's name; (3) has the power to appoint, supervise and terminate this appointment of local agents in such territory; (4) has the power to accept or decline risks; and (5) collects premium moneys from producing agents and brokers and remits such moneys to such insurers pursuant to the account current system.

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(j) Suspension or revocation of a license in any other state, province, district, or territory:

(k) Forgery of another's name to an application for insurance;

(l) Cheating on an examination for an insurance license.

(2) In the event that the action by the commissioner is to not renew or to deny an application for a license, he shall notify the applicant or licensee of the reasons for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand on the commissioner for a hearing before the commissioner to determine the reasonableness of the commissioner's action. Such hearing shall be held within thirty days after the date of receipt of the written demand and shall be held pursuant to article 4 of title 24, C.R.S.

Source: R & RE, L. 77, p. 496, § 1.

10-2-213. Fiduciary responsibilities. (1) (a) All premiums belonging to insurers and all unearned premiums belonging to insureds received by a licensee under this part 2 shall be treated by such licensee in a fiduciary capacity. The commissioner may promulgate such rules as are necessary in this regard.

(b) All premiums received, less commissions if authorized, shall be remitted to the insurer or its agent entitled thereto on or before the contractual due date or within forty-five days after receipt thereof if there is no contractual due date.

(c) All returned premiums received from insurers or credited by insurers to the account of the licensee shall be remitted to or credited to the account of the person entitled thereto within thirty days after such receipt or credit.

(2) If any licensee has failed to account for any collected premium to the insurer to whom it is owing or to its agent entitled thereto for forty-five days after the contractual due date or ninety days after the receipt thereof if there is no contractual due date, the insurer or its agent shall promptly report such failure to the commissioner in writing.

(3) Every insurer shall remit unearned premiums to the insured or the proper agent or shall otherwise credit the account of the proper licensee as soon as is practicable after entitlement thereto has been established, but in no event more than forty-five days after the effective date of any cancellation or termination effected by the insurer or after the date of entitlement thereto as established by notification of cancellation, or termination, or otherwise. It shall be the responsibility of any licensee having knowledge of a failure on the part of any insurer to comply with this provision for remitting unearned premiums to promptly report such failure to the commissioner in writing.

(4) No licensee under this part 2 shall commingle premiums belonging to insurers and returned premiums belonging to insureds with his personal funds or any other funds except those directly connected with his insurance business.

Source: R & RE, L. 77, p. 497, § 1.

10-2-214. Investigation by commissioner. (1) The commissioner may examine and investigate the business affairs and conduct of every person

applying for or holding a license in such person has been or is subject to or regulations of this state or practices in any state.

(2) On receipt of any information indicating that an insurance company is operating in unfair or deceptive practices in violation of the license under this part 2, the commissioner may appear and show cause why the license should not be or refuse to issue the person a license, or may refuse to show cause, revoke, suspend

(3) The license of a partner revoked or the renewal thereof, that an individual licensee known by one or more of the members of the partnership or corporation to the division of insurance nor

(4) In addition to or in lieu of suspension or revocation of a license, any person may, after hearing, be subject to a fine of not more than \$500 and \$100 for each such violation.

Source: R & RE. L. 77, p. 4

10-2-215. Surrender of license. A licensee shall promptly notify the commissioner regarding any suspension, revocation or annulment of a license.

(2) Upon suspension, resident of this state, the commissioner of each state who has 10-2-207 (11).

(3) Upon suspension, rev see shall forthwith deliver i by mail.

(4) Any licensee who ceases to reside in the state defined in section 10-2-207 shall be considered a nonresident by personal delivery of the license to said residency.

(5) The commissioner may suspend or destroyed license issued to a licensee in a form prescribe such loss, theft, or destruction.

Source: R & RE. L. 77, p. 4

10-2-216. Termination re-
insurer shall promptly give a
positive date thereof to the com-

(3) An agent, solicitor or broker may commingle with premium funds any additional funds as he or she may deem prudent for the purpose of advancing premiums, establishing reserves for the paying of return premiums, or for any contingencies as may arise in his or her business of receiving and transmitting premium or return premium funds.

(4) Each willful violation of this section shall constitute a misdemeanor.

Enacted by Laws 1986, ch. 69, § 1, eff. Jan. 1, 1987.

Effective date—Laws 1986, ch. 69:

"This act shall take effect on January 1, 1987." [Laws 1986, ch. 69, § 2.]

CHAPTER 48.18—THE INSURANCE CONTRACT

Sec.

48.18.2901. Renewal required—Exceptions.

48.18.100. Forms of policies—Filing, certification, and approval

Notes of Decisions

Motor vehicle policies 4.5

be modified simply by agreement of the carrier and the named insured. *Mission Ins. Co. v. Guarantee Ins. Co.* (1984) 37 Wash.App. 695, 683 P.2d 215.

4.5. Motor vehicle policies

Motor vehicle liability policy's omnibus clause, required by § 46.29.490, cannot

48.18.110. Grounds for disapproval

(1) The commissioner shall disapprove any such form of policy, application, rider, or endorsement, or withdraw any previous approval thereof, only:

(a) If it is in any respect in violation of or does not comply with this code or any applicable order or regulation of the commissioner issued pursuant to the code; or

(b) If it does not comply with any controlling filing theretofore made and approved; or

(c) If it contains or incorporates by reference any inconsistent, ambiguous or misleading clauses, or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract; or

(d) If it has any title, heading, or other indication of its provisions which is misleading; or

(e) If purchase of insurance thereunder is being solicited by deceptive advertising.

(2) In addition to the grounds for disapproval of any such form as provided in subsection (1) of this section, the commissioner may disapprove any form of disability insurance policy if the benefits provided therein are unreasonable in relation to the premium charged.

Amended by Laws 1985, ch. 264, § 9.

1985 Amendment. Near the end of subsec. (1)(a), preceding "pursuant to the code" inserted "issued"

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48.17.520

INSURANCE

which such agent was not licensed at the time of death or commencement of disability.

Amended by Laws 1985, ch. 264, § 8.

1985 Amendment. Deleted subsec.
(3).

48.17.590. Procedures for cancelling written agreements between companies and agents

(1) If an insurer intends to cancel a written agreement with an agent, or intends to refuse any class of renewal business from the agent, the insurer shall give the agent not less than one hundred twenty days' advance written notice of such intent. Every insurer canceling a written agreement subject to this section shall permit, for not less than one year after having given notice of its intent to terminate the agency agreement, insureds to process their renewals through the agent, as long as he or she retains an agent's license for the kind of insurance involved, as to any of the policies which have not been replaced with other insurers as expirations occur. An agent with a canceled agreement subject to this section shall remain an agent of the canceling insurer as to actions associated with any such policies just as if he or she were appointed by such insurer as its agent. This subsection shall not apply to: (a) Agents or policies of a company or group of companies if the business is owned by the company or group of companies and the cancellation of any such contractual agreement does not result in the cancellation or nonrenewal of any policies of insurance; (b) life, disability, surety, ocean marine and foreign trade, and title insurance policies; or (c) agents whose licenses are then or become subject to an outstanding order of the commissioner issued pursuant to RCW 48.17.540.

(2) No insurer shall cancel or refuse to renew the policy of the insured because of the termination of the agent's contract.

(3) No insurer may cancel or amend a written agreement with an agent, or refuse to accept business from such agent, if the cancellation, amendment, or refusal is arbitrary, capricious, discriminatory under RCW 48.30.300, or based in whole or part upon the sex, race, creed, color, religion, national origin, or place of residency of the agent, his or her applicants, or policyholders.

(4) Any insurer or agent accepting brokerage business who rejects the business of a broker shall provide upon request of the broker the reasons in writing for the rejection.

(5) No insurer may cancel its agreement with an appointed agent with respect to insurance or refuse to accept insurance business from such agent unless it complies with the provisions of this section.

Enacted by Laws 1986, ch. 286, § 1.

48.17.600. Separation of premium funds

Text of section effective Jan. 1, 1987.

(1) All funds representing premiums or return premiums received by an agent, solicitor or broker in his or her fiduciary capacity shall be accounted for and maintained in a separate account from all other business and personal funds.

(2) An agent, solicitor or broker shall not commingle or otherwise combine premiums with any other moneys, except as provided in subsection (3) of this section.

INSURANCE

(3) An agent, solicitor or broker advancing premiums, establishing funds, or for any contingencies in receiving and transmitting premiums.

(4) Each willful violation of this section shall be a misdemeanor. Enacted by Laws 1986, ch. 69, § 1, et seq.

Effective date—Laws 1986, ch. 69, § 1. "This act shall take effect on January 1, 1987." [Laws 1986, ch. 69, § 2.]

CHAPTER 48.18—TH

Sec.
48.18.2901. Renewal required—Ex-

48.18.100. Forms of policies—1

Notes of Decisions

Motor vehicle policies 4.5

4.5. Motor vehicle policies
Motor vehicle liability policy's omission of the "no fault" clause, required by § 46.29.490, is not a violation of the code.

48.18.110. Grounds for disapproval

(1) The commissioner shall disapprove a policy, rider, or endorsement, or only:

(a) If it is in any respect in violation of any applicable order or regulation of the code; or

(b) If it does not comply with the code; or

(c) If it contains or incorporates any misleading clauses, or if it is likely to mislead or deceptively affect the coverage of the contract; or

(d) If it has any title, heading, or subtitle which is misleading; or

(e) If purchase of insurance is advertised.

(2) In addition to the grounds provided in subsection (1) of this section, any form of disability insurance which is unreasonable in relation to the cost of the insurance.

Amended by Laws 1985, ch. 264, § 8.

1985 Amendment. Near the end of subsec. (1)(a), preceding "the code" inserted "issued".

WYOMING

(c) The agent or broker shall keep at his place of business a complete record of transactions under his license and those of his solicitors. The record shall show, as to each insurance policy or contract placed or countersigned by or through the licensee, the names of the insurer and insured, the number, expiration date of, premium payable as to the policy or contract and any other information the commissioner reasonably requires. The commissioner shall keep the record available for inspection for a period of at least three (3) years after completion of the transactions. (Laws 1967, ch. 136, § 189; 1977, ch. 49, § 2; W.S. 1977, § 26-9-137; Laws 1983, ch. 190, § 1.)

Effective dates. — Section 3, ch. 49, Laws 1977, makes the act effective May 27, 1977.

§ 26-9-130. Reporting and accounting for premiums.

(a) Any premiums or return premiums received by an agent, broker or solicitor are trust funds received in a fiduciary capacity, and the agent, broker or solicitor, in the regular course of business, shall account for and pay the funds to the insured, insurer or agent entitled thereto.

(b) The licensee shall establish a separate trust account for premiums specified in subsection (a) of this section and shall not use the account for or commingle it with his own funds. He shall maintain an accurate record and itemization of the funds deposited in the account.

(c) Any agent, broker or solicitor who diverts or appropriates any funds, to which he is not lawfully entitled, to his own use is guilty of embezzlement and upon conviction shall be punished as provided by law. (Laws 1967, ch. 136, § 190; 1977, ch. 49, § 1; W.S. 1977, § 26-9-138; Laws 1983, ch. 190, § 1.)

Effective dates. — Section 3, ch. 49, Laws 1977, makes the act effective May 27, 1977.

Personal liability of agent. — Where defendant insurance agent sold plaintiff insurance coverage for plaintiff's aircraft, defendant had a duty to see that the funds solicited from plaintiff were applied to the use for which they were secured. Having so failed, he must personally account for his actions, and failing to show reasonable exercise of such duty, his personal liability is established. He authored and executed the plan which led to his own misfortune, and he cannot be heard to complain that someone else, i.e., the corporations over which he had

control, should be made to respond. *Preston v. Natrona Serv., Inc.*, 489 P.2d 622 (Wyo. 1971).

Measure of damages. — Where there is no evidence of greater loss sustained by the insured, the measure of damages has been held to be the premiums or assessments paid by the insured with interest thereon. *Preston v. Natrona Serv., Inc.*, 489 P.2d 622 (Wyo. 1971).

Am. Jur. 2d, ALR and C.J.S. references. — Revocation or suspension of insurance agent's license for withholding or misappropriation of premiums, 17 ALR4th 1106.

§ 26-9-131. Exchange of business.

(a) A general lines agent may occasionally place an insurance coverage with an insurer as to which he is not then appointed as an agent, and the insurer shall accept that business only when placed through a licensed agent, resident of this state, of the insurer. Both agents involved in such an exchange of business shall be then licensed as to each kind of insurance represented by the coverage.

f records. — (1) No written agreement between insured insurer. Such written records of both the insured insurer and for six months after the agreement and for six months after the director for his confidential

insurances which include the provisions of the Idaho Code, except as provided by the administrator.

a copy of the trust agreement shall be furnished to the insured as part of the official records for the duration of the term, as added by 1983, ch.

between insurer and insurer utilizes the services of the administrator of the insured shall not be deemed to be a payment of return premium if the insured has received by all limit any right of the insured administrator's failure to maintain. [I.C., § 41-903,

Confidentiality. — (1) The administrator's principal agreement required by the administrator, insurers and insureds maintained in accordance

records maintained by the insured and inspection. Any records including the identity of insureds, shall be confidential, proceedings instituted

(3) The insurer shall retain the right of continuing access to books and records maintained by the administrator sufficient to permit the insurer to fulfill all of its contractual obligations to insured persons, subject to any restrictions in the written agreement between the insurer and administrator on the proprietary rights of the parties in such books and records. [I.C., § 41-904, as added by 1983, ch. 186, § 1, p. 501.]

Sec. to sec. ref. Sections 41-904 — 41-911 are referred to in § 41-902.

41-905. Advertising — Approval. — An administrator may use only such advertising pertaining to the business underwritten by an insurer as has been approved by such insurer in advance of its use. All insurers shall have the prior approval of the director before approving advertising for use by an administrator. [I.C., § 41-905, as added by 1983, ch. 186, § 1, p. 501.]

41-906. Inclusion of underwriting standards. — The agreement required in section 41-902, Idaho Code, shall make provision with respect to the underwriting or other standards pertaining to the business underwritten by such insurer. [I.C., § 41-906, as added by 1983, ch. 186, § 1, p. 501.]

41-907. Charges, fees, or premiums collected held in fiduciary capacity — Establishment of account — Disbursements. — (1) All insurance charges, fees or premiums collected by an administrator on behalf of or for an insurer or insurers, and return premiums received from such insurer or insurers, shall be held by the administrator in a fiduciary capacity. Such funds shall be immediately remitted to the person or persons entitled to such funds or shall be deposited promptly in a fiduciary bank account established and maintained by the administrator.

(2) All such funds (charges, fees or premiums) shall be used to establish the premium tax under section 41-402, Idaho Code.

(3) If charges, fees or premiums deposited in a fiduciary account have been collected on behalf of or for more than one (1) insurer, the administrator shall keep records clearly recording the deposits in and withdrawals from such account on behalf of or for each insurer. The administrator shall, upon request of an insurer, furnish such insurer with copies of such records pertaining to deposits and withdrawals on behalf of or for such insurer.

(4) The administrator shall not pay any claim by withdrawals from a fiduciary account. Withdrawals from such account shall be made, as provided in the written agreement between the administrator and the insurer required by section 41-902, Idaho Code, for any of the following:

- (a) Remittance to an insurer entitled to such remittance.
- (b) Deposit in an account maintained in the name of such insurer.
- (c) Transfer to and deposit in a claims-paying account, with claims to be paid as provided by section 41-907 (this section), Idaho Code.
- (d) Payment to a group policyholder for remittance to the insurer entitled to such remittance.



ALASKA STATE LEGISLATURE
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February 17, 1987

MEMORANDUM

TO: Representative Mike Navarre

ATTN: Pat Malone

FROM: Penelope Weyhrauch 
Legislative Analyst

RE: Insurance Agents and Brokers: Commingling of Funds
Research Request 87.087 (Supplemental Information)

I have attached some information that I recently received on the commingling of funds by insurance agents and brokers. Attachment A was prepared by the National Association of Professional Insurance Agents and discusses language employed by state regulations and statutes regarding the receipt of premium payments by agents. Attachment B includes a copy of Colorado Regulation 78-12 concerning agent fiduciary responsibilities and a copy of Colorado Insurance Code 10-2-213 regarding fiduciary responsibilities by an insurance agent or broker. I hope this information is useful to you.

Attachments

ATTACHMENT A

There are two basic types of language employed by state regs and statutes concerning receipt of premium payments by agents. First, there are those that state such payments are held in trust or in a fiduciary capacity by the agent. These are:

Alabama	§ 27-7-36	held in trust
Arkansas	§ 66-2831	held in trust
Delaware	Reg. 21, § 12	held in trust
D.C.	§ 35-429	held in trust
Florida	§ 626.561	held in trust
Illinois	§ 505	fiduciary capacity
Kentucky	§ 304.9-400	fiduciary capacity
Maine	§ 1613	fiduciary capacity
Michigan	§ 500.1207	fiduciary capacity
Missouri	§ 375.051	fiduciary capacity
Minnesota	Reg. § 2795.1300	fiduciary capacity
Montana	§ 33-17-1102	fiduciary capacity
Rhode Island	§ 27-3-36	fiduciary capacity
South Dakota	§ 58-30-88	fiduciary capacity
Washington	§ 48.17.180	fiduciary capacity

Second, there are those states that specifically require a separate account or prohibit commingling of funds. These are:

Alaska	§ 21.27.360	separate account
California	§§ 1734 to 1735	separate account
Colorado	Code § 10-2-213 and Reg. § 78-12	separate account
Georgia	§ 33-23-79	no commingling
Hawaii	§ 431-397	no commingling
Idaho	§ 41-1064	separate account
New York	§ 125	no commingling
Nevada	Code § 683A.400 and Reg. § 683A.410	separate account
Pennsylvania	§ 40-25-404	no commingling
Utah	§ 31-17-22	separate account
Wyoming	§ 26-9-130	separate account

Kansas, at K.S.A. § 40-3712 prohibits commingling, but does not require a separate account.

10/24/86
KJH

ATTACHMENT B
COLORADO RULES & REGULATIONS

Regulation 78-12

CONCERNING AGENT FIDUCIARY RESPONSIBILITIES

June 11, 1979

Amended effective March 1, 1980

I. AUTHORITY

This regulation is promulgated under the authority of 10-1-108(8), 10-1-109, 10-2-220 and 10-3-1110, C.R.S. 1973.

II. PURPOSE

The purpose of this regulation is to clarify the responsibility of insurance agents and brokers to treat each insurance policy and premiums handled thereon as a separate account of their insureds unless specific authorization has been obtained from insureds to comingle multiple obligations and funds.

III. RULE

1. No insurance premium or refund received by an insurance agent, broker or agency by reason of the application for, issuance or termination of any particular policy may be credited to any other obligation owed by the insured to such agent, broker, agency or other insurer unless specific written authorization has been obtained from the insured to so credit, or a blanket authorization has been obtained from the insured to handle all policies and obligations from one account.

2. Upon receipt, the insurance producer must treat all premiums and returned premiums in a fiduciary capacity, including but not limited to the following:

a. Upon receipt the insurance producer must treat all premiums and return premiums as trust funds and segregate them from his own funds, and

b. the insurance producer must keep an accurate record of all fiduciary funds, and

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COLORADO RULES AND REGULATIONS

c. the insurance producer must not treat insurance premiums or returned premiums as a personal or business asset, and

d. the insurance producer's financial statement should not reflect fiduciary funds as an asset or as income to the insurance producer, and

e. an insurance producer may not use fiduciary funds as collateral for a personal or business loan, but the insurance producer may receive interest on such funds and use as a compensation balance with the financial institution, and

f. any deposit of such premium and returned premium funds into a bank or savings account must be into a separate insurance trust account until actually remitted to the insurer or person entitled thereto. Such deposits will be subject to the uniform fiduciary's law as delineated in C.R.S. 1973, 15-1-101 *et seq.*

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(j) Suspension or revocation of a license in any other state, province, district, or territory;

(k) Forgery of another's name to an application for insurance;

(l) Cheating on an examination for an insurance license.

(2) In the event that the action by the commissioner is to not renew or to deny an application for a license, he shall notify the applicant or licensee of the reasons for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand on the commissioner for a hearing before the commissioner to determine the reasonableness of the commissioner's action. Such hearing shall be held within thirty days after the date of receipt of the written demand and shall be held pursuant to article 4 of title 24, C.R.S. 1973.

History.—L. 77, S.B. 472, § 1.

§ 10-2-213. Fiduciary responsibilities

(1) (a) All premiums belonging to insurers and all unearned premiums belonging to insureds received by a licensee under this part 2 shall be treated by such licensee in a fiduciary capacity. The commissioner may promulgate such rules as are necessary in this regard.

(b) All premiums received, less commissions if authorized, shall be remitted to the insurer or its agent entitled thereto on or before the contractual due date or within forty-five days after receipt thereof if there is no contractual due date.

(c) All returned premiums received from insurers or credited by insurers to the account of the licensee shall be remitted to or credited to the account of the person entitled thereto within thirty days after such receipt or credit.

(2) If any licensee has failed to account for any collected premium to the insurer to whom it is owing or to its agent entitled thereto for forty-five days after the contractual due date or ninety days after the receipt thereof if there is no contractual due date, the insurer or its agent shall promptly report such failure to the commissioner in writing.

(3) Every insurer shall remit unearned premiums to the insured or the proper agent or shall otherwise credit the account of the proper licensee as soon as is practicable after entitlement thereto has been

established, but in no event more than forty-five days after the effective date of any cancellation or termination effected by the insurer or after the date of entitlement thereto as established by notification of cancellation, or termination, or otherwise. It shall be the responsibility of any licensee having knowledge of a failure on the part of any insurer to comply with this provision for remitting unearned premiums to promptly report such failure to the commissioner in writing.

(4) No licensee under this part 2 shall commingle premiums belonging to insurers and returned premiums belonging to insureds with his personal funds or any other funds except those directly connected with his insurance business.

History.—L. 77, S.B. 472, § 1.

§ 10-2-214. Investigation by commissioner

(1) The commissioner may examine and investigate the business affairs and conduct of every person applying for or holding a license under this part 2 to determine whether such person has been or is engaged in any violation of the insurance laws or regulations of this state or has engaged in unfair or deceptive acts or practices in any state.

(2) On receipt of any information regarding the possible violation of the insurance laws or regulations of this or any other state or the possible engaging in unfair or deceptive practices by a person applying for or holding a license under this part 2, the commissioner may require such person to appear and show cause why the commissioner should not revoke, suspend, or refuse to issue the person's license and may, on failure of such person to show cause, revoke, suspend, or refuse to issue or renew the license.

(3) The license of a partnership or corporation may be suspended or revoked or the renewal thereof refused if the commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers, or managers acting on behalf of the partnership or corporation and such violation was not reported to the division of insurance nor corrective action taken in relation thereto.

(4) In addition to or in lieu of any applicable denial, suspension, or revocation of a license, any person who violates any provision of this



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February 2, 1987

MEMORANDUM

TO:

ATTN:

FROM: Penelope Weyhrauch
Legislative Analyst

RE: Solutions to the Insurance Crisis
Research Request 87.080

You asked for a discussion of what caused the insurance crisis and a presentation of possible solutions, other than tort reform, to the crisis.

What Caused the Insurance Crisis

The insurance crisis, which began in 1985, is generally considered a crisis because of the lack of available and affordable insurance for some consumers. Most groups which have studied the insurance crisis attribute its occurrence to insurance companies' policy of cash flow underwriting. Cash flow underwriting is the practice of charging inadequate premiums to generate cash for investment, and then relying upon investment returns to offset underwriting deficits.

During the late 1970s and the early 1980s, insurance companies offered premiums at bargain levels to attract more money for investments. Table 1 shows insurance companies' income from underwriting and investments for the years 1981 to 1984. In 1984, interest rates began to fall and investment income no longer offset expenses and underwriting losses. Insurance companies began to increase premiums and to select the risks they would underwrite with greater caution.

Table 1
U.S. Insurance Industry
Underwriting Loss and Investment Return Rates

	<u>1981</u>	<u>1982</u>	<u>1983</u>	<u>1984</u>
Underwriting Loss (in billions of dollars)	6.3	10.3	13.3	21.0
Investment Returns (in billions of dollars)	13.2	14.9	15.8	17.3
Net Gain (Loss)	6.9	4.6	2.5	(3.7)

SOURCE: Council of State Governments, December 1985.

* * * * *

According to a report done by the National Conference of State Legislatures (NCSL), "The large increase in premiums in recent months is due to the fact that premiums paid in the early 1980s did not accurately reflect the real cost of insurance and insurance companies are now trying to make up for losses." The NCSL, which has done extensive research on insurance, also reports that other factors which influenced a legitimate increase in insurance costs include an increase in sales and property values, an expansion in business activities, and general economic growth.¹

Insurance has also become more difficult to obtain because foreign-based companies who share part of the risk with domestic insurance companies began to withdraw from the U.S. market. The withdrawal of reinsurers was the result of underwriting losses and a strong U.S. dollar.

Insurers say that underpricing in combination with severe claim losses in 1980-1984 caused the current crisis. They claim that the major factor in underpricing was insurers' inability to predict the losses they would have to pay. Insurers have lobbied for tort reform, contending that courts are including coverages never intended in policies and that million dollar jury awards are becoming common, forcing insurers to increase premium costs.

Arguments regarding the need for tort reform in addressing the insurance crisis were considered to be valid by the federal Tort Policy Working Group on the Causes, Extent and Policy Implications of the Current Crisis in

¹Brenda Tolin, "Controlling Liability Insurance Costs: State Initiatives in the Area of Insurance Regulation," State Legislative Report, National Conference of State Legislatures, May 1986.

Insurance Availability and Affordability, in their report of February 1986. The group stated that developments in tort law are a major cause of sharp premium increases. The group further stated that "...there is little to suggest that the recent massive increases in premiums is related solely to these losses, or that the cost of liability insurance will decline significantly as the industry limits its underwriting losses and restores its desired level of overall profitability."

Addressing the Insurance Crisis

Many states have addressed the insurance crisis by enacting reforms to their civil justice systems (tort reform), while others have looked at tightening regulations on the insurance industry or establishing new state insurance mechanisms. Attachment A is a summary of 1986 legislative action on the liability insurance issue in the fifty states.

New insurance mechanisms and strategies that some states are considering include allowing the pooling of risks, allowing joint underwriting associations, and developing market assistance plans. These terms are defined beginning on the next page. Attachment B identifies states which are implementing new insurance mechanisms and strategies. Insurance regulatory reforms being considered by states include: expanding data submitted by insurers; permitting policy cancellation only with cause; requiring the mandatory notice of nonrenewals, cancellations and rate increases; and instituting studies which estimate tort reform savings. Attachment C identifies states which have instituted insurance regulation reforms.

Alaska Legislation

Tort Reform. The 1986 Alaska Legislature passed a tort reform bill (Ch 139, SLA 86) which, among other things, limits the recovery of damages in a civil action, provides for the reduction of future damages to present value, requires the apportionment of damages for multiple defendants, and limits the joint liability of certain parties. Don Koch, with the Department of Commerce and Economic Development, Division of Insurance, said that while insurance companies have not responded to the tort reforms with rate decreases, there has been an improvement in availability. Mr. Koch believes that most insurance companies will wait to see how the new reforms work before they reduce their rates. Other tort reform legislation that was considered by the legislature but was not passed included a bill on the periodic payment of judgments (HB 490) and a bill on verdicts, damages and liability in civil actions (HB 481).

Insurance Reform. In addition to tort reform legislation recently enacted or introduced in Alaska, the 1985-1986 Legislature also considered the following bills which addressed the insurance crisis:

HB 356	Assignment of Group Insurance Policies
HB 506	Reinsurance Fund and Insurance Pooling
HB 522	Unfair Insurance Claims Settlement Practices
HB 547	Health Insurance Pool for High Risk People
HB 585	Joint Self-Insurance for School Districts
HB 702	State Reinsurance Fund
SB 88	Alaska Life/Disability Insurance Guarantee Assoc.
SB 156	Form of Payment for Insurance Settlements
SB 288	Liquor License Holders' Insurance Corporation
SB 366	Cancellation of Insurance Policies
SB 404	Joint Insurance Arrangements
SB 445	Miscellaneous Changes in Insurance Laws
SCR 20	Availability of Marine Insurance

Two bills listed here, HB 356 and HB 506, were signed into law. The other bills listed here, excluding HB 522, did not progress out of committees in their house of origin. House Bill 522 died in the Senate Rules Committee. Shari Kochman--aide to Representative John Sund, who sponsored HB 522--said that the bill was not high on the list of priorities last year, but that it is considered a priority this year. The bill related to an insurance broker's receipt of premium payments, the cancellation or nonrenewal of insurance policies, and medical malpractice insurance for nurses and nurse midwives, among other things. Attachment D includes a complete summary of insurance-related legislation introduced in 1985-1986, additional information on insurance legislation passed during that time and House Bill 522.

Solutions to the Insurance Crisis, Other than Tort Reform

In researching solutions to the insurance crisis, I gathered information from the National Conference of State Legislatures, the Conference of Insurance Legislators, the Congressional Quarterly, the Council of State Governments, and the National Insurance Consumer Organization (NICO). I discussed some alternatives with Don Koch to get his response on how these solutions might work in Alaska. The alternatives that follow are gathered from these sources and are divided into two sections: Insurance Mechanisms and Strategies, and Insurance Regulation. The alternatives listed in each section are in no particular order.

Insurance Mechanisms and Strategies

1. Allowing the State to act as an insurance company could provide consumers with insurance when none is otherwise available to them. The State could act as an insurance company in a manner similar to

those states that self-insure worker's compensation. Mr. Koch said that implementation of this alternative would put the State in the position of replacing private markets. He said that this would be similar to the implementation of the Medical Indemnity Corporation of Alaska (MICA).

The MICA is a statutorily created insurance company which insures physicians and hospitals in Alaska (AS 21.88.020--Attachment E). The MICA was capitalized with State funds and operates with low-interest State loans (with a borrowing limit of \$6 million). The MICA has already borrowed \$5 million, and according to Mr. Koch, has been a financial concern for the State. Mr. Koch said that because MICA was created by the State, the corporation believed it was their obligation to offer insurance to anyone, even very poor risks. Although MICA is now more selective, Mr. Koch is still concerned for MICA's financial stability. If MICA goes out of business, the State will not recover the \$5 million loaned to the corporation.

2. Allowing the State to act as a reinsurance company could provide insurance companies with a reinsurer when one might otherwise not be available. Reinsurance is the mechanism by which the original insurer transfers part or all of the liability to a second insurer (the reinsurer).

A system of State or federal reinsurance, similar to that used during the race riots of the 1960s, could be established. During that time, insurers were pulling out of the inner city areas of the nation. The federal government agreed to offer reinsurance for riot damages, and in return, insurers formed pools to assure full coverage (including fire, liability, etc.) in distressed areas. The federal government collected a reinsurance premium and also required the insurers to impose certain safety standards for risks they undertook. The federal government made a \$125 million profit operating this insurance program.²

According to Mr. Koch, if the State acts as a reinsurance company, the State would be liable for insurance losses if an insurance company went bankrupt. He believes this would be a risky position for the State to be in, particularly in light of the present budget deficit. He also mentioned that setting aside funds for future liability payments could violate Alaska's constitutional prohibition on the dedication of funds.

3. Allowing banks to sell insurance will increase competition in the insurance market and provide more alternatives to consumers. The Florida legislature recently passed legislation which allows

²There is no state, according to Jay Angoff of the National Insurance Consumers' Organization, that is considering acting as a reinsurance company.

financial institutions to enter the reinsurance business. Mr. Koch believes that allowing banks to insure will give them too much leverage. His primary concern is that banks may attempt to coerce people into buying insurance in order to get a loan.

4. Authorizing the establishment of joint underwriting associations may aid in providing coverage of risk that individual insurers do not want to cover. Joint underwriting associations (JUAs) are established by state law and require that insurers insure certain risks. There are no JUAs in Alaska, though the automobile and worker's compensation assigned risk plans operate on a similar principle. Mr. Koch believes that establishing JUAs in Alaska will adversely affect the availability of voluntary underwriting in Alaska.
5. Allowing insurance pools affords consumers with common insurance needs a way to reduce insurance costs. In a pool, the group is often responsible for a portion of the losses experienced by individuals within the group. Savings result from both partial self-insurance and economies of scale. Tennessee and Michigan indicate that savings have been realized by allowing consumers to pool; buyers have obtained higher amounts of coverage and smaller municipalities have been able to insure at rates lower than those that would have been available to them on an individual basis. However, Utah reports that pooling legislation enacted in 1976 has not changed the availability or affordability of insurance in the state. Alaska allows the pooling of insurance for school districts and municipalities by statute (Ch 136, SLA 86). There have not been any pools set up under the statute, to Mr. Koch's knowledge.

Another form of "pooling" called "reciprocal insurance" is defined in AS 21.75. By statute, ten or more persons in the state may organize as a reciprocal insurer. Financial accountability is the primary difference between the pooling of insurance and reciprocal insurers. Pools set up under Ch 136, SLA 86 are free from State surveillance; reciprocal insurers in Alaska have certain financial requirements which they must meet--such as adequate capitalization--in order to begin operating. Mr. Koch hopes that if the legislature decides to allow other entities to pool outside of the reciprocal insurer mechanism in AS 21.75, they require such pools to have adequate capitalization and some government regulation.

6. Establishing Market Assistance Plans (MAPS) will provide information on markets available for high risk and unique consumers. MAPS are developed through state insurance regulatory agencies in an effort to coordinate those seeking insurance and those willing to sell often hard-to-get types of insurance.

The Division of Insurance responded to the unavailability of day care insurance in Alaska by coordinating with the Department of Health and Social Services (DHSS). This effort, the Coordination of Alaska Day Care Insurance Search (CADIS), has been successful in finding appropriate and affordable insurance for day care providers in Alaska. The CADIS worked by making inspection reports completed by the DHSS available to day care providers. Day care providers were then able to provide specific information (compiled by a neutral party) to insurance brokers, who in turn were able to provide the information to insurers. Mr. Koch said that a lack of information was one of the main factors deterring insurers from insuring day care providers. Making inspection reports available to day care providers also provided them with information regarding their deficiencies, which providers often corrected.

7. Developing an interstate organization may increase the availability of insurance. NICO suggests that states group together and agree to license insurance companies in their state only if they agree to write insurance in all the states within the group. Western states--such as California, Oregon, Washington and Alaska--could band together to demand insurance availability in their states. Mr. Koch said that some state insurance commissioners are politically motivated and believes it would be difficult to successfully coordinate an interstate insurance organization.
8. Establishing a State office of insurance consumer advocacy will provide consumers with an advocate to represent the interests of consumers in regard to rate increases and other insurance issues. Mr. Koch said that the Division of Insurance has a consumer advocacy specialist who is responsible for representing the interests of consumers in insurance issues.
9. Employing mediation and arbitration usually reduces the costs of lawsuits, which means lower litigation expenses for insurance companies. This may ultimately lead to lower insurance rates for consumers. The use of alternative forms of dispute resolution, such as mediation and arbitration, may also create incentives to settle disputes at the earliest possible time and to refrain from filing frivolous cases. The State of Michigan recently enacted a law which requires pretrial mediation of all medical malpractice cases and of other personal injury claims for more than \$10,000.
10. Urging the federal government's involvement in insurance regulation may result in federal legislation addressing the insurance crisis. Both Congress and the Reagan administration have considered federal tort reform legislation. The administration developed tort reform legislation and sent it to Capitol Hill, but Congress has not been willing to act on national insurance legislation. This reluctance to act may be because insurance has traditionally been an area of state regulation. The last major congressional legislation

on the subject was the McCarran-Ferguson Act, which was passed to overcome a 1940 Supreme Court decision authorizing federal regulation of insurance.

One suggestion for federal legislation is to subject the insurance industry to both federal and state antitrust laws. Under the McCarran-Ferguson Act, insurance companies are exempt from federal antitrust rules. This exemption makes it harder to stop companies if they act in concert to raise prices for a particular line of insurance. Another suggestion is that the federal government act as a reinsurer, much the same as it did during the race riots of the 1960s. This alternative has not been seriously considered by Congress.

11. Authorizing the development of captive insurers creates another opportunity for self-insurance. Captive insurance companies are subsidiaries set up to provide insurance for the parent corporations. Vermont, Colorado, and Tennessee have all authorized the formation of captive insurers. The Conference of Insurance Legislators believes that use of this vehicle has been effective in regard to the availability and affordability of insurance.
12. Increasing state regulatory staff may provide greater surveillance of the insurance industry and result in more consistent insurance rates for consumers. According to the NCSL, many state regulatory agencies are understaffed. State regulatory agencies are often expected to act as a watchdog over insurance companies, act as a consumer advocate, and act as an insurance clearinghouse between both groups, as well as supply a number of other necessary regulatory functions. Mr. Koch would like to increase surveillance over insurance companies and provide additional insurance information to consumers, but said he requires additional staff to do so.

Insurance Regulation

1. Expanding reporting requirements for insurance companies may help state regulatory agencies monitor the insurance industry. Insurance companies could provide information such as how much is reserved for claims as compared to the amount actually awarded, and specific information on how civil justice doctrines affect insurance companies.

State regulatory agencies often have little information from insurance companies which would allow them to understand the industry's methods. Terminology and accounting methods used by the industry often differ from the general understanding of such concepts. For example, reports of industry losses for 1985 have been calculated at anywhere from a \$5.5 billion loss to a \$1.7 billion profit. The

NCSL believes that the discrepancies are due, in part, to industry accounting methods on certain types of income, including returns on investments.

In a study done by the Conference of Insurance Legislators (applicable sections appear in Attachment F), the State of Oregon reported that there is no lack of available medical malpractice insurance in Oregon. This is primarily due to information obtained from closed claims data filed pursuant to the state's 1975 medical malpractice reform law, which showed loss trends. Distribution of this information aided in establishing a climate where medical malpractice insurance is available in the private market. Tennessee reported that its 1977 law requiring the filing of closed claims data is effective in making medical malpractice insurance available in Tennessee. Several states, including Pennsylvania, Delaware and Louisiana, are increasing their state disclosure requirements. According to Mr. Koch, the State of Alaska has fairly strict disclosure standards as compared with other states.

2. Requiring cancellation, nonrenewal and policy termination notification will allow consumers an opportunity to seek other insurance without a gap in insurance coverage. The current lack of available and affordable insurance for some consumers stems from abrupt cancellations and the nonrenewal of coverage by insurers. It has been suggested that insurance companies be permitted to cancel or refuse to renew coverage only in certain clearly defined circumstances, such as the nonpayment of premiums or fraud on the part of the insured. Requirements which address the timely notification of a cancellation or nonrenewal of a policy may cut down on the exposure and/or disruption of business caused by the sudden cessation of liability coverage.

Oregon, Maryland and Nevada have enacted requirements which address the cancellation and renewal of insurance policies. According to the Conference of Insurance Legislators, it is not known how these requirements affect insurance availability and affordability. The state of Alaska does not currently have requirements which address the timely notification of a policy cancellation or nonrenewal. Commercial policies can be cancelled with a ten-day notice, and often premiums are not returned to the policy holder for 60 to 90 days. As a result, policy holders can experience a gap in insurance coverage and not have sufficient funds to purchase a new policy.

Mr. Koch said that the Division of Insurance has supported a cancellation/nonrenewal notification bill for the past two years. He believes that a 45 to 60-day cancellation notice with a requirement that the policy continue until the company returns the premium to the policy holder would be a benefit to policy holders.

3. Amending Alaska law to decrease deposit requirements for companies not licensed in Alaska will increase the availability of insurance in the state. According to Mr. Koch, AS 21.34.040 allows companies not licensed in Alaska to do business in the state only if they have a deposit of \$3.5 million in trust in the United States. Mr. Koch said that only two foreign-based companies can meet this requirement, and 88 other foreign-based companies are barred by this statute from doing business in Alaska. Mr. Koch suggested that a deposit level of \$1.5 million, which is the deposit level in most states, be established. Mr. Koch cautioned that amending this law should not include a decrease in the amount of capitalization and surplus funds required to do business in the state.
4. Requiring insurance companies to itemize state-by-state expenses may eventually lead to insurance companies basing state rates on what occurs in that state. Mr. Koch is not sure how the logistics of a state-by-state itemization by insurance companies would work. He believes that it would be difficult for some companies to attribute expenses for business conducted in Alaska if only a small percentage of their business is in the state.
5. Regulating prices may aid in keeping the insurance industry on an even keel. However, Mr. Koch believes that setting limits on what insurers may charge will also limit the availability of insurance.
6. Establishing rate regulation laws could ensure that rates are adequate, reasonable and not unfairly discriminatory. The three types of rating laws are prior approval, file and use, and open competition. Alaska utilizes the most stringent of these approaches, a prior approval law, which requires the Division of Insurance to approve insurance rate changes before they can be implemented.

* * * * *

I hope this information is helpful to you. Attachment F, referenced in this memorandum, contains additional information on states which have implemented some of the alternatives suggested here. Attachment G is a compilation of alternatives on what states should do to address the crisis on what states are considering doing. If you have any questions or require additional information, please contact our agency.

Attachments

ATTACHMENT A

**1986 STATE LEGISLATIVE ACTION:
LIABILITY INSURANCE
(NCSL)**



National Conference of State Legislatures



CIVIL LAW + ACTIONS
Liability +
Tort Reform



info-key

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President David E. Nething
Majority Leader
North Dakota Senate

Executive Director
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Summary

1986 State Legislative Action:

Liability Insurance

The attached summary represents various actions taken or planned for the interim by state legislatures. This list highlights legislative activity and some regulatory initiatives. It is not a comprehensive survey of all enacted legislation.

We have attempted to briefly summarize action taken in legislatures which have already adjourned their 1986 sessions.

This information has been produced through the cooperation of state legislative staff personnel in each state.

Michael Bird/Brenda Trolin
March 10, 1986 (original report)

UPDATE: September 25, 1986

ALABAMA

1986 Session Completed

Enacted

- SB 239 - Authorizes two or more counties to establish self-funded insurance funds for the purpose of providing liability protection for member counties and employees acting in the line and scope of their employment.
- HB 202 - Requires insurance companies which sell medical liability insurance to report to the appropriate state licensing agencies any judgment or settlement resulting from a claim for personal injury caused by an error, omission or negligence in the performance of professional services.
- HB 178 - Grants immunity from suit to the Board of Medical Examiners and the Medical Licensure Commission.
- SB 369 - Grants immunity to the Board of Dental Examiners, certain members, agents, employees, consultants and others in connection with hearing investigations.

Legislation Considered - Not Passed

- o House Bills 213-219 comprised a legislative package proposing to:
 - o HB 213 - establish noneconomic damage caps at \$250,000; modify the collateral source rule; limit attorneys' contingency fees; permit structured settlements; and alter the standard of proof.
 - o HB 215 - allow introduction into evidence the amount of reimbursed expenses related to a pending civil suit.
 - o HB 217 - amend the "scintilla" rule by increasing the minimum standards of proof needed to be met to bring about a tort liability action.
 - o HB 218 - cap liability for punitive damages in civil actions at \$250,000 or the amount of non-punitive damages, whichever was less. Would have changed burden of proof from preponderance of the evidence to beyond a reasonable doubt.

ALASKA

1986 Session Completed

Enacted

- SB 377 - Places limits of \$500,000 for noneconomic damages for each claim based on a separate injury or incident. It also:

- o Bars a person who suffers personal injury or death from recovering damages if the injury or death occurs in the commission of a felony.
 - o Provides for itemization of damages between economic and noneconomic losses.
 - o Provides for periodic payment in certain circumstances.
 - o Limits liability of members of board of directors of nonprofit corporations; public or nonprofit hospitals; school districts; and citizens advisory committees of a municipality.
 - o Modifies joint and several liability by making contributory fault (chargeable to the claimant) diminish the amount of damages proportionate to his fault.
 - o Allows a defendant to introduce into evidence the amount of compensation from collateral sources.
 - o Establishes prejudgment interest accrual principle.
- HB 506 - authorizes municipalities, school districts and regional educational areas to self-insure jointly or purchase coverage on a group basis.
- SB 442 - authorizes the Department of Commerce to provide technical assistance to individuals intending to form reciprocal insurers for provision of marine liability insurance.

ARIZONA

1986 Session Completed

Enacted

Seven tort reform bills were sent to the Governor. Five were vetoed. The two which have been enacted into law include:

- o HB 2377 - establishes penalties for unjustified actions and raises limits for mandatory arbitration.
- o HB 2170 - prescribes liability for liquor to a certain intoxicated person or minor; defines "obviously intoxicated" and prescribes certain liability limitations.
- o HB 2375 - modifies insurance regulation and provides for alternative insurance options as follows:
 1. self-insurance for boards of directors of non-profit organizations;
 2. pooling for political subdivisions;
 3. self-insurance for schools;

4. conditions for non cancellation of policies for commercial and industrial risks;
 5. a temporary joint underwriting association for all lines;
 6. the Department of Insurance to set rules and regulations for disclosure of loss experience.
 7. provides authority for profit and non-profit corporations to ensure directors and officers against certain liability.
 8. establishes a study commission on insurance.
- o HB 2418 - authorizes the establishment of a joint underwriting association for provision of medical malpractice coverage for licensed midwives and registered nurses.

Among the legislation vetoed were bills calling for structured settlements (SB 1378), limitation of joint and several liability (HB 2013), collateral source rule modification (HB 2163) and scheduled contingent attorneys fees (HB 2376).

Interim

A petition to refer to the people a proposal to invoke legislative authority to place caps on damages has received over 200,000 signatures and will appear on the November, 1986 ballot. This petition, Proposition 103, also calls for periodic payments and scheduled attorneys fees.

CALIFORNIA

Under Consideration

- o No less than 40 bills have been introduced thus far, including legislation extending all provisions of the state's medical malpractice laws to general tort liability.
- o AB 4406 would expand the annual information provided by insurers to the Insurance Commissioner to include total premiums paid (by individual lines of coverage), total reinsurance ceded and premiums paid, claims made or occurrence base policy identification, trial and judgment incidence, lines of coverage provided, average settlements and judgments, etc.
- o AB 4407 would compel all admitted insurers to offer, in California, every category of direct commercial liability insurance or reinsurance for commercial liability insurance offered by the insurer anywhere in the U.S. Similar provisions are stipulated for surplus line providers.
- o AB 3554 would establish a State fund for providing excess liability coverage for local governments and liability insurance for nonprofit organizations.

- o AB 3875 would require 45 days notice of intent to renew a policy conditioned upon a premium increase.
- o SB 1538 seeks to establish an assigned liability risk pool and SB 1581 would create a rate review board.

Previous Action

- o Proposition 51, which passed by a margin of 62% - 38%, will eliminate joint and several liability in all suits seeking noneconomic damages.
- o Restricted attorneys' contingency fees, an issue upheld by the U.S. Supreme Court in 1985.

COLORADO

1986 Session Completed

Enacted

- o SB 67 will reduce awards by sums from specific collateral sources.
- o SB 67 will limit damages for non-economic loss to \$250,000 unless a court finds "clear and convincing evidence," in which case up to \$500,000 can be awarded. Eliminates awards for derivative non-economic loss except when court finds "clear and convincing evidence" and may award up to \$250,000. Provides that an action against an architect, engineer or land surveyor must be certified by similar professionals.
- o SB 69 will make uniform most statutes of limitations at three years. Time limits for bringing tort actions are either 1 or 2 years.
- o SB 70 will eliminate the doctrine of joint and several liability. Limits liability of a defendant to his proportionate share of negligence or fault.
- o SB 76 extends "good Samaritan" laws to limit the liability of individuals, businesses and corporations, directors of non-profit organizations and government entities when they volunteer their time without pay or enforce a policy or regulation to protect another person.
- o SB 86 limits the liability of vendors to \$150,000 if liquor has been served to an intoxicated patron or a minor. (Became law without Governor's signature). Actions can be brought only by individuals other than the intoxicated person.
- o SB 1167 permanently extends the division of risk management and its fund which were scheduled to expire 6/30/86. Requires purchase of property or liability insurance policies by state agencies to be approved by the division.
- o HB 1185, 1186 and 1187 limit liability for employers, shareholders, officers and board members resulting from the flow of water from a

reservoir. Establishes immunity for state engineers and employees when monitoring reservoirs.

- c HB 1192 limits liability of manufacturers of firearms when products are operated properly.
- o HB 1196 clarifies the immunity of public entities and their employees.
- o HB 1197 ties punitive damages to actual damages in a one-to-one ratio with 2/3rd paid to injured parties and 1/3rd to the state general fund.
- o HB 1201 limits liability for mental health professionals when they use an accepted standard of care but fail to anticipate a patient's violent behavior.
- o HB 1204 permits exemptions to notice of intent to cancel, nonrenew, change benefits or increase rates. Authorizes the Insurance Commissioner to inspect any rate, underwriting rule, policy form or contract and prohibit those deemed hazardous to the public/policyholders. Also requires claims-made policy forms to be filed on or after 1-1-87 except for public entity self-insurance pools.
- o HB 1206 changes the regulation of investments of assets by domestic insurers based upon model NAIC legislation.
- o HB 1205 limits a homeowner's liability when property is entered illegally.
- o 1193 lengthens notice provisions for midterm cancellations of commercial and medical malpractice policies from 45 or 60 days to 90 days. Requires 90 day notice of a unilateral premium increase or coverage reduction and an explanation for said action. Allows cancellations and coverage deductions only with cause.
- o HB 1358 authorizes the Insurance Commissioner to promulgate rules requiring insurers to file supplemental reports or closed - claim files or both for any line, class or subclass, authorizes permissive public hearings to review rates and investigations of availability affordability problems. Sunsets 7-1-89.

CONNECTICUT

1906 Session Completed

Enacted

Public Act 86-338 accomplishes the following:

- o increases from 30 days to 60 days notice of nonrenewal of commercial and personal liability insurance policies.
- o increases from 30 days to 60 days notice of rate or coverage changes for insured risks paying an annual premium of \$50,000 or less.

- o establishes 8 grounds for cancellation of policies including nonpayment of premiums, substantial loss of reinsurance, material misrepresentations, etc. Cancellations are prohibited unless one or more of these grounds are substantiated.
- o requires insurers to submit data on multi peril, general liability and auto coverage lines which includes information comparing aggregate premiums charged and premiums established through rating mechanisms.

Substitute HB 6134 would accomplish the following civil justice changes:

- o modify joint and several liability.
- o reimpose modified sovereign immunity for municipal governments.
- o allow all judgments (currently limited to medical malpractice) to be reduced by sums awarded through collateral sources.
- o impose a penalty, which could include defense costs, for filing suits in absence of probable cause.
- o impose periodic payments on future economic and noneconomic damages exceeding \$200,000.
- o schedule attorneys contingency fees (a five-tiered approach commencing at 33% of the first \$300,000 and finishing at 10% of any amount exceeding \$1.2 million).
- o Recovery is not barred if the plaintiff's negligence was not greater than the combined negligence of the person or persons against whom recovery is sought. Damages shall be diminished in proportion to the plaintiff's percentage of negligence. A defendant is liable to claimant for only his percentage of fault. Provision is made for reallocation of uncollectible amounts among defendants.
- o Liquor liability
 - (a) Sellers (to intoxicated persons) are liable to the person injured for not more than \$20,000 or not more than an aggregate of \$50,000 to all injured parties. (b) A rebuttable presumption that the seller who sold alcoholic liquor to the intoxicated person is solely liable for any damages payable to the injured person is established.
- o Directors, Officers, Trustees
 - Any person who serves as a director, officer, or trustee of a nonprofit organization qualified as tax-exempt under IRS provisions and who is not compensated for services shall be immune from civil liability for acts or omissions resulting in injury (provided that person is acting in good faith and within the course and scope of his or her official duties).

Previous Action

Established a market assistance plan and statutorily authorized the creation of joint underwriting associations.

Interim Studies

Public Act 86-338 instructs a legislative committee to analyze underwriting standards, classification systems and premium development techniques. It further instructs the committee to make recommendations re: the claims-made form and potential return to prior approval.

DELAWARE

1986 Session Completed

Enacted

- o SB 533 - limits personal liability of directors of corporations in cases where directors are accused by shareholders of violating their "duty of care."
- o HB 470 requires expanded disclosure of information by property/casualty insurers on a line by line basis for the state of Delaware and as total.
- o HB 444 alters cancellation and nonrenewal notice requirements for commercial, municipal and professional liability policies. Notices must be delivered a minimum of 60 days prior to the effective date of the cancellation or nonrenewal. HB 444 prohibits cancellations or nonrenewals unless one or more of ten reasons (such as premium nonpayment or breach of contractual duties) exists. Suspension of insurer cancellation/nonrenewal authority occurs after the Commissioner has deemed unavailability to be critical.

FLORIDA

1986 Session Completed

Enacted

The Tort Reform and Insurance Act of 1986 accomplishes the following:

- o It freezes rates for all commercial property and liability coverages in Florida at their May 1, 1986 levels from July 1, 1986 until January 1, 1987;
- o It requires a 40 percent roll-back of insurance premiums applicable to one-fourth of the policy-term premium of all commercial liability policies in Florida, pro-rated for the period that such policies are in effect from October 1, 1986 until January 1, 1987; and
- o It requires that all commercial property and liability insurers file new rates with the department which are based upon the rates that were in effect on January 1, 1987.

During the period from July 1, 1986 until January 1, 1987, the applicable insurers would be prohibited from cancelling or nonrenewing their insureds at a rate greater than 30 percent of their cancellation and nonrenewal rates for the previous 24 months during any 30 day

period. Insurers would be permitted to escape the roll-back provisions to the extent that they could show that the resulting rates would be inadequate or would impair their solvency. Lastly, the rates to be implemented on January 1, 1987 would be based on 1984 rates but would be adjusted upward (or downward) as justified by each insurer to comply with actuarial principles.

- o Authorizes financial institutions to participate in reinsurance and Florida insurance exchanges.
- o Authorizes commercial liability risks to be group insured.
- o Increases the department's rate review and enforcement authority.
- o Creates a property/casualty insurance excess profits law.
- o Authorizes creation of a commercial property/casualty joint underwriting association.
- o Expands the types of health care providers that can self-insure and authorizes CPAs, architects, engineers, veterinarians, land surveyors and insurance agents to self-insure.
- o eEstablishes notice requirements for cancellation, nonrenewal and renewal of premium of commercial liability policies.
- o Authorizes the creation of commercial self-insurance funds.
- o Modifies the application of the doctrine of joint and several liability.
- o Limits when punitive damages may be pled, specifies to whom they are to be distributed, and caps the maximum amount of such damages in certain cases.
- o Caps noneconomic damages in civil actions at \$450,000.
- o Requires, under certain circumstances, periodic payment of future damages exceeding \$250,000.
- o Creates a five member Academic Task Force for Review of the Insurance and Tort Systems.

Interim

Insurers and three industry trade groups are challenging the constitutionality of Florida's new law.

GEORGIA

1986 Session Completed

Enacted

- o SB 369 and SB 440 - respectively authorize local governments and school boards to join together for purposes of securing liability insurance.
- o HB 1146 - (Act No. 1670) compels plaintiffs found to have filed frivolous suits to pay fees and costs incurred by defendants.
- o HB 1185 - (Act No. 1486) regards dismissal of actions for frivolous suits.
- o HB 1471 - (Act No. 1619) clarifies sovereign immunity of municipal corporations.
- o HB 1549 - (Act No. 1422) and HB 1526 (Act. No. 1621) establish immunity for governmental employees and officials.
- o HB 1503 - (Act No. 1456) places tighter restrictions on cancellation and renewal of policies by insurance companies.
- o SB 553 - (Act No. 1457) establishes assigned risk pools for certain property/casualty insurance risks and authorizes the insurance commissioner to order a refund of portions of premiums.
- o SB 384 - (Act No. 1518) requires insurers to file itemized annual reports.

HAWAII

1986 Session and Special Session Completed

Enacted

- o HB 1993-86 - provides for additional exceptions to the state's tort claims act.
- o HB 2238-86 - provides a statutory mechanism for ensuring that child care providers will be able to secure liability insurance.
- o HB 1695-86 - authorizes mass merchandising of motor vehicle, property casualty insurance to the employees of any employer or to the members of any association or organization under a mass merchandising plan audited by the insurance commissioner.
- o HB 1694-86 - authorizes the licensure and operation of pure captive insurance companies and association captive insurance companies.
- o HB 2549-86 - allows for the formation of workers' compensation self-insured groups.

- o SI-86, special session legislation, accomplishes the following:
- o Beginning October 1, 1986, all authorized insurers transacting commercial liability insurance shall implement a 10% rate reduction, excepting motor vehicle and medical malpractice policies (new rates in effect through September 30, 1987). The Insurance Commissioner is empowered to except companies who petition and show that such rates affect solvency of company.
- o Beginning October 1, 1987, all authorized insurers providing commercial liability insurance shall implement a 12% rate reduction, excepting motor vehicle policies only effective through September 30, 1988.
- o Effective October 1, 1988, all authorized insurers shall implement a 15% rate reduction, excepting motor vehicle policies, effective through September 30, 1989.
- o Provides for a closed claim study which could result in rebates or credits to insureds if premiums are excessive.
- o Prohibits cancellation of the insured prior to expiration of agreed term or one year from effective date of the policy or renewal, with 8 specific exceptions.
- o Provides for nonrenewal of policies if insurer gives 45 days notice with reasons for nonrenewal.
- o Provides that insurance contracts shall not cover punitive or exemplary damages unless specifically included.
- o Provides for limitation of attorneys' fees for plaintiff and defendant to a reasonable amount (determined by court of jurisdiction).
- o Provides that plaintiff or defendant in a settlement may request attorneys' fees be subject to approval of court of jurisdiction.
- o Provides that attorneys' contingent fees in any action for medical tort are subject to court of jurisdiction approval.
- o Provides that courts may assess either party a reasonable sum for attorneys' fees if the court finds that the party's claim or defense was frivolous (amount shall not exceed 25% of amount originally prayed for).
- o Provides for periodic payment of damages in excess of \$1,000,000 if defendant is the State, political subdivision of the state or any governmental agency.
- o Provides for a statute of limitations on medical torts; no suit can be brought more than 2 years after the plaintiff discovers or should have discovered the injury, and not more than 6 years after the date of the alleged act or omission causing the injury (exception for minors).

- o Provides for payment of valid liens (arises out of claim for payment made from collateral sources for costs and expenses arising out of injury) from special damages recovered.
- o Abolishes joint and several liability with four specific exceptions.
- o Provides standard for determination of loss or impairment of earning capacity.
- o Places a \$375,000 cap on non-economic damages.
- o Establishes a court annexed arbitration program for cases having a probable jury award of \$150,000 or less.
- o Abolishes cause of action for serious emotional distress arising from damage to property or material objects.
- o Appropriates \$100,000 for subsidy payments covering liability insurance premiums of certain obstetricians and gynecologists.
- o Appropriates \$400,000 for the insurance commissioner to carry out purposes of this act and hire additional staff.
- o Appropriates \$200,000 to implement court annexed arbitration program.
- o Provides for closed case reports prior to 1988 and 1989 sessions, evaluating the effects of the act along with recommendations for change or repeal of provisions.
- o Provides for the chief justice to prepare a report on court annexed arbitration prior to 1987 regular session.

IDAHO

1986 Session Completed

Enacted

- o SB 1439 - limits dram shop and social host liability.
- o HB 1469 - places limits on attorney contingency fees.

Legislation Considered - Not Passed

A major proposal (SB 1297) calling for establishment of a state insurance fund was among the bills not passing.

ILLINOIS

1986 Session Completed

Enacted

SB 1200, passed on the final day of session, accomplishes the following:

- o Joint and several liability. It retains joint liability in cases of medical malpractice, environmental concerns and medical costs. Defendants who are less than 25% at fault for an injury would not be jointly liable for other damages.
- o Collateral sources. Any judgment against a defendant would be reduced by any insurance reimbursements to the plaintiff above \$25,000.
- o Comparative negligence. A plaintiff who is more than 50% responsible for his injury would not be permitted to collect damages in cases of negligence or product liability.
- o Municipal immunity. Grants broad immunity from liability suits to municipalities; exempts present or former public employees from punitive damages for actions arising from official duties; exempts a public entity from liability for "hazardous recreational activities" when warning of the hazard is posted.
- o Requires insurers to provide loss information with notification of cancellation or at request of insured.
- o Requires 90-day notice to the state of termination of any line of insurance in the state.
- o Requires 60-day notice to insureds of cancellation, nonrenewal or premium increase of 30% or more.

Previous Action

- o In December 1985, the Insurance Department launched a market assistance plan.
- o Select Committees in both the House and Senate have examined the affordability/availability issue.

INDIANA

1986 Session Completed

Enacted

- o SB 393 authorizes judges to determine what are frivolous suits and to assess fees for such suits.
- o SB 394 modifies the state's collateral source rule. Juries are to be instructed not to take into account taxes to be paid on potential awards.
- o SB 85, dealing with dram shop, asserts that licensed sellers are not liable for the actions of their customers unless they know customers making purchases are intoxicated.
- o HB 1255 allows the state to administer insurance pools for local governments.

- o HB 1284 grants volunteers immunity from liability unless the entity which they assist has insurance.

IONA

1986 Session Completed

Enacted

- o Increase the risk manager's duties in relation to providing insurance and risk management assistance to local governmental entities and increase the risk manager's authority to self-insure fidelity exposures for state officials.
- o Authorize local governmental entities to enter into alternative financing agreements for insurance, self-insurance, risk sharing or risk pooling, and for the funding of such agreements.
- o Create an Insurance Assistance Act, which sets out requirements for data collection and analysis, authorization for certain insurance assistance programs, provision for the financing of the programs and required insurance rate adjustment reviews.
- o Modify laws relating to the recovery of damages, including:
 - o limiting the liability of the state for financial regulatory activities.
 - o exempting social hosts from liability for the service of alcohol to guests.
 - o restricting the discovery and use of medical malpractice peer review and disciplinary proceedings.
 - o expanding the use of voluntary agreements in medical malpractice cases.
 - o creating a retailer's exemption in products liability actions.
 - o limiting the liability of municipalities for licensing and inspection activities.
 - o limiting the liability of municipal officers and employees for punitive damages.
 - o authorizing the court to stay court actions if past actions by the party have been frivolous.
 - o prohibiting the stating of money damages demanded in original pleadings and filings.
 - o requiring the certification of pleadings and motions, and providing sanctions for the failure to so certify or for actions in violation of the certification requirement.

- o authorizing the use of structured and other nonlump-sum payment methods by the court.
- o creating a state of the art defense in products liability actions.
- o raising the required findings for the award of punitive or exemplary damages, and creating a new system for the award and disbursement of such damages.
- o Establish a Liability and Liability Insurance Study Commission to be comprised of eight legislators, four members of the public or private sector, the Attorney General and the Insurance Commissioner.

Interim

A continuing legislative/public member study will focus on tort liability and insurance issues for which there is insufficient documentation of need and effectiveness. Items likely to receive attention are the collateral source rule, damage caps, attorney fees, premium rollbacks and innovative judicial mediation techniques.

KANSAS

1986 Session Completed

Enacted

- o HB 2661 - caps damage awards against health care providers at \$1 million. Noneconomic damage awards in these same medical malpractice judgments are capped at \$250,000 (subject to cost of living adjustments). Juries must itemize noneconomic damage awards and all settlements are to be paid periodically.

A "pinhole" provision permits claimants to petition courts to award supplemental benefits for medical-related expenses up to a maximum of \$3 million.

- o SB 512 - prohibits cancellation of business and professional liability insurance policies unless one of 5 causes for cancellation can be determined (as nonpayment of premiums, material misrepresentations, etc.).

This legislation also requires insurers to give policyholders 60 day notice of a decision to nonrenew.

- o SB 382 - allows deductible health care provider liability insurance.
- o SB 400 modifies civil procedures regarding determination of frivolous suits.

Legislation Which Failed

- o SB 540 would have established a \$1 million liability cap for various professionals.

Interim

An interim study on liability insurance has been commenced.

KENTUCKY

1986 Session Completed

Enacted

- o SB 309 - will permit the Insurance Commissioner to establish a voluntary risk sharing association for hard-to-get lines of commercial liability coverage.

Legislation Considered - Not Passed

- o Among dozens of introduced bills which did not pass was legislation capping awards, providing for structured settlements, modifying the collateral source rule and providing changes in the areas of medical malpractice.

Interim

Legislative leadership authorized the creation of a task force to review the entire issue including authority to investigate the State Insurance Department and the insurance industry.

LOUISIANA

1986 Session Completed

Enacted

- Act 18 - Provides that those who sell, serve or furnish alcoholic beverages are generally not civilly liable for damages caused by purchasers and those served.
- Act 111 - Relative to joint self-insurance programs by local governmental subdivisions.
- Act 473 - Relative to the funding and operation of the Department of Insurance, to establish the budget units of the Department, to create a special fund to provide monies for operation of the department.
- Act 499 - Requires that written notice of partial settlement of medical malpractice claims be sent to the attorney general.
- Act 548 - Requires property and casualty insurers to provide additional information in their annual reports.
- Act 641 - Authorizes governmental subdivisions to form, join and participate in interlocal risk management groups.

Act 662 - Authorizes sheriffs and others to form an interlocal risk management agency.

Act 754 - Prohibits midterm cancellation or rewriting of insurance.

Act 830 - Empowers the attorney general to represent consumers in all proceedings before the Insurance Rating Commission.

Act 843 - Authorizes the Louisiana Insurance Rating Commission to use subpoenas and other methods of discovery.

Act 857 - Requires increased data reporting to the commissioner of insurance.

Act 902 - Allows statewide professional, trade and occupational associations to establish one or more professional or public liability trust funds without such funds being deemed insurance.

Act 952 - Establishes a special committee to study the affordability and availability of liability insurance. Provides for limited civil liability in connection with hazardous waste and asbestos abatement and cleanup.

MAINE

1986 Session Completed

Enacted

- o Public Law 671 prohibits midterm cancellations unless cause (such as nonpayment of premiums, fraud, breach of contract, potential insurer insolvency, etc.) can be confirmed. Notice of cancellation must be made 10 days prior to the cancellation. Notice of a nonrenewal must be made 30 days prior to a policy's expiration date. Policyholders can request that the Superintendent of Insurance verify that the insurer has established cause for the nonrenewal.
- o LD 2080 grants immunity to servers unless minors they serve can prove they were negligently served. Servers who are negligent or reckless in serving minors or visibly intoxicated adults could be sued. Per occurrence caps of \$250,000 on awards against alcohol servers are established. These caps exclude medical care and treatment expenses.
- o Public Law 713 authorizes political subdivisions to participate in public self-funded pools.
- o Public Law 804 shortens statute of limitations for suits related to medical and legal professional liability

Legislation Considered - Not Passed

LD 2053 would have given the Insurance Commissioner authority to establish a joint underwriting association for provision of liability coverage for day care operators, public entities, liquor retailers and municipalities.

Interim

An interim commission comprised of legislators, legal and insurance representatives will explore tort liability.

MARYLAND

1986 Session Completed

Enacted

- o Awards for noneconomic damages would be capped at \$350,000 per SB 558.
- o Prior approval of premium rates would not be required for three additional years per HR 329.
- o SB 600 provides personal immunity for directors of charitable organizations provided the organization itself is insured.
- o SB 899 will require that personal lines providers make coverage available to licensed operators of in-home day care facilities.
- o SB 1015 authorizes pooling and self-insuring for certain types of casualty risks, particularly local governments and nonprofit organizations.
- o SB 379 permits a CCUA (Commercial Casualty Underwriting Association - a private association comprised of all Maryland licensed insurers) to write insurance for "subpools" (e.g., day care centers) upon the Insurance Commissioner's determination that commercial insurance is unavailable.

Interim

A Joint Task Force is exploring the feasibility of establishing a catastrophic loss fund to cover catastrophic losses for all commercial casualty lines. The task force is also examining the possibility of establishing a Maryland Reinsurance Exchange.

MASSACHUSETTS

Enacted

- o HB 6172 accomplishes the following regarding medical malpractice:
 - o establishes an independent medical review board comprised of disciplinary and risk management units and vested with subpoena powers.
 - o requires medical malpractice insurers and tribunals to report final disposition of medical malpractice cases.
 - o eliminates the collateral source rule and establishes a mechanism to have awards itemized.

- o establishes a \$500,000 cap on general noneconomic damages except where plaintiff is substantially impaired or disfigured.
- o schedules attorneys fees (40% of first \$150,000 down to 25% of excess over \$500,000).
- o amends the outside statute of limitations (after date of occurrence which gave rise to an original claim) to 7 years.
- o requires the Insurance Commissioner to set final rates and permits imposition of a surcharge on medical malpractice premiums. The maximum amount of coverage for physicians and hospitals is doubled.
- o a medical malpractice commission shall study the health insurance industry including premiums, reimbursement practices, feasibility of a patient compensation fund, etc.
- o establishes a medical malpractice analysis unit in the Department of Insurance.

MICHIGAN

Enacted

- o HB 4550 - prescribes liability for retail liquor licensees under certain circumstances; requires security for that liability and provides procedures, defenses and remedies.
- o HB 4676 - health facilities with medical staff, including HMO's, shall report to appropriate licensing boards and to the Department of Health any disciplinary action taken against a member of the medical staff and relevant circumstances.
- o HB 5163 - makes uniform the liability of municipal corporations, political subdivisions, and the state, its agencies and departments, when engaged in the exercise or discharge of a governmental function; defines and limits liability; authorizes the purchase of liability insurance; provides for defense of public officers, and their immunity in certain circumstances.
- o HB 5154 - provides for a \$225,000 limitation on non-economic damages in medical malpractice cases, unless one of the following circumstances exist: death; intentional tort; foreign object wrongfully left in body; injury involves reproductive system; discovery of claim was prevented by fraudulent conduct of health care provider; limb or organ was wrongfully removed; loss of bodily function. HB 5154 also:
 - o stipulates that the trier of fact shall itemize damages into economic and non-economic.
 - o provides a cost-of-living escalator in the cap which is tied to the annual increase in the consumer price index.

- o permits a party named as one of multiple defendants in a medical malpractice case to file an affidavit of noninvolvement.
- o requires that plaintiffs and defendants in medical malpractice cases file an affidavit containing a written opinion from a licensed physician, dentist or other appropriate health care provider stating that the claim or defense has merit.
- o allows defendant to recover (contribution) from co-defendants any amount for which they may have been liable.
- o provides for implementation of pre-trial mediation in all medical malpractice claims, regardless of dollar amount of claim.
- o addresses prejudgment and postjudgment interest rates.
- o provides that evidence that expense or loss was paid or is payable by collateral source is admissible after the verdict and before judgment is entered; court will be required to determine the amount of expense which has been paid by collateral source and then reduce that amount by an amount equal to the premiums paid for the benefit by the plaintiff, the plaintiff's family or employer.
- o joint and several liability - the trier of fact shall determine the total amount of damages and the percentage of total fault of all parties regarding each claim as to each plaintiff, defendant and third party defendant. Then the amount shall be reduced by collateral source payments. If a party's share is uncollectible, then a reallocation of the uncollectible amount occurs (a party shall not be required to pay an amount which exceeds its percentage of fault).
- o mandates structured payment provisions if judgment for future damages exceeds \$250,000 gross present cash value; then court enters an order that defendant shall satisfy the entire judgment amount, less cost and attorneys fees, by purchase of an annuity contract; requires itemization of past economic and noneconomic damages and future damages.

MINNESOTA

1986 Session Completed

Enacted

HF 1950 contains the following civil justice system modifications:

- o imposition of a \$400,000 cap on "intangible losses".
- o provision for the automatic reduction from judgments of payments made from collateral sources.
- o prohibition of victims seeking punitive damages in original complaints.

- o allows the court to award costs in frivolous suits.
- o exempts future damages from prejudgment interest.

SF 2078 accomplishes the following insurance regulation and provision modifications:

- o creates a state risk management fund.
- o requires P/C insurers to submit annual reports on liquor and product liability and medical malpractice and any other line designated by the commerce commissioner. These reports shall contain: written and earned premiums, investment income, incurred claims, operating and underwriting gains and losses.
- o creates a state-run joint underwriting association (specifically for day care providers, foster homes, group homes and sheltered workshops).
- o In determining whether rates are or are not excessive, the commissioner will be authorized to utilize a definition of "less than 5 insurers writing more than 75% of the coverage" as non-competitive.
- o SF 1612 - authorizes the state's temporary j.u.a. to issue medical malpractice insurance to hospitals and nursing homes unable to get coverage.

MISSISSIPPI

1986 Session Completed

Enacted

- o HB 755 - authorizes the Commissioner of Insurance to establish a plan for the availability of certain general liability insurance policies. In 1985, HB 983 established immunity for government employees and officials and modified sovereign immunity. HB 983 placed a statute of limitation on suits filed against the state.
- o SB 2166 - reestablishes sovereign immunity for the state effective July 1, 1987, and for political subdivisions effective October 1, 1987.
- o The Mississippi Insurance Commission has imposed a moratorium on p/c rate increases effective through December 30, 1986.

MISSOURI

1986 Session Completed

Enacted

- o SB 663 - caps noneconomic damages awardable in medical malpractice suits at \$350,000. This legislation also requires certain doctors to carry

medical malpractice insurance and adds additional reporting requirements regarding disciplinary actions taken by hospitals against doctors. SB 663 requires submission to court of an affidavit from a licensed health care provider averring that a medical malpractice action is not frivolous.

- o HB 1435 and 1461 - create a "Missouri Public Entity Risk Management Fund" for participating political subdivisions whose contributions will be used to pay insured claims and legal fees for such claims. Coverage for tort claims will cover official actions of employees. A limit of \$800,000 is established for payment for any single occurrence. Contribution by political subdivisions will be determined by the Board in accordance with standard rating procedures. The minimum contribution will be \$1,000.
- o SB 647 - reestablishes sovereign immunity with several exceptions.
- o SB 701 - updates statutory language of the "FAIR Plan", authorizing that plan to assist people in securing basic property insurance in non-urban areas, and to issue its own policies. Raises coverage limit on commercial property at one location to one million dollars.

MONTANA

1986 Special Sessions Completed

Enacted

- o SB 2 - authorizes bond issues for local government self-insurance funds.
- o SJR 1 - authorizes an interim study commission to review public and private sector problems regarding liability insurance.
- o HB 16 - authorizes the Insurance Commissioner to establish a market assistance plan, and, if necessary, a joint underwriting association for provision of liability insurance coverage.
- o SB 22 - revises limits on tort recovery against public entities.
- o Special session legislation caps government liability at \$750,000 per claimant and \$1.5 million per incident. Previously enacted statutes on this same matter were found unconstitutional by Montana's Supreme Court.

Legislation Introduced - Not Passed

- o HB 21 would have created a state reinsurance program.

NEBRASKA

1986 Session Completed

- o Established a major study commission to review the scope of the entire issue during the 1986 interim.

NEW HAMPSHIRE

1986 Session Completed

Enacted

HB 513 - will accomplish the following:

- o place a \$875,000 cap on pain and suffering awards;
- o reduce the statute of limitations from six to three years;
- o prohibit policy cancellations unless 60 days notice is given.
- o permit judges to assess costs and attorneys fees from frivolous lawsuits and frivolous defenses.
- o apply liability caps of \$500,000 (per occurrence) and \$150,000 (per person) to municipalities. When municipalities are found over 50% liable, joint and several liability will apply with only several liability applying when municipalities are 50% or less liable.
- o defines "good business practice" for purposes of defense in liquor liability lawsuits. Intoxicated drivers will need to show "gross" negligence in future suits against sellers and servers.
- o requires contingency fee agreements to be in writing with final costs set out at the end of litigation. Attorneys will be required statutorily to offer hourly rate and contingency fee options. Judges will be permitted to review contingency fee costs in all judgments exceeding \$200,000.
- o outlaw punitive damages (existing practice).
- o set out the burden of proof in medical malpractice actions.
- o limit the liability of directors and officers of charitable organizations and societies.

HB 479 (Chapter 59) - relates to regulation of surplus lines insurance coverage.

HB 414 (Chapter 58) - provides for licensing of insurance consultants.

HB 360 - relates to credits for reinsurance.

Interim

HB 513 - also creates a Tort Reform Commission to evaluate the workability of the new law and to study issues, as the collateral source rule, not resolved in this session. The Commission will report in December, 1986 and December, 1987.

NEW JERSEY

Enacted

- o SB 1678 - grants immunity to volunteer unpaid athletic coaches provided these individuals have participated in league-established safety and training programs.

Under Consideration

- o AB 2400 - 2404 have passed the General Assembly proposing the following: structured settlements for awards exceeding \$300,000; a \$500,000 per claimant or \$1 million per occurrence cap on judgments entered against a public entity; immunity for volunteers and public officials; arbitration for all liability claims of \$20,000 or less; rate filings based on New Jersey loss experience; and a graduated cap on "pain and suffering" awards in the private sector. These bills are now before the Senate.
- o Assembly Bills 2357-2365 would apply various tort and regulatory reforms in the area of municipal liability. Besides establishing an excess insurance fund, the bills would modify joint and several liability and provide for structured settlements.
- o The Senate has put forth two packages. Majority Democrats have developed a major package, SB 2312-2323, of insurance reform bills and selected civil justice reform measures. SJR 40 also calls on the federal government to take over regulation of the insurance industry. Minority Republicans have a six-bill package of insurance and civil justice modifications and reforms. Hearings on liability insurance may occur during the summer.
- o S. 1718 would create an excess insurance fund and require all public entities, except the state, to join. All public entities would be assessed premiums and the coverage would be for claims exceeding \$500,000 up to \$20 million. This legislation has passed the Senate and is before the House Insurance Committee.
- o Other Senate legislation seeks to provide indemnification of hazardous waste contractors and modify standards of negligence.
- o SB 346 - now in the Assembly, would grant immunity to boards of trustees of nonprofit corporations carrying out their official duties.

Previous Actions

- o Counties, municipalities and school boards may self-insure or join together in regional insurance pools.
- o The Insurance Commissioner prohibited midterm cancellations and nonrenewals unless notice is given.
- o A market assistance plan aimed at making liability insurance available for municipalities, day care centers, taverns and restaurants has been established.

NEW MEXICO

1986 Session Completed

Enacted

- HB 178 - provides school districts with insurance coverage at a cost savings and clarifies statutes related to the public school insurance authority.
- SB 103 - creates a District Court Arbitration Fund and provides for collection of an arbitration user fee.
- HB 317 - extends the coverage which the risk management division is able to provide to school districts through the public school insurance authority.
- SB 110 - caps attorneys fees for workers compensation cases at 20% of the first \$5,000; 15% of next \$5,000 and 10% of remaining benefits.
- HB 244 - provides for certain limitations on liability for alcoholic liquor sales or service. Establishes caps of \$20,000 for property damage, \$50,000 for injury to or death of one person; \$100,000 for injury to or death of two or more persons for each transaction or occurrence.
- SB 105 - expands the applicability of the self-insurance and risk pooling provisions of the Municipal Code to include other political subdivisions and local public bodies.
- Committee substitute for HB 226 - requires most insurers to submit quarterly financial reports to the superintendent of insurance. Based on these reports, the superintendent is required to compile an annual report for legislators.
- HB 242 - creates a public child contractor liability fund.
- SB 137 - creates a Metropolitan Court Mediation Fund; provides for collection of certain costs to fund mediation programs for certain civil and criminal actions.

Study Groups

- o establishing a legislative liability insurance study committee.

NEW YORK

Enacted

Insurance and civil justice reforms are both included in omnibus legislation signed by the Governor in late June. SB 9351-A and A-10663 (Chapter 220, 1986 Session Laws) accomplish the following tort reforms:

- o compels courts to offset awards by amounts received from collateral sources (similar 1985 legislation regarding medical malpractice).

- o allows recovery of up to \$10,000 in court costs and attorneys fees for frivolous suits and defenses in personal injury, property and wrongful death actions.
- o establishes "gross negligence" as the determinant of liability of directors, trustees, officers of nonprofits.

The same legislation accomplishes the following insurance reforms:

- o creates a flex rating system to replace open, competitive ratemaking. Insurers must file rates to reflect enacted tort reforms within 90 days. The Insurance Department in September, 1986, informed insurers that the net effect of tort reforms would compel reductions ranging from 3% to 20% depending on line of coverage.
- o authorizes the Insurance Department to conduct a selected review of rates for the period 6/85 - 6/86. Mandates that every rate filed since 6-1-86 be reviewed.
- o the flex rating system includes Commissioner - imposed "bands" on rate increases/decreases by line. If a proposed rate increase/decrease falls within the band, rates are filed and used. If the proposed rates are outside the band, rates are filed and subject to approval. Bands can be changed. Commercial, professional and public entity lines are included in flex-rating (not homeowners or automobile).
- o authorizes a discretionary joint underwriting association for troubled commercial, public entity and professional liability lines pursuant to Insurance Department determination of unavailability. Requires establishment of a j.u.a. for public entities by 10-1-86 unless the Department determines that coverage is available.
- o prohibits unwarranted midterm cancellations.
- o requires P/C policies to extend a minimum of one year.
- o prohibits policy cancellations unless warranted (as when there is fraud - nonpayment - material charges, etc.). Lack of reinsurance is not in and of itself a reason to cancel unless solvency is threatened.
- o requires at least 60 days notice to not renew or to affectuate a premium increase exceeding 10%.
- o enables policyholders to secure claims loss history.
- o permits municipalities, school districts and other public entities to form reciprocal insurers.
- o permits certain nonprofits and charitable/religious organizations to collectively purchase P/C coverage.

- o authorizes, through a "sunshine" provision, the Insurance Superintendent to report financial and loss data and codefendants in suits regarding recreational, childcare, dram shop, municipalities, owners, landlords and tenants, etc.
- o expedites access to provision of excess and surplus lines.
- o appropriates \$3 million to enhance the Insurance Department's regulatory authority.
- o A. 10664 and S. 9391A, "toxic tort" legislation (CH. 682, Session Laws 1986) includes the following proposals related to toxic torts and torts generally:
 - o extension of statute of limitations for filing toxic tort actions from 3 years after exposure to 3 years after discovering an injury; with one year revival of claims.
 - o in personal injury actions, joint and several liability is inapplicable for noneconomic losses if the defendant is less than 51% liable (with some exceptions).
 - o authorization of structured settlements when awards exceed \$250,000.
 - o A. 11584 and S. 9470 (CH. 226, Session Laws, 1986) affect medical malpractice as follows:
 - a) allow the Insurance Superintendent to establish medical malpractice rates.
 - b) phase in issuance of claims - made policies.
 - c) require certificates of merit and encourage arbitration in order to discourage frivolous suits.
 - d) enhance examination processes regarding physician misconduct.

NORTH CAROLINA

1986 Regular and Special Session Completed

Enacted

- o SB 873 will require insurers to provide additional data based on North Carolina and/or regional experience, to support rate increase requests.
- o SB 873 restores the Insurance Commissioner's rollback authority on rates found to be excessive. Challenges to rollback decisions can be made and, when filed, rate amounts purported to be in excess will be placed in an escrow account. Refunds would be made with interest (computed at the prime rate plus 3%).

The same legislation calls for two non-voting members to serve on the state's Rating Bureau, and places additional burdens on plaintiff's attorneys in proving they have meritorious claims. It requires 45 day notice of policy cancellations, nonrenewals and premium increases and authorizes formation of local government self-insurance pools.

- o SB 873 amends rules of civil procedure so that in matters in controversy stemming from all negligent actions where the damages sought exceed \$10,000, pleadings for an unspecified amount over \$10,000 shall be sought.
- o HB 2103 establishes a 1.75% premium tax rate for domestic and foreign insurers, said rate to sunset 1-1-88.
- o Authorized the Insurance Commissioner, on a standby basis, to establish joint underwriting associations.
- o Authorized the Insurance Commissioner to extend the state's FAIR plan to all areas of the state.
- o Called for a referendum on a state radioactive repository site act.

OHIO

Enacted

- o HB 875 permits political subdivisions to participate in joint liability insurance pooling arrangements.
- o SB 366 grants immunity from civil action damages with specific conditional exceptions, for volunteers of nonprofit or charitable associations. Immunity relates to liability arising from civil actions for injury, death or loss to persons or property.

Under Consideration

- o SB 330 has been assigned to a conference committee, conferees have been designated, and an informal review and discussion process will commence in the latter part of September. SB 330 propose the following insurance reforms:
 - o requiring advance notice of policy nonrenewals;
 - o authorizing the establishment of joint underwriting associations;
 - o prohibiting mid-term policy cancellations;
 - o permitting banks to invest in the reinsurance market;
 - o formalizing mechanisms for existing market assistance plans; and
 - o expanding the Insurance Department's powers to include subpoena of insurer records and standby authority for prior approval of rates.
- o SB 330 proposes the following civil justice reforms:
 - o deducting benefits and/or payments from collateral sources from awards;
 - o permitting structured settlements when awards exceed \$100,000;

- o modifying the allocation of damages under joint and several liability when certain damages are not collectable;
- o authorizing hearings to determine if suits are frivolous; and
- o authorizing pre-trial settlement offers which would require non-judicial settlement when offers exceed plaintiff's demands.

OKLAHOMA

1986 Session Completed

Enacted

SB 488 accomplishes the following insurance regulation changes:

- o requires the 10 largest P/C insurers to annually submit reports on premiums, losses, settlements, judicial dispositions, etc. among 11 coverage categories.
- o requires the 50 largest P/C insurers to annually submit data on premiums, losses, judgments over \$250,000, etc. on a less detailed, more restricted basis than for the 10 largest insurers.
- o implements unfair claims settlement practices statutory language and permits the Insurance Commissioner to require periodic reports from violators.

SB 488 accomplishes the following civil justice system changes:

- o limits punitive damages to actual damages and applies a stricter standard for justifying consideration of punitive damages.
- o allows judges to direct juries to itemize verdicts (constitutional prohibition on a mandate).
- o allows prevailing parties to recover up to an aggregate of \$10,000 in attorneys fees and court costs in judicially-determined frivolous suits.
- o amends the interest payable on actual damages sought from 15% to the T-Bill rate plus 4%.

HB 1983 authorizes the Insurance Commissioner to establish a market assistance plan.

Interim

SB 488 creates an 18-member (10 legislators - 8 public members) Select Committee on Insurance Rates and Tort Claims.

OREGON

Not In Session in 1986

Interim

A liability insurance interim committee has recently and unanimously endorsed a proposal that would make punitive damage; non-insurable as a matter of public policy. Additional recommendations may surface in early fall.

PENNSYLVANIA

Enacted

- o HB 1391 provides for 30 day notice of cancellation and 60 day notice of premium increase.
- o HB 1625 provides for immunity for referees.

Under Consideration

- o Senate Bills 1392-95 have been introduced. Collectively, they propose to accomplish the following:
 - 1) authorize establishment of a joint underwriting association for all lines of unavailable liability coverage.
 - 2) require 60 days notice of insurance premium rate increases.
 - 3) require disclosure of insurance company loss experience within the state.
 - 4) establish a central risk management agency - provide advice to local governments.
 - 5) establish a joint self-insurance fund for municipalities and authorize cities to join.
- o SB 1513 proposes major medical malpractice modifications.
- o The House has completed a comprehensive hearing process, begun last September, which has looked at key problems, major causes and options to resolve the crisis. Major tort and product liability reform legislation, HB 2425 and 2426, are in committee. The legislature reconvenes in September.

RHODE ISLAND

1986 Session Completed

Enacted

- o S. 2891, Sub B and HB 8534, Sub A - (related to medical malpractice) establish reporting requirements for every insurer providing professional liability insurance to licensed physicians, dentist or dental hygienists as to any settlement or arbitration award of claim or any action for damages for death or personal injury. This legislation

also establishes a joint underwriting association for the provision of medical malpractice coverage.

SOUTH CAROLINA

1986 Session Completed

Enacted

- o HB 2266 restores some of the state's sovereign immunity by reestablishing approximately 20 categorical, qualified immunities.

It also places monetary liability limits on the state and its political subdivisions of \$250,000 per incident and \$500,000 per occurrence.

Legislation Considered - Not Passed

- o SB 895, originally calling for numerous medical malpractice tort reforms, was revised to limit punitive damages to actual damages; establish preaction discovery and set up a certification process determining whether suits are frivolous. Final passage did not occur.

Previous Action

- o South Carolina's Insurance Commissioner has been empowered to establish a joint underwriting association for any professional group unable to secure liability insurance coverage. This authority was previously restricted to j.u.a. formation for health care providers.

SOUTH DAKOTA

1986 Session Completed

Enacted

- o SB 280 which will require pre-discovery, fact-finding hearings before a judge to prove, by clear and convincing evidence, that there was willful and malicious conduct in order to file for punitive damages.
- o SB 281 authorizes structured settlements for awards exceeding \$100,000.
- o SB 282 will cap medical malpractice awards at \$1 million. (Includes all recoverable damages).
- o SB 216 permits establishment of self insurance pools for public entities for purposes of securing liability coverage. This can occur only if a master insurance contract is not purchased.
- o HB 1106 revises provisions relating to property insurance policy nonrenewal notice. Increases notice time from 20 days to 30 days, effective 7-1-88 and from 20 days to 45 days for the period 7-1-86 to 6-30-88.

- o Waiver of sovereign immunity for public entities, other than the state, will occur only to the extent that said entities have purchased liability coverage (SB 233).

Legislation Considered - Not Passed

Bills which were introduced but were not passed included legislation abolishing the doctrine of joint and several liability (HB 1261), limiting punitive damages (SB 269), reforming the tort system as it pertains to public entities (HB 1278), mandating an offset for payment of special damages in certain circumstances (SB 279), creating a joint underwriting association for medical malpractice (HB 1269) and requiring insurers to file case reports with the Insurance Division (HB 1281).

Interim

1986 Summer Interim Judiciary Committee - A study of the entire area of liability insurance, including relative legislation considered by the Sixty-First Legislative Session; a review of what information is needed by the division of insurance to regulate insurance companies' rates; and a study of alternative ways to regulate costs of defending tort claims lawsuits. The committee has met once with a second scheduled for early July.

TENNESSEE

1986 Session Completed

Enacted

- o HB 1582 (Public Chapter No. 656) will prohibit cancellation of or failure to nonrenew commercial risk insurance policies with some exceptions.
 - o Immunity from suit for directors of nonprofit organizations (exempt from federal taxation), of governing bodies of electrical cooperatives and electrical membership corporations is authorized in HB 1940.
 - o Regarding dram shop, HB 1199 prohibits any judge or jury from pronouncing any damages against an alcohol seller unless it is ascertained that the sale of intoxicating beverages was the proximate cause of subsequent injury or death.
- SB 1702 (Public Chapter No. 726) - all members of boards, commissions, agencies, authorities, and other governing bodies of any governmental entity, created by public or private act, whether compensated or not, shall be immune from suit arising from activities of the entity unless conduct amounts to willful, wanton or gross negligence.
- SB 1854 (Public Chapter No. 730) - provides immunity for local education agency employees, including board members, superintendents, teachers and nonprofessional staff members for suits arising from detection, management or removal of asbestos.

HB 1199 (Public Chapter No. 519) - prohibits any judge or jury from pronouncing damages against an alcohol seller unless it is ascertained that the sale of intoxicating beverages was the proximate cause of subsequent injury or death.

SB 1458 - (Public Chapter No. 535) raises the capital and surplus requirements of insurance companies in Tennessee.

Interim

SR 43 directs a special committee to study liability insurance issues including (but not limited to) availability, coverage cost, liability limits and litigation.

TEXAS

Not In Regular Session in 1986

Interim

- o A market assistance plan for hard-to-get lines of liability coverage has been established.
- o A joint legislative committee on Liability Insurance and Tort Law and Procedure Reform has been established and conducted several meetings. Additional meetings are currently scheduled with November 15, 1986 targeted as a final reporting date.
- o The State Board of Insurance has initiated a closed claims survey that will review about 73% of the liability coverage provided in the state for the years 1983-1985.
- o Examination of the state's ability to create a state insurance pool for governmental units is underway by the State Board of Insurance.

UTAH

1986 Session Completed

Enacted

- o Repealed joint and several liability (SB 64).
- o Established a \$100,000/\$300,000 cap on dram shop liability and set a 2-year statute of limitation (SB 182).
- o Authorized establishment of market assistance plans and joint underwriting associations (SB 91).
- o SB 111 limits noneconomic damages to \$250,000 in medical malpractice judgments while SB 155 establishes structured settlements for medical malpractice judgments only.

- o Limited directors' and officers' liability through revamped standards of care (SB 214). Governor vetoed.

Legislation Considered - Not Passed

- o Modifications to statutes of limitation, mandatory arbitration and establishment of pretrial screening panels were introduced but failed to pass.

Interim

- o An interim committee tackled this subject in 1985 and another has been formed for 1986.

VERMONT

1986 Session Completed

Enacted

- o Pooling by municipal governments is authorized via HB 8641.
- o HB 8657 empowers the Insurance Commissioner to establish a joint underwriting association for a broad array of hard-to-get lines of liability insurance coverage.

Legislation Introduced - Not Passed

Unsuccessful attempts to cap attorneys' contingency fees and limit noneconomic damages were made.

Prior Action

A market assistance plan was established in January.

VIRGINIA

1986 Session Completed

- o No major action in 1986 session.
- o An interim study committee has been established and is reviewing the entire liability insurance issue.
- o A joint underwriting association for provision of medical malpractice coverage has been created by the State Corporation Commission.

WASHINGTON

1986 Session Completed

Enacted

SB 4630 - accomplishes the following:

- o Caps, noneconomic damages per a statutory formula. The estimated cap range is \$117,000 - \$493,000. The formula is .43 x average annual wage (currently \$18,029) x plaintiff's life expectancy (no less than 15 years; use Insurance Commissioner's mortality table).
 - o Abolishes claims involving joint and several liability except for the following:
 - a) hazardous waste and solid waste disposal sites;
 - b) business torts; and
 - c) manufacturers of generic products.
 - o Accelerates the statute of limitations for contractors.
 - o Authorizes structured settlements for all judgments exceeding \$100,000.
 - o Establishes a voluntary market assistance plan requiring participation of 25 admitted or non-admitted companies.
- HR 2080 and 2083 - respectively authorize the establishment of a joint underwriting association and self-insurance mechanism for provision of liability coverage for day care providers.
- SB 3636 - enables the Insurance Commissioner's office to be funded from dedicated rather than General Revenue sources.
- HB 1972 - authorizes local governments to self-insure.
- SB 4541 - requires prior notice to policyholders of cancellation and further requires 20 days prior notice of rate and form changes before policy renewal anniversary dates.

Legislation Considered - Not Passed

Among the bills failing to pass was legislation giving the Insurance Commissioner additional time to review rate applications and to base rates on Washington State experience; authorizing establishment of joint underwriting associations for any hard-to-get line of coverage; memorializing Congress to modify the McCarran-Ferguson Act; and compelling all insurance companies to file all financial information with the National Association of Insurance Commissioners.

WEST VIRGINIA

1986 Session and Special Session Completed

Enacted

- o Regular session legislation (SB 714) caps noneconomic damages awards in medical malpractice judgments at \$1 million per incident. HB 149 (special session) permits a judge, with discretionary power, to instruct a jury regarding these caps.

- o SB 714 prohibited insurers from cancelling or nonrenewing health care provider policies unless insurers could prove that the risk of loss had increased or that they could not back up their own risk with reinsurance. HB 149 removes most causal and durational restrictions on nonrenewals.
- o SB 714 required expanded disclosure of claims, investments, judicial dispositions, etc. related to West Virginia. The legislation further required the Insurance Commissioner to conduct public hearings whenever rates were expected to increase 10% or more with verification of past loss experience in medical malpractice settlements and judgments required. HB 149 reduced reporting requirements to profit and loss, reserve and surplus data on an aggregate rather than company basis. Public hearings on rate increases exceeding 10% must be held within 60 days of the rate filing.
- o HB 149 eliminates joint and several liability for individual defendants who are 25% or less responsible.
- o Other special session legislation, SB 3, authorizes the following regarding the state's political subdivisions:
 - o individual or collective self-insurance; and
 - o purchase of liability insurance through the State Board of Insurance and Risk Management.
- o SB 3 also limits noneconomic damages in suits involving political subdivisions to \$500,000, deploys the 25% rule (see HB 149 above) regarding joint and several liability and lays out standards for liability immunity of political subdivision employees.

Interim Studies

A legislator/citizen interim committee on liability insurance will be organized in late June.

WISCONSIN

1986 Regular Session and Special Session Completed

Enacted

The legislature approved medical malpractice legislation during its special session. Major ingredients of the medical malpractice legislation include:

- o \$1 million cap on noneconomic damages;
- o sliding scale for attorney contingency fees (from 1/3 of first \$1 million if proving negligence, to 25% of damages if defendant admits negligence, to 20% of damages exceeding \$1 million).
- o elimination of pretrial screening panels to be replaced with a voluntary, non-binding mediation process.

Special session legislation (AB 8) also accomplishes the following:

- o authorizes the establishment of risk sharing pools for liability insurance coverage for public and private sector entities. Risk sharing pools cannot be authorized to produce coverage for risks the Insurance Commissioner determines to be "uninsurable".
- o increases minimum capital and surplus requirements.
- o increases, from 30 days to 60 days, the notice period for mid-term cancellations.

Interim

A final report from an Insurance Commissioner's Task Force on Property/Casualty Insurance was due in July, 1986. The final report will include recommendations. Three subcommittees, on Civil Justice Reform, Pools and MAPs and Industry Actions, have already reported.

The Legislative Council is considering an interim study of the civil justice system.

WYOMING

1986 Session Completed

Enacted

- o HB 12 will modify the standards of care used to determine medical malpractice.
- o HB 13 will remove individuals legally supplying alcoholic beverages from liability for resultant damages caused by individuals consuming the alcoholic beverages.
- o HB 14 will authorize courts to determine frivolous suits. Plaintiffs in frivolous suits could be made liable for payment of reasonable court expenses and attorneys fees.
- o HB 15 provides for an affidavit of non-involvement as a summary means to obtain early dismissal of suits against defendants who are clearly not involved in the occurrence giving rise to the tort claim.
- o HB 38 creates statutory definitions of unfair insurance claims practices.
- o HB 39 grants any officers, commissioners or board members of government and nonprofit entities immunity from liability for any action, omission or inaction of the respective government or corporate body.
- o HB 40 establishes pretrial screening panels for medical malpractice suits.
- o HB 44 modifies the state's sovereign immunity and liability limits.

- o HB 59 makes certain entities not liable for injuries incurred at amateur rodeos unless there is willful neglect.
- o SF 17 repeals the doctrine of joint liability.
- o SF 21 and SF 26 respectively create state and local government self-insurance programs and establish pools for state and local government entities.
- o SF 69 prohibits midterm cancellations with some exceptions, such as nonpayment of premiums. Authorized cancellations must be preceded by a 10-45 day notice to policyholders. A 45-day notice with statement of reasons is required for nonrenewals.

Legislation Considered - Not Passed

Bills restricting punitive damages, capping awards, limiting noneconomic damages, restricting attorneys fees, placing moratoria on suits against the state and authorizing joint underwriting associations were introduced but did not pass.

ATTACHMENT B
OPTIONAL INSURANCE MECHANISMS

A) OPTIONAL INSURANCE MECHANISMS

I. SELF-INSURE AND/OR GROUP PURCHASE

ARIZONA	(Nonprofits; Municipalities; Schools)
GEORGIA	(Municipalities; School Boards)
INDIANA	(State-Administered Pools)
IOWA	(Local governments; public sector entities)
MARYLAND	(Local governments; Nonprofits)
MINNESOTA	(State Risk Management Fund)
SOUTH DAKOTA	(Public Entities)
VERMONT	(Municipal governments)
WASHINGTON	(Day care providers; Local governments)
WISCONSIN	(Risk Retention Pooling - Public/Private Entities)
WYOMING	(State and local governments)

II. JOINT UNDERWRITING ASSOCIATIONS

ARIZONA	
HAWAII	(Child care providers)
MINNESOTA	
MONTANA	
NORTH CAROLINA	
VERMONT	
UTAH	
WASHINGTON	

III. MARKET ASSISTANCE PLANS

Majority of States

IV. CAPATIVE LICENSURE/OPERATION

HAWAII

ATTACHMENT C
INSURANCE REGULATION REFORM

B) INSURANCE REGULATION REFORM

I. EXPANSION OF DATA SUBMITTED BY INSURERS

ALABAMA
ARIZONA
COLORADO
CONNECTICUT
GEORGIA
WEST VIRGINIA

II. PERMIT POLICY CANCELLATION ONLY WITH CAUSE

ARIZONA
CONNECTICUT
KANSAS
TENNESSEE
MAINE
WEST VIRGINIA
WYOMING

III. MANDATORY NOTICE OF NONRENEWALS/CANCELLATION/RATE INCREASES

COLORADO	
CONNECTICUT	(60 days)
KANSAS	(60 days)
MAINE	(30 days)
NEW HAMPSHIRE	(60 days)
WASHINGTON	(20 days)
WISCONSIN	(60 days)
WYOMING	(10-45 days)

IV. ESTIMATE TORT REFORM SAVINGS

WASHINGTON

D) FURTHER/SPECIAL LEGISLATIVE ACTION

1986 Interim Studies

ARKANSAS
CONNECTICUT
IDAHO
KANSAS
KENTUCKY
MAINE
MONTANA
NEBRASKA
NEW HAMPSHIRE
NEW MEXICO
OREGON
TEXAS
VIRGINIA
WISCONSIN

1986 Special Sessions

MONTANA	(concluded)
NORTH CAROLINA	(concluded)
WEST VIRGINIA	(concluded)
WISCONSIN	(May 20-?)

ATTACHMENT D
LEGISLATION SUBJECT SUMMARY

11/6/30/86
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LEGISLATION SUBJECT SUMMARY

R01-33F-3045

SUBJECT	NUMBER	ABREVIATED TITLE	SPONSOR	REQUESTED BY	CURRENT STATUS
HYDROELECTRIC PROJEC	HB 219	POWER DEV'T LOANS/JOINT OPERATING AGENCIES	STATE LOANS		CHAPTER 80 SLA 85
	HB 351	FEDERAL ALASKA POWER ADMINISTRATION	PIGNALBERI		(H) L&C
	HB 389	DIRECT SERVICE CHARGES FOR APA POWER SALES	RULES	THE GOVERNOR	(H) C&RA
	HB 477	REAPPROPRIATING SUSITNA/BRADLEY/POWER FUNDS	RULES	GOV	CHAPTER 41 SLA 86
	HJR 36	LICENSING OF BRADLEY LAKE HYDRO PROJECT	NAVARRE		(S) RES
	SB 27	APPROP: STATEWIDE CAPITAL PROJECTS	FAIKS		CHAPTER 96 SLA 85
	SB 123	POWER DEVELOPMENT FUND & APA REPORT	RULES	THE GOVERNOR	(S) RES
	SB 338	REAPPROPRIATING SUSITNA/BRADLEY/POWER MONEY	STURCULEWSKI		(S) FIN
	SB 342	REAPPROPRIATING SUSITNA/BRADLEY/POWER FUNDS	RULES	THE GOVERNOR	(S) L&C
	SB 395	ADVISORY VOIE ON SUSITNA PROJECT FUNDING	FISCHER.V		(S) RES
	SB 454	APPROP: UTILITIES, MUNICIP'S, HYDRO PROJ'S	FERGUSON	BY REQUEST	(S) L&C
	SB 476	ENERGY PROJECTS FOR RAILBELT; APA DESIGN & POWER	FINANCE		(H) LOAN
IMPLACHMENT	HB 516	INPEACHMENT & DISQUALIFICATION OF JUDGES	GRUENBERG		(S) RLS
IMPLIED CONSENT	HB 394	INTOX. TEST; OPERATORS OF BOATS/AIRPLANES	PIGNALBERI		(H) SA
	SB 20	INTOX. TEST; OPERATORS OF BOATS/AIRPLANES	RAY		CHAPTER 76 SLA 85
	SB 74	DRUNK DRIVING: DRUGS, SENTENCES, BREATH TEST	ABOOD		(H) JUD
	SB 76	ATTORNEY CONTACT ONLY AFTER EVIDENCE SEIZED	ABOOD		(S) JUD
INITIATIVES	HB 270	MUNIC. RECALLS/REF'DUMS/INITIATIVES/ELECTNS	LARSON		(H) C&RA
	HJR 28	CONST'L AMENDMENT & APPROP. BY INITIATIVE	MARROU		(H) JUD
INJUNCTIONS	HB 544	CORPORATE & BUSINESS NAMES; INJUNCTIONS	PHILLIPS		(S) FIN
INSURANCE	HB 56	PROOF OF INSURANCE WHEN REGISTERING VEHICLE	COLLINS		(H) L&C
	HU 68	MANDATORY INSURANCE FOR LICENSED DRIVERS	SHULTZ		CHAPTER 69 SLA 86
	HR 77	CAPITAL FUNDS REQUIRED OF INSURERS	CATO		CHAPTER 5 SLA 85
	HB 80	INCREASING FEES PAID BY INSURANCE COMPANIES	RULES	THE GOVERNOR	CHAPTER 26 SLA 85
	HB 182	DISPOSITION OF UNCLAIMED PROPERTY	RULES	THE GOVERNOR	CHAPTER 133 SLA 86
	HB 277	ALLOW INVESTMENTS IN AFRICAN DEV'MENT BANK	JUDICIARY	BY REQUEST	(S) L&C
	HD 313	INS. POLICIES; MENTAL HEALTH COVERAGE REQ'D	DAVIS		(H) FIN
	HB 356	ASSIGNMENT OF GROUP INSURANCE POLICIES	GRUENBERG		CHAPTER 4 SLA 86
	HB 358	NONPROBATE TRANSFERS	GRUENBERG		(H) JUD
	HB 437	PREFERRED/EXCLUSIVE PROVIDER INSURANCE	JENKINS		(H) L&C
	HB 476	NOTICE OF INCREASE IN CAR INSURANCE PREMIUM	MILLER.WH	BY REQUEST	(S) RLS
	HB 481	VERDICTS/DAMAGES/LIABILITY IN CIVIL ACTIONS	RIEGER		(H) L&C
	HB 490	PERIODIC PAYMENT OF JUDGMENTS	SZYMANSKI		(H) L&C
	HB 506	REINSURANCE FUND AND INSURANCE POOLING	TAYLOR		CHAPTER 136 SLA 86
	HB 522	UNFAIR INSURANCE CLAIMS SETTLEMENT PRACTICES	SUND		(S) RLS
	HB 535	INSURANCE REQUIRED FOR VEHICLE REGISTRATION	RIEGER		(S) RLS
	HB 540	ASSIGNED RISKS; CREDIT LIFE MORTGAGE INSUR.	SUND		(H) L&C
	HB 547	HEALTH INSURANCE POOL FOR HIGH RISK PEOPLE	SUND		(H) L&C
	HB 585	JOINT SELF-INSURANCE FOR SCHOOL DISTRICTS	MATIS		(H) L&C
	HB 589	GROUP LIFE & HEALTH INS. FOR RESIDENTS	SUND		(S) L&C
	HB 654	STATE MOTOR VEHICLE INSURANCE PROGRAM	KOPONEN		(H) L&C
	HB 657	CREATE STATE WORKERS' COMP FUND	KOPONEN		(H) L&C
	HB 702	STATE REINSURANCE FUND	LABOR&COMMERCE		(H) JUD
	HB 710	PREMIUM TAX FOR DOMESTIC INSURERS	LABOR&COMMERCE		(H) L&C
	SB 88	AK LIFE/DISABILITY INSURANCE GUAR ASSOC	RULES	THE GOVERNOR	(S) L&C
	SB 116	ALLOW INVESTMENTS IN AFRICAN DEV'MENT BANK	RODEY		(S) L&C
	SB 156	FORM OF PAYMENT FOR INSURANCE SETTLEMENTS	RODEY		(S) L&C
	SB 222	INSURANCE BENEFITS; PSYCHOLOGICAL SERVICES	JOSEPHSON		(S) HESS
	SB 288	LIQUOR LICENSE HOLDERS' INSURANCE CORP.	JOSEPHSON		(S) L&C

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06/30/86
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LEGISLATION SUBJECT SUMMARY

NOT-33F-3045

SUBJECT	NUMBER	ABBREVIATED TITLE	SPONSOR	REQUESTED BY	CURRENT STATUS
INSURANCE	SB 295	MENTAL HEALTH DISABILITY INSURANCE	FAIKS		(H) RLS
	SB 340	SURPLUS LINES INSURANCE BROKERS	RULES	BY REQUEST	(S) L&C
	SB 365	BROKER AS INSURER'S AGENT FOR PREMIUMS	RULES	THE GOVERNOR	(H) L&C
	SB 366	CANCELLATION OF INSURANCE POLICIES	RULES	THE GOVERNOR	(S) L&C
	SB 379	PREMIUM TAX DOMESTIC AND FOREIGN INSURELMS	RULES	THE GOVERNOR	CHAPTER 118 SIA 86
	SB 380	MINIMUM INSURANCE FOR COMMERCIAL VEHICLES	RULES	THE GOVERNOR	(S) L&C
	SB 381	JOINT INSURANCE ARRANGEMENTS	JOSEPHSON		(S) FIN
	SB 440	USE OF BLOOD TESTS BY INSURERS	DEVRIES		(S) L&C
	SA 442	MARINE INSURANCE; RECIPROCAL INSURERS	ELIASON		CHAPTER 48 SIA 86
	SB 443	SURPLUS LINES INS. BROKERS MONTHLY REPORTS	MALFORD		(S) JUD
	SB 445	MISCELLANEOUS CHANGES IN INSURANCE LAWS	FISCHER, V		(S) L&C
	SB 455	REDUCED AUTO INS. RATES/PERSONS OVER 55	LABOR&COMMERCE		(S) L&C
	SCR 20	AVAILABILITY OF MARINE INSURANCE	ZHAROFF		(S) FIN
	SCR 35	URGING NATIONAL REGULATION OF INSURANCE	FISCHER, V		(S) RLS
BJR 45	FISHERMEN'S INJURIES COMPENSATION	LABOR&COMMERCE		LEGIS RESOLVE 49	
INTEREST	HB 20	INTEREST ON PUBLIC UTILITY DEPOSITS	GOLL		CHAPTER 50 SIA 86
	HB 51	INTEREST ON ESCROW ACCTS FOR MORTGAGE LOANS	DUNCAN		(H) FIN
	HB 109	SETTING INTEREST RATES FOR STATE LOANS	RULES	THE GOVERNOR	(H) LOAN
	HB 161	STUDENT LOANS; ELIGIBILITY/INTEREST RATES	BINKLEY		CHAPTER 65 SIA 86
	HB 217	INTEREST RATES FOR VARIOUS LOANS/CONTRACTS	DUNCAN		AWAITING CONC/RECLD
	HB 370	INTEREST RATE ON STATE LOAN PROGRAMS	ADAMS		(H) LOAN
	HB 459	USE OF INTEREST EARNED ON GRANT MONEY	MARTIN		(H) FIN
	HB 501	AK POWER AUTHORITY; REPORTS, FUND INTEREST	RULES	THE GOVERNOR	(H) LOAN
	HB 557	INTEREST ON ATTORNEY TRUST ACCOUNTS	DUNCAN		(H) RIS
	HB 622	INTEREST RATE ON DELINQUENT TAXES	SIGNALBERI		(H) JUD
	SB 6	INTEREST ON ESCROW ACCTS FOR MORTGAGE LOANS	RAY		(S) L&C
	SB 216	INTEREST RATE ON AGRICULTURAL LOANS	COGHILL		(S) RES
	SB 281	INTEREST RATE ON STATE LOAN PROGRAMS	MALFORD		(H) LOAN
	INTERNATIONAL RELATI	HB 465	STATE FISCAL INVOLVEMENT IN SOUTH AFRICA	CLOCKSON	
HB 633		ALASKA EXPORT DEVELOPMENT AUTHORITY	MARTIN		(H) L&C
HCR 7		JOINT SPECIAL COMMITTEE ON FOREIGN TRADE	RULES		LEGIS RESOLVE 5
HCR 10		SUPPORTING INTERNATIONAL YOUTH YEAR	CLOCKSON		LEGIS RESOLVE 13
HCR 17		END STATE INVESTMENTS RELATED TO S. AFRICA	DUNCAN		(H) SA
HJR 13		SISTER STATE RELATION WITH NEILONGJIANG	RULES	THE GOVERNOR	LEGIS RESOLVE 2
HJR 15		EXPORT OF ALASKA OIL	MARTIN		(H) O&G
HJR 23		RETENTION OF WEST COAST U.S. CUSTOMS OFFICE	MARTIN		LEGIS RESOLVE 14
HJR 37		AMERICANIZATION OF ALASKA'S FISHERIES	GOLL		(H) RES
HJR 39		EXPORT OF ALASKA OIL	OIL AND GAS		LEGIS RESOLVE 25
HJR 43		HIGH SEAS SALMON INTERCEPTION	GOLL		LEGIS RESOLVE 24
HJR 52		URGING NUCLEAR-FREE SUBARCTIC AND ARCTIC	KOPONEN		RETURN TO (H) RIS
HJR 53		US/USSR BOUNDARY DISPUTE IN BEIKING SEA	JENKINS		LEGIS RESOLVE 37
HJR 55		PROMOTING SOUTHEAST INTERTIE WITH CANADA	GRUSSENDORF		(H) RLS
HJR 56		U.S. SENATE CONSENT TO GENOCIDE CONVENTION	GRUENBERG		(H) HESS
HJR 60		INTERNATIONAL YEAR OF PEACE	MILLER, MM		LEGIS RESOLVE 55
HJR 65		FOREIGN MARKETING OF PINK SALMON PRODUCTS	HEPRMANN		(S) RLS
HJR 68		HIGH SEAS INTERCEPTION OF SALMON	RULES	BY REQUEST	(H) RLS
HJR 72		AK, YUKON & N.W. TERR. LEG./JOINT MEETING	CE&A		LEGIS RESOLVE 47
HJR 74		FRIENDSHIP WITH NEILONGJIANG PROVINCE	RULES	THE GOVERNOR	LEGIS RESOLVE 48
HR 8		SISTER STATE RELATIONSHIP WITH TAIWAN	RINGSTAD		HOUSE RESOLVE 5
SB 59		PACIFIC RIM FELLOWSHIP PROGRAM	RUIFS	THE GOVERNOR	(S) FIN
SB 328		STATE FISCAL INVOLVEMENT IN SOUTH AFRICA	FISCHER, V		(S) HESS
SCR 14		END STATE INVESTMENTS RELATED TO SO. AFRICA	FISCHER, V		(S) SA
SJR 7		COOPERATION BETWEEN AK & FOREIGN NATIONS	COGHILL		(S) JUD

06/30/86
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LEGISLATION SUBJECT SUMMARY

RU1-331-1000

SUBJECT	NUMBER	ABBREVIATED TITLE	SPONSOR	REQUESTED BY	CURRENT STATUS
TEACHERS	HB 234	RETIREMENT CREDIT FOR MILITARY SERVICE	MFSS		(H) SA
	HB 289	TENURE & REDUCTIONS-IN-FORCE BY SCHOOL BDS	TULLER		(H) HESS
	HB 674	CERTIFICATION REQUIREMENTS FOR TEACHERS	NAVARKH		(H) HESS
	HR 10	TEACHERS CONTRACT NEGOTIATION	FURNACE		(H) HESS
	SB 85	TEACHER TRAINING ABOUT ABUSE OF MINORS	DEVRIES		(S) SA
	SB 121	CHANGES IN VARIOUS RETIREMENT LAWS	RULES	THE GOVERNOR	(S) FIN
	SB 145	POST-RETIREMENT PENSION ADJUSTMENTS	FISCHER.V		(S) SA
	SB 192	CREDITS WAIVED ON TEACHERS' SICK LEAVE BANK	ELIASON		CHAPTER 21 SLA 86
	SB 217	NEGOTIATING UNITS FOR PRINCIPAL-TEACHERS	SACKETT		(H) HESS
	SB 230	TENURE & REDUCTIONS-IN-FORCE BY SCHOOL BDS	FERGUSON		(S) HESS
	SB 266	CERTAIN TEACHERS PLACED IN EXEMPT SERVICE	RULES	THE GOVERNOR	CHAPTER 50 SLA 85
	SB 385	LIMITING CERTAIN RETIREMENT CREDITS	KERTTULA		(S) HESS
	SB 420	ENDS TEACHER OUTSIDE SERVICE CREDIT	FISCHER.P		(S) HESS
	SJR 4	ALASKAN TEACHER TRAVELING ON SPACE SHUTTLE	FERGUSON		(S) HESS
TOBACCO	HB 249	CIGARETTE EXCISE TAX; HEALTH PROGRAMS	ADAMS		(H) HESS
	SB 94	CIGARETTE EXCISE TAX; HEALTH PROGRAMS	FISCHER.V		CHAPTER 24 SLA 85
TORTS	HE 97	GOVT LIABILITY; HAZARDOUS REC ACTIVITIES	DUNCAN		(H) JUD
	HB 368	UNIFORM COMPARATIVE FAULT ACT	GRUENBERG		(H) JUD
	HB 418	LIABILITY FOR EMERGENCY MEDICAL CARE	HARROU		CHAPTER 122 SLA 86
	HB 481	VERDICTS/DAMAGES/LIABILITY IN CIVIL ACTIONS	RIEGER		(H) L&C
	HB 532	LIMITATIONS ON CIVIL LIABILITY	COTTON		(H) JUD
	HB 640	TRESPASS AND USE OF LAND	STURLEY	BY REQUEST	(H) RES
	SCR 65	SUSPENDING UNIFORM RULES - SB 377	RULES		LEGIS RESOLVE 58
	SB 307	HAZARDOUS SEWAGE TREATMENT FACILITIES	ELIASON		(S) RES
	SB 377	CIVIL LIABILITY/TORT REFORM	KELLY		CHAPTER 139 SLA 86
	SB 382	LIMITING CIVIL ACTIONS	KERTTULA		(S) L&C
	SB 392	ANNUITY CONTRACTS FOR PERIODIC PAYMENTS	JOSEPHSON		(S) L&C
TOURISM	SB 445	CAP ON AWARDS, ATTY FEES; PERIODIC PAYMENTS	FISCHER.V		(S) L&C
	SB 451	COMPARATIVE FAULT AND SEVERAL LIABILITY	HALFORD		(S) L&C
	HJR 20	TOURISM - INTERNATIONAL AIRLINE TRAVELERS	RIEGER		LEGIS RESOLVE 15
TRADE PRACTICES	HB 125	CONSUMER PROTECTION ACT EXTENDED TO BUSINESSES	RULES	THE GOVERNOR	(S) JUD
	HB 138	REGULATING SALE OF RESIDENTIAL TIME-SHARES	RULES	THE GOVERNOR	(H) L&C
	HB 315	MANDATORY PRICE LABELING & UNIT PRICING	DAVIS		(H) L&C
	HB 517	ARTISTS AND WORKS OF ART	GRUENBERG		(S) RLS
	HB 544	CORPORATE & BUSINESS NAMES; INJUNCTIONS	PHILLIPS		(S) FIN
	HB 551	COMPETITION IN MOTION PICTURES DISTRIBUTION	SHULTZ		(H) JUD
	SB 138	ALCOHOLIC DRINK DISCOUNTS AND CONTESTS	FISCHER.V		CHAPTER 68 SLA 86
	SB 363	COMPETITION IN MOTION PICTURES DISTRIBUTION	JUDICIARY		(S) L&C
	SB 416	LIMITED WARRANTIES FOR USED MOTOR VEHICLES	JOSEPHSON		(S) TRSP
	HB 111	LOCAL SERVICE ROADS AND TRAILS	RULES	THE GOVERNOR	CHAPTER 5 SLA 86
TRAILS	HB 291	APPROP: LOCAL SERVICE ROADS AND TRAILS	TRANSPORTATION		(H) FIN
	SCR 4	STATEWIDE TRAILS DEVELOPMENT PLAN	FISCHER.V		(S) FIN
	SJR 10	ROADS/TRAILS; ANILCA CONSERVATION UNITS	COCHILL		(H) FIN
TRANSPORTATION	HR 24	REGIONAL ORGANIZATION OF DOT/PT	CATO		(H) TRSP
	HB 55	WARNING SIGNS/TALES FOR INTOXICATED PERSONS	COLLINS		(S) RLS
	HB 60	APPROP: FY86 OPERATING BUDGET/LOAN PROGRAMS	RULES	THE GOVERNOR	CHAPTER 98 SLA 85
	HB 133	REGULATING SAFETY OF MOTOR/AIR CARRIERS	RULES	THE GOVERNOR	CHAPTER 104 SLA 85
	HB 224	MANDATORY SEAT BELTS FOR ALL CAR OCCUPANTS	MILLEN.MH		FAILED (H) ON HILLON
	HB 258	REDUCING AIRLINE FARES	C&RA		(H) C&RA

court action. Allows a person to claim escheated real property for seven years after the court judgment of escheat. (SCS CSHB 182(Fin))

Effective Date: September 7, 1986

- Chapter 134 **STATE GUARANTY OF BONDS FOR VETERANS LOANS**
Provides that the state will guarantee revenue bonds of the Alaska Housing Finance Corporation, the proceeds of which are to be used for residential mortgages for certain veterans. Requires the question of the state guaranty of the bonds to be submitted to the voters. Authorizes the corporation to issue not more than the principal amount of \$600,000,000 of these bonds if the question is approved. (HB 533)

Effective Date: June 10, 1986

- Chapter 135 **ALASKA WATER USE ACT**
Makes miscellaneous changes in the Alaska Water Use Act (AS 46.15), relating to permits, appropriations of water, administrative and judicial adjudications, options of the Commissioner of Natural Resources in litigation involving water rights, federal reserved water rights, enforcement, and the data collection authority of the commissioner. (HCS CSSB 150(Res))

Effective Date: June 10, 1986

- Chapter 136 **INSURANCE FOR SCHOOLS AND MUNICIPALITIES**
Allows municipalities, school districts, and REAA's to join together to buy insurance coverage or to group self-insure. Does not apply to certain types of insurance. Specifies certain procedures and financial requirements for these joint insurance arrangements. (SCS CSSH 506(Jud))

Effective Date: June 10, 1986

- Chapter 137 **BARBERS, HAIRDRESSERS, AND COSMETOLOGISTS**
Extends the termination date of the Board of Barbers and Hairdressers to June 30, 1989, and makes various changes in the licensing laws for barbers, hairdressers, and cosmetologists. Requires the board to establish instructors licensing requirements. Increases the number of hours an apprentice in barbering must complete. Prohibits practitioners from practicing outside of a licensed shop or school except in certain limited cases. (SCS CSHB 305(L&C) am S)

Effective Date: June 10, 1986

Chapter 138

FINANCIAL ADMINISTRATION - PROGRAM RECEIPTS

Establishes a uniform system of accounting and budgeting for program receipts of state agencies. Provides for setting of charges for miscellaneous state services, including publications and information, medical and institutional care, probation supervision, and intragovernmental technical assistance. Authorizes the sale of miscellaneous state property, including surplus hatchery broodstock and eggs. Prohibits a state agency from charging for a service after June 30, 1987, unless the charge is authorized by statute.

(SCS CSHB 696(Fin) am S)

Effective Date: Section 1 takes effect July 1, 1987;
section 102 takes effect June 10, 1986;
remainder of Act takes effect July 1,
1986

Chapter 139

TORT REFORM

- ① Establishes limits regarding the recovery of damages in a civil action. ② Provides for itemization of the verdict and for reduction of future damages to a present value. ③ Requires apportionment of damages for multiple defendants, and limits the joint liability of certain parties. ④ Changes the period during which an offer of judgment may be made, and ⑤ increases the interest rate on certain offers of judgment. ⑥ Establishes a period during which prejudgment interest will accrue. ⑦ Prohibits the court award of attorney fees in certain civil actions unless specifically allowed by statute or agreement between the parties. Applies to actions accruing after June 11, 1986. (CCS SB 377)

Effective Date: June 11, 1986

Chapter 140

ADOPTION

Requires the state registrar of vital statistics to release the name and address of an adopted person's biological parents if the person is at least 18 years of age and requests the information. Provides for similar disclosure of medical, social, and other information about an adoptee's biological parents. Requires disclosure of adopted person's name and address to the biological parents on request, if adopted person is 18 or older and has filed written consent. Allows courts to grant a biological parent or other relatives visitation rights with an adopted child as part of the adoption decree. Allows parties who were denied adoption visitation rights by a court since January 1, 1984, to ask courts to reconsider the denial. Requires persons consenting to adoption to be informed of certain legal rights and makes other requirements regarding consents. Allows notice of

Y9 N29 A2
Y25 N15
UNAN CONSENT
READING UNAN CONSENT
E CSHB 518(C&RA)AM

E AS PASSAGE
F RECONSIDERATION
4 THIRD READING
JR AM 4 Y23 N16 A1
Y18 N22
RATION Y34 N6
AS PASSAGE

- REFERRAL(S)

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ING UNAN CONSENT

PAS

04/29/86	(H)	2493	TRANSMITTED TO (S)
04/30/86	(S)	2533	READ THE FIRST TIME - REM
04/30/86	(S)	2533	HESS REFERRAL WAIVED
05/12/86	(S)	2673	FIN RPT SCS 3DP 2DNP RULES

HB 521

AN ACT RELATING TO THE ISSUANCE OF MUNICIPAL GENERAL OBLIGATION
PROVIDING FOR AN EFFECTIVE DATE.

PRIME SPONSOR: RULES COMMITTEE BY REQ OF THE GOVERNOR
CO-SPONSORS:

CURRENT STATUS: (H) FIN

DATE	PAGE	ACTION
01/27/86	(H) 1901	READ THE FIRST TIME - REFERRAL
01/27/86	(H) 1901	GOVERNOR'S TRANSMITTAL LETTER
01/27/86	(H) 1901	ZERO FISCAL NOTE
01/27/86	(H) 1901	2 ZERO FISCAL NOTES/ANALYSIS H.
02/26/86	(H) 2231	LOAN RPT CS(LOANS) 1DP 4NH
04/14/86	(H) 2699	C&RA RPT CS(C&RA) NEW TITLE 5 FINANCE RULES

HB 522

CSHB 522 JUD

AN ACT RELATING TO AN INSURANCE BROKER'S RECEIPT OF PREMIUM PAYMENTS,
THE CANCELLATION OR NONRENEWAL OF INSURANCE POLICIES, THE COMPOSITION
OF THE BOARD OF THE MEDICAL INDEMNITY CORPORATION OF ALASKA, AND THE
PROVISION OF MEDICAL MALPRACTICE INSURANCE FOR NURSES AND NURSE MIDWIVES.

PRIME SPONSOR: SUND
CO-SPONSORS: KOPONEN, GRUENBERG, TAYLOR

CURRENT STATUS: (S) RLS

DATE	PAGE	ACTION
01/29/86	(H) 1918	READ THE FIRST TIME - REFERRAL(S)
04/15/86	(H) 2722	L&C RPT CS(L&C) NEW TITLE 3DP 2NR
04/15/86	(H) 2723	ZERO FISCAL NOTE
04/28/86	(H) 2938	JUD RPT CS(JUD) NEW TITLE SDP 1NR
04/29/86	(H) 3014	RULES TO CALENDAR 4/30/86
04/30/86	(H) 3014	READ THE SECOND TIME
04/30/86	(H) 3014	JUD CS ADOPTED UNAN CONSENT
04/30/86	(H) 3015	AM NO 1 FAILED Y3 N32 A3
04/30/86	(H) 3015	ADVANCED TO THIRD READING UNAN CONSENT
04/30/86	(H) 3015	READ THE THIRD TIME CSHB 522(JUD)
04/30/86	(H) 3015	PASSED Y33 N1 A6
04/30/86	(H) 3028	TRANSMITTED TO (S)
05/01/86	(S) 2555	READ THE FIRST TIME - REFERRAL(S)
05/10/86	(S) 2740	L&C RPT SCS 2DP 1NR NEW TITLE
05/10/86	(S) 2776	JUD REFERRAL WAIVED RULES

now -> HB 71

HB 523

AN ACT ESTABLISHING THE SMALL BUSINESS LOAN GUARANTEE PROGRAM; AND
PROVIDING FOR AN EFFECTIVE DATE.

PRIME SPONSOR: SUND
CO-SPONSORS: TAYLOR, GRUSSENDORF, THOMPSON

ATTACHMENT E

ALASKA STATUTE 21.88.010-900

- (1) AS 21.03
- (2) AS 21.06
- (3) AS 21.09, except AS 21.09.090
- (4) AS 21.18.010
- (5) AS 21.18.030
- (6) AS 21.18.040
- (7) AS 21.18.120
- (8) AS 21.21.321
- (9) AS 21.36
- (10) AS 21.69.400
- (11) AS 21.69.630
- (12) AS 21.69.600, 21.69.630, and 21.69.630
- (13) AS 21.78
- (14) AS 21.90
- (15) AS 21.42.345 and 21.42.355
- (16) AS 21.89.040
- (17) AS 21.89.090. (§ 1 ch 130 SLA 1986; am § 1 ch 92 SLA 1974; am § 2 ch 95 SLA 1975; am § 2 ch 84 SLA 1976; am § 24 ch 40 SLA 1981; am § 3 ch 45 SLA 1981)

Effect of amendments. — The first 1981 amendment added "and AS paragraph (17)." The second 1981 amendment added "and AS paragraph (17)." 21.42.355" in paragraph (15).

Sec. 21.87.350. Existing certificates of authority. A health care service contractor registered to do business in this state on July 1, 1986, is entitled to be registered under this chapter, whether or not it meets the requirements of this chapter. (§ 1 ch 130 SLA 1986)

Chapter 88. Health Care Providers Insurance.

Article

1. Purpose (§ 21.88.010)
2. Medical Indemnity Corporation of Alaska (§§ 21.88.020 — 21.88.030)
3. Loan Fund (§ 21.88.310)
4. General Provisions (§ 21.88.900)

Cross references. — For severability provisions of 1976 Act, see § 46, ch. 102, SLA 1976, in the Temporary and Special Acts; for purpose of 1976 amendatory Act, see § 1, ch. 177, SLA 1976 as amended by § 7, ch. 46, SLA 1982, in the Temporary and Special Acts; for effect of 1978 Act on certain policies, see § 21, ch. 177, SLA 1978 as amended by § 8, ch. 46, SLA 1982, in the Temporary and Special Acts.

Article 1. Purpose.

Section

10. Purpose of this chapter

Sec. 21.88.010. Purpose of this chapter. It is the purpose of this chapter to provide a means of furnishing health care providers with adequate insurance against liability for medical negligence. (§ 41 ch 102 SLA 1976)

NOTES TO DECISIONS

Chapter 48, SLA 1976, enacted in violation of Alas. Const., art. II, § 14. — When the free conference committee recommended adoption of a version of ch. 102, SLA 1976 (which, inter alia, enacted AS 21.88), that differed in many respects from the version originally passed by the house; the free conference committee's bill was passed by the senate by a recorded vote; but in the house there was no roll call or recorded vote and the free conference committee bill was passed there by a simultaneous voice vote, this voice vote constituted "final passage" of ch. 102, SLA 1976, and thus violated the recorded vote requirement of Alas. Const., art. II, § 14. *Flumley v. George E. Hale, M.D., Inc.*, Sup. Ct. Op. No. 1847 (File Nos. 4014, 4017, 504 P.2d 497 (1976)).

But this holding is to be applied prospectively. — Although the supreme court held that ch. 102, SLA 1976 (which, inter alia, enacted AS 21.88), was enacted in violation of the recorded vote requirement of Alas. Const., art. II, § 14, the supreme court held that its holding in this case should be applied prospectively in light of its conclusions that its decision was one of first impression, that substantial reliance had followed from the legislature's alternative interpretation of law, that undue hardship would have resulted from retroactive application of its holding, and that the rationale of the holding did not compel retroactivity. *Flumley v. George E. Hale, M.D., Inc.*, Sup. Ct. Op. No. 1847 (File Nos. 4014, 4017, 504 P.2d 497 (1976)).

Article 2. Medical Indemnity Corporation of Alaska.

Section

20. Corporation created
30. Corporation board of governors
40. Corporation plan of operation
50. Powers and duties of the corporation
55. Termination
60. Premium tax

Section

70. Statistic
80. Rates
90. Payment of premiums; cancellation of insurance
95. Transfer of corporate assets and liabilities

Sec. 21.88.020. Corporation created. There is created the Medical Indemnity Corporation of Alaska which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state. (§ 41 ch 102 SLA 1976)

Sec. 21.88.030. Corporation board of governors. (a) The corporation shall exercise its powers through a board of governors which is

appointed by the governor of the state and confirmed by the legislature. Members of the board of governors shall be Alaska residents as follows:

(1) four physicians licensed in the state and engaged in private practice in the state; no more than two of the physicians shall practice or live in a municipality having a population of more than 100,000, and two of the physicians must be indemnified against loss by reason of liability for an act or omission in the delivery of professional health care by the Medical Indemnity Corporation of Alaska;

(2) an administrator or senior executive officer employed by a hospital licensed in the state;

(3) two professionals from the insurance industry who are authorized or licensed to do business in the state;

(4) two persons who are not health care providers or financially interested in the field of health care or representatives of the insurance industry.

(b) The term of office of each governor is three years, except that the governor of the state shall designate two initially appointed governors to serve for one year and two initially appointed governors to serve for two years. Upon the expiration of the term of a governor, the governor of the state shall appoint a successor who shall be from the same class described in (a) of this section as the governor whose term has expired.

(c) Upon a governor's early resignation, death or inability to serve, the governor of the state shall appoint a successor from the same class defined in (a) of this section as the terminating governor, who shall serve for the unexpired term.

(d) The director or a designee of the director is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(e) Members of the board of governors receive compensation from the corporation and necessary travel expenses according to a policy approved by the director.

(f) A governor, officer, or employee or former governor, officer, or employee of the corporation is not liable for damages or other relief in any action by reason of the person's actions or inactions as a governor, officer, or employee of the corporation, or by reason of the actions or inactions of the corporation, its board of governors, officers or employees unless the person acts with actual knowledge that the person was acting outside the scope of the person's authority, or unless at the time the person was acting for a purpose which the person knew was not in the best interests of the corporation, or with respect to any criminal action the person had actual knowledge or should have known the person's action was unlawful. If a claim or action is brought against a person entitled to the protection of this subsection, the claim or action shall be defended by the state. If it is established that the person was acting with actual knowledge that the person was acting outside the

scope of the person's authority, or at the time was acting for a purpose which the person knew was not in the best interests of the corporation, or with respect to any criminal action the person had actual knowledge or should have known the person's action was unlawful, then the person shall reimburse the state for the cost to the state of the person's defense. (§ 41 ch 102 SLA 1976; am §§ 4, 5 ch 177 SLA 1978; am § 2 ch 103 SLA 1980; am § 1 ch 46 SLA 1982)

Effect of amendments. — The 1980 amendment deleted "of \$100 per day when the board meets" following "the corporation", and added "according to a policy approved by the director", both in subsection (e).

The 1982 amendment substituted "the insurance industry who are authorized or licensed to do business" for "insurance companies authorized" in subsection (a)(3).

Sec. 21.00.040. Corporation plan of operation. (a) Within 30 days after May 29, 1976, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair and reasonable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments to it become effective upon the director's approval. If the board of governors fails to submit a plan of operation, or if at a subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to carry out the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in AS 21.00.050 shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular times and places for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish the procedures for awarding contracts to carry out the provisions of this chapter;

(6) establish the procedures for issuing contracts of insurance as provided in AS 21.00.050 and for the determination of rates;

(7) contain additional provisions necessary for the execution of the powers and duties of the corporation. (§ 41 ch 102 SLA 1976)

Sec. 21.00.050. Powers and duties of the corporation. (a) The corporation shall

(1) in the form approved by the director, issue to all physicians and hospitals who are found to be acceptable risks under standards

developed under (5) of this subsection, and who pay the premiums for it, a contract or contracts indemnifying physicians and hospitals and their employees who are health care providers against loss by reason of liability for covered claims for an act or omission in the delivery of professional health care in this state, and agreeing to tender on behalf of the physicians and hospitals and their employees who are health care providers a defense to a covered claim in a proceeding brought under AS 09.55.530 — ~~09.55.560~~; the limits of liability for policies issued by the corporation shall be approved by the director; the contract shall cover the defense against but need not indemnify liability for punitive damages arising from a covered claim; at the option of the corporation, if approved by the director, and for an additional premium the contract may cover claims against the physician or hospital that arise out of professional services performed by the physician or hospital for any period before the contract is issued, except that coverage will not be provided for a claim already filed or of which the physician or hospital had or reasonably should have had notice at the time the retrospective insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued by the corporation which shall be determined by the board of governors in accordance with AS 21.88.080 and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090, 21.06.120, 21.06.140, 21.06.160, 21.06.250, AS 21.09.180 — 21.09.200, 21.09.250, 21.09.280, AS 21.12.030(b)-(e), AS 21.18, AS 21.21, AS 21.24 and AS 21.36; and shall be exempt from participation as a member insurer in the Alaska Insurance Guaranty Corporation;

(4) carry out the obligations of the contracts issued by the corporation by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(5) establish standards for the acceptability of risks; in establishing these standards the corporation may exclude an applicant for insurance based on individual risk selection factors, but may not exclude an applicant based only on the classification of the applicant.

(b) The corporation may

(1) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services; employees of the corporation are not considered state employees;

(2) negotiate for and procure reinsurance from private casualty insurers or reinsurers for any and all liability incurred by contracts issued by it;

(3) provide coverage to insureds for other hazards customarily included in medical malpractice insurance policies when there is a

finding by the director that this coverage is not available to insureds of the Medical Indemnity Corporation of Alaska in the private insurance market at a competitive price;

(4) borrow or advance funds necessary to carry out the purposes of the corporation;

(5) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(6) sue or be sued in the name of the corporation;

(7) provide risk management advice and services to hospitals;

(8) negotiate and become a party to contracts for management services for the corporation;

(9) perform all other acts necessary and proper to carry out the duties of the corporation;

(10) in a form approved by the director and for an additional premium determined under AS 21.88.080, issue endorsements which provide indemnity for claims not yet reported which arise out of professional services rendered during a period of continuous coverage under the originally issued contract, to physicians and hospitals who pay the premium for it and who are terminating their original covered claims contract with the corporation for a period of not less than one year;

(11) subject to approval by the director, extend coverage to a person, entity, or facility that renders health care services in the state under the supervision of a physician. (§ 41 ch 102 SLA 1976; am §§ 6 — 10, 40 ch 177 SLA 1978; am §§ 3, 4, 7 ch 103 SLA 1980; am §§ 2 — 4 ch 46 SLA 1982)

Reviser's notes. — In 1984, in subsection (a), former paragraphs (4), (5), (6), and (8) were renumbered as present paragraphs (2), (3), (4), and (5), respectively, and, in subsection (b), former paragraphs (11) and (12) were renumbered as present paragraphs (10) and (11), respectively.

Effect of amendments. — The 1980 amendment, in subsection (a), substituted "the limits of liability for policies issued by the corporation shall be approved by the director" for "the minimum limit of liability issued to physicians shall be \$300,000 per occurrence and \$600,000 aggregate liability per year, and the minimum limit of liability provided in contracts issued to hospitals shall be \$300,000 per occurrence and an annual aggregate liability of

\$1,000,000 minimum plus an additional \$20,000 per bed for each occupied bed over 66" near the middle of paragraph (1). The amendment, in paragraph (5) (now (6)) of subsection (a), substituted "an applicant for insurance" for "a physician", "an applicant" for "a physician", and "applicant" for "physician"; and repealed former paragraph (10) of subsection (b) (since deleted).

The 1982 amendment, in paragraph (1) of subsection (a), substituted "corporation, if approved by the director" for "physician or hospital" and substituted "before the contract is issued" for "after December 31, 1974, if the coverage is issued before January 1, 1977." The amendment also rewrote paragraphs (3) and (12) (now (11)) of subsection (b).

Sec. 21.88.055. Termination. (a) If at any time the corporation posts written premiums for two consecutive years of less than 35 per cent of all premiums written in Alaska for physicians' medical malpractice insurance or posts written premiums for one calendar year of less than 20 per cent of all premiums written in Alaska for physicians'

medical malpractice, the director may hold a public hearing in accordance with AS 21.06.180 — 21.06.230 to determine whether the business of the corporation should be terminated.

(b) Upon the effective date of an order of termination issued by the director under (a) and (d) of this section, the terms of the governors appointed under AS 21.88.030 expire, and the corporation, its governors, officers and employees are relieved of all further liabilities for all their obligations to the creditors and policyholders of the corporation, and the business of the corporation shall be liquidated according to AS 21.78.

(c) At any time after termination of the corporation by the director, the director may, after public hearing held in accordance with AS 21.06.180 — 21.06.230 and (d) of this section, order reactivation of the corporation if the director finds that malpractice insurance is unavailable for physicians and hospitals on the voluntary market. The business of the corporation shall commence operation upon appointment by the governor of new governors to the board.

(d) In determining whether to terminate or reactivate the business of the corporation the director shall consider the following:

- (1) the level of expected premiums and losses for continued operation;
- (2) the requirement for state funds to support continued operation;
- (3) the availability of alternative markets for coverage to a substantial majority of physicians and hospitals in the state;
- (4) the costs of continued operation of the corporation;
- (5) the impact that the continued operation of the corporation will have on rates charged for coverage by the corporation or by alternative markets; or
- (6) the expected number of physicians or hospitals who would participate if the operations were continued.

(e) If after public hearing held in accordance with (a) and (c) of this section the director determines that continuing the business of the corporation would result in substantial underwriting loss unless excessive premiums are charged to participating physicians and hospitals, the director may order termination of the corporation. (§ 11 ch 177 SLA 1978)

Sec. 21.88.080. Premium tax. (a) The corporation shall pay a premium tax in the amount of one and one-half per cent of the total direct premium income received by the corporation during the year ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premiums, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. The tax shall be paid to the director annually before April 1 of each year.

(b) The corporation is exempt from taxation under this section for a period of five years starting from July 1, 1978. (§ 41 ch 102 SLA 1976; am § 12 ch 177 SLA 1978)

Sec. 21.88.070. Statistics. The corporation shall collect, maintain and report information concerning claims against health care providers which it insures. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, a report that becomes available to the public may not include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All statistics including the supplemental reports shall be made available to the State Medical Board. (§ 41 ch 102 SLA 1976; am § 14 ch 177 SLA 1978)

Sec. 21.88.080. Rates. The rates and rating plans used by the corporation for the policies issued shall be determined by license category of health care providers in accordance with all of the following:

- (1) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;
- (2) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which is actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for covered claims reported and unpaid, reserves for covered claims incurred during the policy period and not reported, and reasonable expenses for the operation of the corporation;
- (3) rates shall not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including covered claims paid, reserves for covered claims reported and unpaid, reserves for covered claims incurred during the policy period and not reported, and reasonable expenses for the operation of the corporation;
- (4) rates may not be unfairly discriminatory;
- (5) rates shall be adjusted annually;
- (6) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation as developed for the preceding four policy years;

(7) in considering losses to be incurred, changes in the law, national, regional or local trends in medical negligence awards, and other relevant factors may be considered;

(8) income from the investment of reserves shall be considered;

(9) individual risk underwriting factors shall be considered;

(10) disciplines and classifications within the license categories of health care providers shall be considered;

(11) amounts sufficient for repayment of loan obligations shall be considered;

(12) if the earned premiums of the corporation for any given year are less than the incurred claims, claim expenses, underwriting expenses, reserves for that year and provision for repayment of any loans, the corporation may, subject to the prior approval of the director, levy an assessment upon the insureds who held policies during that year; the assessment, which may be made in periodic installments, shall be made within three years and may not exceed 150 per cent of the insured's premium for that year; the termination of any policy does not relieve the insured of contingent liability for the insured's proportionate share of the obligations to the corporation which accrued while the policy was in force;

(13) if the earned premiums of the corporation for any given year exceed its incurred claim expenses, underwriting expenses, reserves for that year and provision for repayment of any loans, the corporation may, subject to the prior approval of the director, apportion and pay or credit its insureds who held policies during that year; a payment or credit shall be proportionate to the insured's earned premium for that year;

(14) upon application by any person, the director may issue a certificate authorizing the corporation to extinguish all or a portion of an assessment levied, or which could be levied, under (12) of this section for all insureds with policies in force when the certificate is issued, and to omit provisions levying an assessment under (12) of this section in all policies delivered or issued for delivery after the certificate is issued, if the director determines that there is a sound actuarial basis for the extinguishment; the director may at any time revoke the certificate; a policy in force at the time of revocation is not subject to the revocation of the certificate for the remainder of the period for which the premium has been paid, but after revocation a policy may not be issued or renewed without providing for an assessment of the insured. (§ 41 ch 102 SLA 1976; am §§ 13, 15, 40 ch 177 SLA 1978; am § 5 ch 103 SLA 1980; am § 5 ch 46 SLA 1982)

Reviser's notes. — In 1984, former paragraphs (1), (3), and (14), repealed in 1978, were deleted and the remaining paragraphs were renumbered accordingly.

Effect of amendments. — The 1980

amendment substituted "insured" for "physician's" near the middle of paragraph (15) (now (13)).

The 1982 amendment rewrote paragraph (17) (now (14)).

Sec. 21.88.090. Payment of premiums; cancellation of insurance. The corporation may provide for installment payment of premiums in which each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice of cancellation. Cancellation is not effective until 30 days after the date notice is posted by the corporation. (§ 41 ch 102 SLA 1976)

Sec. 21.88.095. Transfer of corporate assets and liabilities. (a) The corporation may, subject to the prior approval of the director, transfer its assets and liabilities to a company which meets all of the following conditions:

(1) the company possesses a valid certificate of authority to transact casualty insurance business in the state; in evaluating the capital and surplus of the company for qualification for a certificate of authority, the value of the assets and liabilities transferred by the corporation may not be considered;

(2) the company pays to the corporation the full value of any surplus in the corporation not represented by any unrepaid proceeds of loans by the loan fund to the corporation;

(3) the company executes a complete reinsurance and hold harmless agreement in a form approved by the director covering all of the obligations of the corporation to its creditors and policyholders; and

(4) the company executes modifications of loan agreements with the loan fund by which the company agrees

(A) to assume the obligations;

(B) that, if at any time the company writes less than the premium levels provided in AS 21.88.065(a), the director may determine that the loan provisions shall be modified to provide a scheduled amortization repayment of the principal over a period not to exceed 10 years and at an interest rate of four points above the federal discount rate, as that rate is adjusted from time to time; and

(C) that the provision for repayment provided in AS 21.88.210(b)(1) shall be modified to provide for annual installments of at least 25 per cent of the excess of premium and investment income collected over the total of claims, reserves and expenses on the Alaska medical malpractice book of business or 25 per cent of the excess of premiums and investment income collected over the total of claims, reserves and expenses on the corporation's total book of business, whichever is greater;

(5) the company meets such other requirements as the director may reasonably require to protect the interests of the state, the health care provider insureds, the involved company, and the public;

(6) the company provides the board of governors with a written statement from the director that the company qualifies under (1) — (5) of this subsection.

(b) If and while the company to which the assets and liabilities of the corporation are transferred in the manner provided in (a) of this section continues to write premiums in excess of the levels provided in AS 21.08.055, it shall enjoy the benefit of the following provisions:

(1) the company is entitled to carry forward and offset against its premium tax obligation to the state the amount by which the aggregate claims paid on reinsurance assumed under (a)(3) of this section exceeds aggregate reserves on the same business established at the date of the reinsurance agreement; and

(2) the obligation to repay to the loan fund loans assumed by the company at the time of transfer of the assets and liabilities of the corporation need not be shown as a liability on the books of the corporation. (§ 16 ch 177 SLA 1978)

Secs. 21.08.110 — 21.08.180. *Joint Underwriting Association.*
(Repealed, § 40 ch 177 SLA 1978.)

Article 2. Loan Fund.

Section

210. Fund established

Sec. 21.08.210. Fund established. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans may be made from the fund to the corporation upon certification by the director that a loan is necessary and under the following circumstances:

(1) to provide surplus in respect to policyholders which may not exceed a total of \$3,000,000 outstanding at any time; these obligations shall be subordinated to all other obligations of the corporation; loans made under this paragraph shall be repaid to the fund in annual installments of at least 25 per cent of the excess of premiums earned over the total of claims, reserves, expenses, and assessments made by the association, if any; interest shall be paid on the outstanding balance at a rate equal to seven per cent a year;

(2) if the director determines that the corporation is unable to procure reinsurance from a private casualty insurer or reinsurer for any liability incurred by contracts issued by it, additional loans up to an aggregate of \$6,000,000 when taken together with loans made under (1) of this subsection to compensate for fluctuations in loss experience; loans made under this paragraph shall be in parity with all other obligations of the corporation except that they shall be subordinated to obligations of policyholders and claimants for indemnity of loss; these loans shall be repaid within five years at an annual interest rate of six per cent.

(c) If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund as evidence of the loan.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals \$6,000,000. (§ 41 ch 102 SLA 1976; am §§ 17, 18 ch 177 SLA 1978; am § 6 ch 103 SLA 1980)

Effect of amendments. — The 1980 "collected" near the middle of paragraph amendment substituted "earned" for (1) of subsection (b).

Article 4. General Provisions.

Section

900. Definitions

Sec. 21.08.900. Definitions. In this chapter

(1) "chiropractor" means a person licensed under AS 08.20;

(2) "continuous coverage" means one or more successive policy periods which is uninterrupted by cancellation or failure to renew for any reason;

(3) "corporation" means the Medical Indemnity Corporation of Alaska;

(4) "covered claim" means

(A) a claim by an injured patient reported to the corporation during the period of continuous coverage by the corporation of the insured health care provider for an act or omission in the delivery of health care services; and

(B) additional claims as defined in the policy, with the prior approval of the director, and which are reported within specified periods after the expiration of the policy;

(5) "dental hygienist" means a person licensed under AS 08.32;

(6) "dentist" means a person licensed under AS 08.36;

(7) "dispensing optician" means a person licensed under AS 08.71;

(8) "governor" means a member of the board of governors of the Medical Indemnity Corporation of Alaska;

(9) "health care provider" means 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 licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; a hospital as defined in AS 18.20.130, including a governmentally owned

or operated hospital; a corporate entity covered under AS 21.88.050(b)(11); an employee of a health care provider acting within the course and scope of employment;

- (10) "hospital" means an institution licensed under AS 18.20;
- (11) "nurse" means a person licensed under AS 08.68;
- (12) "optometrist" means a person licensed under AS 08.72;
- (13) "pharmacist" means a person licensed under AS 08.80;
- (14) "physical therapist" means a person registered under AS 08.84;
- (15) "physician" means a person licensed under AS 08.64;
- (16) "psychologist" and "psychological associate" means a person licensed under AS 08.88. (§ 41 ch 162 SLA 1976; am §§ 19, 20, 40 ch 177 SLA 1978; am § 6 ch 46 SLA 1982)

Revisor's notes. — Reorganized in 1984 to alphabetize the defined terms.
Effect of amendments. — The 1982 amendment deleted "during the same period of continuous coverage" following "delivery of health care services" in paragraph (17)(A) (now (4)(A)).

Chapter 89. Miscellaneous Provisions.

Section

- 18. Settlements
- 28. Required motor vehicle coverage
- 30. Payment
- 48. Eye care under health and accident insurance

Section

- 58. Arson information
- 68. Medicare supplemental insurance

Sec. 21.89.010. Settlements. A settlement made under a motor vehicle liability insurance policy of a claim against an insured arising under that policy from an accident or other event insured against for damage to or destruction of property owned by another person shall not be construed as an admission of liability by the insured, or the insurer's recognition of that liability, with respect to any other claim arising from the same accident or event. The settlement shall be inadmissible in evidence in any legal action. (§ 1 ch 123 SLA 1966)

Sec. 21.89.020. Required motor vehicle coverage. (a) An automobile liability policy that insures an owner or operator of a motor vehicle against loss resulting from liability for bodily injury or death, or for property injury or destruction, or both, that is sold in the state, shall contain limits in at least the amount prescribed for a motor vehicle liability policy in AS 28.20.440 and AS 28.22.010.

(b) This section may not be construed to apply only to automobile liability policies obtained to satisfy a requirement of AS 28.20.

(c) An insurance company offering automobile liability insurance in this state for bodily injury or death shall offer coverage prescribed in AS 28.20.440 and 28.20.445, or AS 28.22.010 — 28.22.130, with limits equal to at least the limit purchased voluntarily to cover the insured person's liability for bodily injury or death, for the protection of the

persons insured under the policy who are legally entitled to recover damages for bodily injury or death from owners or operators of uninsured or underinsured motor vehicles. The limit written may not be less than the limit in AS 28.20.440 or AS 28.22.010.

(d) An insurance company offering automobile liability insurance in this state for injury to or destruction of property shall offer coverage prescribed in AS 28.20.440 and 28.20.445, or AS 28.22.010 — 28.22.130, with limits not less than those prescribed in AS 28.20.440 or AS 28.22.010, to cover the insured person's liability for injury to or destruction of property, for the protection of the persons insured under the policy who are legally entitled to recover damages for injury to or destruction of the covered motor vehicle from owners or operators of uninsured or underinsured motor vehicles.

(e) The coverage required under (c) and (d) of this section may be waived in writing by the insured in whole or in part. After selection of the limits by the insured or the exercise of the option to waive the coverage in whole or in part, the insurer is not required to notify any policy holder in any renewal, supplemental or replacement policy, as to the availability of the coverage or optional limits, and the waived coverage may not be included in any renewal, supplemental or replacement policy. The insured may, at any time, make a written request for additional coverage or coverage more extensive than that provided on a prior policy. (§ 1 ch 105 SLA 1966; am §§ 2, 3 ch 70 SLA 1984)

Revisor's notes. — Subsections (a), (c) and (d) of this section are amended effective January 1, 1989 by §§ 18-30, ch. 70, SLA 1984. Until 1989, for the text of the subsections as amended by §§ 18-30, ch. 70, SLA 1984, see those provisions in the Temporary and Special Acts.

Effect of amendments. — The 1984 amendment, effective January 1, 1985, added subsections (c)–(e) and, in subsection (a), deleted "after January 1, 1980, by an insurance carrier authorized to transact business in this state" following "state," substituted "AS 28.20.440 and AS 28.22.010" for "AS 28.20.440(b)(2), and meet the requirements of AS 28.20.440(b)(3) unless waived as provided

in that paragraph," and made a series of related technical changes.

Editor's notes. — Prior to January 1, 1985, subsection (a) read as follows: "An automobile liability policy that insures an owner or operator of a motor vehicle against loss resulting from the insured's liability for bodily injury or death, or for property injury or destruction, or both, which is sold in this state after January 1, 1980, by an insurance carrier authorized to transact business in this state, shall contain limits in at least the amount prescribed for a motor vehicle liability policy in AS 28.20.440(b)(2), and meet the requirements of AS 28.20.440(b)(3) unless waived as provided in that paragraph."

NOTES TO DECISIONS

This section does not require stacking in the single policy context. This conclusion follows from the fact that uninsured motorists insurance may be waived in Alaska. *Curran v. Fireman's Fund Ins. Co.*, 383 F. Supp. 712 (D. Ala. 1975).

Insured was allowed to "stack" the uninsured motorists coverage provided

him in a single multivehicle policy where the insured, under the interpretation of the contract propounded by the insurer, would receive absolutely no additional coverage for his premium dollars paid for uninsured motorists coverage on the vehicle other than the one involved in the accident and where the only possible interpretation of the contract was that the

ATTACHMENT G

WHAT STATES SHOULD DO--
DIFFERENT VIEWS ON TORT, INSURANCE REFORMS

from State Government News
Council of State Governments
March/April 1986

State Government News

The Council
of State
Governments



March / April 1986

THE LIABILITY CRISIS: Who's To Blame?

Shelton
Reference Library
State Capitol

What States Should Do— Different Views on

A Small Business View

Tort Reforms

• Develop alternative dispute resolution mechanisms.
• Limit class action suits.
• Abolish contributory negligence.
• Clarify comparative negligence to require an established level of fault to trigger liability.
• Cap lawyers' fees or adopt a sliding scale.
• Streamline the discovery process.
• Cap or limit prejudgment interest awards.
• Develop even-handed jury instructions.
• Cap or limit noneconomic and punitive damages.
• Uniform national product liability legislation or comprehensive state reform.
• Cap or modify joint and several liability.
• Streamline jury awards.
• Limit liability in dram shop cases.
• Reserve the exclusive remedy doctrines in workers' compensation and abolish co-employee and dual capacity suits.
• Offset collateral source awards or inform juries of collateral sources.
• Require the judge, rather than the jury, set dollar amounts in damages.
• Cap damages in installments.
• Streamline pre-trial proceedings.
• Require plaintiffs pay defendants' attorney fees when litigation is frivolous or if court awards are less than offered settlements.

Insurance Reforms

• Review mandatory insurance coverage imposed by government, excluding workers' compensation.
• Establish state reinsurance programs.
• Require state governments to underwrite insurance if coverage is unavailable in the private sector.
• Require businesses to establish risk retention pools for certain types of insurance coverage.
• Require state workers' compensation funds to offer other types of liability coverage.
• Prohibit mid-term cancellation of policies except for good cause.
• Require advance notice of nonrenewal of insurance.
• Require prior approval of insurance rates by state regulatory agencies.
• Require or encourage insurance companies to establish Self-Insurance Assistance Programs (SIAPs).
• Compare made versus non-made policy forms.

- Require insurance companies to form assigned risk pools to force insurers to provide coverage.
- Eliminate barriers to financial institutions entering the insurance business.

Source: Wayne L. Campbell, National Federation of Independent Business. NFIB does not necessarily endorse any of these proposed solutions.

The Health Professions' View

Tort Reforms

- Require medical expert witnesses to be teachers or practitioners and not experts for hire.
- Require itemizing of economic damages.
- Cap medical malpractice awards and require court review of excessive awards.
- Require pretrial screening of claims filed.
- Admit evidence of funds from other sources.
- Limit or adopt a sliding scale for attorney contingency fees.
- Apportion liability based on degree of negligence.
- Ban requests for specific dollar amounts.
- Require plaintiffs to pay court costs in case of frivolous claims and untrue allegations.
- Require a health professional's affidavit with filing of a malpractice complaint.
- Permit nonbinding arbitration.
- Permit payment of future damages on a periodic basis rather than a lump sum.
- Adopt a two-year statute of limitations on medical malpractice and related suits.
- Require notice of intent to sue.

Discipline, Regulation

- Require hospitals to conduct risk management programs.
- Require hospitals to report disciplinary actions and potential malpractice physicians.
- Establish a Patient's Compensation Fund to finance awards in excess of \$100,000.
- Require health care providers to carry malpractice insurance coverage.
- Require insurance companies to document that the increase in malpractice premiums is supported by claims experience.
- Require the state medical board to investigate reports of possible malpractice.
- Require continuing medical education.

Tort, Insurance Reforms

- Increase physician license fees to support disciplinary efforts

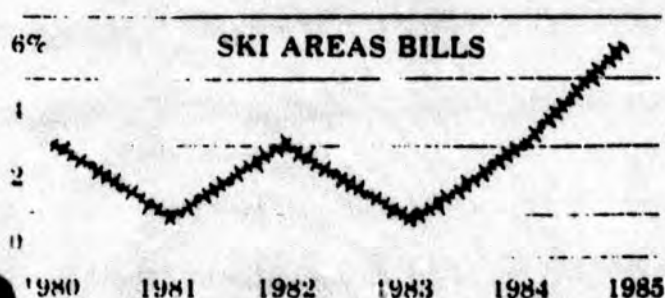
Source: The State Issues Forum of the American Hospital Association and the American Medical Association's model state laws. Note: This is a combined and abbreviated listing. The two group's individual recommendations differ in various details.

A Consumer View

- Repeal statutes that prohibit businesses and consumers from joining together to buy insurance in groups so that the price of liability insurance will fall.
- Prohibit rate increases from taking effect until such increases are approved by the insurance commission. Because insurance commissions do not have the staff to analyze many rate filings, most increases automatically take effect.
- Allow greater consumer representation before regulatory bodies. States should authorize citizens insurance boards or offices of public advocates to intervene in rate cases. In New Jersey, the insurance company seeking the rate increase pays the public advocate's cost.
- 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 help bring down premiums for medical malpractice insurance.
- Enact tough conflict-of-interest statutes to close the "revolving door" of state regulators with the industry.
- Require that insurance companies disclose their loss data on a line-by-line basis. Disclosure would enable regulators to better discern whether rates are excessive, inadequate or unfairly discriminatory.
- Establish state reinsurance programs.

Source: The National Insurance Consumer Organization

Higher Premiums Mean Higher Costs Percentage of gross income spent on premiums.



Source: National Ski Areas Association

An Insurance View

Tort Reforms

- Use arbitration and mediation as an alternative lengthy and costly litigation.
- Make modified comparative negligence, where plaintiffs recover only if their negligence is less than the defendants', the standard instead of pure comparative negligence, which allows recovery even if plaintiffs are more responsible for their injuries than the defendants.
- Replace joint and several liability, which can hold a defendant who is only marginally responsible for injuries liable for the full amount of damages. Current courtroom tactics seek out "deep-pocket" defendants by their ability to pay.
- Restore state-of-the-art defenses. Judge product manufacturers and professionals by standards in effect at the time a product was made or an action was taken.
- Repeal the collateral source rule and allow the introduction of evidence of other sources of damage payments to plaintiffs.
- Abolish or reduce punitive damages which have become windfalls for plaintiffs and their attorneys. Punitive damages are a criminal-trial punishment mechanism.
- Place ceilings on noneconomic damages. These damages include "pain and suffering," "loss of consortium," "loss of companionship," among others. Plaintiffs' actual damages, such as lost wages and medical expenses, would not be affected.

Market/Regulatory Actions

- Adopt a "claims-made" general liability policy which would cover only claims made during the term of the policy.
- Balance the rights of consumers with the insurers' need to reach changes in risk or financial status in covering cancellations, nonrenewals and policy changes.
- Set up Marketing Assistance Programs as a short-term means of making certain lines of coverage more available. Insurance buyers should monitor and minimize losses in hard-to-insure lines, to improve chances of obtaining coverage.
- Recognize that risks posed by toxic substances, asbestos and chemical wastes are too difficult for the private insurance industry and group self insurance to cover. It is impossible for the insurance industry to cover these exposures under the current liability rules, and these risks may have to be funded by public revenues.

Source: The Alliance of American Insurers, including the voices of the American Insurance Association and the National Association of Independent Insurers

What States Are Considering To Solve the Insurance Liability Crisis

Regulatory Initiatives

Prohibitions and restrictions on midterm cancellations and nonrenewals.
 Requiring prior approval of rates rather than file and use arrangements.
 Joint Underwriting Associations.
 Market Assistance Plans.
 Modification of open competition rating acts.
 Upgrading state insurance department manpower and resources.
 Requiring rates to reflect loss experience.
 "Claims made" rather than "occurrence based" policies.
 Improved regulation of new entrants.
 Regulation of surplus line providers.
 Requiring submission of data regarding incidence and verity of claims losses.
 Lowering "surplus" ratios for specific lines of coverage.
 Limiting the percentage amount which an insurer can vary rates from the fixed rate.

Risk Management

Establish risk retention pools for certain lines of coverage.
 Strengthen disciplinary procedures in all state agencies governing professions.
 Enhance hazard management and public safety.
 Strengthen risk assessment techniques.

Marketplace Intervention

Limit policy exclusions.
 Authorize banks and thrifts to engage in insurance activities.
 Review the need for mandatory coverage and mandated amounts of coverage.



Refiners won't touch toxic cleanup.

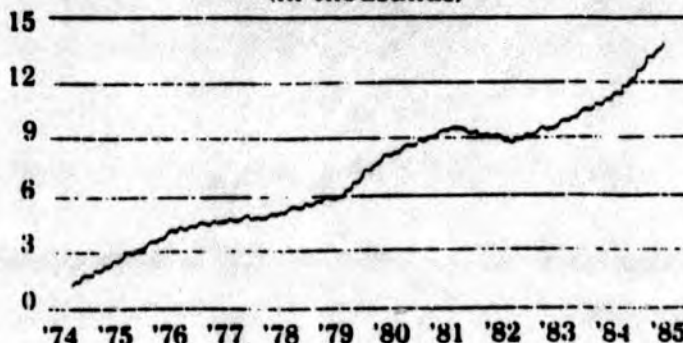
- Restrict annual premium increases/decreases based on evidence of change in risk.
- Require notice to insureds regarding cancellations and/or nonrenewals.
- Provide excess profits standards.
- Establish or expand risk pooling authority.
- Establish or expand state reinsurance, backup insurance and self-insurance programs.
- Prohibit surplus line providers unless appropriately licensed.

Tort Reforms

- Establish courts of claims to hear suits against government defendants.
- Establish pretrial screening panels to determine validity of suits.
- Impose penalties for filing frivolous suits.
- Abolish/limit prejudgement interest awards.
- Cap noneconomic and punitive damages.
- Cap attorneys' fees.
- Abolish or modify the collateral source rule and joint and several liability.
- Authorize structured settlements and itemized jury verdicts.
- Redefine standards of care.
- Revitalize a restricted form of sovereign immunity.
- Modify statutes of limitation.
- Authorize judges only to determine damage and award amounts.
- Adopt comparative negligence standards.
- Limit the discovery process.

Source: Statement by Vermont Rep. Edward R. Zuccaro on behalf of the National Conference of State Legislatures before the U.S. House Subcommittee on Commerce, Transportation and Tourism. NCSL does not necessarily endorse any of these proposed solutions.

Litigation Explosion Product Liability Lawsuits (in thousands)



Source: Administrative Office of U.S. Courts

The number of product liability lawsuits filed in U.S. district courts has risen more than eight-fold since 1974.

ATTACHMENT F

CAN ANY OF THESE LAWS SOLVE THIS PROBLEM?

CONFERENCE OF INSURANCE LEGISLATORS
TASK FORCE ON AVAILABILITY AND AFFORDABILITY
OF LIABILITY INSURANCE

NOVEMBER 11, 1986

6. ARBITRATION

PURPOSE:

To speed settlements and lower court costs, legislators have established panels which hear arguments and render decisions and awards in "uncomplicated cases."

BACKGROUND:

Arbitration has been one of the most talked of remedies in regard to easing liability insurance problems but only three responding states, Michigan in 1975,⁸⁵ Washington in 1979,⁸⁶ and Utah in 1983⁸⁶ established arbitration in medical malpractice cases. In each, Insurance Department sources believed the measure to have been ineffective.⁸⁷ Utah raised its arbitration threshold to \$2,500 in 1985.⁸⁸ It is too early to judge the results.

SUB-SUMMARY:

No definite beneficial results to date.

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	0	0	6	1	7
AFFORDABILITY	0	0	6	1	7

IV.

INSURANCE REFORMS

Insurance reforms generally fall under two headings: those that intervene in the insurer's decision making process, such as laws that prohibit cancellation and non-renewal, and those that allow greater freedom to buyers and/or insurers or others to arrange for coverage outside traditionally regulated insurance structures.

12. NON-CANCELLATION/NON-RENEWAL AND NOTICE OF POLICY TERMINATION REQUIREMENTS

PURPOSE:

To cut down the exposure and/or disruption of business caused by sudden cessation of liability coverage, many states have enacted laws to bar mid-term cancellation, non-renewal, and provide advance notice that coverage stopped well in advance of the termination date.

BACKGROUND:

Nearly all non-cancellation laws enacted before 1986 applied only to personal lines. In general, the experience has been that when underwriters are forced to retain a risk they become very selective about the risk they accept. That has the effect of assuring reasonably priced coverage to good risks while forcing high risks into assigned risk and FAIR plans.

Oregon, in 1985, adopted a noncancellation/non-renewal rule covering all commercial insurance.¹³⁵ It is too early to judge its long term effectiveness in terms of availability and affordability.

However, Maryland enacted a non-cancellation law in 1973.¹³⁶ But, according to the Maryland Insurance Department, the law has provided no availability or affordability change in the 12 years since its enactment.¹³⁷

Nevada tried to accomplish the same thing by regulation,¹³⁸ with no definitive results.¹⁴⁰

Notification that the insurer intends to get off the risk has been effective in relieving commercial auto liability insurance problems in Indiana and Hawaii.¹⁴⁰ But, Maryland enacted just such a law¹⁴¹ and Department sources say it brought "no change."¹⁴²

SUB-SUMMARY:

There is too little commercial insurance experience on which to draw to know how effective non-cancellation policies will be in making non-personal liability coverage available and affordable.

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	4	2	5	3	14
AFFORDABILITY	0	3	7	4	14

13. AUTHORIZING GROUP INSURANCE

PURPOSE:

To end the prohibitions against sales of group insurance which affords economies of scale in marketing and in shared claims information and loss experience, legislation has been proposed authorizing corporations, governments or professionals to buy group insurance.

Washington, has authorized group professional and commercial insurance. Washington's law¹⁴³ has been perceived as effective in encouraging availability of medical malpractice and government liability, as well as for cooperative and fraternal insurance, according to legislative respondents.¹⁴⁴ The measure has also been judged effective in helping make government liability rates affordable.

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	1	3	2	6	12
AFFORDABILITY	0	1	4	7	12

14. AUTHORIZING POOLS

PURPOSE:

To allow an opportunity to self-insure and realize economies of scale through pooling their own risks, legislation has authorized municipalities and others to pool their risks.

BACKGROUND:

Municipalities and others have flocked to join pools or form new ones to share risks because they cannot find or afford coverage and don't want to self-insure alone.¹⁴⁵

WHAT WORKED:

Early reports indicate large savings from what they had been paying for liability coverage.¹⁴⁶ In Tennessee, legislative sources report that a pooling measure¹⁴⁷ proved "very effective" in regard to medical malpractice and "effective" in regard to the affordability and availability of government liability insurance.¹⁴⁸

Michigan Department sources believe the state's 1982 pooling statute eased the problems in 1985-86.¹⁴⁹

But in Utah, State Insurance Department sources view pooling legislation enacted in 1976¹⁵⁰ as having affected "no change" in the availability or price in any major line of liability insurance.¹⁵¹

SUB-SUMMARY:

In general, pools have been effective. Buyers have obtained high amounts of coverage in a single policy. Pools have enabled smaller municipalities to insure at rates lower than those that would otherwise

be available to them on a individual basis. The question: do pool managements have what it takes for the long haul? They had better because they are without guaranty fund protection. And while they essentially are self-insurance mechanisms the real challenge can be in paying third party claims -- where the beneficiary is not a pool member.

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	2	5	3	4	14
AFFORDABILITY	2	3	5	4	14

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wise

15. BROADENED SELF INSURANCE AND CAPTIVES

To allow more opportunities for self-insurance, three states have authorized the setting up of captive insurance companies which can be in-house insurers (pure captives) or entities which serve the insurance needs of several companies, generally in the same business (association captives).

BACKGROUND:

Captives are providing cover now for an estimated 2200 U.S. corporations.¹⁵² The number of U.S. owned captives has increased from some 1250 in 1980.¹⁵³ No one knows or will say how many commercial premium dollars have been diverted from the normal insurance market into captives and other forms of self-insurance but, according to one industry source, close to one-third of commercial premium dollars have gone the self-insurance route.¹⁵⁴

Most captives are located overseas and have been providing coverage without the help of one single state legislative act.

WHAT WORKED BEST:

Vermont,¹⁵⁵ Colorado,¹⁵⁶ and Tennessee¹⁵⁷ have authorized captive formation.

Vermont premium volume had increased to \$47 million by year end 1985, up from \$22 Million in 1984 and from \$13 million in 1983.¹⁵⁸ Some of the largest U.S. corporations including Boeing Aircraft Co, CitiCorp and Westin Hotel Co. contributed to that volume.¹⁵⁹

WHAT WORKED LESS:

Colorado captive activity has leveled,¹⁶⁰ with no new captives formed last year.¹⁶¹ Still the law, like Vermont's, cannot help but be judged effective in easing availability and affordability problems. Colorado 1985 premium volume was \$49.2 million.¹⁶²

ONE REASON WHY:

Sources point to the fact that Vermont's requirements are less stringent.¹⁶³ Its capitalization requirements are low compared to the other two states with single parent captives needing capital and paid-in surplus of \$250,000 and association captives, \$500,000. Both Colorado and Tennessee requiring \$750,000 for one company captive and \$1 million for groups.¹⁶⁴

CAUTION:

When it comes to captives and self-insurance the effectiveness of state law has to be qualified because the "insurance" captives provide is not the same as normal insurance. Captives are not required to meet the same state capital and surplus, or financial reporting requirements as normal insurers, although they are subject to state insurance department's oversight. As far as claim payments go, the same caveats that apply to pools apply to captives, especially on third parties' claims. Then the beneficiary may not be within the captive's corporate or association "family." Also the comfort factor is less. Guaranty Fund legislation does not cover captives.

SUB-SUMMARY:

From the experience of two states, Vermont and Colorado, it would be difficult to say that these statutes have not been effective in regard to availability and affordability.

Worth considering also, is that when large insurance buyers have the option of going the captive route, it cannot help but make traditional insurers more agreeable to make insurance available at affordable prices.

When it comes to off-shore captives there is no state insurance department regulation at all. Also, in determining the effectiveness of captive laws, insurers have cautioned that the captive management has not lived through the ups and downs of insurance cycles. At the same time, it is also fair to note the fact that the management of many captives is handled by some of the world's largest insurance brokerage with long histories in the insurance business. Captives may be only as good as their own money and someone else's ability to manage it.

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	0	2	1	1	4
AFFORDABILITY	0	2	2	0	4

16. JOINT UNDERWRITING ASSOCIATIONS

PURPOSE:

To provide for coverage of risk that individual insurers do not want to cover, joint underwriting associations have been authorized. In regard to liability insurance in responding states, they have mainly, but not exclusively, been used in medical malpractice.¹⁶⁵

BACKGROUND:

By their nature joint underwriting associations cannot help but make insurance more available than it would be without them.

WHAT WORKED:

Both Insurance Department and legislative sources in responding states which adopted them, view them as "very effective."¹⁶⁶ Responding states reported that of 28 JUA laws and statutory applications, 14 were perceived as being either "very effective" or "effective" in regard to availability,¹⁶⁷ and 12 were perceived as being either "very effective" or "effective" in regard to affordability. Most applications were in medical malpractice.¹⁶⁸

Obviously, medical malpractice JUAs have not helped "lower" premiums prices, especially in medical malpractice.¹⁶⁹ Some sources point out, however, that JUAs have helped make the insurance more "affordable" than it would have been without them.¹⁷⁰

Question: does what makes insurance more affordable for health care providers, make it not affordable for insurers, their policyholders, and the society? Answer: Yes. Insurance industry sources say JUAs were

designed to be self-supporting,¹⁷¹ but earlier this year most of the 12 JUA's in the nation were facing large deficits.¹⁷² Some wanted to expand their "base" by increasing their membership.¹⁷³ In other words, they were seeking subsidization from other insurers through legislation. Relatedly, physicians mutuals which wrote "long-tail" coverages have flirted with insolvency.¹⁷⁴ Among the most troubled has been Medical Liability Mutual Insurance Company (MLMIC) in New York, whose "shortfall" was close to \$750 million.¹⁷⁵

SUB-SUMMARY:

JUAs have worked for medical malpractice availability. But the price has been very high. And when it comes to making medical malpractice liability "affordable," the first answer has been some form of subsidy.

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	6	8	9	5	28
AFFORDABILITY	6	6	11	5	28

CONCLUSION ON INSURANCE REFORMS:

Non-cancellation laws are an effective quick fix but can eventually be counter productive. JUAs work very well in assessing coverage, but they involve subsidization of one commercial enterprise by another raising fundamental questions of fairness. So do pools and captives. But with each there is some kind of trade off: Drying up of the normal market in the case of non-cancellation laws and JUAs; less solvency regulation and the third party claims question in the case of pools and captives; and, in the case of offshore captives, there are alien jurisdictions over whom U.S. based insureds and state governments have little regulatory clout in the event of claims disputes and/or insolvencies.

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	13	20	20	20	73
AFFORDABILITY	8	14	31	20	73

135. O.R.S. 836-85001-85040

136. M.I.L 48A, 547A.

137. Response to Question 16, note 3 supra.

138. Nevada Insurance Department Regulations.

139. Note 137, supra

140. H.R.S. 294.9-C; responses to Question 16, note 3, supra.

141. M.I.L. 48A, 547A.

142. Response to Question 16, note 3 supra.

143. Washington Insurance Code 48.62-120W, 1979

144. Response to Question 18, note 3 supra.

Reform

VI.

REGULATORY REFORMS

When it comes to regulatory reforms the question focuses quickly on rating laws. But despite the focus, a wide universe of opinion remains as to which kind of rating law best promotes availability and/or affordability of insurance. In the crisis of 1985-86 it has not been unusual for a legislator and regulator to question the rating law in his or her state and to contemplate the alternative. As Mississippi Insurance Commissioner George Dale said in a follow-up interview:

"All the file and use states are looking at prior approval and all the prior approval states are looking at file and use."¹⁷⁶

At the same time, Commissioner Dale and others who have worked with insurance regulation have for years pointed out that rating laws cannot change prices overall, that premium levels will move where they will regardless of rating laws.¹⁷⁷ But, study has shown that where rate changes do not need government approval or sanction, rates can change more quickly to serve the availability needs of the real world market.¹⁷⁸

17. FILE AND USE/USE AND FILE/NO FILE ("Open Competition")

PURPOSE:

About half the states have laws designed to encourage competitive behavior and allow each company to set the own prices without State approval. The same laws do, however, require that rates not be excessive, inadequate, or unfairly discriminatory.

WHAT WORKS:

Among respondent states which have an open competition rating law, sources in only one, Tennessee,¹⁷⁹ believe its rating statute was effective in promoting availability and affordability of liability insurance.¹⁸⁰

In New York where file and use had been in effect since 1970,¹⁸¹ one legislative source qualified his enthusiasm for the statute this way:

"Open rating, where working, works great, however in a tight market, it has been used to create great instability in the marketplace."¹⁸²

In response to tight markets in the late 1960's, New York switched from prior approval to competitive rating.¹⁸³ In the after shock of price increases and dropped coverages of 1985-86, the State adopted, "flex rating."¹⁸⁴ So has Oregon.¹⁸⁵

And in California where the nation's classic "no file" law, the McBride-Grunsky Insurance Regulatory Act,¹⁸⁶ has been in effect some 40 years, Insurance Commissioner Roxani Gillespie has changed "no file" to "flex file." The Department now requires insurers to submit data

supporting rate increases of more than 25 per cent for liability insurance.¹⁸⁷

In promulgating the new rule, the Commissioner said:

"Historically, competition has been a strong regulatory force--to the benefit of the insurance buying public. However, due to significant operating deficits caused by extreme competition and rapidly increasing loss costs during the early 1980s, commercial liability insurers have imposed, in the last two years, substantial rate increases which have caused hardship in many cases for commercial insureds and their customers. Given these recent conditions, some regulatory method is therefore necessary whereby the Commissioner can be informed in a timely manner of substantial rate increases in commercial liability insurance."¹⁸⁸

(SUB-SUMMARY ON FILE AND USE AND PRIOR FOLLOWS PRIOR APPROVAL SECTION.)

DOES NO LAW WORK BEST?

Ironically, some definite information regarding non-personal liability insurance comes from Illinois, which has no rating law. In Illinois, combined ratios (losses plus expenses divided by premium) for commercial insurance lines, as well as for other liability and medical malpractice lines, show that Illinois insurers of outgo to income is consistently higher than the regional and countrywide ratios.¹⁸⁹ Insurers' losses are as high or higher in Illinois as in other states which have rating laws.¹⁹⁰

In other words, Illinois businesses and professionals are getting more for their money than their neighbors in Iowa, Indiana, Wisconsin, Missouri, and Michigan.¹⁹¹

The following charts track those ratios.¹⁹²

18. PRIOR APPROVAL

PURPOSE:

To meet the same statutory mandate, the laws in some other states provide that the rate changes cannot go into effect without approval of the Insurance Commissioner.

BACKGROUND:

Half the states have prior approval rating laws.

WHAT WORKED:

Sources in only two respondent jurisdictions, Hawaii and Puerto Rico, saw their prior approval laws¹⁹³ as "very effective" in fostering both availability and affordability.¹⁹⁴

WHAT DIDN'T

From that point the cheers subside. Nebraska sources say that the state's prior approval law, in effect since 1947, has produced "no change" in liability insurance availability and/or affordability.¹⁹⁵

In South Carolina, which has had prior approval for the same 40 year period, sources also say there has been no difference from what would have happened anyway.¹⁹⁶

In other jurisdictions, sources did not say if the law had any effect, positive or negative. In three states, Alaska, Washington, and West Virginia, there have been a total of more than a century of rating law years, but no responses as to whether those laws had been effective.¹⁹⁷

SUB-SUMMARY:

In regard to both kinds of laws, recurring availability and affordability crises speak for themselves. Under both forms of law, rates have gone up and insurance prices have risen sharply.

Assessing the past (or future) effectiveness of insurance rating law is not easy.

The sudden skyrocketing of prices beginning in late 1984 proved that insurance buyers could be subject to fearsome increases. But low prices, whether produced from private competition or government suppression, are only one test of a law's effectiveness. Another test is whether the law permits the industry to respond to changes, such as a serious capacity shortage, produced from one or several causes e.g. falling investment yields, underwriting losses, herd driven premium prices. Under more permissive rating laws like the file and use statutes, the industry has been able to begin to restore that capacity rather quickly, albeit painfully, in many cases. Increases such as took place in early 1985, would have been much more difficult and might have not been so widespread under a system where the full exercise of prior approval laws was dominant.

But still another test is the law's ability to discourage irresponsible price cutting or "price war," especially the kind such as took place in the late seventies and the first half of the present decade. While that memory is still fresh it may be worthwhile to note that the possibility of price wars had been dismissed not so long ago. In 1969, as New York began consideration of "open" rating, then New York Superintendent of Insurance Richard E. Stewart wrote:

"Important segments of the insurance industry have urged until recently that if rates were left to the forces of open competition, the economic law of the jungle would apply and produce chaos. They assert that unbridled competition would unleash rate wars and ruinous competitive practices...

"There is no evidence in the past two decades that greater reliance on the forces of the marketplace to set rates results in price wars...."

But the price wars did come, brought on by changes that no one could have predicted when that statement was made nearly 20 years ago. Competitive rating laws did not prevent the price war. But neither did prior approval. Prior approval may be the law in half the states but well over half the states have experienced availability and affordability problems in 1985-86. In rate regulation, the search continues.

FILE & USE

	VE	E	NC	NK/DA	CP	TOTAL
AVAILABILITY	2	3	7	5	4	21
AFFORDABILITY	2	2	8	5	4	21

PRIOR APPROVAL

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	5	0	3	17	25
AFFORDABILITY	3	3	3	16	25

19. FLEX RATING

PURPOSE:

To realize the benefits of sensible competition, while maintaining a degree of control, New York and Oregon have adopted flex rating in nearly all commercial lines and most professional liability lines, except medical malpractice.¹⁹⁸ It is too early to judge the effect.

20. EXCESS PROFITS

PURPOSE:

To keep insurers from taking advantage of their advantage in selling what many consider to be essential to personal, professional, public, and corporate well being, curbs on profits have been proposed.

Nebraska, New York (commercial and private passenger auto), North Carolina and South Carolina have excess profit provisions.¹⁹⁹ Nebraska and New York report that the measures have effected "no change."²⁰⁰ South Carolina sources said the effect was not known.²⁰¹

Few question the value of excess profits provisions. But they can be relied on only where there is adequate funding to investigate, document and prosecute possible abuses.

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	0	0	2	2	4
AFFORDABILITY	0	0	2	2	4

21. INCREASED DATA TO INSURANCE DEPARTMENTS

PURPOSE:

To better understand what is really happening in regard to insurance profits, premiums, losses etc., legislators and insurance commissioners have been asking for more data from insurers.

BACKGROUND:

Many insurance law changes in recent years have included a provision that companies furnish specific data to State Insurance Departments. The legislation seldom, if ever, provides for additional personnel and computer resources to handle the additional data.

WHAT WORKED AFTER A WHILE:

Oregon's experience provides an example. Closed claim data, filed pursuant to the state's 1975 medical malpractice reform law,²⁰² remained unused until the State Medical Association refined the data.²⁰³ Now the sorted and refined data has helped the Department spot and review claim and loss trends and establish a climate where medical malpractice liability insurance is available in the private voluntary market.²⁰⁴ The Oregon Department reports that "there is no availability problem" in medical malpractice insurance in Oregon.²⁰⁵

Sources in Tennessee report that its 1977 law²⁰⁶ requiring the filing of closed claims data to the department was effective in regard to medical malpractice.²⁰⁷

But favorable opinions in regard to increased data are not universal. Michigan reports that information furnished to the Department

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But favorable opinions in regard to increased data are not universal. Michigan reports that information furnished to the Department

in regard to medical malpractice, government and commercial liability yielded "no change."²⁰⁸

SUB-SUMMARY:

Quality data like that produced from closed claim studies can help enhance availability. The key is having the staff and equipment to refine and apply the needed information.

	VE	E	NC	NK/DA	TOTAL
AVAILABILITY	0	3	5	2	10
AFFORDABILITY	0	3	5	2	10

CONCLUSION ON REGULATION:

"Open" rating has enabled the market to recover faster and respond to its environment, with price moving up or down -- as experience has shown all too clearly. But prior approval has not kept rates down for long. It remains to be seen whether flex rating will offer the best -- or worst -- of both worlds. Both excess profits laws and measures requiring increased data can help if legislators provide regulators with the resources for implementation.

	VE	E	NC	NK/DA	CP	TOTAL
AVAILABILITY	7	6	17	26	4	60
AFFORDABILITY	5	8	18	25	4	60

176. Telephone interview with George Dale, Commissioner of Insurance, State of Mississippi, July 1986.

VI.

ADMINISTRATIVE ACTION

In the crisis of 1985-86, several Commissioners were able to effect significant relief in some lines of insurance -- especially when the legislature had already given them the powers they need to bring about industry cooperation.

22. MARKET ASSISTANCE PROGRAMS^{**}

To establish an additional, medium of communication between buyers and sellers of insurance in a tight market, Insurance Commissioners, acting as motivators, have established so called Market Assistance Programs (MAPs).

BACKGROUND:

During the crisis of 1985-1986, Market Assistance Programs have proved themselves an effective catalyst to availability in some lines of liability insurance.

Where MAP programs have been most effective, notably in New Hampshire and North Carolina, the legislature had already passed "stand-by JUA" legislation,²⁰⁹ meaning that the commissioner could mandate the establishment of a JUA to write insurance in a troubled line.

With over 90 per cent of the applications received actually placed, New Hampshire Commissioner Bergeron sees the eventual phasing out of the MAP, with the risks it covers -- municipal, day care, and liquor liability placement going back to the normal market or self-insurance.²¹⁰

North Carolina Commissioner James E. Long reports an equally high percentage of placement of risks handled through his Department's MAP Program.²¹¹

Several respondent states were divided on whether the MAPS were effective.

As with other areas of inquiry, several states declined to offer answers regarding the effectiveness of their MAP programs.

OTHER ADMINISTRATIVE ACTIONS:

In Oregon, Commissioner Josephine M. Driscoll used administrative powers, as noted earlier in this report, to ban cancellations in commercial insurance and to initiate flex rating.

SUB-SUMMARY

There is little question that a MAP can be effective in making insurance available, especially when the Commissioner has a JUA among his persuasive assets. One caution: different MAPs have addressed different lines of insurance in different states. It is also fair to say they have been successful in lines where at least part of the problem was not related to reality but only perception, as has been the case with day-care. No one is beating the drums for proposed MAPs for such real

lingering availability and affordability problems such as hazardous waste, medical malpractice, asbestos removal liability.

208. N.C.I.C. 58-4500-460.

209. Remarks by Louis E. Bergeron, COIL Seminar, note 1, supra

210. Remarks by James E. Long, Insurance Commissioner, State of North Carolina, COIL Seminar note 1, supra.

** The survey responses for MAPs are not included in any above tabulations. Map experience is still very new, while some MAPs may be phased out as the need becomes less acute. However, there is little doubt that standby JUA law, not included in the Questionnaire provides Commissioner with formidable leverage in encouraging insurers to cooperate with MAP programs.

Also worth noting is the fact that from early indications, it is apparent that MAPs have been effective in lines of insurance affecting smaller businesses and institutions such as dram shop and day care liability as distinct from larger long tale and "open ended" risks like hazardous waste liability.



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
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Mail Stop 3100
(907) 465-3991

January 30, 1987

MEMORANDUM

TO: Representative John Sund
ATTN: Shari Kochman
FROM: Penelope Weyhrauch
Legislative Analyst
RE: Federal Government Medical Malpractice Insurance
Research Request 87.097

You asked for information regarding medical malpractice insurance for federal government physicians. Federal government physicians include: physicians working for the U.S. Public Health Service (USPHS), Indian Health Service (IHS) and Veteran's Administration, physicians in the military and physicians in other federal government agencies. According to John Fanning, the Legislative Coordinator with the U.S. Public Health Service, Office of Health Planning and Evaluation, federal government physicians are not covered by malpractice insurance. An individual who is injured by a federal government physician in the normal course of the physician's job requirements may sue the federal government under the Federal Tort Claims Act. When an individual is successful in their claim against the federal government, damages are paid from a fund administered by the U.S. Department of Justice.

Jeffrey Axelrad, Torts Branch Director with the U.S. Department of Justice, confirmed that federal government physicians are protected from individual liability for malpractice by the Federal Tort Claims Act. Mr. Axelrad said that the vast majority of federal government physicians are exclusively protected, which means suing the federal government under the act is the only remedy an injured individual has. A very small percentage of federal government physicians may also be individually liable. Physicians with the U.S. Bureau of Prisons are the largest group of federal government physicians not exclusively protected under the act. An individual with a malpractice claim against a physician not exclusively protected will first sue the federal government and then the physician.

Representative Sund
January 30, 1987
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Claims which exceed \$25,000 are handled by the U.S. Department of Justice. Claims under \$25,000--which represent the bulk of malpractice claims against the federal government--are handled by the U.S. Attorney's Office. Mr. Axelrad said that comprehensive statistics on the number of malpractice claims brought against the federal government are no longer compiled because many different agencies would be required to coordinate records and the cost of compiling and coordination exceeds the value of maintaining such statistics. Although no records of the number of claims filed are available, in 1986, the U.S. Department of Justice settled 154 malpractice claims asking for damages of more than \$25,000. The total settlement cost of these claims was \$33.3 million.

Lawsuits brought against the federal government must be processed through the Department of Justice and are subject to the department's supervision.¹ Mr. Axelrad said that the number of malpractice lawsuits brought against the federal government is increasing annually. He estimated that 400 malpractice lawsuits were brought against the federal government in 1985. In 1986, the number of lawsuits increased to 600. Of the estimated 600 lawsuits in 1986, 52 lawsuits asking for damages of more than \$200,000 were litigated, and a total of \$27.7 million was paid out in settlements for these cases. Many cases take several years to reach settlement and approximately one-tenth of the suits filed are dismissed. Mr. Axelrad said that statistics on malpractice lawsuits handled by the U.S. Attorney's Office are incomplete and difficult to obtain.

In regard to military physicians, I contacted Captain Hughes, Administrator of the Troop Medical Clinic at Elemendorf Air Force Base in Anchorage. Captain Hughes said that military personnel cannot sue the federal government in court if injured by a military physician, and are compensated for service-connected disabilities only. Families of military personnel can sue the federal government under the Federal Tort Claims Act.

* * *

I hope this information is helpful to you. If you have any questions or would like additional information, please contact our agency.

PW

¹Malpractice claims may be filed with agencies and settled without a lawsuit.



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ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

February 19, 1986

MEMORANDUM

TO: Representative Steve Rieger
ATTN: Lisa Rubenstein
FROM: Mark Torgerson *MT*
Legislative Analyst
RE: Insurance and Tort Reform
Research Request 86-089

You asked this agency to address a number of issues on tort reform, including:

- California's cap on medical malpractice damage awards;
- current regulation of insurance premiums in Alaska, and the effect of damage awards on insurance premiums;
- the impact of insurance rates on State commerce;
- the impact of tort claims on the State treasury; and
- tort reform efforts in other states and Congress.

We contacted private insurance companies, the Alaska Department of Insurance, the Alaska Department of Administrations Division of Risk Management, State and national medical associations, the American Trial Lawyers Association, the Insurance Services Office, and the National Association of Insurance Commissioners.

Effect of California's Limit on Damages in Medical Malpractice Cases

California's Legislature enacted the Medical Injury Compensation Reform Act (MICRA) in 1975. As you know, a section of the act limits the dollar damages for noneconomic losses incurred by an injured party in

a medical malpractice suit to \$250,000.¹ According to Ron Neupauer, Underwriting Manager for the Medical Insurance Exchange of California (MIEC), the effect of the section's damage "cap" on jury awards, out-of-court settlements and malpractice insurance rates cannot be easily quantified. Mr. Neupauer explained that the statutory cap was appealed in the courts, and its constitutionality was questionable until the United States Supreme Court recently refused to hear an appeal from the state court, thereby affirming the law's validity. Mr. Neupauer asserted that the provisions in the law were not strictly followed or enforced because of this "constitutional cloud." Mr. Neupauer further stated that the law's effect on the size of damage awards and insurance costs may be discernible in the future.

A recent letter written by Jay Dee Michael of the California Medical Association provides the following information on the size of malpractice awards and on malpractice premiums in California:

	<u>Nationwide</u>	<u>California</u>
Average size of malpractice awards	\$974,000	\$396,000
Premium increase in average policy since 1975	300 percent	150 percent
Premium increase in average policy in 1985	33 percent	15 percent

We contacted Mr. Michael, who was unsure of the year(s) used to calculate the size of the award and the source of the information. We are attempting to verify these data and will forward our findings to you.

The above average shown for California malpractice awards conflicts with data provided by the California Board of Medical Quality Assurance. By law, attorneys, insurers and courts must report malpractice settlements, judgments and arbitration awards of \$30,000 or more to the board. Ms. Joyce Miller, Administrative Analyst for the board, provided data showing that the average award per reported claim increased by 86 percent between 1980 to 1984, from \$153,929 to \$286,301. Because this does not include payments for settlements and judgments less than \$30,000--which usually comprise the majority of claims--these averages overstate the actual average settlement.

Mr. Neupauer stated that MIEC's average annual increase of premium in the state was just under five percent during the past 10 years. He also stated that MIEC also insures doctors in Alaska, Nevada, Idaho and

¹Noneconomic losses in the act include pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.

Representative Rieger
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Hawaii. In these states, the rate of premium increases has been more rapid than those in California, and rates for all of these states but Idaho are now higher than those in California.² According to Mr. Neupauer, the MIEC believes that California's tort reforms "have had a significant moderating effect" on the rate of increase in malpractice premiums for California doctors.³

Regulation of Insurance Rates in Alaska

In response to your request for information on regulation of insurance rates in Alaska, we provided your office with a copy of House Research Agency memorandum 85-239, "Regulation of the Insurance Industry in Alaska." As that memo points out, AS 21.39.010 gives the Alaska Division of Insurance rate-regulating authority. Each insurer must file its proposed rates and supporting data with the division, which can disapprove rates deemed excessive, discriminatory or inadequate to make a reasonable underwriting profit.

In addition, the division allows "deviations" from the approved rates. The majority of insurers are members of an approved rating organization (such as the Insurance Services Office, Inc.), which files standard rates on members' behalf. Alaska Statute 21.39.070 provides that rating organization members may apply to the Division of Insurance for a deviation from the standard rates. The division approves requests for deviations if they meet the same general standards required in rate filings (excessiveness, etc.). According to Don Koch, Chief of Market Surveillance for the division, there is no limit to deviations, but each must be justified by the insurer and approved by the Division of

²Mr. Neupauer stated that the rates MIEC charges Alaska's doctors now exceed MIEC's California rates by an average of 32 percent. At one time, MIEC's rates for Alaska and California were identical.

³"Tort reforms" includes other provisions of the 1975 act. For example, the act provides that evidence of collateral sources of benefits available to the injured party may be admitted by the court. Lawyers argue that this encourages juries to reduce an injured party's award accordingly.

Insurance.⁴ Insurers may request a deviation on all insurance they sell or may limit deviations to a specific class within one line of insurance. According to Richard Block of the Alaska National Insurance Company, many insurers sold insurance below filed rates until recently.

Correlation Between Damage Awards and Insurance Premiums

You asked if there is any correlation between the size of damage awards and insurance premium rates. Insurance companies generally set rates by determining the amount needed to pay for claims and for "loading," which is intended to cover the insurer's sales expense, overhead and profit. Losses include payments for settlements and court-awarded damages. Although the size of damage awards affects the extent of a company's underwriting losses, an insurance company may decide not to adjust premiums if its return on invested funds compensates for the losses.

For example, liability insurance premiums decreased in the late 1970s and early 1980s while underwriting losses during this same time increased steadily. Note, however, that interest rates were at record high levels during this period. Lower interest rates in recent years have reduced investment income causing insurance companies to pay more careful attention to underwriting losses and increasing premiums when underwriting losses are experienced.

Impact of Insurance Rates on State Commerce

You asked us to determine the impact of rising insurance rates on business activity in the state, specifically, the number of jobs lost, businesses closed, or professions changed to reduce liability risks. To the best of our knowledge, there is no method to separate the effects of insurance rates from the effects of other economic factors which influence a business's ability to make a profit. These other factors include the number of competitors, demand for business services, regulatory impacts, and operating costs.

⁴In addition, insurers may request "schedule ratings" which allow further deviation from the rate filing. These deviations apply to specific factors such as safety or business location. According to Mr. Koch, insurers must document and justify deviations allowed buyers. Mr. Koch stated that the division can make field investigations and declare rate law violations for unjustified deviations. Because of staff shortages, the division has made no field investigations during the past two years.

We contacted 13 state commercial air and surface carriers and asked each to assess the impact of insurance rates on their business activity.⁵ One of the 13 companies--Seair--stated that they stopped operations specifically because of unavailability of insurance.⁶ The other companies have continued operations although some have laid off employees who have not normally been laid off. The owners of companies affected by lay-offs stated that these were caused by a number of factors, including increased competition (resulting in less revenue) and rising operating costs. In addition, all of the contacted companies stated that insurance costs were a major factor affecting operating costs.⁷

We contacted Martha MacDermaid, Executive Director of the Alaska State Medical Association (ASMA), to ascertain the impact of insurance costs on the medical profession. Ms. MacDermaid stated that the ASMA recently surveyed members to determine the effect of insurance costs on business. Although the results of the survey are incomplete, Ms. MacDermaid stated that some obstetricians are quitting the obstetric practice because of insurance costs. Moreover, some doctors have "gone bare," that is, they have decided to practice without insurance protection. We will send the results of the ASMA survey when it is received.

Impact of insurance rates on tourism. Like other businesses, those involved in tourist-related enterprises (boating, aviation) are paying more for liability insurance than was required in prior years. Some of these businesses cannot get the amount of coverage which they previously purchased; others cannot afford it. According to Mr. Hank Rust of Rust's Air Taxi in Anchorage, his business paid \$100,000 in 1985 for insurance on six airplanes. Mr. Rust has been told that identical coverage could double when the policy is renewed in 1986.

Mr. Rust further stated that the additional insurance costs must either be absorbed as an additional cost or passed on to customers via more expensive fares. Mr. Rust said that profits could be affected in either case because the demand for services is roughly the same each

⁵Attachment A includes the companies contacted.

⁶According to Seair's President Al Gay, the company can get insurance for five of the airline's 32 planes.

⁷As you know, the rising cost and unavailability of liability insurance is a nationwide phenomenon. For example, the American Trucking Association recently claimed that 100 companies failed financially because of increased insurance costs.

year, and competition has increased because of the recent deregulation of the Alaska Transportation Commission. Mr. Rust noted that increased fare prices could 'scare away' potential customers.⁸

Insurance Rate Increases During the Past Two Years. According to Richard Block, the only way to accurately determine insurance cost increases for businesses and professionals is by individual survey. As noted, insurance companies file rates with the Division of Insurance. However, insurers usually deviate from the filed rates based upon the particular risk involved and competition for the business. In recent years, insurance premiums were often 20 to 50 percent below filed rates. Currently, premiums are at or slightly above filed rates. In other words, premiums for many buyers can more than double with no change in the standard rate filing. This makes standard rate filings of little value in an attempt to determine premium increases. Moreover, the Division of Insurance does not keep usable records on deviations.

Premium increases for some businesses have been proportionately larger than increases for others. For example, the American Medical Association reported that average increases for general practitioners--considered a low risk segment of the medical profession--increased 31.4 percent during the past two years. However, average premiums for all physicians increased by 44.8 percent during the same period.

As another example, the National Society of Professional Engineers reported that average premiums for engineers and architects increased by 15 percent in 1984 and 35 percent in 1985. However, the average premium increases for structural engineers has been higher because they have experienced the worst loss records in the profession in recent years.

Impact of Tort Claims on the State Treasury.

You asked us to find out the number of tort claims filed against the State in 1985, the number of cases the State lost, payments on these cases, and the range of damage awards paid by the State. According to information supplied by the Department of Law, 120 tort complaints were filed against the State of Alaska during fiscal year 1985, and 78 complaints have been filed during fiscal year 1986. These complaints include physical injury cases and nonphysical injury claims such as sexual harassment or wrongful termination. A list of these cases is

⁸We contacted Dave Stewart of the Alaska Division of Tourism. According to Mr. Stewart, the division received no complaints related to insurance from businesses involved in the tourist industry.

included as Attachment B. The Department of Law does not record whether it wins or loses a case; nor does it keep records of damages awarded. However, the Department of Administration's Division of Risk Management compiles data on all claims filed by third parties against the State. These records include the legal complaints handled by the Department of Law. In addition, the data include claims for physical and nonphysical injuries, with no available breakdown between the two types. Attachment C contains tables from the Division of Risk Management. These tables contain historical data on third-party claims filed against the State. Those categories which contain predominantly third-party physical injury claims include general liability, malpractice and auto liability. Attachment C also contains a table showing frequency, severity and average of general liability claims paid since 1980. Note that most claims incurred are in the \$0-\$50,000 range.

The following table shows total State losses for primarily third-party physical injuries in fiscal years 1983 to 1986. Outstanding reserves are estimated amounts needed to pay on unsettled claims. Loss and expense payments include amounts paid for claims and related litigation expenses during the year. Recoveries include amounts received from other insurance sources. As the table illustrates, the State has incurred almost \$8,000,000 for filed injury claims during the past four years.⁹

TABLE 1
SUMMARY OF LOSSES
GENERAL LIABILITY, AUTO LIABILITY AND MALPRACTICE

Fiscal Year	Outstanding Reserves	Loss Payments	Expenses Payments	Recoveries	Net Incurred
1983	\$1,726,290	\$810,034	\$477,807	\$7,448	\$3,021,579
1984	1,165,907	551,688	294,546	9,306	2,021,447
1985	1,562,392	401,734	214,586	241	2,178,953
1986	<u>624,545</u>	<u>58,806</u>	<u>8,095</u>	<u>0</u>	<u>691,446</u>
Total	\$5,079,134	\$1,822,262	\$995,034	\$16,995	\$7,913,425

⁹Note that some injured parties with potential claims against the State have probably not filed their claims. In addition, recoveries lag losses and reserves may not necessarily equal losses paid. The actual net incurred loss will not be known until all cases are settled.

Representative Rieger
February 19, 1986
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Tort Reform in Other States and Congress

In order to address your question on tort reform activity in other states during the past five years, we sent requests for information to all 49 states and a number of congressional committees. When the information is received, we will forward our findings.

In addition, Attachment D contains a list of medical malpractice legislation enacted between 1971 and 1985. During this time, eight states placed statutory caps on malpractice damages while thirteen states limited attorney contingency fees. Moreover, the statutes in 12 states allow periodic payments on damage awards.¹⁰

Congressional Bills. There are a number of insurance-related bills pending in Congress; Attachment E provides a summary of the proposed legislation. Please contact our agency if you wish to review copies of these bills.

I hope that this information is helpful to you. Please call me if you have additional questions.

MT

Attachments

¹⁰States with damages caps are California, Indiana, Louisiana, Nebraska, New Mexico, South Dakota, and Virginia. States with limits on contingency fees include California, Florida, Indiana, Iowa, Michigan, Nebraska, New Jersey, New York, Oregon, South Dakota, Tennessee, Virginia, and Utah. Periodic payments are allowed in Alaska, Arkansas, California, Delaware, Florida, Indiana, Louisiana, Maine, Maryland, New York, South Carolina and Wisconsin.

Attachment A

Businesses Contacted for this Memorandum

<u>Air Carriers</u>	<u>Location</u>
Alaska Aeronautical Industries	Anchorage
Rust's Air Taxi	Anchorage
Seair	Anchorage
Wilbur's Flying Service	Anchorage
Harold's Air	Fairbanks
Cook Inlet Aviation	Homer
Channel Flying	Juneau
<u>Trucking Firms</u>	
Big State Trucking	Anchorage
Carlisle Enterprises	Anchorage
Frontier Transportation	Anchorage
Lynden Transport	Anchorage
Air Land Transportation	Fairbanks
Weaver Brothers Trucking	Kenai

ATTACHMENT B

**Special Tort Report
February 11, 1986**

FY '85

***** SPECIAL TORT REPORT ***** AS OF 02/11/86

WMNO	ATTY	TITL	ODAT	CDAT
----	----	----	----	----
33000185	2602	BILLINGSLEY V SMITH (-----DCAK)	840702	850919
33000285	1801	SMITH D&E V ST (PROP DAMAGE--TRCT)	840724	840904
33000385	1603	POLLARD V KALWARA & ST (UNLAWFUL SEIZURE--TRCT)	840724	850424
33000485	9987	DAVIDSON V ST (NEGLIGENT DESIGN--TRCT)	840730	000000
33000585	3806	URQUHART V ST & DON FRANK (GRAVEL OVERLOAD--TRCT)	840803	841231
33000685	2602	MCWAIN V WOOTEN & ST (DOT/PF IMPROPER GRADING--TRCT)	840810	000000
33000785	2602	SOUZA V ENDELL & ST (1983 FINGER INJURY--USDC)	840810	000000
33000885	1603	STANDBERG V ST (KLEHINI DROWNING--TRCT)	840813	000000
33000985	2601	GOVT EMPL INS CO V HOWELL (PD--TRCT)	840820	840829
33001085	2602	DEWITT V ST (FAIL TO PROVIDE MED ASST--TRCT)	840821	000000
33001185	9915	MYERS V ST (FOSTER CARE PLACEMENT--TRCT)	840829	000000
33001285	9994	BICKMORE V ST (1983--TRCT)	840829	840919
33001385	3806	YODER V ST (INTENTNL TORT OF CO-WORKER--TRCT)	840829	850403
33001485	2602	LOCKHART V BETZ (1983 RACE DISCRIM--TRCT)	840829	850814
33001585	9902	ROBERTS V ST (UNSWTH)	840914	000000
33001685	9950	MORONEY V ST (NEG SUPER KOR--TRCT)	840906	000000
33001785	3806	CRANE V WILKIE & ST (RAPE IN STA PK LOT--TRCT)	840906	000000
33001885	3806	NORMAN V NC MACHINERY (FAIL TO INSPECT VEHICLE--TRCT)	840906	850701
33001985	1318	SKULTKA V ST (FISHERMAN--TRCT)	840919	860131
33002085	2601	LOCKHART V BETZ (1983 RACE DISCRIM--DCAK)	840919	841114
33002185	2422	K & R ENTERPRISES, INC V ST (NEG RECORDKEEPING--TRCT)	840920	850828
33002285	2602	PRZYBYLA V JOHNSTON (HARRASS ST TROOPER--TRCT)	840925	000000
33002385	9955	NICKERSON V ST (1983--TRCT)	840928	860131
33002485	3806	HOLZHEIMER V CLARK (CIV RTS '83--TRCT)	840928	000000
33002585	3806	SCHEIBL V CLARK & ST (EXCESS FORCE--TRCT)	841012	000000
33002685	9989	VANDER SLOOT V VAN GELDER (EXCESS FORCE--TRCT)	841012	851107
33002785	3806	STRACK V ST (NEG HWY MAINT--TRCT)	841012	841231
33002885	3806	L&H ENTERPRISES V ST (DETRIMENTAL REL--TRCT)	841012	000000
33002985	2316	MANCUSO V ST (DAMAGE TO SEIZED VESSEL--TRCT)	841026	841114
33003085	9953	FAIKS V PITTMAN (SLANDER--TRCT)	841026	000000
33003185	9955	SANFORD, M V ST (IMPROPER GAS DISPOSAL--TRCT)	841102	000000
33003285	2804	SHADE, A V ST (DEFECTIVE PLANE TIEDOWN--TRCT)	841102	000000
33003385	9989	DARBYSHIRE, I V ST (4TH AMEND/1983--TRCT)	841102	000000
33003485	4005	NEWSOM, P V DICKENS, H (CIVIL RIGHTS/1983--DCAK)	841102	850513
33003585	9953	LUPRO, INC (CAP. OFFICE SUPPLY) V ST (ANTITRUST--TRCT)	841121	000000
33003685	9994	ST V MORRISON (JAIL SUPERVISION--)	841121	000000
33003785	9945	NELSON, J V ST (UNSWTH--TRCT-WA)	841220	000000
33003885	2602	ST V DUFREY, M (WC--TRCT)	841220	000000
33003985	9902	RYAN, A V. ST (UNSWTH--TRCT-WA)	841220	000000
33004085	9915	RICHEY, B V ST (FAILURE TO MONITOR--TRCT)	841220	000000
33004185	9945	DONALDSON, M V ST--(BREACH OF WC SETTLEMENT--TRCT)	841224	000000
33004285	9955	RECTOR V ST (EDDIE--TRCT)	841224	850919
33004385	9989	JUDICIAL MISCONDUCT	841224	000000
33004485	2602	ANDERSON V WILSON (1983 COPYRIGHT INFRINGE--FED.)	850104	000000
33004585	9989	BENKA, J V AK POWER AUTHORITY (WRONGFUL TERM--TRCT)	850108	850429
33004685	9989	KIDWELL, S V AK POWER AUTHORITY (WRONGFUL TERM--TRCT)	850108	000000
33004785	9989	ARMOUR, C V. AK POWER AUTHORITY (FAIL TO INSPECT--TRCT)	850108	000000
33004885	2602	WILSON V. MCCONNELL (PI--TRCT)	850108	851231
33004985	1603	BOEING JETFOIL CONTRACT NEGOTIATION	850111	850111

***** SPECIAL TORT REPORT ***** AS OF 02/11/86

WMNO	ATTY	TITL	ODAT	CDAT
33005085	1603	BARRETT V ST (PI S&F--)	850111	850111
33005185	1603	ZABEK, B V. ST (SEX HARASSMENT--TRCT)	850115	000000
33005285	9953	NICK, E V. ST (API NEG RELEASE--TRCT)	850123	000000
33005385	9955	HOFF, J V. ST (HWY MAINT--TRCT)	850123	000000
33005485	1603	HAMMOND V ST (NEG HWY MAINT--TRCT)	850123	850123
33005585	9989	WILLMARTH, R V ST (FALSE ARREST--TRCT)	850123	000000
33005685	9905	DORIS, C V. API (NEG RELEASE--TRCT)	850123	000000
33005785	1417	BULCOA V. O/S SMARAGD & ARC (WRGFUL DEATH/ADMIR--TRCT)	850123	000000
33005885	9953	AGF CONSTR. INC V. ST (NEG SUPER IC--TRCT)	850131	000000
33005985	2601	1985 SERVICE RECEIPT (ADMIN. FILE--ADMIN)	850131	850227
33006085	2602	SPECIAL LITIGATION MISC (ADMIN FILE--ADMIN)	850131	851118
33006185	1318	MASON V LYNCH V NANGLE (NEG RECORDKEEPING--TRCT)	850201	000000
33006285	1603	ALMONTE, L V ST (S&F--CLAIM)	850214	860114
33006385	1603	HEUSSLER V HOLBROOK (HWY MAINT--CLAIM)	850214	000000
33006485	2420	EITEL, G V HUNT (JUDICIAL ABUSE--DCAK)	850219	000000
33006585	1603	CHURCH, K V ST (NEG DESIGN--CLAIM)	850227	850802
33006685	9911	BROWNE, S V COTTLE, A & ST (SEXUAL HARASSMENT--TRCT)	850228	000000
33006785	9953	CHRISTIAN, C V ST (HWY MAINT--TRCT)	850301	000000
33006885	9950	HANSON V ST (NEG BLASTING--TRCT)	850301	000000
33006985	3806	CONSUMERS INSURANCE CO V ST (HWY MAINT--TRCT)	850308	000000
33007085	1801	LOY V ST (TRESPASS--TRCT)	850308	000000
33007185	3806	GALLAHAN, R V ST (MALPRACTICE--TRCT)	850308	850730
33007285	3806	YODER V ST (APPEAL)	850308	000000
33007385	3806	CONRAD V ANDERSON & ST (PI/HWY MAINT--TRCT)	850312	000000
33007485	9996	SAHM V ST (SEXUAL HARASSMENT--TRCT)	850320	851227
33007585	1603	BAUDER, B V ST (NEG INVESTIGATION--CLAIM)	850328	000000
33007685	3019	BLAKE, S V HALL, J (FALSE ARREST--TRCT)	850328	860122
33007785	1603	DELANEY, L V ST (EMPLOYEE SANCTION--CLAIM)	850328	000000
33007885	1603	JOHN, M V LARSON, R (INMATE PROPERTY LOSS--TRCT)	850403	000000
33007985	1603	KUNTZ, J V ST (FALSE ARREST--TRCT)	850403	000000
33008085	2602	TETLIN VILLAGE COUNCIL V THORSRUD (TRESPASS--TRCT)	850405	000000
33008185	9991	BOUFFIOUX, T V ST (FAILURE TO WARN-SUICIDE--TRCT)	850405	850725
33008285	9987	KALLSTROM-DAVISCOURT CONST V ST (CONTRACT NEG--TRCT)	850410	000000
33008385	4014	MCBETH, J V ENDELL, R (1983 CIVIL RIGHTS--TRCT)	850410	850904
33008485	2601	LACK, J V ST & LACK, L (PFD GARNISHMENT--TRCT)	850410	850828
33008585	9915	BEISH V ST (NEG LICENSING--TRCT)	850410	000000
33008685	3013	RUBALACAVA V ST (APPEAL--USDC-AK)	850417	851121
33008785	1603	WILLARD, K V JAMES, J (NEG RELEASE FROM API--TRCT)	850424	000000
33008885	9900	KELLY V ST (C & U PUNISHMENT--USDC-AK)	850424	000000
33008985	9955	Q.C. COMPANY V ST (FAIL TO DO PLAN REVIEW--TRCT)	850424	000000
33009085	9989	JOHNS V JOLIKER (FALSE ARREST--TRCT)	850424	000000
33009185	9987	BLACKBURN V ST (FERRY S&F--TRCT)	850509	000000
33009285	1603	DUNNING, R ST (FALSE ARREST--USDC-AK)	850509	000000
33009385	3013	STEPHENS, C V. ST (WRONGFUL COLLECTION--TRCT)	850509	000000
33009485	9987	CAMERON V. ST (INMATE INJURY--TRCT)	850509	000000
33009585	4004	COSTLOW V ST (1983--USDC-WA)	850509	000000
33009685	2602	HAUSE, S V. ST (INMATE SUICIDE ATTEMPT--TRCT)	850509	000000
33009785	1211	KING V. ST (FALSE CERTIFICATION--TRCT)	850517	000000
33009885	3013	REYNOLDS, C V ORTON, J (ILLEGAL S&S--TRCT)	850528	851010

***** SPECIAL TORT REPORT ***** AS OF 02/11/86

WMNO	ATTY	TITL	ODAT	CDAT
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33009985	1603	STATON, J V ST (1983--TRCT)	850528	000000
33010085	1603	JEPPSEN, D V ST (SEXUAL DISCRIM--TRCT)	850528	851218
33010185	1603	STOTT, C V ST (S&F ON DOCK--CLAIM)	850528	000000
33010285	9902	WASHBURN V ST (ASBESTOSIS--TRCT-WA)	850531	000000
33010385	9962	BAUMER V ST (S&F--TRCT)	850531	000000
33010485	1603	YOUNG V ST (SLOPE FAILURE--CLAIM)	850531	851107
33010585	9970	CORNELL V ST (NEG CONSTR/MAINT-AIRPORT--TRCT)	850531	000000
33010685	9970	SOUTHCENTRAL AIR V KOREAN AIR V ST (NEG CONSTR-AIRPT--TRCT)	850531	000000
33010785	9955	BURNS V ST (NEG HWY DESIGN--TRCT)	850531	000000
33010885	9989	JONES V ST (NEG POLICE INVESTIGATION--_____)	850531	000000
33010985	3806	GLOVER, D V. ST (NEG HWY MAINT--TRCT)	850605	000000
33011085	3806	COMMEAN, C V ST (AUTO PI CLAIM--CLAIM)	850605	000000
33011185	9915	COOPER V ST (IMPROPER DETENTION--TRCT)	850605	000000
33011285	9915	HOWELL V ST (NEG PROSECUTION--USDC-AK)	850605	851227
33011385	3013	LANTZ, R. V. ST (WITHHOLDING OF FUNDS--TRCT)	850605	850718
33011485	1211	RENAUD, C V. ST. (SEX/AGE DISCRIM--TRCT)	850607	000000
33011585	9970	PEDERSEN V ST (NEG. DESIGN, OP, & MAINT--TRCT)	850613	000000
33011685	3806	QUINLAN V PIONEER HOME (NEG. SUPERVISION--TRCT)	850613	000000
33011785	1603	COHERN M. V. ST (PD-CLAIM)	850613	850718
33011885	1603	EMARD V ST (FALSE ARREST--CLAIM)	850613	851015
33011985	1603	DAVIS D V ST (APPEAL--APCT)	850613	000000
33012085	1603	O'CONNOR V ST (SEX HARRASSMENT--TRCT)	850613	000000

MMMM TORT CASES FY 86 MMMM AS OF 02/12/86

WMNO	ATTY	CDAT	TITL
BLN			
33000186	1604	851107	DOVER V STATE (NEG. INSPECTION--CLAIM)
33000286	3806	000000	GREENE V MAMMOTH OF AK & ST (HWY MAINT--TRCT)
33000386	3013	000000	STEARNS, T. V. WILLIAMS, J. & BAINBRIDGE R. (1983--TRCT)
33000486	9955	000000	ADAMS V. STATE (ROADSIDE OBSTACLE--CLAIM)
33000586	9989	860131	DENARDO V WILLIAMS (WRONGFUL TERMINATION)
33000686	9962	000000	O'BRIEN V ST (NEG DRIVING--TRCT)
33000786	9962	000000	KNIGHT V PARKER (SLANDER--TRCT)
33000886	9914	000000	VANDERSLOOT V VANGELDER (DEFAMATION--DCAK)
33000986	9994	000000	MCCUTCHEON V ST (DEFAMATION--TRCT)
33001086	1603	851107	PETERS V ST (WRONGFUL TERMINATION--CLAIM)
33001186	9953	000000	ASPEN EXPLORATION CORP V SHEFFIELD (EXEC TORT--TRCT)
33001286	9962	000000	FELTHAUSER V ST (SAFE WORK PLACE--TRCT)
33001386	9912	000000	DANIELS V JONES (WHISTLEBLOWER--TRCT)
33001486	9914	000000	AK ENVIRON INDUSTRIES V ROSS (SLANDER--TRCT)
33001586	3806	000000	BRIGGS V ST (NEG HWY MAINT--TRCT)
33001686	2420	000000	EITEL V HOLLAND (WRIT OF MANDAMUS APPEAL--9TH CIR)
33001786	3019	000000	LEMON V ST (FALSE IMPRISONMENT--TRCT)
33001886	1318	860128	GOODLATAM V ST (WRONGFUL DEATH--USSUPCT)
33001986	1318	860206	MASON V LYNCH V ST (PT REV CONTRUCTIVE NOTICE--APCT)
33002086	3806	000000	BLAKE V RICHARDS (FALSE ARREST--TRCT)
33002186	9945	000000	CITY OF HAINES V HESS (CONTRIBUTION--TRCT)
33002286	4009	000000	FRAZIER V ST (FALSE ARREST--TRCT)
33002386	9905	000000	ISACKSON V ST (HWY MAINT--TRCT)

XXXXX TORT CASES FY 86 XXXXX AS OF 02/12/86

WMNO BLN	ATTY	CDAT	TITL
33002486	1603	000000	ST V ALYESKA (INDEM APPEAL--APCT)
33002586	9915	000000	WHEELER VID (FAIL TO MONITOR/INTERVENE--TRCT)
33002686	9950	000000	BEARD V ST (FAIL PROVIDE SAFETY DEVICE--TRCT)
33002786	9970	000000	FOSTER V ST (AIRPORT MAINT--TRCT)
33002886	9991	000000	TAYLOR V PETER KIEWIT SONS, INC (SAFE WORKPLACE--TRCT)
33002986	9945	000000	LARSON V ST (JONES ACT--DCAK)
33003086	9987	000000	LIPSCOMB V DONNELLY (INMATE BATTERY--TRCT)
33003186	9913	860131	EDWARDS V FABB (LEGAL MALPRACTICE PD--TRCT)
33003286	9955	000000	HACKATHORN V ST (HWY MAINT--TRCT)
33003386	9915	000000	TRONICK (MISHANDLING OF BODY--CLAIM)
33003486	9987	000000	EVAN (JAIL SUICIDE--CLAIM)
33003586	1211	000000	JENKINSON V ST (WRONGFUL TERMINATION--TRCT)
33003686	9995	000000	WHITESIDES ENTERPRISES V ST (BULLDOZER RENTAL--TRCT)
33003786	1603	851218	CARLSON V CLERK OF SUPERIOR COURT (COURT CLERK NEG--TRCT)
33003886	9902	000000	OSBORN V AK MARINE HWY SYS (JONES ACT ASBESTOSIS--TRCT-WA)
33003986	9905	000000	HARDMAN V ST (SUICIDE/NEG INMATE SUPRV--TRCT)
33004086	9953	000000	CWC FISHERIES V ST (SET NET RIGHTS--TRCT)
33004186	1603	851218	MORINO V ST (NEG RECORDKEEPING--TRCT)
33004286	4014	000000	SPRINGER V COREY (ASSAULT/1983--DCAK)
33004386	4005	000000	LIPSCOMB V ENDELL (ASSAULT/COND OF CONFINEMENT--TRCT)
33004486	3013	000000	MANTEI V CRAIG (FAIL REMOVE HWY OBSTACLE--TRCT)
33004586	1603	851126	ELROD (TRAILER SPACE/EVIDENCE--CLAIM)
33004686	9950	000000	MOTOROLA, INC. V KOREAN AIR LINES CO. (AIRPORT NEG--TRCT)

MMMM TORT CASES FY 86 MMMM AS OF 02/12/86

WMNO	ATTY	CDAT	TITL
BLN			
33004786	3013	000000	HOLZHEIMER V CLARK (ATTY FEES/COSTS--APCT)
33004886	1603	000000	CARNEY V ST (QUASI JUDICIAL NEG--TRCT)
33004986	9989	000000	ZAHARI V AK POWER AUTHORITY (FAIL REQUIRE INSURANCE--TRCT)
33005086	9962	000000	ANDREWS V ST (TORT--TRCT)
33005186	9962	000000	BENTLEY V HUDSON (MALPRACTICE--DCAK)
33005286	9950	000000	APPLIED MAGNETICS CO V KOREAN AIR (AIRPORT MAINT--TRCT)
33005386	3806	000000	FINCH V ST (PETITION FOR REVIEW--APCT)
33005486	1603	000000	DEMO V HOEY (S&F--TRCT)
33005586	3013	000000	GEE V ST (INMATE PI--TRCT)
33005686	9955	000000	BURTON V ST (NEG DESIGN--TRCT)
33005786	3806	000000	FINCH, ST V (PETITION FOR REVIEW--APCT)
33005886	3806	000000	L&H ENTERPRISES V ST (APPEAL--APCT)
33005986	9999	000000	MCCLURE V EVERGREEN HELICOPTERS (CONTRIBUTION--DCAK)
33006086	9999	000000	ROX V ST (NEG SUPERVISION--TRCT)
33006186	9999	000000	UNDERWRITERS AT LLOYDS V ST (NEG AIRPORT MAINT--TRCT)
33006286	9999	000000	MCKINLEY V DAHLBERG (NEG HWY MAINT--TRCT)
33006386	9989	000000	JONES V ST (WRONGFUL TERMINATION--TRCT)
33006486	1603	000000	FLETCHER V BURNHAM (JUDICIAL IMMUNITY--DCAK)
33006586	1211	000000	WALT V ST (WRONGFUL DISCHARGE/CIVIL RIGHTS--APCT)
33006686	9999	000000	REDMOND V ST (HWY MAINT--TRCT)
33006786	9955	000000	SCHUMACHER V CLARK (AST EXCESS FORCE--TRCT)
33006886	9950	000000	NAHORNEY V KOREAN AIR LINES (AIRPORT MAINT--TRCT)
33006986	9950	000000	VICKERS V KOREAN AIR LINES (AIRPORT MAINT--TRCT)

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***** TORT CASES FY 86

***** AS OF 02/12/86

WMNO --- BLN ---	ATTY ----	CDAT ----	TITL -----
33007086	9999	000000	GORDON V ST (NEGLIGENCE--TRCT)
33007186	9999	000000	CARSON V AVILA (NEGLIGENCE--TRCT)
33007286	9999	000000	ZIEMANN V MUNICIPALITY OF ANCHORAGE (PEDESTRIAN--TRCT)
33007386	1006	000000	BAKKE V BAKKE (NEGLIGENCE--TRCT)
33007486	9999	000000	CHANNEL CONSTRUCTION V ST (NEGLIGENCE--TRCT)
33007586	9999	000000	RICHARDS V ST (NEG FRISK--TRCT)
33007686	9999	000000	SAILOR V ST (SNOWBLOWER--TRCT)
33007786	9950	000000	SCHAPS V ST (AIRPORT MAINT--TRCT)
33007886	9950	000000	BAIRD V KOREAN AIR LINES (AIRPORT MAINT--TRCT)

ATTACHMENT C

Summary of Losses
December 31, 1985

SUMMARY OF LOSSES
AS OF 12/31/85

FISCAL YEAR	-----CLAIMS----- TOTAL	OPEN	OUTSTANDING RESERVES	+	LOSS PAYMENTS	+	EXPENSE PAYMENTS	=	TOTAL INCURRED	-	RECOVERIES	=	NET INCURRED
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COVERAGE: MARINE PII - FERRY ENPL (17)

<i>State</i>	1980	1			5,850				5,850				5,850
<i>employees</i>	1981	1			18,598		963		19,561				19,561
	1982	2			10,000		1,841		11,841				11,841
	1983	74	10	252,385	44,345		22,303		319,034		924		318,110
	1984	284	24	114,176	470,098		43,652		627,926		73,961		553,965
	1985	232	15	250,165	555,232		17,417		822,815		65,278		757,537
	1986	133	75	97,150	106,982		91		204,223		1,078		203,146
	TOTAL	727	124	713,876	1,211,106		86,268		2,011,250		141,240		1,870,010

COVERAGE: TRAVEL ACCIDENT (18)

<i>state</i>	1979	1			35,000				35,000				35,000
<i>employees</i>	1981	1			18,598		1,331		19,929				19,929
	1982	1			75,000				75,000				75,000
	1984	1			75,000				75,000				75,000
	TOTAL	4			203,598		1,331		204,929				204,929

✓ COVERAGE: GENERAL LIABILITY (20)

<i>Third</i>	1978	231	2	4,652	980,952	457,708	1,443,312		123,422		1,319,890
<i>party</i>	1979	289	4	115,823	909,895	474,685	1,500,404		21,048		1,479,355
	1980	267	10	733,635	691,491	420,916	1,846,041		15,607		1,830,435
	1981	211	13	1,750,370	3,017,498	791,351	5,559,219	1,283,301			4,275,918
	1982	217	13	197,161	1,609,421	566,906	2,373,488	442,159			1,931,329
	1983	311	35	1,566,192	504,733	474,865	2,545,789	6,900			2,538,890
	1984	339	42	995,482	336,466	269,387	1,601,336				1,601,336
	1985	449	49	778,463	181,730	176,014	1,136,208				1,136,208
	1986	121	34	582,793	28,810	8,095	619,688				619,688
	TOTAL	2,435	202	6,724,562	8,260,997	3,639,927	18,625,486	1,892,437			16,733,050

SUMMARY OF LOSSES
AS OF 12/31/85

FISCAL YEAR	-----CLAIMS----- TOTAL OPEN	OUTSTANDING RESERVES	LOSS PAYMENTS	EXPENSE PAYMENTS	TOTAL INCURRED	RECOVERIES	NET INCURRED
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✓ COVERAGE: AUTO LIABILITY

(50)

Third party	1978	114		156,007	20,026	176,032		176,032	
	1979	111	-200	1,335,605	50,500	1,385,905	806,501	579,404	
	1980	82		497,423	27,197	524,620	70,049	454,571	
	1981	131		128,248	3,460	131,707		131,707	
	1982	177	1	20,854	5,530	197,209		197,209	
	1983	188	3	160,098	2,122	465,157	548	464,609	
	1984	214	5	117,903	2,820	330,231	8,306	321,925	
	1985	274	13	777,743	12,152	1,009,543	241	1,009,302	
	1986	88	19	41,762	26,246	68,009		68,009	
	TOTAL	1,379	41	1,120,160	3,044,445	123,807	4,288,412	885,644	3,402,768

COVERAGE: AUTO PHYSICAL DAMAGE

(51)

State property	1978	7		1,604	56	1,660	427	1,233	
	1979	28	1	2,315	35,001	1,398	38,714	7,108	31,606
	1980	306	4	358	173,658	14,839	188,855	39,293	149,562
	1981	299	10	89	254,748	13,149	267,984	43,541	224,445
	1982	420	4	965	434,184	15,465	450,614	62,892	387,722
	1983	427	6	113	340,707	16,818	357,637	25,249	332,389
	1984	114	1	6,000	72,140	4,895	83,035	1,639	81,396
	1985	38	1	585	19,616	55	20,256	41	20,216
	1986	7	2	913	3,434	275	4,622		4,622
TOTAL	1,646	29	11,338	1,335,091	66,950	1,413,379	180,189	1,233,190	

COVERAGE: REAA PROPERTY

(70)

<i>State property</i>	1978	6		142,398	601	142,999	11,403	131,596
	1979	8		2,407,922	483	2,408,405	740,224	1,668,181
	1980	2		12,193		12,193		12,193
	1981	2		225,073		225,073	205,073	20,000
	1982	2		621,290		621,290		621,290
	1983	1		850		850		850
	TOTAL	21	0	3,409,725	1,085	3,410,809	956,700	2,454,110

STATE OF ALASKA
SUMMARY OF LOSSES
AS OF 12/31/85

FISCAL	-----CLAIMS-----		OUTSTANDING	LOSS	EXPENSE	TOTAL	NET
YEAR	TOTAL	OPEN	RESERVES +	PAYMENTS +	PAYMENTS =	INCURRED - RECOVERIES =	INCURRED
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✓ COVERAGE: GENERAL LIABILITY-ST ADM (21)

<i>Third party</i>	1978	1		403		403		403
	1979	2		1,500		1,500		1,500
	1980	2		147		147		147
	1981	5		39,169	481	39,650		39,650
	1982	2	1	15,000		15,000		15,000
	1983	3		2,364		2,364		2,364
	1984	9		5,714	16,880	22,595	1,000	21,595
	1985	13	4	3,586	20,977	26,918		26,918
	1986	4		3,750		3,750		3,750
	TOTAL	41	5	18,586	55,402	112,326	1,000	111,326

COVERAGE: MAR P&I - FERRY 3RD PARTY (23)

<i>Third party</i>	1978	62		170,029	42,206	212,235	131,325	80,910
	1979	72	2	7,600	376,947	439,218	342,169	97,049
	1980	71	3	9,930	572,049	613,043	450,545	162,498
	1981	155	5	54,188	635,716	74,392	79,605	684,691
	1982	292	7	260,526	657,838	94,380	1,012,745	850,853
	1983	270	4	32,511	531,976	28,529	593,016	516,097
	1984	74	1	5,000	27,288	188	32,476	32,476
	1985	66	4	11,082	20,076	5	31,162	31,162
	1986	30	5	10,925	9,659		20,584	20,584
	TOTAL	1,092	31	391,763	3,001,579	325,435	3,718,776	2,476,322

COVERAGE: MARINE P&I - OTHER (24)

<i>Third party</i>	1978	3		29,042	2,680	31,722	9,469	23,252
	1979	2		1,446	250	1,696	207	1,489
	1980	3		3,403		3,403	1,275	2,128
	1981	4		9,300	125	9,425		9,425
	1982	1		275		275		275
	1983	2		351		351		351
	1985	3		5,373		5,373		5,373
	TOTAL	18		-0	49,189	3,054	9,951	42,292

STATE OF ALABAMA
SUMMARY OF LOSSES
AS OF 12/31/85

FISCAL YEAR	-----CLAIMS----- TOTAL	OPEN	OUTSTANDING RESERVES	+	LOSS PAYMENTS	+	EXPENSE PAYMENTS	=	TOTAL INCURRED	-	RECOVERIES	=	NET INCURRED
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COVERAGE: AIRPORT LIABILITY (27)

<i>Third party</i>	1978	13			177,099		45,314		222,413		197,089		25,324
	1979	43			266,423		219,493		485,916		415,293		70,623
	1980	24	3	740,000	111,989		7,568		859,557		94,644		764,913
	1981	31	2	87,336	74,809		75,358		237,503		34,517		202,986
	1982	36	1	331,923	222,903		83,111		637,937				637,937
	1983	28	2	19,009	298,190		11,135		328,333		1,537		326,796
	1984	22	6	594,525	8,720		118,473		721,717				721,717
	1985	17	4	17,173	10,392		13,717		41,282				41,282
	1986	6	5	322,129			1,961		324,090				324,090
	TOTAL	220	23	2,112,094	1,170,524		576,129		3,858,747		743,080		3,115,667

COVERAGE: AIRCRAFT LIABILITY (28)

<i>Third party</i>	1981	1											
	1982	4			23,500		529		24,029				24,029
	1983	2	1	12,374	767		2,626		15,767				15,767
	1985	4	2	36,058	71,892		4,163		112,112				112,112
	TOTAL	11	3	48,432	96,159		7,317		151,908				151,908

COVERAGE: MISCELLANEOUS (29)

<i>Third party</i>	1979	5			59,139		131,286		190,426		639		189,786
	1982	3			687,000		61,109		748,109		79,056		669,052
	1983	1			75,000				75,000				75,000
	1985	1	1	893			14,107		15,000				15,000
	TOTAL	10	1	893	821,139		206,503		1,028,534		79,696		948,839

✓ COVERAGE: MALPRACTICE (40)

<i>Third party</i>	1982	1					18,225		18,225				18,225
	1983	1					820		820				820
	1984	4	2	52,522			5,459		57,981				57,981
	1985	2	1	600			5,083		5,683				5,683
	TOTAL	8	3	53,122			29,587		82,709				82,709

STATE OF ALASKA
 RANGE TABLE SHOWING
 FREQUENCY, SEVERITY, AND AVERAGE
 FOR TOTAL INCURRED CLAIMS WITHIN SPECIFIED RANGES
 VALUED AS OF: 02/11/86

COVERAGE IS: GENERAL LIABILITY

FISCAL YEAR	0 - 50,000	50,001- 100,000	100,001- 150,000	150,001- 200,000	200,001- 250,000	250,001- 300,000	300,001- 500,000	500,001- ALL
1981								
TOTAL \$	672,079	269,404	110,000	153,367			1,734,379	2,619,995
FREQ.	196	4	1	1			4	3
AVG LOSS	3,394	67,351	110,000	153,367			433,594	873,331
1982								
TOTAL \$	797,736	428,353	122,530	357,962	237,409		673,109	670,174
FREQ.	212	6	1	2	1		2	1
AVG LOSS	3,762	71,392	122,530	178,981	237,409		336,554	670,174
1983								
TOTAL \$	734,035	318,250	501,503	260,000	202,672	270,000		520,000
FREQ.	302	4	4	1	1	1		1
AVG LOSS	2,430	79,570	125,375	260,000	202,672	270,000		520,000
1984								
TOTAL \$	365,934	597,034	240,000			300,000		
FREQ.	33	1	2			1		
AVG LOSS	1,557	74,329	120,000			300,000		
1985								
TOTAL \$	945,535	150,000	125,000					
FREQ.	456	2	1					
AVG LOSS	2,082	75,000	125,000					
1986								
TOTAL \$	256,897	150,000				300,000		
FREQ.	156	2				1		
AVG LOSS	1,646	75,000				300,000		
TOTAL								
TOTAL \$	4,275,250	1,913,071	1,096,033	711,329	440,081	870,000	2,407,488	3,810,169
FREQ.	1,661	26	9	4	2	3	6	5
AVG LOSS	2,575	73,580	122,115	177,832	220,041	290,000	401,248	762,034

ATTACHMENT D

Medical Malpractice Legislation Enacted in the U.S. 1971 - 1985

✓ - Dr. McCune
✓ - Marilyn - Coalition

MEDICAL MALPRACTICE LEGISLATION
ENACTED IN THE UNITED STATES 1971 - 1985

STATES SURVEY UPDATE 1985

Deborah R. Siegel, Director
Long-Range Planning
Medical Society of the State
of New York

**MEDICAL MALPRACTICE LEGISLATION
ENACTED IN THE UNITED STATES 1971 - 1985**

STATE	HAVE PROVISIONS FOR:	DO NOT HAVE PROVISIONS FOR:
<u>ALABAMA</u>	Claims Made & Occurrence policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments
<u>ALASKA</u>	Claims Made & Occurrence policies Collateral Sources Periodic Payments *	Caps on Awards Caps on Physicians' Personal Assets Contingency Fees

* Jury cannot be advised of periodic payments use.

Highest premium \$5 mil/\$5 mil is \$40,246 annually.

<u>ARIZONA</u>	Claims Made & Occurrence policies Collateral Sources	Caps on Awards Caps on Physicians' Personal Assets Contingency Fees Periodic Payments
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Highest premium (\$3,000,000 coverage) is \$30,000 annually. \$5 mil/\$5 mil coverage available.

<u>ARKANSAS</u>	Claims Made & Occurrence policies Collateral Sources Periodic Payments	Caps on Awards Caps on Physicians' Personal Assets Contingency Fees
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Average premiums range between \$900 and \$7,000. \$7,000 highest in the state.

<u>CALIFORNIA</u>	Claims Made & Occurrence policies Caps on Awards Collateral Sources Contingency Fees Periodic Payments	Caps on Physicians' Personal Assets
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The highest premium (\$1 mil/\$3 mil coverage) is \$51,920 for Neurosurgeons. \$10 mil/\$10 mil is available. \$2 mil/\$4 mil is the most common, but there are a large number of \$5 mil/\$5 mil policies.

Have had a cap on pain and suffering (non-economic damages) since 1975 (\$250,000). It was upheld by the Supreme Court this year. They feel, as far as it's effect on premium costs, that it will be felt more now and in the next few years than it had been previously. While it is believed to be of value, no empirical data will be available before November or December, 1985. There are already signs that the trial lawyers will go for higher economic damages and will try to undo what's been done-there have been proposals to this effect and also to raise the level of the cap.

<u>COLORADO</u>	Occurrence policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments
-----------------	---------------------	--

Average premiums range from \$1,600.- \$26,000. \$26,000 highest.

STATE	HAVE PROVISIONS FOR:	DO NOT HAVE PROVISIONS FOR:
<u>CONNECTICUT</u>	Claims Made Policies Collateral Sources	Caps on Awards Caps on Physicians' Personal Assets

Contingency Fees (not mandated but are used).

Periodic Payments (not mandated but are used in large settlements).

Highest premium (for Neurosurgeons, Cardiologists, Orthopedics) is \$27,000, but will rise to \$31,800 after an 18% increase. The highest coverage is \$1 mil.

<u>DELAWARE</u>	Claims Made policies Collateral Sources Contingency Fees * Periodic Payments	Caps on Awards Caps on Physicians' Personal Assets
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* The contingency fee schedule is 35% on first \$100,000; 25% on next \$100,000; and 10% on the balance.

Average premiums range between \$5,000-\$10,000. The highest is \$21,000 for fourth year OB/GYN's.

<u>FLORIDA</u>	Claims Made & Occurrence policies Contingency Fees * Periodic Payments **	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources
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* Contingency fee scale (subject to Supreme Court changes). The sliding scale ranges from 15% - 45% depending upon the point at which the case is settled. 15% on awards in excess of \$2 mil.

** On awards over \$500,000.

Highest premium (OB Surgeons and Neurosurgeons) \$78,450 (\$100,000/\$300,000). Highest coverage: \$1 mil/\$3 mil.

<u>GEORGIA</u>	Claims Made policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments
----------------	----------------------	--

Highest premium is \$37,000. Highest coverage is \$10 mil/\$10 mil.

<u>HAWAII</u>	Claims Made policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees * Periodic Payments
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* Attorney fees must be approved by the court.

Highest premiums are \$33,000 annually. Total physician liability: \$5 mil/\$5 mil.

<u>IDAHO</u>	Claims Made & Occurrence policies	Caps on Awards * Caps on Physicians' Personal Assets Collateral Sources * Contingency Fees * Periodic Payments
--------------	-----------------------------------	--

* Caps, collateral sources and contingency fees had statutes but were declared unconstitutional several years ago.

STATE	HAVE PROVISIONS FOR:	DO NOT HAVE PROVISIONS FOR:
<u>ILLINOIS</u>	Claims Made & Occurrence policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments

The highest premium is \$83,000 (Neurosurgeons) and total physician liability is \$5 mil/
\$5 mil. Most physicians in state carry \$1 mil/\$3 mil.

<u>INDIANA</u>	Claims Made & Occurrence policies *	Collateral Sources
	Caps on Awards	
	Caps on Physicians' Personal Assets	
	Contingency Fees **	
	Periodic Payments	

* Four companies writing occurrence policies and one writing claims made (with a long tail).

** Via a statute created patients compensation fund.

Feel very strongly that their \$500,000 cap on awards has helped keep premiums down.

<u>IOWA</u>	Claims Made & Occurrence policies **	Caps on Awards
	Collateral Sources *	Caps on Physicians' Personal Assets
	Contingency Fees *	Periodic Payments

* Modified collateral sources provision and contingency fees are not statutorily mandated, but are used.

** Are moving towards claims made only.

The highest coverage is \$5 mil.

<u>KANSAS</u>	Claims Made & Occurrence policies	Caps on Awards
	Collateral Sources	Contingency Fees *
		Periodic Payments

Physicians' Personal Assets and Awards beyond coverage are covered via a "health care stability fund". This adds a 110% surcharge on premiums.

* Attorneys fees are not covered by statute, but are expected to be "reasonable" - the courts don't like to get involved - generally 25% - 50% of settlement.

Premiums for physicians who can't get coverage through two companies, possibly get it through JUA - if they pass personal interview which determines the physicians willingness to properly inform patients.

Have a cap on punitive damages.

Premiums are very variable.

<u>KENTUCKY</u>	Claims Made policies	Caps on Awards
		Caps on Physicians' Personal Assets
		Collateral Sources
		Contingency Fees
		Periodic Payments

STATE	HAVE PROVISIONS FOR:	DO NOT HAVE PROVISIONS FOR:
<u>LOUISIANA</u>	Claims Made & Occurrence policies Caps on Awards Periodic Payments *	Caps on Physicians' Personal Assets Collateral Sources Contingency Fees

* Periodic payments are used via authority of the Attorney Generals office.

Since 1975 have three caps of \$500,000 each:

Medical malpractice - private physicians; medical malpractice - employers of physicians in Louisiana; state liability for all other tort actions.

The highest premium is in the range of \$21,000.

<u>MAINE</u>	Claims Made Periodic Payments	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees
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Have instituted monthly meetings with trial lawyers in response to their liability crisis.

Highest premium \$40,000 (Neurosurgeons).

<u>MARYLAND</u>	Claims Made & Occurrence policies Contingency Fee * Periodic Payments **	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources
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* Contingency fee statute allows judge to review attorney's fees.

** Periodic payments optional, not mandated.

The highest premium (OBGYN) is \$35,000 for \$1 mil/\$3 mil. Highest coverage is \$1 mil/\$3 mil with a \$5 mil excess.

<u>MASSACHUSETTS</u>	Claims Made & Occurrence policies Collateral Sources	Caps on Awards Caps on Physicians' Personal Assets Contingency Fees * Periodic Payments
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* Though no statutory provision for contingency fees, they are used: 33 1/3% - 50%.

The highest premium is \$15,300 (Orthopedics, Plastic Surgeons, Neurosurgeons, OBGs).

<u>MICHIGAN</u>	Occurrence policies Contingency Fees *	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Periodic Payments
-----------------	---	--

* Court rule allows 33% contingency fees.

Highest premium \$55,000 (OBGs', Neurosurgeons). \$1 mil/\$1 mil highest coverage.

<u>MINNESOTA</u>	Claims Made policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments
------------------	----------------------	--

Highest policy is \$20,000. Total physicians liability \$4 mil/\$5 mil.

STATE	HAVE PROVISIONS FOR:	DO NOT HAVE PROVISIONS FOR:
<u>MISSISSIPPI</u>	Modified Claims Made policies Collateral Sources	Caps on Awards Caps on Physicians' Personal Assets Contingency Fees * Periodic Payments *

* Contingency fees and periodic payments are used.

Highest premium (Neurosurgeons/Anesthesiologists) \$31,000. \$5 mil/\$5 mil highest coverage available.

<u>MISSOURI</u>	Claims Made & Occurrence policies *	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments **
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* Are moving to claims made only.

** Although not statutorily mandated the judge may opt for it.

The range of premiums is \$1,200 - \$34,000. \$34,000 is the highest. Total physicians' liability is \$5 mil/\$5 mil.

<u>MONTANA</u>	Claims Made policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments
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The highest premium is \$20,000.

<u>NEBRASKA</u>	Claims Made & Occurrence policies Caps on Awards * Collateral Sources Contingency Fees	Caps on Physicians' Personal Assets Periodic Payments
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* Caps on awards are covered via a participating voluntary state fund. The cap is \$1 mil.

The highest premium is about \$11,000. Total physician liability is \$1 mil/\$3 mil.

<u>NEVADA</u>	Occurrence policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees * Periodic Payments
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* Contingency fees are used - generally 30% - 40% but can go up to 50%.

The highest premium is \$44,160 for \$1 mil/\$3 mil coverage. The highest coverage available is \$5 mil/\$7 mil.

<u>NEW HAMPSHIRE</u>	Occurrence policies *	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments
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* Moving towards Claims Made.

STATE	HAVE PROVISIONS FOR:	DO NOT HAVE PROVISIONS FOR:
<u>NEW JERSEY</u>	Claims Made & Occurrence policies Contingency Fees *	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Periodic Payments

* Sliding scale contingency fees.

Average premium is \$9,000; the highest is \$30,000 (Neurosurgeons) \$1 mil/\$1 mil coverage. The highest coverage is \$5 mil.

Currently before legislature is a four part bill which includes caps on awards, collateral sources, periodic payments, expert witness and certificate of meritorious claim.

<u>NEW MEXICO</u>	Claims Made policies Caps on Awards * Caps on Physicians' Personal Assets	Collateral Sources Contingency Fees Periodic Payments
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* Caps on awards excluding punitive damages.

Have since 1976 a \$500,000 cap (excluding punitive damages). Feel it has had somewhat of an effect on premium costs. The courts are very conservative - only two cases have been awarded the \$500,000. The conservative climate, the cap and the whole malpractice bill are what keeps the premiums low.

<u>NEW YORK</u>	Claims Made & Occurrence policies Collateral Sources Contingency Fees * Periodic Payments	Caps on Awards Caps on Physicians' Personal Assets
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* Contingency Fees: 33 1/3 - 30% of first \$250,000; 25% next \$250,000; 20% next \$500,000; 15% next \$250,000; and 10% of any further amount.

Highest premium is \$83,000 for Neurosurgeons - \$1 mil/\$3 mil.

New York physicians pay the highest premium rates overall in the country. Downstate especially so.

<u>NORTH CAROLINA</u>	Claims Made policies Collateral Sources	Caps on Awards Caps on Physicians' Personal Assets Contingency Fees * Periodic Payments
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* Contingency fees are not a statutory provision, though they are used - average is 20-30%.

The highest premium is \$17,000 (Neurosurgeons). \$5 mil/\$5 mil coverage is available.

<u>NORTH DAKOTA</u>	Claims Made & Occurrence policies Collateral Sources	Caps on Awards Caps on Physicians' Personal Assets Contingency Fees *
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* Contingency fees are not a statutory provision, though they are used - generally 33 1/3%.

The average premium is very variable and the highest is \$45,000 (Neurosurgeon). Highest coverage is \$10 mil.

STATE	HAVE PROVISIONS FOR:	DO NOT HAVE PROVISIONS FOR:
<u>OHIO</u>	Claims Made & Occurrence policies Collateral Sources	Caps on Awards Caps on Physicians' Personal Assets Contingency Fees Periodic Payments

Current bills will attempt for a cap on punitive damage and certain economic damages, contingency fees and periodic payments. Feel the "situation is deteriorating rapidly." Major hospital carriers are requiring hospital medical staffs to change bylaws to include as criteria for membership that a physician carry \$1 mil coverage. Feel this will only encourage larger awards.

Highest premium is \$17,000 for Neurosurgeon -- \$1 mil/\$3 mil. The highest coverage is \$5 mil. There is a \$250,000 cap on pain and suffering and collateral sources provision.

Have had a \$250,000 cap since 1975 on non-economic damages - no cap on economic or punitive damages.

<u>OKLAHOMA</u>	Occurrence policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees * Periodic Payments *
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* Neither contingency fees or periodic payments are statutorily mandated but can be used (contingency fees are generally 40 - 50% of award).

Average premium is \$4,000. The highest premium is \$12,000 (OBGs, Neurosurgeons, Plastic Surgeons) \$1 mil/\$3 mil.

<u>OREGON</u>	Claims Made & Occurrence policies Contingency Fees *	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Periodic Payments
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* Contingency fees: 35% on first \$100,000; 35% on next \$100,000 and 10% on balance.

Highest premium, \$3 mil coverage: \$40,000. Going to \$64,000 in 1986 (Neurosurgeon).

<u>PENNSYLVANIA</u>	Claims Made & Occurrence policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments
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No limit on amount of insurance physician can buy, a catastrophic loss fund covers \$1 mil. including personal assets.

<u>RHODE ISLAND</u>	Occurrence policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments *
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*Periodic payments not statutorily mandated, in actuality, they are used.

Highest premium is \$30,000 (\$1 mil/\$3 mil coverage).

STATE	HAVE PROVISIONS FOR:	DO NOT HAVE PROVISIONS FOR:
<u>SOUTH CAROLINA</u>	Periodic Payments Caps on Physicians Personal Assets *	Caps on Awards Collateral Sources Contingency Fees

* Physicians Personal Assets are covered through a patients compensation fund (no cap).

Highest premium (\$1 mil/\$3 mil) is \$5,600 for a Neurosurgeon.

<u>SOUTH DAKOTA</u>	Claims Made & Occurrence policies Caps on Awards Collateral Sources Contingency Fees	Caps on Physicians' Personal Assets Periodic Payments
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Have had a \$500,000 cap on general damages since 1974-75. Feel it hasn't made any difference on premium costs as premium rates continue to go up.

The highest premium is \$32,000 for Orthopedic Surgeons and Neurosurgeons. Can buy as high a policy as they wish.

<u>TENNESSEE</u>	Occurrence policies Collateral Sources Contingency Fees *	Caps on Awards Caps on Physicians' Personal Assets Periodic Payments **
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* Contingency fees maximum is 33%.

** No provision for periodic payments but judge can use.

Highest premium approximately \$30,000.

<u>TEXAS</u>	Claims Made & Occurrence policies** Caps on Awards *** Caps on Physicians' Personal Assets* Collateral Sources	Contingency Fees ** Periodic Payments **
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* Homestead rule covers physicians' personal assets.

** Contingency fees and periodic payments are not statutorily mandated, but are used.

*** A \$500,000 cap on awards since 1975. This cap is now being challenged. Feel the cap has had a positive effect on keeping premium costs down.

*** Moving towards claims made policies.

\$1 mil/\$3 mil is the highest coverage.

<u>UTAH</u>	Occurrence policies * Collateral Sources Contingency Fees **	Caps on Awards Caps on Physicians' Personal Assets Periodic Payments
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* Moving towards claims made policies.

** Contingency fees - 33 1/3%.

Highest policy is \$18,600.

STATE	HAVE PROVISIONS FOR:	DO NOT HAVE PROVISIONS FOR:
<u>VERMONT</u>	Claims Made	Caps on Awards Caps on Physicians' Personal Assets/ Collateral Sources Contingency Fees * Periodic Payments

* Contingency fees not mandated but used.

Rural community and general conservative climate keep situation under control.

The highest premium for \$1 mil/\$3 mil coverage (Neurosurgeons) is \$10,889 or \$24,622 depending on company (mature rates). Highest coverage is \$1 mil/\$3 mil with a \$9 mil excess.

<u>VIRGINIA</u>	Claims Made & Occurrence policies Caps on Awards * Contingency Fees	Caps on Physicians' Personal Assets Collateral Sources Periodic Payments
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* Caps on awards \$1 mil.

Highest premium is \$42,000 (Neurosurgeon). Highest coverage is \$5 mil.

<u>WASHINGTON</u>	Claims Made policies *	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments
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* Claims made policies only starting in 1986.

Average premium \$8,500. Highest premium \$25,690 (\$1 mil - Neurosurgeon). Highest coverage available \$5 mil/\$7 mil.

<u>WEST VIRGINIA</u>	Claims Made & Occurrence policies	Caps on Awards Caps on Physicians' Personal Assets Collateral Sources Contingency Fees Periodic Payments
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The average premium is \$11,700. The highest is \$48,000 (Neurosurgeon). \$10 mil coverage available.

<u>WISCONSIN</u>	Claims Made & Occurrence policies ** Caps on Physicians' Personal Assets* Periodic Payments **	Caps on Awards Collateral Sources Contingency Fees ***
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* A physician is required to purchase \$200,000 coverage which makes him eligible for a patients compensation fund. Awards beyond his coverage and personal assets are handled via this fund.

** 85-90% are occurrence policies.

*** Contingency fees are not statutorily mandated, but are used.

*** A modified periodic payment rule is used for awards of future damages of \$1 mil.

The highest premium is \$44,600 (Neurosurgeon).

<u>STATE</u>	<u>HAVE PROVISIONS FOR:</u>	<u>DO NOT HAVE PROVISIONS FOR:</u>
<u>WYOMING</u>	Claims Made & Occurrence policies Collateral Sources Structured Awards *	Caps on Awards Caps on Physicians' Personal Assets Contingency Fees

* Structured awards are not consistently recognized by the courts.

Highest premium (\$1 mil coverage) under \$20,000.

ATTACHMENT E

Insurance-Related Legislation

Insurance-Related Legislation: A Roundup

While federal regulation of the insurance industry is blocked by the McCarran-Ferguson Act of 1945 (PL 79-15), there are a number of bills in the 99th Congress that address specific insurance problems. Following is a roundup of their status.

Product Liability

Manufacturers hope recent concern over the availability of business insurance will rekindle interest in legislation to set federal standards to govern product-liability lawsuits. They contend that such standards, which they have been seeking since the late 1970s, would reduce exorbitant settlements.

Sen. John C. Danforth, R-Mo., chairman of the Commerce, Science and Transportation Committee, has promised early action on a bill (S 1999) to establish federal standards and set up a new system to allow victims to recover damages without going to court.

An earlier version without the compensation system (S 100), which had been pushed for several years by Sen. Bob Kasten, R-Wis., died in the committee last May on an 8-8 tie vote. (1985 Weekly Report pp. 2730, 1586)

Trial lawyers heatedly oppose the concept of uniform tort-law standards, and so do many state officials. Consumer groups and organized labor are fighting provisions that they say would make it difficult for victims of unsafe products to recover damages.

In the House, leaders of the Energy and Commerce Committee, which has jurisdiction over the matter, are interested in product-liability legislation but are waiting for the Senate to take the lead.

Pollution Liability

Insurers failed to obtain major relief from liability for hazardous-waste cleanup costs in a bill (HR 2005) to reauthorize the "superfund" cleanup program.

The House and Senate each passed versions of the reauthorization bill, and a conference to settle differences will probably take place early in the new session.

In neither bill did insurers get their prime objective: relaxation of the "strict, joint and several liability" standard that can hold them responsible for toxic-waste problems decades after a policy lapsed, regardless of how small a share of responsibility they carry.

They could yet win some relief, however, through a House provision that would make it easier for the Environmental Protection Agency to make out-of-court settlements to release from liability parties who have contributed only small amounts of waste to a dump site. (1985 Weekly Report p. 2619)

Vaccine Compensation

Legislation (S 827) to compensate people injured by adverse reactions to some vaccines remains stalled in the Senate Labor and Human Resources Committee.

Sen. Paula Hawkins, R-Fla., says the bill is needed both to help victims and to ensure the availability of vaccines. Some pharmaceutical companies have stopped making certain vaccines, such as DPT (diphtheria, pertussis and tetanus), because of the risk of lawsuits on

behalf of children who suffer rare but severe side effects.

Opponents of the bill object to a provision that would require victims to give up their right to sue if they want to receive compensation from the government (1985 Weekly Report pp. 2742, 1591)

Medical Malpractice

The American Medical Association is backing a bill (S 1804) by Sen. Orrin G. Hatch, R-Utah, to spur states to revise their medical malpractice laws.

The bill would offer states up to \$4 million as an incentive to enact specific changes in malpractice laws, such as limiting attorneys' fees and putting a cap of \$250,000 on awards for pain and suffering.

The bill is pending in the Senate Labor and Human Resources Committee, which Hatch chairs.

Another approach was offered by Reps. Richard A. Gephardt, D-Mo., and W. Henson Moore, R-La., in HR 3084. Their bill would set up an alternative to lawsuits, featuring a combination of binding arbitration by an independent body and judicial review of claim amounts.

Other bills would set up screening boards to examine claims (S 175, HR 2659), make it easier for doctors to insure themselves (S 1357, HR 2261), and make it possible for military personnel to sue for malpractice in military hospitals (HR 3174).

Antitrust Exemption for Insurance

House Judiciary Committee Chairman Peter W. Rodino Jr., D-N.J., says his panel will re-examine the antitrust exemption the industry enjoys as a result of the McCarran-Ferguson Act. (Background, p. 149)

The law exempts the insurance industry from federal regulation so long as it is regulated by the states, and it allows insurance companies to share information and set joint rates without violating antitrust laws.

The insurance industry generally opposes efforts to limit its privileges. A few executives of larger companies, however, have said they would be willing to give up the antitrust exemption, which they feel protects smaller, less efficient companies.

Taxation

The property-casualty insurance industry would be hit hard by the tax-reform bill (HR 3838) passed by the House Dec. 17. That segment of the industry has paid little tax in recent years because of its investment and accounting practices.

The House bill would tax the companies' income from currently tax-exempt securities, and would impose a 20 percent minimum tax on property-casualty companies beginning in 1988.

Life and health insurance companies were generally relieved that the House bill ignored proposals to tax employees' health insurance and the increase in the value of life insurance policies.

Blue Cross and Blue Shield companies would have to pay \$1.7 billion in taxes, however, because of a provision that would tax them as if they were profit-making companies (1985 Weekly Report pp. 2190, 2705)



P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

February 5, 1986

MEMORANDUM

TO: Representative John Sund

ATTN: Shari Kochman

FROM: Jay Moor *JM*
Legislative Analyst

RE: Disability Insurance: The California Plan
Research Request 87.098

You requested information on the Disability Insurance Program administered by the Employment Development Department (EDD) of the State of California. Mr. Charles Burger (Telephone: 916-445-0518) of the EDD provided the attached Annual Report and Actuarial Evaluation of the Disability Insurance Fund which contains detailed answers to your questions. Also attached are portions of the California statute related to disability compensation.

THE CALIFORNIA PLAN

California has three programs for protection against wage loss:

1. **Workers Compensation** is applicable where unemployment results from on-the-job injuries;
2. **Unemployment Insurance** covers someone who is out of work but able and available to work; and
3. **Disability Insurance** covers the person who is unable to perform his or her usual or customary work because of illness or injury (physical or mental) incurred off the job.

Who Is Covered

California first adopted its Unemployment Insurance Program in 1935. In 1946, provisions were added to establish the Disability Insurance Program which applied to all workers covered by unemployment insurance (with certain common exclusions). In 1961, coverage was extended to agricultural workers; in 1965, to foreign farm workers; in 1968, to some hospital workers; in 1972, to most nonprofit organizations; in 1976, to school district employees; and in 1978, to certain domestic workers. Workers are

covered for wages lost due to illness, injury, pregnancy, communicable disease, and to enrollment in alcoholism or drug treatment programs.

Alternative Plans

There are several disability insurance plans. Most employees contribute to the State Plan (and, therefore, the Disability Insurance Fund) through a tax withheld from wages. Self-employed persons may elect to cover themselves. An employer may provide a voluntary plan where premiums are deducted from wages. Voluntary programs do not contribute to the Disability Insurance Fund.

Benefits

In order to receive benefits, the claimant must: 1) file a claim form; 2) go through a seven-day waiting period; 3) earn at least \$300 in wages during the base period; 4) submit to an examination if requested; and 5) file a certification of disability. Benefits may be reduced or denied if a claimant receives worker's compensation, sick leave pay, or regular wages during the claim period (worker's compensation is generally applied in work-related cases). Full disability benefits may be paid for permanent disability, even if worker's compensation is paid. There are provisions for using disability insurance to cover the difference between regular wages and sick leave pay. The claimant is not eligible for disability insurance payment for any day he is entitled to receive state or federal unemployment insurance benefits.

The maximum period of benefits is 52 weeks. The minimum weekly benefit is \$50; the maximum is \$224. Pregnancy is now covered with the same benefits as any other disability. In 1979, a hospital benefit of \$12 per day, up to 20 days, was discontinued, and the savings were used to increase basic benefits.

Claims

The system is set up to process claims sent in by mail. The first claim is mailed by the claimant's doctor with an opinion on the probable duration of disability. The claim is processed in one of 21 field offices. Trained claims examiners apply standards of normal expectancy of duration to each claim and may make unscheduled visits to claimants or require a medical examination to verify a claim.

The Disability Insurance Fund

The Disability Fund has, until recently, been solvent. The balance in the fund reached a record level of \$635 million in 1979. This was attributable to several factors. The rate of disablement had been decreasing since 1970. Although the number of claims has generally increased over time, the proportion of taxpayers filing claims has declined. Furthermore, the system used a tax rate based on expected claims. In 1977, the taxable wage ceiling was raised from \$9,000 to \$11,400 in order to cover an expected increase in the number of claims due to pregnancies, a phenomenon which did not occur until several years later. The program paid out over \$1 billion to 600,000 claimants last year. Another 200,000 claimants were not eligible for benefits.

To lower the fund balance from the 1979 high, taxpayers were given a rebate, there was benefit enhancement, and a new variable formula for contributions was installed. In 1980, the balance was \$166 million. Then, in 1985, the variable tax rate overreacted to the previous year's increases and dropped too far, wiping out the fund. The EDD is now recommending a change in the formula if the fund is to avoid continued bankruptcy. To cover this year's losses, the fund has had to borrow from the General Fund.

California Disability Insurance Fund (Millions of Dollars)

	<u>1982</u>	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986(Est.)</u>
Receipts	829	859	1,148	918	1,273
Disbursements	854	860	991	1,224	1,331
Difference	(25)	(1)	157	(305)	(41)
Fund Balance	132	130	286	(19)	(60)

(numbers do not add due to rounding)

If you have any questions or wish additional information, please contact our agency.

JM

Attachments

YOUR RIGHTS

You are entitled to the reason and authority for any determination of eligibility which reduces or denies your benefits.

You may appeal any determination of your eligibility by notifying the disability office that you wish to appeal. You are entitled to a hearing before an administrative law judge and appeals may be carried from the administrative law judge to the Appeals Board and subsequent to that, to the courts.

Information about your claim will be kept confidential except for the purposes allowed by law.

YOUR OBLIGATIONS

You are responsible for filing your claim and other forms promptly and accurately.

Time limits are explained on the applicable form.

If a form is "late" and you believe you have "good cause", you should include an explanation of the reason(s) on or with the form.

If you are not sure how to answer a question or what is required, attach an explanatory note or contact the disability insurance office.

OTHER PROGRAMS

IF INJURED ON THE JOB or ill as a result of occupation, you should notify your employer.

IF YOU WILL NEED RETRAINING or other services in order to return to work, you should contact the Department of Rehabilitation (under *California, State of* in the telephone book "white pages").

IF YOUR DISABILITY IS TOTAL and is expected to continue for a year or more, you should contact the Social Security Administration (listed under *United States Government, Health and Human Services* in the telephone book).

IF YOU ARE ABLE AND AVAILABLE TO WORK but unemployed, you may be eligible for Unemployment Insurance.

FOR HELP IN FINDING WORK, contact a Job Service office.

Employment Development Department offices, including Unemployment Insurance and Job Service, are listed under *California, State of* in the telephone book.

Disability Insurance

FOR DISABILITIES BEGINNING ON
AND AFTER JANUARY 1, 1985



State plan

ADMINISTERED BY
STATE OF CALIFORNIA
EMPLOYMENT DEVELOPMENT DEPARTMENT

This pamphlet is for general information only, and does not have the force and effect of law, rule, or regulation.

DL 2515 REV. 38 112 841

Under the California Unemployment Insurance Code, "disability" includes any illness or injury, either physical or mental, including pregnancy, childbirth or related medical condition, that prevents you from doing your regular or customary work.

The cost of the disability insurance program may vary from year to year. For specific tax rates contact the nearest disability insurance or Employment Tax office.

Employers, self-employed individuals or persons in family employment may elect disability insurance self-coverage; see "elective coverage".

HOW TO APPLY

1. Obtain a claim form. You can get one from any office of the Employment Development Department by telephone, letter, or in person. Your doctor, hospital or employer may also have forms available. (Out of state: To obtain a claim form write to Employment Development Department, Disability Insurance, P.O. Box 13140, Sacramento, CA 95813.)
2. Fill out and sign the "Claim Statement of Employee." Write or print clearly. Be sure all information is correct, be especially careful with your social security number, addresses and dates. Errors can delay payment of a claim. If you wish to explain an answer more fully, attach a note to the form.
3. Give the form to your doctor for completion of the "Doctor's Certificate." A claim cannot begin more than seven days before you were examined by or under the care of the certifying doctor. Your doctor may be any licensed physician and surgeon, osteopath, chiropractor, podiatrist, optometrist, dentist, psychologist* or medical officer of a United States medical facility. An accredited religious practitioner may also certify.
4. Mail your claim not later than the 41st day after the first day for which benefits are payable. Earlier filing will speed your payment. Late filing results in loss of payment for the number of days the claim is late unless "good cause" for the delay is established.

*additional requirements apply.

HOW BENEFITS ARE PAID

The Disability Insurance Program is designed to serve you by mail. You do not need to leave home or the hospital to receive benefits.

When your claim is received, the disability insurance office serving your community, will request the information necessary to determine your eligibility. In the meantime, unless you had already recovered, you may be sent a "continued claim" form to certify to benefits while awaiting the responses for requested information.

Benefits may begin with the day after the seven-day waiting period of disability or the first day of hospitalization, including certain "short stay" facilities, whichever comes first. (You may be paid for the waiting period if your disability exceeds 21 days.)

Benefits are paid as rapidly as possible after receipt of all needed information if you meet all eligibility requirements. The benefit check will be mailed to you. If you are eligible for continued benefits, a "continued claim" form for the next period will be enclosed. Normally these periods will be for two weeks. Partial weeks are paid at 1/7th of the weekly benefit amount for each day of disability.

VOLUNTARY PLANS

A majority of employees of an employer may voluntarily consent to be covered by an insured or self-insured plan with that employer instead of the State Plan. If you have chosen coverage under such a plan the provisions of this pamphlet may not apply to you; you should obtain information about your coverage and file your claim through your employer.

ELECTIVE COVERAGE

The current cost can be obtained by contacting your local Employment Tax District Office.

Employers and self-employed persons may elect coverage. The cost is set annually based on claim experience.

Individuals in family employment, not subject to the Code, may also elect coverage at the same rate as other employees.

Claims are filed in the same manner as State Plan claims, however there are some differences in eligibility requirements from those listed in this pamphlet. For information, contact your disability insurance office or any Employment Tax Office.

HOW YOUR BENEFIT RATE IS DETERMINED

The weekly and maximum benefit amounts of your claim will be based on the wages paid to you during a certain past 12 month period known as the **base period**. Only wages subject to the disability insurance tax law can be used and they must total at least \$300. The date on which your claim begins determines what your base period will be and thus the wages which will be used in computing your benefits. If you wish your claim to begin at a date later than the date your disability begins, contact the nearest Disability Insurance Office before you submit your claim.

The **base period** is divided into four consecutive calendar quarters. The month in which your claim begins determines which four quarters must be used. To determine your base period use the following chart which shows how base periods are determined:

If your claim begins in:	Then Your Base Period Is the Twelve months ending the last:			
	September 30	OCT NOV DEC	JAN FEB MAR	APR MAY JUN
FEB MAR APR	September 30	OCT NOV DEC	JAN FEB MAR	APR MAY JUN
MAY JUN JUL	December 31	JAN FEB MAR	APR MAY JUN	JUL AUG SEP
AUG SEP OCT	March 31	APR MAY JUN	JUL AUG SEP	OCT NOV DEC
NOV DEC JAN	June 30	JUL AUG SEP	OCT NOV DEC	JAN FEB MAR

For example: A claim beginning in July is based on the four quarters of the previous year. A claim beginning in August uses the last three quarters (nine months) of the previous year plus the first quarter of the year in which the claim begins.

EXCEPTIONS. If you were paid less than \$300 in wages in the base period and your claim begins during an Unemployment Insurance Benefit Year, the Unemployment Insurance base period will be substituted.

If you were in the military service, received workers' compensation benefits, or did not work because of a trade dispute during your base period, you may be able to substitute wages paid in prior quarters to make your claim valid or increase your benefit amount. If your claim is invalid because of extended unemployment during your base period, you may also be able to substitute wages paid in prior quarters to make your claim valid.

WAGE CONTINUATION

WAGES. If you receive wages from an employer while disabled, benefits and wages added together are limited to your weekly wage (less overtime) immediately prior to disability.

BENEFIT MAXIMUMS

The maximum amount of benefits is 52 times the weekly rate but not more than your total base period wages, except:

WHILE RESIDENT IN AN ALCOHOLIC RECOVERY HOME OR A DRUG FREE RESIDENTIAL FACILITY: While participating in an approved alcoholic recovery program or drug-free residential program on referral or recommendation of a doctor, disability benefits are payable for a limited period.

- * Disabilities caused by acute or chronic alcoholism, or drug abuse, being medically treated do not have this limitation.

BENEFITS ARE NOT PAYABLE

- When you are entitled to temporary disability benefits for workers' compensation, *except* if they are at a lesser weekly rate than your disability insurance, the difference may be paid to you.
- When you are entitled to unemployment insurance.
- If you had left the labor market prior to becoming disabled.
- When legal custody is the cause of unemployment.
- When confined by court order or certification as a delinquent, drug addict or sexual psychopath.

BENEFIT SCHEDULE

Here is how your "weekly" rate (the amount of benefits paid for a seven day period) is determined from the quarter of your base period during which you were paid the highest wages.

Wages in Highest Quarter	Weekly Benefit Amount	Wages in Highest Quarter	Weekly Benefit Amount	Wages in Highest Quarter	Weekly Benefit Amount	Wages in Highest Quarter	Weekly Benefit Amount
\$ 75 - 1149 99	50	1250 - 2274 99	85	4375 - 2399 99	140	8450 - 4524 99	185
1150 - 1174 99	51	2275 - 2299 99	86	2400 - 2424 99	141	4525 - 4549 99	186
1175 - 1199 99	52	2300 - 2324 99	87	2425 - 2449 99	142	4550 - 4574 99	187
1200 - 1224 99	53	2325 - 2349 99	88	2450 - 2474 99	143	4575 - 4599 99	188
1225 - 1249 99	54	2350 - 2374 99	89	2475 - 2499 99	144	4600 - 4624 99	189
1250 - 1274 99	55	2375 - 2399 99	90	2500 - 2524 99	145	4625 - 4649 99	190
1275 - 1299 99	56	2400 - 2424 99	91	2525 - 2549 99	146	4650 - 4674 99	191
1300 - 1324 99	57	2425 - 2449 99	92	2550 - 2574 99	147	4675 - 4699 99	192
1325 - 1349 99	58	2450 - 2474 99	93	2575 - 2599 99	148	4700 - 4724 99	193
1350 - 1374 99	59	2475 - 2499 99	94	2600 - 2624 99	149	4725 - 4749 99	194
1375 - 1399 99	60	2500 - 2524 99	95	2625 - 2649 99	150	4750 - 4774 99	195
1400 - 1424 99	61	2525 - 2549 99	96	2650 - 2674 99	151	4775 - 4799 99	196
1425 - 1449 99	62	2550 - 2574 99	97	2675 - 2699 99	152	4800 - 4824 99	197
1450 - 1474 99	63	2575 - 2599 99	98	2700 - 2724 99	153	4825 - 4849 99	198
1475 - 1499 99	64	2600 - 2624 99	99	2725 - 2749 99	154	4850 - 4874 99	199
1500 - 1524 99	65	2625 - 2649 99	100	2750 - 2774 99	155	4875 - 4899 99	200
1525 - 1549 99	66	2650 - 2674 99	101	2775 - 2799 99	156	4900 - 4924 99	201
1550 - 1574 99	67	2675 - 2699 99	102	2800 - 2824 99	157	4925 - 4949 99	202
1575 - 1599 99	68	2700 - 2724 99	103	2825 - 2849 99	158	4950 - 4974 99	203
1600 - 1624 99	69	2725 - 2749 99	104	2850 - 2874 99	159	4975 - 4999 99	204
1625 - 1649 99	70	2750 - 2774 99	105	2875 - 2899 99	160	5000 - 5024 99	205
1650 - 1674 99	71	2775 - 2799 99	106	2900 - 2924 99	161	5025 - 5049 99	206
1675 - 1699 99	72	2800 - 2824 99	107	2925 - 2949 99	162	5050 - 5074 99	207
1700 - 1724 99	73	2825 - 2849 99	108	2950 - 2974 99	163	5075 - 5099 99	208
1725 - 1749 99	74	2850 - 2874 99	109	2975 - 2999 99	164	5100 - 5124 99	209
1750 - 1774 99	75	2875 - 2899 99	110	3000 - 3024 99	165	5125 - 5149 99	210
1775 - 1799 99	76	2900 - 2924 99	111	3025 - 3049 99	166	5150 - 5174 99	211
1800 - 1824 99	77	2925 - 2949 99	112	3050 - 3074 99	167	5175 - 5199 99	212
1825 - 1849 99	78	2950 - 2974 99	113	3075 - 3099 99	168	5200 - 5224 99	213
1850 - 1874 99	79	2975 - 2999 99	114	3100 - 3124 99	169	5225 - 5249 99	214
1875 - 1899 99	80	3000 - 3024 99	115	3125 - 3149 99	170	5250 - 5274 99	215
1900 - 1924 99	81	3025 - 3049 99	116	3150 - 3174 99	171	5275 - 5299 99	216
1925 - 1949 99	82	3050 - 3074 99	117	3175 - 3199 99	172	5300 - 5324 99	217
1950 - 1974 99	83	3075 - 3099 99	118	3200 - 3224 99	173	5325 - 5349 99	218
1975 - 1999 99	84	3100 - 3124 99	119	3225 - 3249 99	174	5350 - 5374 99	219
2000 - 2024 99	85	3125 - 3149 99	120	3250 - 3274 99	175	5375 - 5399 99	220
2025 - 2049 99	86	3150 - 3174 99	121	3275 - 3299 99	176	5400 - 5424 99	221
2050 - 2074 99	87	3175 - 3199 99	122	3300 - 3324 99	177	5425 - 5449 99	222
2075 - 2099 99	88	3200 - 3224 99	123	3325 - 3349 99	178	5450 - 5474 99	223
2100 - 2124 99	89	3225 - 3249 99	124	3350 - 3374 99	179	5475 and over	224
2125 - 2149 99	90	3250 - 3274 99	125	3375 - 3399 99	180		
2150 - 2174 99	91	3275 - 3299 99	126	3400 - 3424 99	181		
2175 - 2199 99	92	3300 - 3324 99	127	3425 - 3449 99	182		
2200 - 2224 99	93	3325 - 3349 99	128	3450 - 3474 99	183		
2225 - 2249 99	94	3350 - 3374 99	129	3475 - 3499 99	184		

PENALTIES

You may be disqualified for receipt of benefits:

- for the amount of time a claim is late (without good cause).
- if you have made a false statement or failed to report a material fact.
- if you fail to have an independent medical examination when requested (costs for such examinations are paid by the Department).

The Unemployment Insurance Code provides for penalties of fine, imprisonment and loss of benefit rights for fraud against the disability insurance system.

FROM:



TO:

State of California
Employment Development Department
P.O. Box 13140
Sacramento, CA 95813-4140



HAVE YOU COMPLETED ALL ITEMS AND CHECKED YOUR SOCIAL SECURITY ACCOUNT NUMBER?

The Information Practices Act beginning with Section 1798 of the Civil Code imposes conditions on the gathering, maintenance, disclosure, and correction of personal information by public agencies.

1. Right to inspect and correct Civil Code Section 1798.34 gives you the right to inspect any personal records maintained about you by the Employment Development Department. Section 1798.35 permits you to request that the record be corrected if you believe that it is not accurate, relevant, timely or complete.
2. Exemptions: Certain limited types of information that would generally be considered personal are exempt from disclosure to you. (a) Medical or psychological records where knowledge of the contents might be harmful to the subject (Civil Code Section 1798.3); (b) Records of active, criminal, civil or administrative investigations (Civil Code Section 1798.3); (c) Names of individuals submitting letters of reference (Civil Code Section 1798.38).
3. Appeal rights: If you are denied access to records which you believe you have a right to inspect or if your request to amend your record is refused, you may file an appeal with your local Employment Development Department office.

REVERSE SIDE AND FOLD UP ON THIS LINE
PLEASE DO NOT STAMP

FOLD ON THIS LINE

FOLD ON THIS LINE

NOTE: If you need assistance in a language other than English, write that language here

CLAIM STATEMENT OF EMPLOYEE

COMPLETE ALL ITEMS. IF INCOMPLETE, THIS FORM WILL BE RETURNED, CAUSING A DELAY IN BENEFIT PAYMENTS

1. Print your full name: FIRST LAST		2. IMPORTANT: Enter Your Social Security Account Number	
City and state worked under in last two years: Your mailing address: STREET ADDRESS, P.O. OR R.F.D. APT. NO. CITY OR TOWN STATE AND ZIP CODE		3. What was the first day you were too sick to perform all the duties of your regular or customary work, even if it was a Saturday, Sunday, holiday, or a normal day off? MONTH DAY YEAR MONTH DAY YEAR	
Your home address: (if different from mailing address) STREET ADDRESS OR SPECIFIC DIRECTIONS TO YOUR HOME IF P.O. BOX OR R.F.D.		4. What was the last day you worked? MONTH DAY YEAR	

5. Employer's Business Name		Telephone Number ()	
Employer's Business Address		CITY STATE AND ZIP CODE	
6. Your occupation with this employer		Your Badge or Payroll number	
What is your usual occupation?		Office: 2	
Were you an employer or self-employed individual?		Comp: 2503 B	
Did you work more than 14 days during your last period of employment which ended on the date shown in item (4) above?		2501 H	
Did you stop work because of sickness or injury?			
If "No," please give reason:			
Have you filed for or received UNEMPLOYMENT INSURANCE benefits between the last day you worked and the first day you became disabled?			
Has, or will your employer continue your pay, by means of sick leave, vacation, pension, gift or other means?			
7. Was this disability caused by your work? If "Yes," describe HOW			
Are you claiming or receiving Workers' Compensation benefits for any on-the-job injuries or illnesses during the period covered by this claim?			
8. Have you recovered from your disability?		By	
If "Yes," enter date of recovery:			
9. Have you returned to work for any day, part time or full time after the date shown in item (8) above?			
If "Yes," please enter such dates:			

10. I hereby claim benefits and certify that for the period covered by this claim I was unemployed and disabled, that the foregoing statements including any accompanying statements are to the best of my knowledge and belief true, correct and complete. I hereby authorize my attending physician, practitioner, hospital and employer to furnish and disclose all facts concerning my disability and wages or earnings that are within their knowledge and to allow inspection of and provide copies of any hospital records concerning my disability that are under their control. I understand this authorization is granted for a period of 18 months from the date of my signature or the effective date of the claim, whichever is later. I agree that a photocopy of this release shall be as valid as the original.

Claim signed on: MONTH DAY YEAR	Claimant's signature: (DO NOT PRINT)	TELEPHONE NUMBER
Under Section 2101 of the California Unemployment Insurance Code, it is a misdemeanor willfully to make a false statement or knowingly to conceal a material fact in order to obtain the payment of any benefits, such misdemeanor being punishable by imprisonment not exceeding six months or by a fine not exceeding \$100 or both.		
If your signature is made by mark (X) it must be attested by two witnesses with their addresses. SIGNATURE-WITNESS SIGNATURE-WITNESS ADDRESS ADDRESS		If an authorized agent is filing for benefits for an INCAPACITATED claimant, or a spouse is filing for a MENTALLY INCAPACITATED individual, contact the office listed below, or any Employment Development Department office, for the required forms and instructions.

TEAR ALONG DOTTED LINE

KEEP FOR YOUR RECORDS

INFORMATION COLLECTION AND ACCESS

STATE LAW REQUIRES THE FOLLOWING INFORMATION TO BE PROVIDED WHEN COLLECTING INFORMATION FROM INDIVIDUALS

AGENCY NAME Employment Development Department (EDD)	TITLE OF OFFICIAL RESPONSIBLE FOR INFORMATION MAINTENANCE Manager, Disability Insurance Office	
LOCAL CONTACT PERSON Manager of the Employment Development Department Facility	ADDRESS 5009 Broadway Sacramento, CA	TELEPHONE NUMBER (916) 739-2944

AUTHORITY WHICH AUTHORIZES THE MAINTENANCE OF THE INFORMATION

- Sections 2601 through 3272 of the Unemployment Insurance Code.
- Sections 2706-1, 2706-2, 2706-1 and 2710-1, Title 22, California Administrative Code.

THE FOLLOWING ITEMS OF INFORMATION ARE VOLUNTARY. ALL OTHERS ARE MANDATORY

- All information requested is mandatory.

THE CONSEQUENCES IF ANY OF NOT PROVIDING ALL OR ANY PART OF THE REQUESTED INFORMATION

- Failure to supply any or all information may cause delay or may cause you to be denied benefits to which you are entitled.
- Willfully making a false statement or representation or knowingly withholding a material fact to obtain or increase any benefit or payment will result in a disqualification to receive benefits and/or service, and could lead to prosecution.

TEAR OUT THIS TAB BEFORE MAILING

DOCTOR'S CERTIFICATE

Certification may be made by a licensed medical or osteopathic physician and surgeon, chiropractor, dentist, podiatrist, optometrist, designated psychologist or an authorized medical officer of a United States Government facility. All items on this sheet must be completed.

Patient File No. _____

11. I attended the patient for the present medical problem from: MONTH DAY YEAR To MONTH DAY YEAR At intervals of _____

12. History: _____
 State the nature, gravity and the likely course of the accompanying disorder or disorders.
 Findings: _____
 Diagnosis: _____
 Type of treatment and/or medication rendered to patient: _____

13. Diagnosis confirmed by: (Specify type of test or X-ray) _____

14. Is this patient now pregnant or has she been pregnant since the date of treatment as reported above? Yes ☐ No ☐ If "Yes", date pregnancy terminated or future EDC. _____
 Is the pregnancy normal? Yes ☐ No ☐ If "No", state the abnormal and involuntary complication causing maternal disability: _____

15. Operation: _____ Or to be performed: _____ Type of operation: _____
 Date performed: _____

16. Has this patient at any time during your attendance for this medical problem, been incapable of performing his or her regular work? Yes ☐ No ☐ If "Yes", the disability commenced on: _____

17. APPROXIMATE date, based on your examination of patient, disability (if any) should end or has ended sufficiently to permit the patient to resume regular or customary work. Even if considerable question exists, make SOME "estimate". This is a requirement of the Code, and the claim will be delayed if such date is not entered. Such answers as "indefinite" or "don't know" will not suffice. _____

18. Based on your examination of patient, is this disability the result of "occupation" either as an "occupational disease" or as an "occupational accident"? Yes ☐ No ☐ (This should include aggravation of pre-existing conditions by occupation)

19. Have you reported this OR A CONCURRENT DISABILITY to any insurance carrier as a Workers' Compensation Claim? Yes ☐ No ☐ If "Yes", to whom? _____
 (Name of carrier or firm)

20. Further comments (if indicated): _____

21. Was or is patient confined as a registered bed patient in a hospital? Yes ☐ No ☐
 Was patient treated in the surgical unit of a hospital or surgical unit? Yes ☐ No ☐
 If you please provide name and address: _____

22. Date and hour entered as a registered bed patient and discharged from such Hospital pursuant to your orders.

ENTERED			STILL CONFINED			DISCHARGED		
on	at	A.M. P.M.	on	at	A.M. P.M.	on	at	A.M. P.M.
_____	_____	_____	_____	_____	_____	_____	_____	_____

23. Would the disclosure of this information to your patient be medically or psychologically detrimental to the patient? Yes ☐ No ☐

I hereby certify that, based on my examination, the above statements truly describe the patient's disability (if any) and the extent and duration thereof, and that I am a _____ licensed to practice by the State of _____.

PRINT OR TYPE DOCTOR'S NAME AS SHOWN ON LICENSE _____

SIGNATURE OF ATTENDING DOCTOR _____

NO. AND STREET _____ CITY _____ ST. CODE _____ STATE LICENSE NUMBER _____ TELEPHONE NO. _____ DATE OF SIGNING THIS FORM _____

THE PRINCIPAL PURPOSES FOR WHICH THE INFORMATION IS TO BE USED

- To determine your eligibility for disability insurance benefits.
- To be summarized and published in condensed form for the use and information of government agencies and the public (your name or identification will not appear in publications).
- To be used to locate parents who are being sought for failure to provide support for minor children.
- To be used by other governmental agencies to determine eligibility for public social services under the provisions of Division 9 of the Welfare and Institutions Code.
- To be used by the Employment Development Department to enable it to carry out its responsibilities under the Unemployment Insurance Code.
- To be exchanged pursuant to Section 322 of the Unemployment Insurance Code and Section 1798.24 of the Civil Code with other governmental departments and agencies both federal or state, which are concerned with any of the following: (1) administration of an unemployment insurance program; (2) collection of taxes which may be used to finance unemployment insurance or disability insurance; (3) relief of unemployed or disabled individuals; (4) investigation of labor law violations or allegations of unlawful employment discrimination; (5) the housing of workers' compensation awards; (6) or whenever necessary to permit a state agency to carry out its mandated responsibilities where the use to which the information will be put is compatible with the purposes for which it was gathered; (7) when mandated by state or federal law. Disclosure under Unemployment Insurance Code Section 322 will only be made in those instances in which it is otherwise the administration of the programs mandated by the code.
- Pursuant to Section 2714 of the Unemployment Insurance Code: (1) information may be revealed to the extent necessary for the administration of public social services or to the Director of Social Services or his representatives; (2) case file records may be released to the Department of Rehabilitation unless the claimant requests otherwise; (3) information shall be released to any law enforcement agency upon request when a felony arrest warrant has been issued against the applicant.

UNDER CIVIL CODE SECTION 1798.24 YOU HAVE THE RIGHT TO REQUEST RECORDS MAINTAINED ON YOU BY THE AGENCY UNLESS EXEMPTED AS DESCRIBED ON THE REVERSE

SEE REVERSE

If you do not understand this form or any form provided by Disability Insurance, call the telephone number shown on the form for assistance.

如果你不明白傷病保險局所提供的這張或任何其他表格，
請照表上所顯示的號碼打電話來，我們會幫助你。

Si no comprende la información en este formulario o cualquier formulario proveído por las Oficinas del Seguro de Incapacidad, y desea asistencia, llame al número telefónico que aparece en el formulario.

Do not complete this claim form if you are insured by a Voluntary Plan maintained by your employer. Ask your employer for information regarding your coverage and for proper forms to complete.

INSTRUCTIONS FOR APPLYING FOR STATE DISABILITY INSURANCE BENEFITS

MEDICAL CARE REQUIREMENTS:

The Doctor's Certificate is absolutely necessary* and must be filled in by a licensed medical or osteopathic physician and surgeon, chiropractor, dentist, podiatrist, optometrist, designated psychologist or an authorized medical officer of a United States Government facility. You must have been examined by or under the care of a physician or practitioner* during some portion of the first eight days of your disability, otherwise you may lose benefits.

HOW TO COMPLETE THIS CLAIM FORM:

First: You must complete ~~ALL~~ parts of the Claim Statement of Employee. Be accurate with the dates. Check your Social Security Account Number carefully.

Second: Ask your Doctor to complete the Doctor's Certificate.

WHEN TO COMPLETE AND MAIL THIS CLAIM FORM:

1. IF YOU WERE NOT HOSPITALIZED, complete and mail this form after the eighth (8) day following the date YOU enter in item 3 on the Claim Statement of Employee.
2. IF YOU WERE HOSPITALIZED, complete and mail this form after the first (1) day of hospital confinement.
3. Important! The claim must be mailed within 48 days of the date you became disabled if you are to receive credit from the day you first became disabled. If the claim is mailed late, and you believe that you have "good cause", you should include an explanation on a separate sheet attached to the claim form.

It is YOUR OWN responsibility to see that this Claim and Doctor's Certificate are filled out **COMPLETELY** and mailed to the Employment Development Department at the address on the form. If any item is not completed on this form, it will be returned for completion, and your benefit payment will be delayed. If you wish your claim to begin later than the date your disability begins, contact the nearest Disability Insurance Office before you submit your claim.

For important information concerning your benefit rates see "How Your Benefit Rate is Determined" in the Disability Insurance Provisions pamphlet (DE 2515).

For additional information contact any Employment Development Department office.

*If you are receiving temporary workers' compensation and are filing for reduced State disability benefits for the same days, the Doctor's Certificate is not required.

**If you belong to the teachings of a church, sect, denomination or organization, and in accordance with its precepts, disqualify for holding any office or position, you may submit the Certification of your preacher, who must be submitted to the Employment Development Department, in place of the Doctor's Certificate. The certificate must be obtained from your preacher or any field office of the Department, and must be attached to this form in place of the Doctor's Certificate.

DE 2501 REV. 81 11-001 FIRST CLAIM FOR DISABILITY INSURANCE

FEDERAL PRIVACY ACT

The Employment Development Department requires disclosure of social security account numbers on a mandatory basis to comply with Unemployment Insurance Code Sections 1263 and 2627; with Title 22, California Administrative Code Sections 1085, 1086, and 1326; and with Title 20, Code of Federal Regulations Part 604.

Social security account numbers may be disclosed pursuant to Sections 322 and 2714 of the Unemployment Insurance Code and Section 1796.24 of the Civil Code to other governmental departments and agencies both federal and state, which are concerned with any of the following: (1) administration of an unemployment insurance program; (2) collection of taxes which may be used to finance unemployment insurance or disability insurance; (3) relief of unemployed or destitute individuals; (4) investigation of labor law violations or allegations of unlawful employment discrimination; (5) the hearing of workers' compensation appeals; (6) or whenever necessary to permit a state agency to carry out its mandated responsibilities where the use to which the information will be put is compatible with the purpose for which it was gathered; (7) or when mandated by state and federal law. Disclosures under Unemployment Insurance Code Section 322 will only be made in those instances in which it furthers the administration of the programs mandated by that code.



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

November 6, 1985

TO: Representative Niilo Koponen
ATTN: Deborah Niedermeyer
FROM: Mark Torgerson *MT*
Legislative Analyst
RE: Cost and Availability of Liability Insurance
Research Request 86-027

You asked this agency to survey liability insurance rate increases for various businesses and professions in Alaska during the past two or three years. You also asked us to compile a bibliography of publications which analyze the causes of, and possible solutions to, the rate increases. We contacted the Alaska Department of Commerce and Economic Development's Division of Insurance, the National Conference of State Legislatures (NCSL), the United States House Subcommittee on Commerce and Transportation, the National Insurance Consumer Organization (NICO), the Children's Defense Fund and various national insurance trade organizations. They provided us with the following information.

Liability Insurance Rate Increases

As you know, commercial and governmental liability insurance rates have increased substantially since mid-1984. The entities affected include private businesses such as commercial fishermen, day care centers, medical professionals, owners of liquor establishments, truckers and air taxi operators; governmental entities such as municipalities and schools have also been hit with significant rate increases. According to Don Koch, Chief of Market Surveillance for the Division of Insurance, rates have risen sharply for all lines of liability insurance.

A listing of the specific rate increases for various businesses was unavailable. Mr. Koch stated that the Division of Insurance does not keep an ongoing record of each insurance company's rates. (The division kept these records at one time, but they were rarely used.) The division becomes aware of rate changes when insurance companies request rate increases or decreases. Mr. Koch stated that the division has rejected some requests for rate increases because they were deemed "excessive" as outlined in AS 21.39.030. Based upon rate requests made in the past eighteen months by insurance companies, Mr. Koch estimated

that liability rates have increased between 25 percent and 50 percent, depending upon the type of entity to be insured. (These rate increases have occurred even though the risk to the insurance companies has not changed.) However, actual rates for some businesses have increased by up to a reported 900 percent. This occurs when a business's insurance company cancels its coverage, thereby forcing the business to find another insurer. According to Mr. Koch, insurance coverage is currently available for all types of businesses except asbestos removal, but businesses whose insurance is cancelled may be required to pay large increases for new insurance. In addition, the new coverage may be limited in amount and scope. Furthermore, the business's new insurer may be a "nonadmitted" (also called "surplus lines") insurance company; that is, the company is not subject to State regulation. Mr. Koch stated that the Division of Insurance has no regulatory control or current ability to track the rates charged by the nonadmitted insurers. He said, though, that the division attempts to monitor their financial solvency.

The governor's task force on insurance problems held a teleconference on October 8, 1985. Some of the witnesses provided specific examples of rate increases. For instance, a nurse midwife stated that her insurance cost would increase from \$3,500 to \$11,000 annually. She said that the average annual salary for a nurse midwife in Alaska is approximately \$40,000 per year. Another witness, a day care operator from Wrangell, stated that the cost of insurance for the day care was \$325 in 1984, and would be approximately \$4,000 to \$6,000 for the next year, if the day care decides to continue its operation. Finally, the Kenai city attorney stated that Kenai's municipal liability insurance was scheduled to increase by 285 percent, to \$318,000 annually, a cost that is equivalent to a two mill property tax. The enclosed press clippings provide other examples of specific rate changes.

Bibliography of Causes and Solutions to the Rate Increases

The attached materials provide information on the causes of the recent increases in insurance rates and potential solutions. As these materials indicate, the participants in this "crisis"--the insured businesses, insurance companies, reinsurers such as Lloyd's of London, lawyers and consumer groups--disagree on specific causes and solutions. Among the causes asserted are the following: 1) the boom/bust cycle in the insurance industry has again hit bottom and is caused by insurance industry management policies; the insurance companies, in competing for investment dollars, lowered rates to "bargain basement" levels during each of the past six years (in the normal cycle, rates decrease for three years and increase for three years); and 2) increasing personal injury litigation has resulted in unexpected and unpredictable insurance company costs.

Representative Koponen
November 6, 1985
Page Three

However, the various participants generally agree that the major factor affecting current insurance rates is the insurance industry's 1984 pre-tax operating losses of \$3.8 billion.

Proposed solutions to the increasing rates and decreasing availability vary among the interested parties. Insurance companies and insured parties (including the recently formed Alaska Citizens for Tort Reform Coalition) generally call for tort reforms (see the enclosed article from The Anchorage Times, October 6, 1985: "Insurance Crisis Takes a Turn for the Worse"). The insurance industry asserts that vague tort laws result in arbitrary jury decisions which produce an atmosphere of uncertainty. They contend that if government will provide a more predictable legal climate via specific tort laws, the industry will have the ability to offer the public a stable insurance cost environment. Lloyd's of London, a major reinsurer (these organizations assume some of the insurance companies' risks) in Alaska and the other states, also advocates tort reforms and has threatened to pull out of the United States insurance market unless changes are made.

Among the tort reforms suggested are those which would limit the damages that could be awarded in a personal injury suit. Some suggest that noneconomic damages (e.g., pain and suffering) be limited while others have proposed that punitive damages be awarded to the state instead of to the injured plaintiff. The argument against awarding punitive damages to the injured party is that he or she should be fully compensated by other court awards. Instead, the punitive damages award could be placed in a specific state fund--a reinsurance fund, for example. However, the effect of such a law may be that fewer punitive damage claims would be filed because the plaintiff's financial incentive to sue for these damages would be limited. Attached is House Research Request 81-195, which addresses some of the available options for dealing with personal injury damage claims. At your request, we can further explore the available options regarding punitive or other types of personal injury damages.

On the other hand, lawyers and some consumer groups such as the National Insurance Consumer Organization (NICO) assert that tort reforms should not be implemented at the expense of victims' rights. National Insurance Consumer Organization advocates a system of state or federal reinsurance similar to that used during the riots of the 1960's. The authorized governmental agency would have standby authority to provide coverage for specific risks. The attached information from NICO explains their proposal and provides a draft entitled "The Omnibus Reinsurance Act of 1985."

Representative Koponen
November 6, 1985
Page Four

Some of the witnesses at the October 8 teleconference advocated formation of a public corporation, similar to the Medical Indemnity Corporation of Alaska (MICA), to improve their particular profession's position concerning the cost and availability of insurance. However, Don Koch stated that MICA is currently having financial problems because of policy losses and inability to get reinsurance. Mr. Koch stated that MICA's future is uncertain.

According to Art Stanford, Administrator of MICA, the corporation was originally formed in 1976 as a result of the high cost and scarcity of medical malpractice insurance in Alaska in the mid-1970s. The Report of the Bodily Injury Reparations Advisory Committee (BIRAC) in 1979 states that another factor leading to MICA's creation was "the rights and expectations of an injured consumer of medical services in a climate of uncertainty and contention." The BIRAC report asserts that MICA was designed "to provide the health professional with the option of buying malpractice coverage at a reasonable rate in the State of Alaska if he was unable to obtain or afford it elsewhere." (BIRAC Report, page 70). The report goes on to say that one of the initial reasons for the formation of MICA was mandatory malpractice insurance in Alaska, i.e., all health care professionals would be required to buy malpractice insurance through MICA as a condition of getting a license in the state. However, the purchase of malpractice insurance is still voluntary, and Mr. Stanford estimates that upwards of 30 percent of Alaska's physicians have no malpractice insurance.

Some solutions to Alaska's liability insurance crisis will be proposed by the the Governor's task force, which will issue a report after its final meeting on November 12, 1985. According to Paul Troeh, Deputy Director of the Division of Insurance, one of the task force's recommendations will be that a long-term task force be created to work on specific solutions to the current liability insurance crisis. If you wish, we can provide you with a copy of the task force's report as it becomes available.

Another possible solution is a pilot project initiated by the Division of Insurance. According to Mr. Koch, the division is forming the project with the Department of Education and the Department of Health and Social Services in order to assist the state's day care operations. Basically, the State will act as a liaison between day care centers and insurance companies, providing necessary information to each party as requested. The details of this voluntary program (entitled CADIS--Co-ordination of Alaska Day Care Insurance Search) are still being ironed out.

Representative Koponen
November 6, 1985
Page Five

We contacted the Children's Defense Fund in Washington, D.C. to gather other possible solutions for the day care insurance problem. Although that organization had no specific legislative proposals, they are sending legislation from California and New Jersey which they deem effective. We will forward their information to you when it arrives.

At your request, we have attached press clippings from state and national newspapers, magazines and journals. We have also attached materials from the National Conference of State Legislatures (NCSL). These materials include draft legislation from other states on municipal and tort liability reforms. The NCSL material also contains studies on various facets of liability insurance. We labeled these materials by source and subject matter. We have also attached materials provided by three national insurance industry trade groups--the Insurance Services Offices, Inc., the American Insurance Association, and the Insurance Information Institute (see computer printout of American newspaper articles). In addition, we have a copy of the Bodily Injury Reparations Advisory Committee (BIRAC) report to Governor Hammond in 1979. The 250 page BIRAC report reviewed "changing conditions in the availability and expense of personal injury insurance." If you would like a copy of the report, please let us know.

Although the information in this memorandum is general in nature, we hope that it is useful to you. Please call us if you want us to explore these issues in more detail.

MT

Attachments

American Bar Association Journal
Discussion of Joint & Several Liability Doctrine
1985

The Attack on Joint and Several Liability

By James Granelli

• In Los Angeles a driver high on drugs went through a stop sign and was broadsided by another motorist. A 16-year-old passenger in his car was crippled and brain-damaged in the 1979 crash. Last March a jury returned a verdict of \$2.16 million against the driver—and the City of Los Angeles. The city had failed to trim bushes that partly obstructed the view of the driver and was found to be 22 percent liable. But unless the award is returned on appeal, the city will pay nearly all of it. The negligent driver has no money and three co-defendants settled for their insurance policy limits—a total of \$200,000. (*Sills v. City of Los Angeles*, C-333504, San Fernando Superior Court.)

• In New York City 12 persons were killed and scores injured in a 1970 gas explosion caused by a restaurant owner who turned on a partly installed gas main that had been inspected by the city. A jury found the city 4 percent negligent, but the verdict exposed the city to millions of dollars in damages because the defendants most at fault were bankrupt. But the city was lucky; the verdict was reversed on other grounds in 1983. (*O'Connor v. City of New York*, 447 N.E.2d 33.)

• In San Diego a university soccer player was a passenger in a car on the scenic Torrey Pines Road when a speeding drunk driver crossed the center line on a curve and smashed into the car, killing two of his teammates and rendering him quadriplegic. The drunk driver offered his insurance policy limits of \$25,000. The city also was named as a defendant on a claim for faulty road design. Rather than risk a jury trial, the city settled in 1983—for \$1.6 million. (*Jugan v. City of San Diego*, Civ.

484152, San Diego Superior Court.)

Across the nation these judgments and settlements have become more common, especially in catastrophic injury cases. Public entities, often dragged into cases as defendants with scant liability exposure, find themselves the target defendants forced to pay off the entire judgment when codefendants can't pay. The real villain, public officials say, is the doctrine of joint and several liability.

Changing the ancient doctrine

Fourteen states have limited or abolished the doctrine in recent years. Municipal officials and some lawmakers want the doctrine changed, and pending legislation in California and New York—home of the nation's largest personal injury verdicts—would doom the joint-and-several rule, if enacted.

Developed over centuries by English and American courts, the rule dictates that when a person is injured by the joint acts of several people, liability is indivisible. That means, in practical terms, a plaintiff can collect an award from the defendants most able to pay—those with "deep pockets."

The rationale is basic fairness. "Who should suffer, the innocent victim or one of the wrongdoers who can afford to pay?" said James Frayne, executive director of the California Trial Lawyers Association. He and CTLA president Robert B. Steinberg of Los Angeles also contend that the joint-and-several rule acts as a deterrent—forcing cities, for instance, to trim trees that could obscure a motorist's vision and lead to an accident—and keeps a penniless victim from going on welfare.

"These cases are not that easy to win," Steinberg said. "So when the city is included, the jury has got to be pretty darned convinced the city was at least partially liable."

"The nature of the beast is such that it's the single greatest problem that cities face in liability issues," said California State Assemblyman Alister McAlister, who is supporting a colleague's proposal to limit the liability of public bodies. And Jay Biggins, consultant to New York City's Office of Management and Budget, complained, "The entire public treasury is considered available to each and every plaintiff. They're treating government as the ultimate insurer."

The League of California Cities has compiled figures from 134 cities statewide on cases involving joint and several liability. It found that those cities paid more than \$15.5 million in settlements and judgments during the fiscal year ending in June 1984. Two years earlier the same cities paid out \$4.5 million. That kind of a hike has forced insurance carriers either to raise premiums drastically—300 percent to 450 percent for one group of California cities—or to stop writing liability policies for public entities.

It is the hand of the insurance industry that the plaintiffs' trial bar sees behind the current efforts to abolish or modify the rule.

"Insurance companies have sold public entities a bill of goods that would save them millions and millions of dollars if they could have the joint-and-several rule changed," said Frayne. Although his group killed four bills to limit the rule in the last five years, Frayne admits the fight this year will be the toughest ever. Not only is the League of California Cities better organized, he said, but more legislators are sensitive to the needs of local governments because they once served on those bodies.

Even if no state changes the rule this year, lobbyists for public entities believe that change is inevitable. "We're very confident that, at some time, we will succeed because the joint-and-several

Articles Provided by Insurance Information Institute

000 DATABASE: L112 DOCUMENT: 850507033015

PAGE 0002

DOCUMENT: 850507033015
PUBDATE : 850502
OFFICE :

AUTHOR Ronnie Chapnell.
TITLE INSURANCE RATES RALLIED AS MUCH AS 400 PERCENT.
SOURCE Anchorage Daily News.
PAGE# Pages A1 and A16.
DESC losses
rate increases
impact
insolvency
business property insurance
commercial liability insurance
workers compensation
IDEN# Alaska
PUBTYPE Newspaper
ABSTRACT Losses have forced insurance companies writing business in Alaska to raise some commercial premiums 200 percent and new businesses are finding coverage difficult to obtain at any price. Don Koch, chief of market surveillance for the Alaska Division of Insurance, said concern is mounting over the ability of some companies to meet the obligations of large claims. Koch said two companies doing business in Alaska went bankrupt in 1984, and he is now concerned about six or seven others. According to Koch, the problems of availability are limited to business property, workers' compensation and commercial liability. New businesses are being forced to turn to the state's assigned risk pool for automobile liability and workers' compensation policies. Increases in the personal lines will be minor compared with those facing businesses.
LOCATION 85050715

----- END OF PRINT REQUEST -----

American Insurance Association Studies

AMERICAN INSURANCE ASSOCIATION
ANNUAL REPORT 1984

JAYNE H. KIMBALL

MANAGER - PUBLIC AFFAIRS
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717 MARKET STREET, SUITE 500
SAN FRANCISCO, CA 94103

415/957-0711

AEETNA LIFE & CASUALTY
AMERICAN GENERAL GROUP
ATA INTERNATIONAL INSURANCE COMPANY
BITUMINOUS INSURANCE COMPANIES
CHUBB & SON INC.
CIGNA CORPORATION
COLONIAL PENN INSURANCE COMPANY
COMMERCIAL UNION INSURANCE COMPANIES
COVENANT GROUP
CRUM AND FORSTER, INC.
EAGLE STAR INSURANCE COMPANY OF AMERICA
EXCELSIOR INSURANCE COMPANY
FARMERS FIRE INSURANCE COMPANY
FIDELITY AND DEPOSIT COMPANY OF MARYLAND
FIREMAN'S FUND INSURANCE COMPANIES
FRONTIER INSURANCE COMPANY
GENERAL ACCIDENT INSURANCE
HARTFORD INSURANCE GROUP
HARTFORD STEAM BOILER INSPECTION & INSURANCE COMPANY
JEFFERSON-PILOT CORPORATION
MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND
MILLERS NATIONAL-ILLINOIS GROUP
MONARCH INSURANCE COMPANY OF OHIO
ORION GROUP, INC.
PENNSYLVANIA HOSPITAL INSURANCE COMPANIES
PHOENIX GENERAL INSURANCE COMPANIES
PROVIDENCE WASHINGTON INSURANCE GROUP
PROVIDENT GENERAL INSURANCE COMPANY
REPUBLIC INSURANCE GROUP
W.J. ROBERTS & COMPANY, INC.
ROYAL INSURANCE
ROYAL INSURANCE COMPANY OF PUERTO RICO, INC.
SELECTED RISKS INSURANCE GROUP
ST. PAUL COMPANIES, INC.
TOKIO MARINE AND FIRE INSURANCE COMPANIES
TRAVELERS INSURANCE COMPANIES
UNITED STATES FIDELITY & GUARANTY COMPANIES
WESTERN EMPLOYERS INSURANCE COMPANY
WESTERN INSURANCE COMPANIES
YASUDA FIRE & MARINE INSURANCE COMPANY OF AMERICA

**STATEMENT
OF THE
AMERICAN
INSURANCE
ASSOCIATION**

**BEFORE THE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON COMMERCE, TRANSPORTATION AND TOURISM
CONCERNING
AVAILABILITY AND AFFORDABILITY OF LIABILITY INSURANCE
SEPTEMBER 19, 1985**



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

Insurance Services Offices, Inc. Studies

The Coming Capacity Shortage

Summary
of the
1984-1985
Service

February 1985

Insurance Services Office, Inc.
National Association of Independent Insurers

1985

A Study of the Property/Casualty
Insurance Industry

May 1985

LIABILITIES OF MUNICIPALITIES
1983

REPORT BY NIMLO STATE CHAIRPERSONS ON THE
COURT DECISIONS AND LEGISLATIVE STATUS OF
SOVEREIGN IMMUNITY DOCTRINE AS TO MUNICIPAL
OFFICERS AND EMPLOYEES IN THEIR STATE

Presented at the NIMLO Midyear
Seminar, May 8-10, 1983
Washington, D.C.

Articles on Risk Management

Furthermore, the screening of on-the-job injuries performed by these centers provides a coherent, orderly mechanism for investigating the causes of injuries and for monitoring workers' compensation claims.

Before this occupational health program was started, unskilled laborers were not required to undergo physicals before being hired, even though all other prospective county employees were required to do so. The pre-employment physicals for unskilled workers have helped eliminate those job candidates whose existing health problems would become a liability for the county. Twenty percent of the candidates for unskilled jobs have been rejected for employment as a result of this health

screening. The program also has brought about a reduction in time lost from work due to injury or illness. The annual physicals and health evaluations have helped in many instances to identify and treat health problems, thus reducing the number of sick days used.

The program has been so successful that the county has opened another health center at the county courthouse, serving an additional 450 employees. The Jefferson County risk manager reports that county employees have responded very favorably to the occupational health program. The program has had a very positive effect upon employee morale and employer-employee relations within the Jefferson County government.

27

*Risk Management in Westchester County**

INTRODUCTION

In March, 1974, Alfred Del Bello became the county executive of Westchester County. This date also marks the birth of the Office of Risk Management. Historically, the insurance responsibility was handled by an individual in the Law Department. This individual had various other jobs and no authority, although it was needed, to develop and implement policy or a risk and insurance program.

The primary goals of the Office of Risk Management were and continue to be the analysis and reduction of risk that could cause Westchester County severe financial loss, thereby forcing a reduction in services to tax-

payees. The objectives to help meet this goal were as follows:

- to establish a policy and procedure statement
- to inspect and examine county facilities to determine modes of operations and uncover employee safety problems
- to develop insurance and indemnification requirements and a system in which to monitor compliance with the above
- to develop a countywide safety program involving input from all departments
- to review security procedures at all county facilities
- to develop a countywide disaster plan
- to develop procedures for the solicitation and purchase of insurance
- to establish record-keeping procedures and reports for top management

*By Robert M. Bieber, Ebasco Risk Management Consultants, Inc. The author is the former Director of Risk Management, Westchester County, New York.

INFORMATION FROM THE NATIONAL
INSURANCE CONSUMER ORGANIZATION (NICO)

LANDSMAN & LASTER

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

(202) 331-0800

JOHN L. LASTER
RON M. LANDSMAN

August 14, 1985

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

Dear Mr. Rule:

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

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

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

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

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

Mr. Rick Rule
August 14, 1985
Page Two

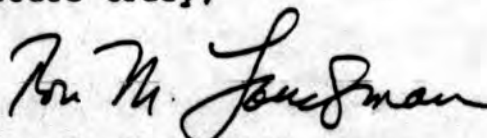
narrow the protection provided to the insurers' commercial customers, changes about which they are, to say the least, extremely unhappy. See Attachment A. Along the same lines, a well-known insurance company executive has justified the mass departure of insurers from medical, toxic waste, and directors'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

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

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

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

Yours truly,



Ron M. Landsman
Counsel, National Insurance
Consumer Organization

RML/kd

Appendix A

JCC 6/18/85

Insurers Told: Exit Some Lines

By JAMES NOLAN
Journal of Commerce Staff

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

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

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

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

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

The touchstone for the discussion was a presentation by the Insurance Services Office Inc., an industry-rating and data-gathering service. The ISO estimates that in the next few

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years the insurance industry will suffer a \$62 billion shortfall in capacity. This means that corporate America will not be able to buy all the insurance it needs because insurers' ability to cover them will fall short by that amount.

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

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

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

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

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

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

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

EPA Chief Deems It Necessary To Keep Toxic Liability Powers

18

By LEAH R. YOUNG
Journal of Commerce Staff

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

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

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

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

But Mr. Thomas pointed out that he is responsible for getting such sites cleaned up while ensuring to the extent possible that the polluter, not the federal government, bears the costs.

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

When the EPA tried to apportion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In Day-Care Crisis Cited

Official Criticizes Insurance Firms

By Sandra Sugawara
Washington Post Staff Writer

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

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

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

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

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

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

Insurance industry executives testified yesterday that the industry was in a slump and urged Congress to allow the industry to voluntarily work out the problem. But Rep.



EDWARD J. MUHL

... testifies before House committee

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

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

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

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

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

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

Mike Casey is on vacation. The Federal Diary will resume when he returns.

Appendix B

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Insurers Told: Exit Some Lines

By JAMES NOLAN
Journal of Commerce Staff

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

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(1)

Adoption Of New Policy

By JAMES NOLAN

Journal of Commerce Staff

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

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

The industry representatives predicted further that American businesses and industry in all likelihood would go unprotected by insurers against liability claims on their assets unless the regulators approve a proposed uniform commercial general liability form for use by Jan. 1, 1968.

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

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

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

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

Speaking in support of the new policy John C. Morrison, a senior vice president at Cigna Corp., said the use of the new commercial general liability policy drafted by the

the financial solvency of some members of our industry.

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

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

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

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

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

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

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

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

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

Every state in the new form is not approved, and it will not be the same American liability underwriter.

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

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

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

Three words in particular.

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

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

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

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

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

Now we get to the sticky part.

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

The insurance industry, therefore, wants to sell only claims made coverage beginning in January 1968.

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

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

New Liability

By JAMES NOLAN

Journal of Commerce Staff

CHICAGO — Major state insurance regulators were openly skeptical last week about the property/casualty industry's plans to use a new commercial general liability standard policy form.

In hearings convened by the Illinois Insurance Department, regulators from New York, Texas, Connecticut and Illinois said time and time again that the insurance industry was intent on reducing the amount of liability coverage corporations could buy beginning in January.

Further, the regulators argued with industry representatives during hours of intense questioning that the proposed policy was much too complex for corporate insurance buyers to understand.

More than a dozen industry representatives countered with arguments that the new policy form was an absolute necessity for the survival of the industry.

The burden of the industry's case was carried by delegates from the Insurance Services Office, an industry-funded policy-making body, which has fashioned the new policy forms.

All of the industry arguments ran on a thread that casualty underwriters have been suffering catastrophic losses in recent years.

A Lloyd's of London delegate who spoke over expressly for the meeting said that unless the U.S. industry is permitted to adopt the new form, the Lloyd's reinsurance market would discontinue backing American underwriters forthwith. Such a move would severely limit the U.S. industry's ability to buy reinsurance, thus spreading risks on major disasters such as a supertanker sinking, an offshore oil well disaster and the coming claims associated with the Bhopal, India, gas leak catastrophe that killed more than 2,000 and injured tens of thousands more less than a year ago.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Outright hostility to the new policy forms was repeated at the meeting by a delegation from the Risk and Insurance Management Society, an organization of some 3,000 corporate insurance buyers.

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

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

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4/21/85

**STATEMENT
OF THE
AMERICAN
INSURANCE
ASSOCIATION**

**BEFORE THE
HOUSE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES
CONCERNING
CHILD CARE AND INSURANCE
JULY 30, 1985**



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

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

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

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

Appendix C (Con't)

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

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

THE INSURANCE CRISIS OF 1985 : WHAT CAN BE DONE?

During the last "crisis" of 1974/5 swine flu vaccine, medical malpractice and product liability were the lines most adversely impacted.

In 1985, we again see product liability and medical malpractice "crises" (even in states with tort "reform"--I recently was invited to address the Virginia Legislature on the medical malpractice "crisis" in the state even though Virginia capped awards for pain and suffering years ago). In 1985, we also see insurance crises developing for day care centers for children, environmental cleanup and nurse-midwives, among other lines. Are all of last year's good day care center insureds suddenly populated with child molesters? Of course not, but the psychology among the insurance industry is reflected by statements made to day care advocates like that of one industry representative who said; "Typically, an underwriter is afraid to write a business regarding children. It is emotion rather than fact." (1) As Federal Insurance Administrator I was involved in studies during the last "crisis" that focused on the medical malpractice and product liability "crises." These, too, were true crises in the mental state of underwriters, but not crises in fact, as the interagency task forces dealing with these issues back then found out.

How could Congress act to stem this boom/bust approach to insurance issues? How can we as a nation insure against the cycle? Must we face this all over again in 1995?

One answer may be found in the way the federal government responded to the riots of the 1960's. You may recall that insurers were pulling out of the inner city areas of the nation, leading bankers to begin pulling mortgages. It was extremely serious. The federal government agreed to reinsure the businesses for the specific peril of concern (riot) in return for their forming pools to assure full coverage (including fire, liability, etc.) in distressed areas. The federal government collected a reinsurance premium (and ultimately made \$125 million profit) and also required the insurers to impose certain safety standards for risks they undertook.

I believe such authority should be ready on a stand-by basis for each insurance line that becomes distressed when the industry cycle hits bottom. Today product manufacturers, day care centers, nurse-midwives and others need insurance at affordable rates. The common thread binding these together is the current "crisis" of the industry cycle plus panic by underwriters. Are all of these insureds, who had no difficulty getting insurance a year ago, suddenly "bad" risks? Of course not.

It is amazing to see what happens in an insurance cycle to the mental state of underwriters. At the top of the cycle, in 1981, insurers were willing to not only take all of the risks they are shunning today, but were willing to go so far as to insure the liability of MGM after their Grand Hotel burned down. Compare that with today's doomsday attitude toward risks that the underwriters have subjectively declared to be taboo. The potential impact on the multiple breadwinning family of day care centers closing down is very serious. Doctors going out of business, birthing centers closing, etc. are other examples of the adverse impact of the current underwriter's psychological attitude. This situation can be mitigated quickly. Here's how:

If a line becomes distressed the government should meet with insurers to determine what's their specific fear (e.g. child abuse at day care centers). The government should then meet with representatives of day care centers and insurers to devise criteria for what's a safe day care center, a model for risk management. Next the program would offer reinsurance to insurers (for a fee) to insure against the specified peril of abuse (child abuse but not fire, or other liability for example). In return, insurers would agree to write, through pools or otherwise, all day care centers which meet the definition of "safe" as devised by the centers, insurers and government. The government would reinsure all business of this sort for participating insurers, even those not in the pools, just as was the case in the riot reinsurance program. This helps the government get spread of risk.

Funding for such a program should be through borrowing authority initially, but self-sustaining over time. A small premium tax of, say, one fourth of one percent on all property/casualty policies could be collected in addition to reinsurance fees on the specific reinsurance line to make the program fiscally sound. As a matter of fact, the federal government is likely to make another profit. As policyholders we all gain by stabilizing the property/casualty cycle. Such an annual tax is de minimus for the ratepayer -- for example, of \$.81 on the average private passenger auto insurance premium, currently. We all gain by securing protection against fluctuation in the economic cycle -- sort of insurance against abusive insurance practice. Currently \$118 billion in premiums per year are written in the property/casualty industry and a yearly premium tax of one-quarter of one percent would produce \$300 million a year. Over the eight to ten year cycle it would add up to well over \$3 billion (due to growth) available to ease availability and affordability in the lines insurers shun at the bottom of the next cycle, in about 1995.

If such a program were in place now, we'd have a way to control the current series of "crises". Since much of the problem relates to reinsurance and availability and the fear of primary insurers to write these coverages at any price.

Such a program is particularly attractive because it will lower costs in distressed lines for good risks and that buys time to allow for substantive review of the contemporary tort system or other areas of potential reform. This gives Congress the time to perform careful laser surgery to excise tort abuses or other changes rather than undertaking radical heart transplants under pressure.

A federally sponsored reinsurance program would provide tremendous incentives for safety through the development of risk management models as industry standards to obtain insurance. Lowered insurance costs to these businesses would mean greater productivity and lower prices for consumers. In any reform schemes enacted by the Congress, the probability that Congressional intent will be frustrated is high (e.g., there is a high probability that Congress might enact some sort of reform and see no improvement in insurance availability or affordability due to the crisis mentality of insurers at cycle bottom). This approach assures that the pricing goal of available/affordable insurance will be accomplished.

CHART e1

THE "CYCLE" AND CONSUMER ABUSE

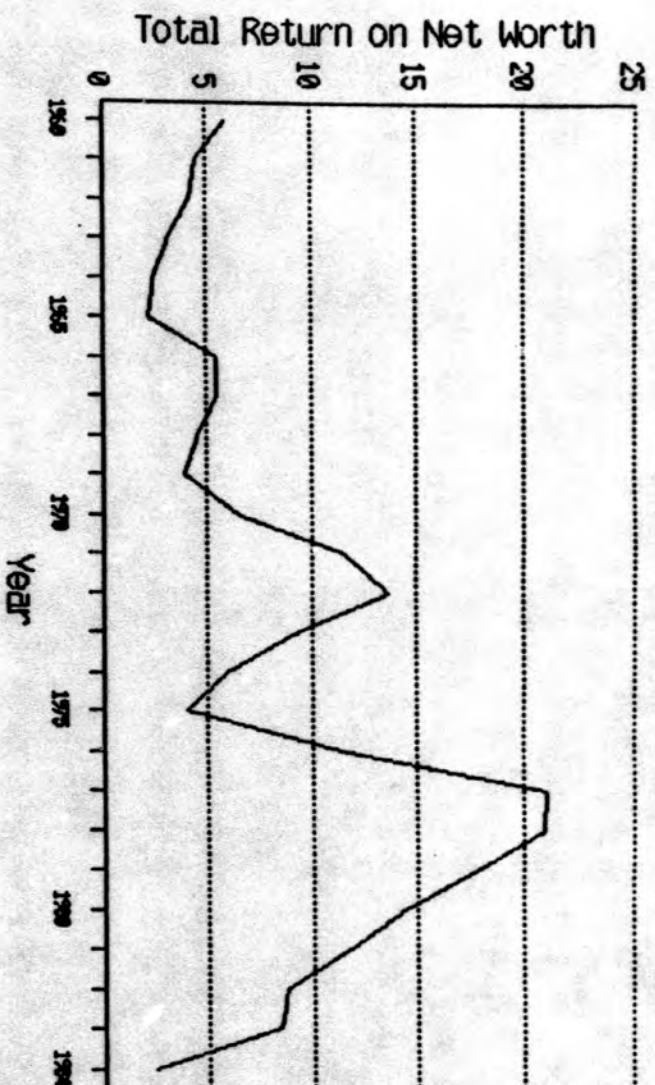


CHART e2

Best's Property/Casualty Stock Index

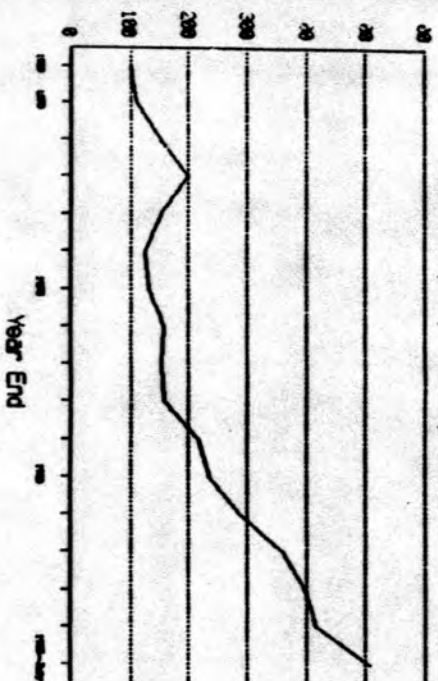
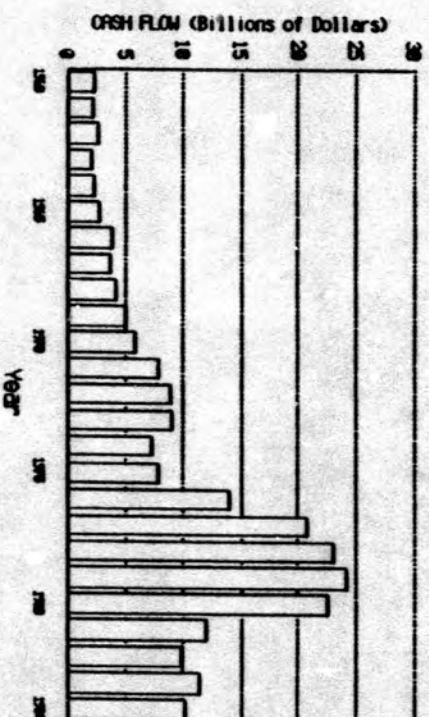


CHART e3

CASH FLOW OF INSURERS



Omnibus Reinsurance Act of 1985

PROBLEM: Many insureds are facing crises in availability and affordability of liability insurance. States, municipalities, environmental concerns, product manufacturers and medical professionals are among the hardest hit. Most day care centers and nurse-midwives cannot find coverage and if they are lucky enough to do so, the cost is prohibitive.

The twin crises of availability and affordability of liability insurance may force manufacturers and service providers out of the normal course of their business. If day care centers close, some families with marginal incomes might lose their homes as well as a second paycheck. Lower cost, high quality care birthing centers may be forced to close, as indeed some have. Products which are safe and beneficial might be kept from markets and physicians or surgeons may quit practice because of unavailable or unaffordable liability insurance. Society cannot function properly when its commerce is so disrupted.

SOLUTION: A federally sponsored reinsurance program to ease availability and affordability of liability insurance in distressed lines of property/casualty insurance.

PRECEDENT: In the late 60's the federal government set up a riot reinsurance program. The federal government agreed to reinsure carriers for the specific peril of concern (riot) in exchange for their forming pools to assure full coverage (including fire, liability, etc.) in distressed areas. The federal government collected reinsurance premiums (and made \$175 million) and also required insurers to impose certain safety requirements upon risks they undertook. (See, 12 USC 1749bbb, 42 USC 4011 (1968)).

IMPLEMENTATION: Legislation would have to be passed to give some federal agency stand-by authority to declare certain lines of property/casualty insurance "distressed" and eligible for reinsurance from the federal program. The "distressed" determination would have to be made upon application or at the agency's discretion. Initial funding would be from borrowing authority from the Treasury, later paid back through the collection of reinsurance premiums and a surcharge upon all property/casualty premiums paid. A surcharge of .25 percent upon all premiums paid would generate about \$300 million per year and with interest would make almost \$6 billion available to reinsure distressed lines at the bottom of the next underwriting cycle.

OUTCOME: Distressed lines of property/casualty insurance will be stabilized against the vagaries of the underwriting cycle. Reasonably safe risks like most day care centers and nurse-midwives will be able to obtain essential insurance. Society will not be faced with the lack of products or services because of unavailable or unaffordable insurance.

OMNIBUS REINSURANCE ACT OF 1985

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

be eligible for participation in such insurance pools.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

property and casualty insurers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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BEFORE THE

AMERICAN RISK AND INSURANCE ASSOCIATION

VANCOUVER, B.C.

August 20, 1985

I am pleased to present our views on taxation of the property/casualty insurance industry. We, at the General Accounting Office, have had an active interest in this area for the past 6 years. In 1981 we submitted a report to the Congress on taxation of life insurance companies. Earlier in 1985 we issued to the Senate Finance Committee a report on taxation of the property/casualty insurance industry. Today, I will focus on the latter.

Mr. Chairman, we believe that the Congress should reexamine several aspects of the tax code dealing with property/casualty insurance companies. These aspects include the deduction for loss reserves, the deduction for acquisition expenses, and the protection against loss account. Before explaining why we believe certain parts of the tax code should be reexamined, I would like to provide some background information on property and casualty insurance company pricing strategies, a financial overview of the industry, and the impact on the industry of certain current tax provisions.

PROPERTY/CASUALTY COMPANY PRICING STRATEGIES

A property/casualty company derives its income from underwriting gains (the excess of premiums over claims and expenses) and investment gains. Because of investment gains, a property/casualty company can still have net income even though its premiums alone are not large enough to cover claims and expenses.

Thus, even though a company has a ratio of claims and expenses to premiums in excess of 100 percent, which normally would indicate the company had suffered an operating loss, it may well have a positive net income.

The ability to offset underwriting and investment income has played an important role in a company's pricing strategy--that is, the amount of premiums it charges for the lines of insurance that it offers. For a number of years the companies have been willing to charge lower premiums to compete for certain insurance lines, even though they will have ratios of claims and expenses to premiums in excess of 100 percent. (For example, in some major lines of business, such as medical malpractice and other liability, these ratios have been more than 150 percent.) The companies expect to make up the premium shortfall through investment income. Through the incremental volume of premiums resulting from this pricing approach, companies are able to generate a larger amount of net cash flow which they can then invest to earn additional investment income. For instance, in 1983 when the industry had a combined ratio of claims and expenses to premiums of about 112%, which produced an underwriting loss of about \$11 billion dollars, it still had a net gain of about \$9 billion and generated a total of about \$12.1 billion in net cash flow, as reported by Best's Management Reports.

While in past years investment gains have exceeded underwriting losses by a fairly wide margin, in more recent years the gap has narrowed. For example, in 1984, underwriting losses for

the industry were \$20.5 billion, while investment income and realized capital gains were \$20.8 billion. As the margin has narrowed, many companies have reacted by raising premiums. Given this, it does not seem unreasonable to expect the gap to widen again as companies within the industry implement new pricing strategies.

FINANCIAL OVERVIEW OF THE PROPERTY/CASUALTY INDUSTRY

We developed a financial overview of the property/casualty insurance industry by studying financial data for stock and mutual companies for the 10-year period 1974 through 1983. We obtained these data from Best's Aggregates and Averages. While Bests' reports omit figures for many small and/or new companies, we believe that the data are sufficiently representative of the overall financial results of the property/casualty industry.

In tables 1 through 5 we show sources of income, broken out by underwriting gains, investment gains, and total gains. We also show disposition of income, broken out by the increase in surplus, dividends to stockholders, and the combined total. Federal income taxes are also shown.

We show in table 1 that, while property/casualty companies had about \$28 billion in underwriting losses from 1974 through 1983, they had about \$100 billion in investment gains during this period, resulting in a total gain of about \$72 billion for those years. From 1974 through 1983, property/casualty companies paid \$1.3 billion in federal income taxes, an amount equal to about 2 percent of the industry's total gains for the period.

Table 1

All P/C Companies - Consolidated Basis
1974 through 1983
(in billions of dollars)

<u>Underwriting</u> <u>gains</u>	<u>Investment</u> <u>gains</u>	<u>Total</u> <u>gains</u>	<u>Federal</u> <u>income</u> <u>tax</u>	<u>Percentage of</u> <u>federal income</u> <u>tax to</u> <u>total gains</u>
(\$28.4) ^a	\$100.7 ^b	\$72.3 ^c	\$1.3 ^d	1.8

^aPositive gains in 1977-78, 79, negative in other years.

^bNegative gain in 1974; positive in other years.

^cNegative total in 1974; positive in other years.

^dNegative taxes in 1974-75; 1982-83; positive in other years.

Table 2 shows that about \$44 billion of property/casualty companies' income from 1974 through 1983 went to an increase in surplus, and about \$17 billion to stockholders in the form of dividends. These two items totaled about \$61 billion, and the \$1.3 billion paid in federal income tax during this time equal 2 percent of this total.

Table 2

All P/C Companies - Consolidated Basis
1974 through 1983
(in billions of dollars)

<u>Increase in</u> <u>surplus</u>	<u>Dividends to</u> <u>stockholders</u>	<u>Total</u>	<u>Federal</u> <u>income</u> <u>tax</u>	<u>Percentage of</u> <u>federal income</u> <u>tax to total</u>
\$44.3 ^a	\$17.0	\$61.3 ^a	\$1.3	2.1

^aNegative in 1974; positive in other years.

The figures in tables 1 and 2 refer to mutual and stock companies combined. Since only stock companies give dividends to stockholders, we developed table 3 to show some ratios solely for stock companies.

We show in table 3 that from 1974 through 1983, stock companies had total gains of \$59 billion and, as we previously mentioned, distributed about \$17 billion to stockholders as dividends. During this period, stock companies paid \$200 million in federal income taxes, an amount equal to 0.3% of their total gains and to 1.2% of their dividends paid.

Table 3
Stock Companies
1974 through 1983
(in billions of dollars)

<u>Total gains</u>	<u>Dividends to stockholders</u>	<u>Federal income tax</u>	<u>Percentage of federal income tax to total gains</u>	<u>Percentage of federal income tax to dividends to stockholders</u>
\$59.0	\$17.0	\$0.2	0.3	1.2

We also wanted to see how the 20 largest companies compared with the other companies. Tables 4 and 5 provide results separately for stock and mutual companies.

Table 4
Stock Companies
1974 through 1983
(in billions of dollars)

	<u>Total gains</u>	<u>Federal income tax</u>	<u>Percentage of federal income tax to total gains</u>
20 largest companies	\$19.8	(\$1.0)	(5.1)
All other companies	39.2	1.2	3.1
All companies	59.0	0.2	0.3

Table 5
Mutual Companies
1974 through 1983
(in billions of dollars)

	<u>Total gains</u>	<u>Federal income tax</u>	<u>Percentage of federal income tax to total gains</u>
20 largest companies	\$17.2	\$0.9	5.2
All other companies	5.6	0.4	7.1
All companies	22.8	1.3	5.7

Tables 1 through 5 have shown that from 1974 through 1983 the industry as a whole, in spite of its underwriting losses, had positive net gains yet paid a small percentage of these gains, 1.8 percent, in federal income taxes. For stock companies, the percentages of taxes paid were lower than for mutual companies--0.3 percent for stock companies and 5.7 percent for mutual companies.

For large companies, the percentages of federal income taxes paid were lower than for smaller companies. For stocks, the 20 largest companies had an income tax rate of -5.1 percent as compared with 3.1 percent for the smaller companies. For mutuals, the 20 largest companies paid 5.2 percent as compared with 7.1 percent for the smaller companies.

As previously mentioned, tables 1 through 5 each cover the 10-year period ending in 1983. Information is not yet available for updating all of the tables through 1984. However, preliminary information shows that the property/casualty companies had a record underwriting loss in 1984 and, as we indicated, investment gains (including capital gains) were approximately equal to the underwriting losses.

Using data from our table 1 and from the preliminary information that has been published for 1984, we constructed table 6 to cover the 10-year period 1975 through 1984.

Table 6

All P/C Companies - Consolidated Basis
1975 through 1984
 (in billions of dollars)

<u>Underwriting</u> <u>gains</u>	<u>Investment</u> <u>gains</u>	<u>Total</u> <u>gains</u>	<u>Federal</u> <u>income</u> <u>tax</u>	<u>Percentage of</u> <u>federal income</u> <u>tax to</u> <u>total gains</u>
(\$47.0)	\$119.1	\$72.1	(\$0.063)	(0.1%)

These figures show that from 1975 through 1984 the investment gains exceeded the underwriting losses by over \$72 billion while taxes were a negative \$63 million, a rate of -0.1% of the total gains.

IMPACT OF CURRENT TAX PROVISIONS

Our analysis of the foregoing financial data gives insight into how current tax policy affects the property/casualty insurance industry. As a result of certain tax advantages, many property/casualty companies have not paid federal income taxes for a number of years, and, in fact, have qualified for refunds or the ability to carry back or carry forward losses for tax purposes. In addition to the tax deferrals resulting from the treatment of loss reserves, the treatment of acquisition expenses, and the protection against loss account, property/casualty companies can also use tax provisions available to other taxpayers. These include excluding interest income from tax-exempt securities and deducting eighty-five percent of the dividends received from domestic corporations. Between 1975 and 1982, about 40 percent of the gross investment income of all property/casualty companies was tax-exempt investment income. The dividends received deduction during this period represented about 20 percent of the gross income of the companies.

While we presented and discussed these facts in our report, we did not recommend any changes in the application of the exclusion of tax exempt interest or the dividend received deduction to property/casualty companies. We limited our study to those provisions of the tax code which applied only to property/casualty companies.

AREAS OF PROPERTY/CASUALTY INSURANCE TAXATION
NEEDING CONGRESSIONAL REEXAMINATION

We indicated in our report on the taxation of the property/casualty insurance industry that the Congress should reexamine three areas of the tax code.

These areas are

- the deduction currently allowed for loss reserves;
- the practice of currently deducting all of the expenses associated with the sale and renewal of insurance policies; and
- the protection against loss account, which defers a portion of a mutual company's income to provide a cushion for catastrophic loss.

Our conclusions and recommendations in each of the three areas were as follows:

First, we concluded that the present practice of deducting in the tax year the full (undiscounted) amount of future estimated settlement costs overstates the loss reserve deduction. Since the assets underlying loss reserves are invested pending final settlement of claims, the firm actually needs to set aside only that amount which, together with subsequent investment earnings, would equal expected subsequent claims. We suggested that the Congress consider amending the tax code to provide that for tax purposes loss reserves be discounted in calculating the loss reserve deduction. We further stated that the discount rate should be based on a moving average of each company's pre-tax net return on its investment portfolio.

We estimated discounted loss reserve levels at several discount rates for 1980-82 (holding all other factors constant) and the additional tax liability that would have resulted. The higher the discount rate used, the greater the reduction in the loss reserve deduction and the greater the increase in tax liability. If a hypothetical discount rate of 7 percent had been used by all companies in 1982, the deduction taken would have been reduced by about \$1.3 billion, and tax liabilities would have been greater by about \$613 million.

Second, we concluded that the present treatment of acquisition expenses fails to match expenses and revenues. Currently, the tax code permits all acquisition expenses to be deducted immediately, even though the premiums associated with these expenses are spread over the life of the contract. In this case we suggested that the Congress consider amending the tax code to provide that acquisition costs be allocated over the life of related contracts so that these costs are matched with premium payments generated by the contracts.

If acquisition expenses were allocated when revenue is recognized, then taxable income would increase. We estimated the additional tax liability that would have accrued for the years 1980-82 if this change had been made and everything else had remained the same. Based on these assumptions, the additional tax liabilities would have been approximately \$164 million in 1982.

We must mention that for both the changes in the tax code the Treasury in 1982 would have received only a portion of these amounts in additional current taxes. Some companies were showing losses for tax purposes. Furthermore, companies might shelter more of their investment income and thereby mitigate any increases in taxes. This could be done through increasing their holdings of tax-exempt securities or equity securities of domestic corporations.

Third, we concluded that the protection against loss account may not protect mutual companies against catastrophic losses because the money in the account is not earmarked for that purpose. Thus, if a catastrophic loss were to occur, the account does not necessarily ensure the company's ability to satisfy its contract obligations. In this case, we recommended that the Congress consider whether or not this special tax preference for mutual property/casualty insurance companies should be retained in its present form.

CONCLUSION

In conclusion, Mr. Chairman, the financial information we have presented indicates that the property/casualty insurance industry has paid a relatively small share of its net income in federal income taxes in recent years. While we are not in a position to comment on what might be an appropriate federal tax burden for the industry, we do believe that the Congress should consider amending the tax code along the lines suggested in our

report. In our view, the changes would result in a better match of the industry's revenues and expenses and represent a more rational approach to its taxation.

This concludes my prepared remarks.



FOR IMMEDIATE RELEASE
August 15, 1985

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

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

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

INSURERS "ON STRIKE"
page 2.

NICO studies show auto premiums are skyrocketing at an 18.2% clip in 1985 and that premium increases of 300% to 1000% in the "distressed" lines of liability insurance are not uncommon. "This gouging has already skyrocketed insurer stock prices to record highs, at a rate of change double that of the Dow Jones Industrials," Hunter said.

Nader and Hunter called for a federal solution to the problem by: 1) federal review of the responses of state regulation to this crisis; 2) asking the Department of Justice to determine if illegal boycotts are being used by insurers; and 3) creation of federal pools to make insurance available to good risks who lose coverage through no fault of their own. "There is precedent in the FAIR Plans that kept insurance available in the cities of our nation when the riots of the late 60's occurred," Nader said.

NICO is a non-profit, public interest group that offers advice to help consumers buy insurance wisely and works for more equitable insurance laws and policies.

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

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

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

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

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

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

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

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

The statistics don't justify any of this!

What is going on?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What Should We Do?

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

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

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

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

The federal government made \$125 million writing this reinsurance!

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

The program worked well.

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

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

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

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

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

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

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

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

Conclusion

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

FOOTNOTES

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

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

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

4/ Hearing on December 3, 1973, Subcommittee on Health of the Committee on Labor and Public Welfare, US Senate. Among the interesting data supplied by ISO at that hearing were exhibits that showed that the average claim cost ISO used for ratemaking significantly exceeded the limit of liability, clearly ratemaking that had run amok. That led to this exchange:

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

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

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

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

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

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

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

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

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

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

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

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

11/

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

a/ Source: US Department of Commerce, Bureau of Economic Analysis.

b/ Source: Bests Management Reports, December 31, 1984, page 1.
Life Insurance Fact Book, page 56.
Blue Cross Association, Telephone call of 1/25/85.

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

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

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

One of the tests of state preparedness to deal with a crisis in availability and pricing of liability insurance is actuarial staff. Of the 52 states (including DC and Puerto Rico) NICO surveyed, we find that 26 have actuaries. So one-half of the states have no actuaries at all.

There are 62 actuaries employed by the states, of the 7,682 actuaries in the nation. It is well known in the industry that those best suited to deal with matters pertaining to liability insurance are those who have passed the examinations enabling them to be "Fellows" in the Casualty Actuarial Society. State regulation has only 8 such persons. They are employed by only 5 states [Connecticut (1), Massachusetts (1), Michigan (1), New Jersey (1) and New York (4).]

Aetna Life and Casualty Insurance Company alone employs 126 actuaries. Travelers has 100.

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

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

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



NATIONAL INSURANCE
CONSUMER ORGANIZATION

5 Rocky Mt. States Lose Liability Cover

By G. A. COOPER
7/13/85
The Colorado Public Insurance Co. has "surrendered" a liability insurance policy for the entire state of Colorado. Unless the state can come up with coverage by Sept. 15, a gap in the state's liability coverage will be left.

We've been the three thousand companies in the country, only they are willing to government entities.

Midwives Facing Loss of Insurance

NY TIMES 7/13/85
By CAROL LAYTON

THE problems that doctors across the country are having with malpractice insurance are also being felt by midwives. About a third of the 2,500 in the profession have been notified that they must leave their malpractice coverage, meaning that they might have to give up their profession unless another insurer will cover them for professional liability.

By G. A. COOPER
7/13/85
Building centers, one of the most expensive places to live in the country, have become threatened by the same medical system that doctors' malpractice coverage.

Birthing Centers Face Shortage of Cover

Insurance Premiums Sink Fishing Fleet

Journalist 7/15/85
GLOUCESTER, Mass. — Sam LeGrande was sitting outside the St. Peter's Club on Rogers Street here, looking in the sun. He would rather have been fishing. But Mr. LeGrande, 64, is one of more than 30 Gloucester commercial fishermen who in the last two weeks have been forced to let their trawlers sit idle because their insurance has been canceled.

Transit Systems Face Liability Shortage

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

Fireworks Makers Face Loss of Insurance

By JAMES HOLLAN
NEW YORK — A Fourth of July without an evening of "boom-boom" is unthinkable. But the way things are in the specialty insurance industry, the Fourth of July might very well be quiet, indeed.

Day Care Insurance Imperiled

Policies Canceled
House Hearing '85

Rate hikes, capacity crunch
seen with July 1 renewals

Auto Insurer To Discontinue Service in D.C.

By Sandra Evans
7/10/85
Dairyland Insurance Co., the No. 1 provider of auto insurance in the District, informed the city government yesterday that it is discontinuing insurance for all of its District policyholders by the end of this year.

About 18,000 customers, most of them high-risk drivers with month-to-month policies, will have to scramble to get insurance from other sources.

The worst is yet to come, reinsurers, brokers predict

By DOUGLAS McLEOD 7/5/85

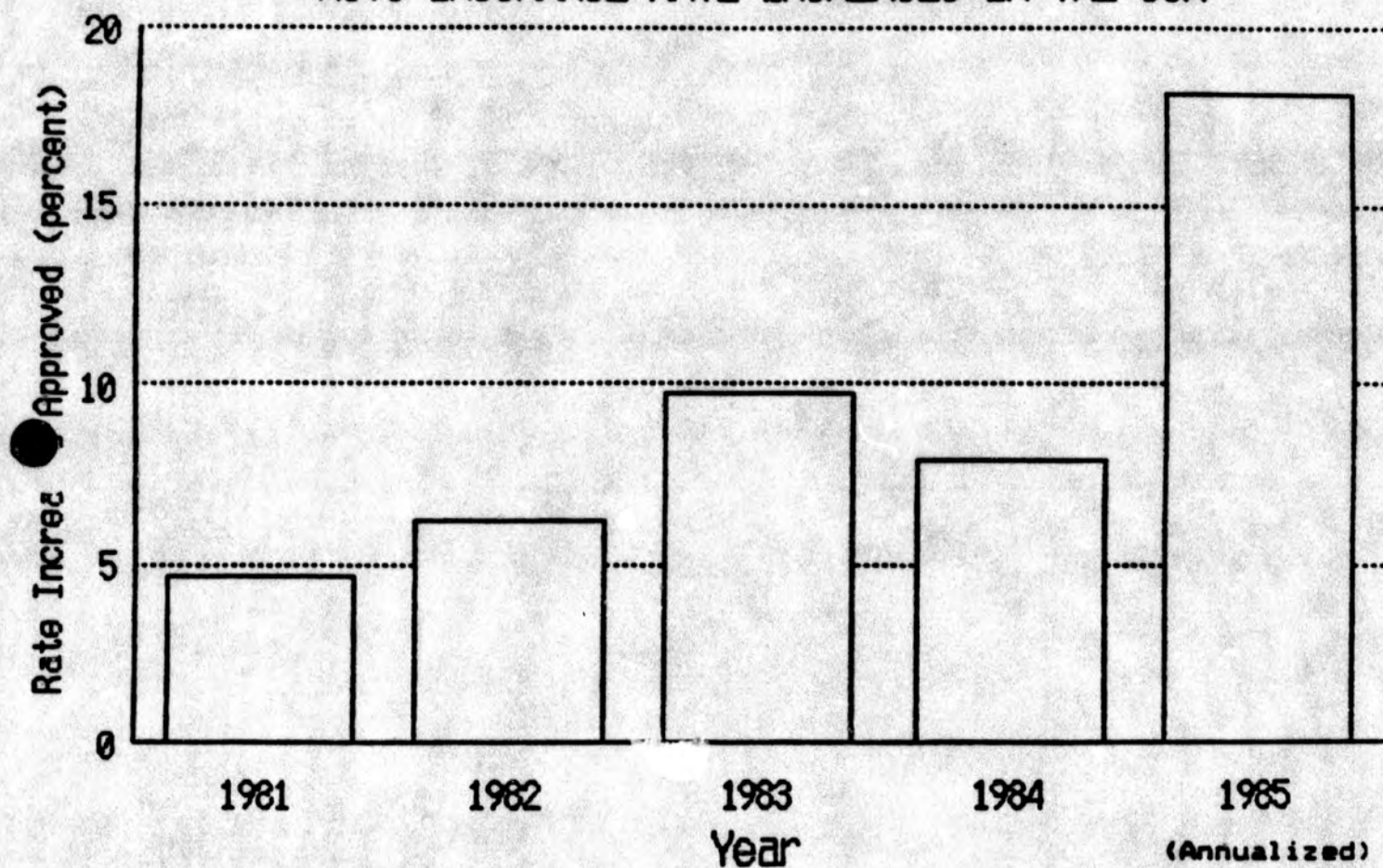
It's summertime, but the living is far from easy for reinsurance buyers. After being battered during last January's renewals with rate hikes, capacity shortages and more restrictive policy terms, reinsuring companies were hit even harder during July 1 renewals. And, there is no relief in sight as next January's renewal season approaches, brokers and reinsurers predict. "I think it's going to be a bloodbath," said an underwriter at Constitution Reinsurance Corp. in New York, referring to next

THE 1985 INSURANCE CRISIS
WHAT'S GOING ON HERE?

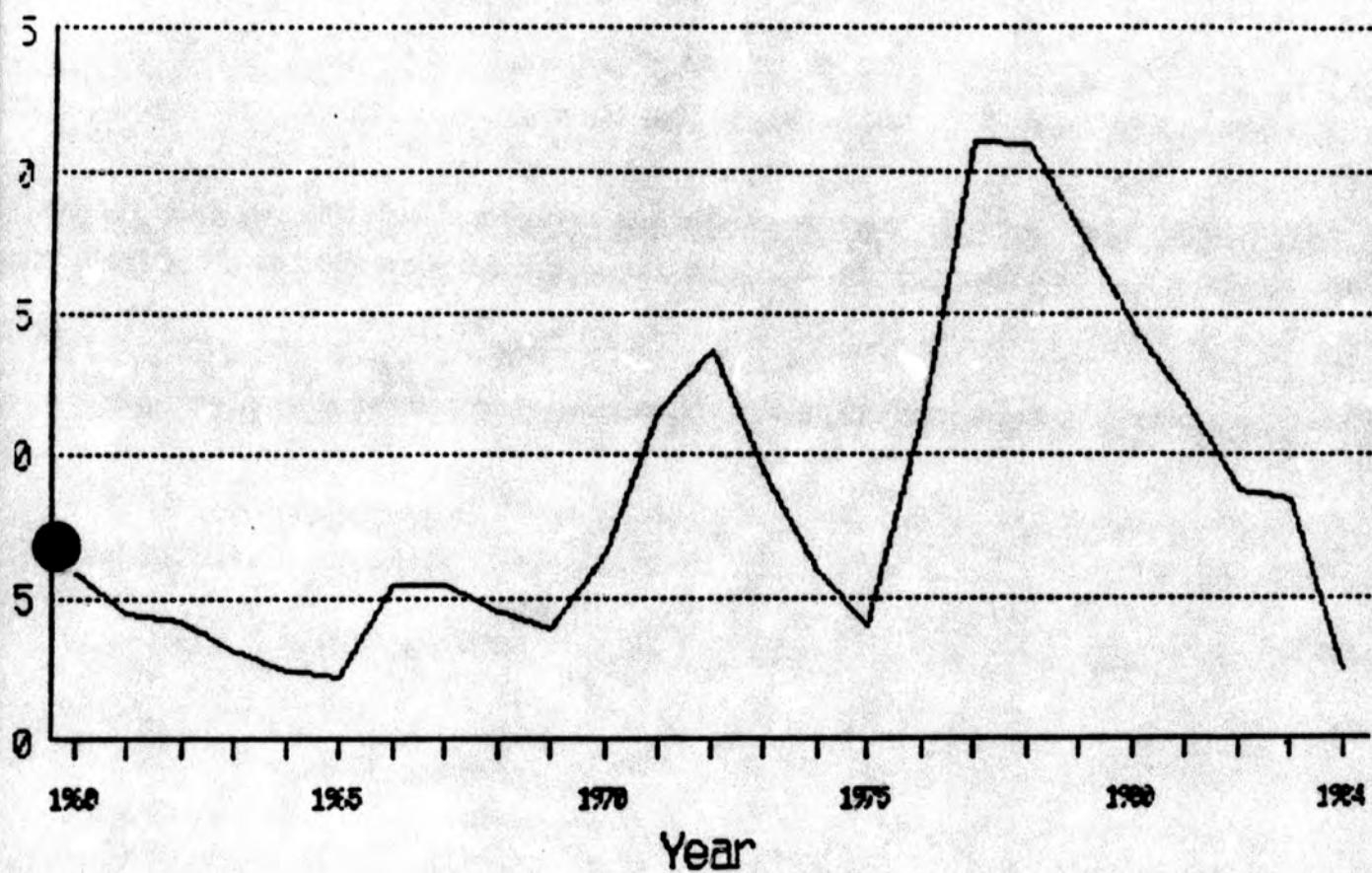
Risky Business
Liability Insurance Is
Difficult to Find Now
For Directors, Officers
Suits by Shareholders Cause
Premiums to Skyrocket

By Sandra Sugar
Allyn M. Chesnut told a personal committee that she has been providing child care in Burke, Va., for eight years. But this year the care will end, because her insurance has been canceled. Karen E. Shaw testified that she also will have to close her day care business at her home in Falls Church, because her insurance policy has been canceled.

AUTO INSURANCE RATE INCREASES IN THE USA



THE "CYCLE" AND CONSUMER ABUSE



Analysis of Rate Filing of

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

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

J. ROBERT HUNTER

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

BACKGROUND

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

WAS THE OVERALL 29% RATE INCREASE JUSTIFIED?

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

- o The filing incorrectly assumes that the yield on investments that the MMLIS will earn is 5%, an unrealistically low assumption, and
- o The filing incorrectly assumes that inflation in the future will be at double-digit levels.

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

HOW SHOULD INVESTMENT INCOME BE FACTORED IN?

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

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

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

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

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

1982	9.1%
1983	8.9%
1984	9.3%

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

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

TREND

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

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

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

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

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

SENSITIVITY ANALYSIS

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

ANALYSIS OF CLASSIFICATION CHANGES

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

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

BALANCE SHEET

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

CONCLUSION

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

Exhibit "A"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND
1985 PROFESSIONAL LIABILITY RATE LEVEL REVIEW - OCCURRENCE COVERAGE

PRESENT VALUE OF PAID MEDICAL MALPRACTICE CLAIMS
(OCCURRENCE BASIS)

<u>Time Interval</u>	<u>Cum. Paid</u>	<u>% Paid Losses By Interval</u>	<u>Years of Discount (n)</u>	<u>Vn (5%)</u>	<u>10%</u>	<u>Present Value</u>
Up to 12 mos.	0.0%	0.0	0.5	.976	.954	-
24	2.0	2.0	1.5	.929	.867	1.858 1.73
36	7.0	5.0	2.5	.885	.768	4.425 3.941
48	19.0	12.0	3.5	.843	.716	10.116 8.591
60	35.0	16.0	4.5	.803	.651	12.848 10.47
72	53.0	18.0	5.5	.765	.592	13.770 10.65
84	68.0	15.0	6.5	.728	.538	10.920 8.07
96	79.0	11.0	7.5	.694	.489	7.634 5.38
108	87.0	8.0	8.5	.661	.445	5.288 3.55
120	92.0	5.0	9.5	.629	.404	3.145 2.02
132	95.0	3.0	10.5	.599	.368	1.797 1.10
144	97.0	2.0	11.5	.571	.334	1.142 .669
156	99.0	2.0	12.5	.543	.304	1.086 .609
168	100.0	1.0	13.5	.518	.276	.518 .27

AVR 7.14 yrs

74.547%

57.1

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

Exhibit "B"

Exhibit C
Loss and Loss Expense
Payout Patterns

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

* Discounted claims payments at 10.5% pre-tax.

Exhibit C

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 Professional Liability Rate Level Review - Occurrence Coverage

Total Limits Rate Level Indication -- \$000's

(1) Year	(2) E. P. at Current Rate Level (Exh. 3)	(3) Ultimate Incurred Loss & ALAE (Exh. 2)	(4) Trend Factor to 7/1/86 at 11% 9%	(5) Losses Trended to 7/1/86 (3)x(4)	(6) Loss Ratio at Current Rate Level (5)/(2)
1979	33,395	24,688	1.826	51,255	1.535
1980	35,732	25,235	1.677	47,200	1.321
1981	33,872	25,904	1.539	43,649	1.289
1982	28,984	25,414	1.412	38,580	1.331
1983	18,203	18,854	1.245	25,785	1.417
	150,185			206,470	1.375
				187,816	1.249

Annual Trend Factor: 11.0%
(Exhibit 4)

- a) Five year loss ratio at current rate level: 1.249
- b) Discount for investment income at 5.0%: (10%) .570
- c) Discounted loss and ALAE ratio (a) x (b): .712
- d) Provision for Unallocated LAE (Exhibit 6): 1.05
- e) Discounted loss and LAE ratio (c) x (d): .748
- f) Permissible discounted loss and LAE ratio: .835
- g) Indicated rate level increase (e) / (f): -10.5
- h) Selected rate level increase: —

INVESTMENT
INCOME AND
TREND CHANGE

ONLY
INVESTMENT
INCOME
CHANGE.

Exhibit "D"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 RATE LEVEL REVIEW - PROFESSIONAL LIABILITY - OCCURRENCE COVERAGE

TREND IN TOTAL LIMITS LOSS RATIOS AT CURRENT RATES
(3000'S)

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

Average Annual Trend:

+ 7.8%

+ 9.3%

r :

.899

.906

(2) Exhibit 3

(3) Exhibit 2

(4) (3) / (2)

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

Selected Trend Factor: 11%

16% relevant

Use 9.0%

COUNTRYWIDE

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

PHYSICIANS, SURGEONS AND DENTISTS

Basic Limits

			Average Loss Ratio at Present Rates	
(1) Policy Year Ending	(2) \$100,000 Basic Limits Incurred Losses*	(3) Premium At Present Rates	(4) (2)÷(3) Actual	(5) Exponential Curve of Best Fit
12/31/75	\$167,810,058	\$615,020,250	.273	.232
12/31/76	139,176,608	524,225,850	.265	.271
12/31/77*	181,630,098	638,830,853	.284	.316
12/31/78*	251,848,210	700,894,098	.359	.369
12/31/79*	280,590,219	717,382,127	.391	.430
12/31/80*	332,612,672	705,726,416	.474	.502
12/31/81*	426,038,352	684,461,050	.622	.585
12/31/82*	497,532,513	666,499,516	.746	.683

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

* Excluding Texas and Massachusetts

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

* Includes Claims Made Data.

Selected Annual Trend16.0%

Exhibit
"F"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 PROFESSIONAL LIABILITY RATE LEVEL REVIEW

Effect of Proposed Classification Changes

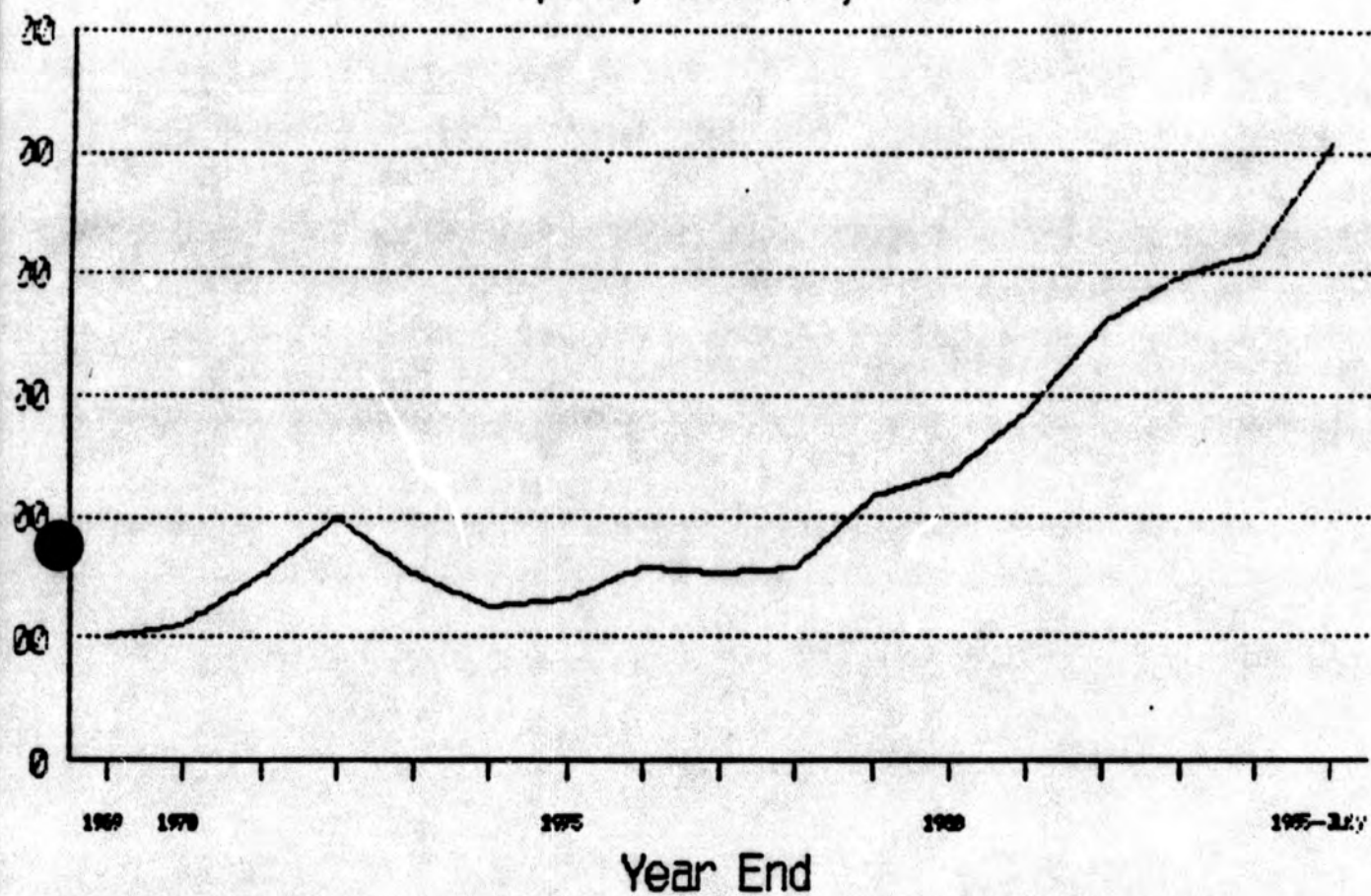
<u>Specialty</u>	<u>Description</u>	<u>Distribution Of Total Limits Premium</u>	<u>Present Relativity</u>	<u>Proposed Relativity</u>
80240	Forensic Medicine	0.0 %	.75	.65
80232	Hypnosis	0.0	.75	.65
80248	Nutrition	0.0	.75	.65
80263	Ophthalmology-No Surgery	0.2	.75	.65
80235	Physiatry and Physical Medicine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

Effect: +2.8%

Current Average Relativity: 2.15

Projected Average Relativity: 2.21

Best's Property/Casualty Stock Index



CALIFORNIA
Draft Legislation to Limit Recovery for Punitive Damages
May 2, 1985

Introduced by Senator Robbins

March 6, 1985

An act to amend Sections 825 and 990 Section 825 of the Government Code, relating to public liability.

LEGISLATIVE COUNSEL'S DIGEST

SB 969, as amended, Robbins. Public liability.

Existing law provides that a public entity is not liable for punitive damages and, although generally liable for a judgment against a public employee, is not authorized to pay that part of a judgment or claim that is for punitive damages.

This bill would provide that a local public entity is authorized to pay that part of a judgment or claim that is for punitive damages if the governing body determines that it is in the best interest of the public makes specified findings.

Existing law authorizes a local public entity to insure against its liability and its employees' liability, and such an entity is authorized to insure against the expense of defending a claim against it or its employees including a claim for punitive damages, but is not authorized to insure for payment of that part of a judgment that is for punitive damages.

This bill would authorize a local public entity to insure, contract, or provide against liability for a claim, including a claim for punitive damages.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

COLORADO
1985 Self-Insurance for the State
Changes Liability Standard for Public Employees

An Act

HOUSE BILL NO. 1001.

BY REPRESENTATIVES Paulson, Bledsoe, Berry, Allison, Taylor-Little, Brown, Gillis, P. Hernandez, Johnson, Neale, Owens, Philips, Reeser, Romero, Schauer, Singer, Swenson, Trujillo, Underwood, Wham, K. Williams, and Younglund; also SENATORS Wells, Strickland, Baca, Beatty, Bishop, Callihan, Gallagher, Glass, Lee, McCormick, Meiklejohn, R. Powers, Traylor, and Wattenberg.

CONCERNING THE LIABILITY OF PUBLIC ENTITIES, OFFICIALS, AND EMPLOYEES, AND MAKING AN APPROPRIATION IN CONNECTION THEREWITH.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Article 30 of title 24, Colorado Revised Statutes, 1982 Repl. Vol., as amended, is amended BY THE ADDITION OF A NEW PART to read:

PART 15

DIVISION OF RISK MANAGEMENT

24-30-1501. Legislative declaration. The general assembly recognizes that the general liability and automobile liability insurance policies of the state of Colorado have been cancelled, that no responsive bids were received, and that, as a direct result, the governor called an extraordinary session of the general assembly to address the need for a method to protect the state and its employees against claims brought under the "Colorado Governmental Immunity Act", article 10 of this title, and arising under federal law. The general assembly further recognizes that the consequences of

CONNETICUT
1895 Discussion of Sovereign Immunity Doctrine

Connecticut General Assembly

07273



OLR Selected Report 85-18

LAN GREEN
DIRECTOR

JOINT COMMITTEE ON LEGISLATIVE MANAGEMENT
OFFICE OF LEGISLATIVE RESEARCH

LEGISLATIVE OFFICE BUILDING
18-20 TRINITY STREET
HARTFORD, CONNECTICUT 06106
(203) 566-8400

February 15, 1985

85-R-0376

FROM: Office of Legislative Research
David O'Connor, Research Attorney

RE: Sovereign Immunity

You have asked for background on the concept of sovereign immunity.

DISCUSSION

Sovereign Immunity in Connecticut

The state is immune from suit in Connecticut in contract, tort, or any other action except where it is clearly waived by statute. Murphy v. Ives, 151 Conn. 259, 262-63 (1963). The areas where immunity is waived are as follows: negligence in maintaining highways, bridges or sidewalks (§ 13a-144); negligent operation of a state motor vehicle (§ 52-556); a contract for the design, construction, repair or alteration of any state highway, bridge, building or public work (§ 4-61); and suits against a municipality for damage resulting from failure to prevent disturbances of the peace (§ 7-465).

The Claims Commission

Despite sovereign immunity, claims against the state, whether based on contract or tort, may be brought by filing a claim with the Claims Commissioner. The Commissioner by himself may make awards of up to \$5,000. If he wants to award more, he must submit the claim to the General Assembly. If the claimant is asking for more and is turned down by the Commissioner, the claimant may bring the claim to the General

ILLINOIS
Governmental Tort Immunity
April 11, 1985

HOUSE BILL 1721
84th GENERAL ASSEMBLY
State of Illinois

1985 and 1986

Introduced April 11, 1985, by Representative Woodyard

SYNOPSIS

(Ch. 85, par. 9-103; amends title)

Amends the Local Governmental and Governmental Employees Tort Immunity Act. Provides that a local public entity may protect itself or its officers or employees, by insurance or other means, from liability arising out of any statute or legal theory. Provides that such protection may be in the form of indemnification.

LRB8405302RLks

LOUISIANA
1985 Proposed Legislation on Self-Insurance Liability of
Public Entities

LIABILITY/PUBLIC: Limitation of liability of public entities

1 AN ACT

2 To enact R.S. 9:2800, relative to the limitation of liability for
3 public entities, to provide with respect to proof of actual or
4 constructive notice of allegedly defective conditions, and to
5 provide for related matters.

6 Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 9:2800 is hereby enacted to read as follows:

8 §2800. Limitation of liability for public entities; notice
9 required

10 Notwithstanding any other provision of law to the contrary,
11 liability under Civil Code Article 2317 shall not be imposed
12 against the state, a state agency, a political subdivision, or any
13 unattached agency, board, commission, or other instrumentality
14 serving a public function for damages caused by a vice or defect in
15 any roadway, sidewalk, public servitude of drainage or sewerage, or
16 any other public way or the subsoil thereof, if the public entity
17 proves that it had neither actual nor constructive notice of the
18 alleged defective condition.

SELF INSURANCE: Membership in interlocal risk management agencies

AN ACT

To enact R.S. 33:1343(F), relative to membership in an interlocal risk management agency, to authorize any statewide association of local governmental subdivisions to become a member of such an agency for purposes of providing accident and health protection to its employees, and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 33:1343(F) is hereby enacted to read as follows:

~~§1343. Authority of governmental subdivision to form, join, and or~~
participate in interlocal risk management agency; employer
contributions toward accident and health protection premiums;
ownership of records;

* * *

F. In addition to local governmental subdivisions, any
statewide association of local governmental subdivisions, including
but not limited to the Police Jury Association of Louisiana and the
Louisiana Municipal Association, may become a member of an
interlocal risk management agency for purposes of providing
accident and health protection to its employees upon approval of
the governing body of the association and the governing body of the
interlocal risk management agency.

MAINE
1980 Study: Self-Insurance for Public Schools

04052

MINORITY REPORT
of the
JOINT STANDING COMMITTEES
ON
BUSINESS LEGISLATION
AND
EDUCATION

A STATE PROGRAM OF FUNDED SELF-INSURANCE
FOR PUBLIC SCHOOLS
(S.P. 627)

Submitted to the
Legislative Council
109th Legislature

February 15, 1980

MARYLAND
1985 Tort Claims Act Amendments
[Tort Reform]

SENATE BILL No. 380
(51r2064)

35

Introduced by Senator Coolahan

Read and Examined by Proofreader:

Proofreader.

Proofreader.

Sealed with the Great Seal and presented to the Governor,
for his approval this _____ day of _____
at _____ o'clock, _____ M.

President.

CHAPTER _____

1 AN ACT concerning

2 Maryland Tort Claims Act

3 FOR the purpose of providing that the waiver of the sovereign
4 immunity of the State and its units is extended to include
5 any claim of any amount to the extent of insurance coverage;
6 providing that sovereign immunity is not waived for certain
7 items; repealing a certain provision regarding the provision
8 of State liability insurance; providing that State personnel
9 are immune from certain tort suits; ~~providing--for the~~
10 ~~separate-trial-of-certain-issues-in-these--suits;~~ providing
11 that certain claims filed with the State shall contain
12 certain additional information; altering the effect of the
13 acceptances of settlements of certain claims against the
14 State; altering the notice requirements for final denials of
15 these claims; altering the conditions which determine when
16 final denials of these claims occur; changing the statute of
17 limitations for certain tort claims against the State and
18 its units; providing certain requirements for the service of
19 certain legal documents; and generally relating to the
20 sovereign immunity of the State and its units and personnel.

EXPLANATION: CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.
[Brackets] indicate matter deleted from existing law.
Underlining indicates amendments to bill.
~~Strike-out~~ indicates matter stricken from the bill by
amendment or deleted from the law by amendment.

NEW YORK
Draft Legislation
New York Municipal Tort Liability Joint
Underwriters' Association
June 25, 1985

STATE OF NEW YORK

4145

1985-1986 Regular Sessions

IN SENATE

March 18, 1985

Introduced by Sen. LEICHTER -- read twice and ordered printed, and when printed to be committed to the Committee on Local Government

AN ACT to amend the general municipal law and the insurance law, in relation to municipal liability insurance contracts

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

- 1 Section 1. The general municipal law is amended by adding a new section
2 ninety-two-c to read as follows:
3 § 92-c. Liability insurance contracts. Notwithstanding any contrary
4 provision of law, each municipal corporation shall submit any proposed
5 contract for liability insurance coverage to the superintendent of in-
6 urance at least sixty days prior to the date on which such contract is
7 to take effect or within fifteen days of notification by such superin-
8 tendent of the disapproval of any such contract, whichever is later. No
9 such liability insurance contract shall take effect unless it is ap-
10 proved by the superintendent of insurance.
11 § 2. The insurance law is amended by adding a new section three hun-
12 dred sixteen-a to read as follows:
13 § 316-a. Municipal liability insurance. (a) The term "municipality" as
14 used in this section shall mean any county, city, town or village.
15 (b) Notwithstanding any contrary provision of law, the superintendent
16 shall establish regulations for the purchasing of liability insurance
17 contracts by municipalities.
18 (c) The superintendent shall review each proposed contract for liabil-
19 ity insurance coverage for a municipality including its terms, condi-
20 tions, rates and broker fees and commissions.
21 (d) The superintendent shall inform the municipality of its approval
22 or disapproval of an insurance contract within thirty days of the
23 receipt of such contract.
24 § 3. This act shall take effect immediately and shall apply to all
25 contracts entered into on or after the first day of January, nineteen
26 hundred eighty-seven.

EXPLANATION--Matter in italics (underscored) is new; matter in brackets [] is old law to be omitted.

LBD08890-01-5

STATE OF NEW YORK

8232

1985-1986 Regular Sessions

IN ASSEMBLY

June 25, 1985

Introduced by COMMITTEE ON RULES -- (at request of M. of A. Gorski) --
read once and referred to the Committee on Local Governments

AN ACT to amend the insurance law, in relation to the New York municipal
tort liability joint underwriting insurance association

The People of the State of New York, represented in Senate and Assem-
bly, do enact as follows:

1 Section 1. The insurance law is amended by adding a new article fifty-
2 seven to read as follows:

ARTICLE 57

NEW YORK MUNICIPAL TORT LIABILITY JOINT UNDERWRITING INSURANCE ASSOCIATION

6 Section 5701. Declaration of legislative purpose.

7 5702. Definitions.

8 5703. New York municipal tort liability joint underwriting in-
9 surance association.

10 5704. Policies.

11 5705. Procedures.

12 5706. Rates.

13 5707. Participation.

14 5708. Appeals.

15 5709. Immunity.

16 5710. Annual statement.

17 5711. Examinations.

18 5712. Stabilization reserve fund.

19 5713. Termination of article.

20 § 5701. Declaration of legislative purpose. The legislature takes cog-
21 nizance of the burdens and difficulties confronting municipalities as
22 they attempt to obtain appropriate personal and property damage liabil-
23 ity insurance. It is therefore the purpose of this article to enable

EXPLANATION--Matter in italics (underscored) is new; matter in brackets
[] is old law to be omitted.

LBD11425-04-5

NEW YORK STATE LEGISLATURE
Study on Municipal Insurance Pools
January 1980
(141 Pages)

04857

MUNICIPAL INSURANCE POOLS

-An Appropriate Alternative for Local Governments?

New York State Legislature
Assembly Ways and Means Committee*

Stanley Fink
Speaker of the Assembly

Arthur J. Kremer
Chairman

John L. Hardy
Secretary to the
Ways and Means Committee

Ralph Laws
Director of Fiscal Studies

Paul D. Moore
Principal Legislative Fiscal Analyst

Alan G. Billingsley
Senior Legislative Fiscal Analyst

*In cooperation with: James W. McCabe, Chairman, Local Governments Committee

January 1980

NEW YORK
Tort Reform Article from Municipal League Bulletin

An Update on the Municipal Tort Liability Reform Project

by John C. Biggins and Robert W. McGrath

Mr. McGrath is Local Government Liaison and Mr. Biggins is Consultant to the New York City Office of Management and Budget. This article is a follow-up to their article "Striking a Balance—A Proposal for Sensible Government Liability Reform" that appeared in the September 1984 issue of the Bulletin.

Municipal officials throughout New York are again turning their attention to the State Capitol as the beginning of the 1985 legislative session draws near. Whether one serves a rural township, a suburban county, or a large city, those of us who work in local government know that the decisions made in Albany can have a dramatic effect on our communities and their taxpayers. We also realize that with reduced federal assistance and an uncertain economic outlook, it is essential for municipalities and their representatives to identify ways the state can provide localities with fiscal relief in which we all have a strong common interest. If we are to make progress on this front, local government leaders must join together on the few means to this end that transcend regional and jurisdictional interests. One of the clearest examples of this "common interest" is the effort to reform municipal tort liability.

"Tort Claims are Killing Us"

Our common interest in municipal tort liability reform legislation starts with shared problems. New York stands almost alone among the fifty states in having unlimited liability for local jurisdictions. As a result, the threat of large damage awards has become a menacing problem for every type of public entity in the state. Between 1979 and 1982, liability costs for the state's counties rose an alarming 186%, costs for villages went up 108%, while New York State's own liability costs, constrained by its non-jury Court of Claims, remained fairly constant.

Nationally, seven insurance carriers that have been major suppliers of public liability coverage have fled the market in the past 18 months, and current forecasts call for premium rate increases as high as 400%. It is apparent that these nationwide trends, exacerbated by the open-ended liability exposure of New York's localities, portend a severe fiscal strain on the state's counties, towns,

villages, cities, school districts, and their respective taxpayers. Throughout the state, local officials are urging reform to balance more equitably the needs of local taxpayers for services, and the rights of private litigants for compensation.

New York City's Mayor Edward I. Koch has noted "that unless reasonable legislative reforms are enacted, tort claims will undermine our ability to provide essential services to citizens at a reasonable cost to taxpayers." Patricia Walsh, Executive Director of the New York State Association of Supervisors and County Legislators, stated that "a large judgment could cost a small local government its insurance protection or even close one down altogether." Suffolk County Executive Peter F. Cohalan urges legislative reform that "will enable public entities to compensate victims fairly and reasonably while easing the burden on, and vulnerability of, public treasuries." A town manager of a community of 7,000 said simply, "Tort claims are killing us."

Three Reasonable Goals

These officials, and over one hundred local governments throughout the state, have joined with the New York State Association of Counties, the New York State Association of Supervisors and County Legislators, the New York State Conference of Mayors, the Association of Towns of the State of New York, and the New York State Association of School Business Officials to work for legislation to reform municipal tort liability. They are requesting that the Legislature enact laws that would accomplish three reasonable goals:

- Amend the doctrine of joint and several liability to limit the damages that governmental defendants are required to pay to their equitable share of judgments;
- Limit recovery of non-economic losses (e.g., pain and suffering) to cases where significant injury is proven according to objective standards; and
- Establish a reasonable cap on recovery against governmental tort defendants, or some other appropriate means of limiting local government liability costs.

Opponents of Tort Reform are United

Local governing bodies are being urged to adopt resolutions in support of these proposals. It is equally important that municipal officials organize now into effective coalitions to educate on a regional basis their Assembly and Senate members on the need for municipal liability reform.

The necessity for such a "network" is underscored by a recent letter sent to members of the New York State Trial Lawyers Association by the chairperson of their legislative committee urging trial lawyers to organize to defeat legislation contrary to the Association's interests. The letter stated in part:

"Our leadership has determined that the key to success is our ability to establish a solid, realistic line of personal communication with legislators and the legislative process in our state. We have learned that we cannot win the battles (which never seem to cease) unless our position on all important issues has an open and willing ear in the legislative halls of Albany and Washington, D.C."

After stating that those who propose tort reform "have special, selfish and indefensible motivations," the letter continues by stating,

"It is our intention to establish a direct one-on-one relationship with as many legislators as possible . . . in order to explain to them the positions which we would want them to take on specific issues and the reasons for taking such positions."

That the trial lawyers would oppose municipal tort reform in New York State should come as no surprise. They advocate one interest—presenting the opportunity to collect unlimited damages against municipal governments. But in local government, do not have the luxury of advocating only a single interest. We must somehow balance many competing interests for the common good, not unlike our obligation to balance

ur budgets. And that is the problem. If he costs of tort claims continue their steep rise, we will all have trouble financing our budgets while providing nial public services and containing

The trial lawyers are not alone in their concern that plaintiffs receive fair compensation. Municipal officials care about plaintiffs' rights too. But we must also recognize that "fair" compensation means something much different in New York than in most states. It means "more" in New York, more than we who have to balance budgets can afford. A vast majority of other states accord their localities some form of protection against unlimited exposure to tort liability. Somehow, plaintiffs in these states manage to be fairly compensated even while their local governments are protected from unlimited liability.

Local Action Urged

While opposition from the trial lawyers is no surprise, their lobbying efforts warrant special attention. Municipal officials must recognize the clear danger in failing to build an equally effective organization to support passage of municipal tort reform in New York State.

calities will not get the fiscal relief they and their taxpayers need unless local officials who have already endorsed municipal tort reform participate actively in the campaign to enlist the support of their peers around the state, and then present a united front in Albany.

With an effective campaign supporting it, municipal tort reform has a fighting chance. It is an opportunity for the state to provide local governments with fiscal relief at no cost to itself, which should be especially attractive in a year in which the Governor ne Legislature may be considering resources that would otherwise be available for increased local government assistance to fund a state tax cut. Local governments, which are responsible for delivering most of the essential public services, have a very compelling argument for fiscal help from the state.

If you would like further information, or are interested in joining the campaign for governmental liability reform, please contact Don Walsh of NYCOM at (518) 463-1185 or Robert W. McGrath, Local Government Liaison, New York City Office of Management and Budget, Room 1216, Municipal Building, One Centre Street, New York, NY 10007; (212) 566-2443.

Municipal Ads

Fire Truck for Sale. 1961 Ford C850 Super Duty Tilt Cab Chassis with 534 gas engine. Equipped with John Bean H.P.V. 750 G.P.M. 2 Stage Volume Pump. John Bean Piston HP Pump. 500 gal. tank. Including one 35-foot 3-section and one 24-foot 2-section extension ladders and one 14-foot roof ladder. Threelengths of 4 1/2-inch hard suction and basket strainer; two electric hose reels with 200 feet of booster hose on each reel. Truck is ready to use.

May be seen at the Village of Canisteo Volunteer Fire Department. Contact Village Clerk Marion Campbell, Village of Canisteo, 35 Main Street, Canisteo, NY 14823. (607) 698-4553. Monday through Friday, 9 a.m. to 4 p.m. Bids may be sent to the above address. The Village of Canisteo reserves the right to reject any and all bids.

1964 Ford American LaFrance 1000 GPM Fire Truck for Sale. The Board of Trustees of the Village of Seneca Falls is offering for sale one 1964 Ford American LaFrance 1000 GPM Fire Truck. Sealed bids will be received on the 11th day of February, 1985 at 10 a.m. in meeting room 209 located on the second floor of the Municipal Building, 136 Fall Street, Seneca Falls, NY 13148. The fire truck may be examined by contacting Village Clerk Scott A. Smith at the above address or by calling (315) 568-8107.

The Village of Seneca Falls reserves the right to accept or reject any or all bids or to accept that bid deemed most advantageous to the Village.

NY COM

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Before you buy that computer, call Bill Karson at (518) 463-1185. NYCOM's **Municipal Automation Project** offers you referrals, advice, and the power of a 500+ member consumer group.

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service
FIELD SERVICES **PLUS**

NORTH DAKOTA
1984 Collateral Source Rule
[Re: Tort Reform]

MODIFICATION OF THE COLLATERAL SOURCE RULE

The collateral source rule in civil actions prevents the introduction of evidence that a patient's injury-related expenses have been reimbursed by other compensation plans such as private insurance, workmen's compensation, etc. This sometimes results in a windfall recovery for the plaintiff. It has been suggested that elimination or modification of the collateral source rule will result in reduced liability for a defendant's insurer and eventually reduce the costs of premiums.

In a 1977 report to the House of Delegates of the American Bar Association, the Commission on Medical Professional Liability recommends that recovery of damages should be reduced by collateral source payments received by the plaintiff as the result of government, employment-related, individually purchased, and gratuitously conferred benefits. (The commission does not take a position on whether any forms of life insurance benefits should be set off.) The commission suggests that the amount to be set off should be deducted by the judge from the jury's assessment of damages against the defendant. Subrogation would not be allowed to any collateral source for medical benefits thus set off. (The commission does not take a position on subrogation as to wage and disability payments.) The commission set forth the following reasoning in support of its suggestion:

Traditionally, the tort law has sanctioned a partial or total double recovery by an injured plaintiff by refusing to reduce a liability judgment by the amounts the plaintiff has received from collateral insurers. This result is grounded on the notion that it is better to allow some overlapping of payments to the innocent plaintiff than to allow the wrongdoer to benefit by the plaintiff's collateral protection. The commission does not agree that a plaintiff should retain collateral payments and receive full compensation from the defendant in a medical malpractice action.

The idea of a windfall runs counter to the basic aim of the tort law, which is to make the plaintiff whole, not to overcompensate him. The extent to which the defendant must respond in damages is better measured by the plaintiff's harm than by the degree of the defendant's fault. However, even if "fault" is an appropriate basis for refusing to permit the defendant to lessen his liability it is a very rough and unfair basis upon which to punish defendants whose culpability in the moral sense may run from almost nil to severe. Finally, the notion of a wrongdoing defendant is increasingly anachronistic in this age of widespread malpractice insurance and growing sources of compensation for injured

OHIO
Municipal Tort Liability
1984

**SUMMARY OF H.B. 482
RELATIVE TO TORT LIABILITY OF
POLITICAL SUBDIVISIONS AND THEIR OFFICERS AND EMPLOYEES**

By John E. Cothran
Coffey, Walter & Griswold
Council to Ohio Municipal League

H.B. 482, which has passed the Ohio House of Representatives and is now pending in the Ohio Senate, would address the problems arising out of a series of court decisions abolishing the common law doctrine of sovereign immunity for torts of Ohio municipalities and other units of local government. The bill, among other matters, would:

1. Provide liability of a municipal corporation for damages in a civil action for injury, death, or loss to person or property caused by an act or omission of a municipal corporation or its officers or employees in connection with a governmental or proprietary function as follows: (a) for the operation of motor vehicles (subject to certain statutory defenses), (b) for the negligent performance of acts with respect to proprietary functions, (c) for failure to keep streets and other public grounds and works open, in repair and free from nuisance, and (d) in those other instances where liability is imposed by the Ohio Revised Code.

2. Create specific statutory defenses against liability for local governments and their officers and employees.

3. Prohibit the award of pre-judgment interest and the award of punitive or exemplary damages.

4. Require that insurance proceeds received by the injured party be deducted from the award of damages against a local government.

5. Limit damages arising from the same cause of action, transaction or occurrence, or series of transactions or occurrences to: (i) not to exceed \$250,000 in favor of any one person, or (ii) not to exceed \$500,000 in the aggregate.

6. Prohibit real or personal property of a political subdivision from being subjected to execution, judicial sale, garnishment or attachment to satisfy a judgment rendered against a political subdivision under the proposed new law. Judgments would be paid out of monies currently appropriated for the purpose of paying judgments, if adequate, or if not adequate, then by payment in the next fiscal year, unless the judgment is paid from:

a. The proceeds of judgment bonds, under a liberalized statutory judgment bond provision; or

b. Equal annual installment payments over a period not less than seven years subject to interest, provided that judgment in favor of the State of Ohio may be paid over not more than equal annual installments without interest.

7. Allow political subdivisions the discretion to settle (by mutual agreement with the injured party) civil actions and to defend and indemnify its employees and officers with respect to judgments and costs of suits, and such settlements, defense or indemnification, as determined by the political subdivision, would be final and not subject to appeal or attack by taxpayers.

8. Provide more flexible authority to political subdivisions to purchase liability insurance.

01051-14157H

Ohio Mun. Attys Assoc., "for the Municipal Attorney" (Aug. 1984)

OHIO
Legislative Alternatives
Re: Municipal Liabilities
1983

LEGISLATIVE ALTERNATIVES IN RESPONSE TO DEVELOPMENTS IN MUNICIPAL LIABILITY

This memorandum summarizes the most recent Ohio Supreme Court cases involving the availability of the defense of sovereign immunity to municipal corporations, outlines possible legislative alternatives that may be pursued in view of the current status of the law, and indicates the general trend of the law with respect to each alternative.

Availability of the defense of sovereign immunity

In Haverlack v. Portage Homes, Inc. (1982), 2 Ohio St. 3d 26, the plaintiffs were homeowners who brought an action for damages and injunctive relief against the City of Aurora and private parties involved in the building of a sewage treatment plant, alleging they had suffered harm caused by odors and noises from the plant. The Ohio Supreme Court rejected the city's contention that the suit was barred by the doctrine of sovereign immunity, and reversed the Court of Appeals for Portage County, which had granted summary judgment to the city. The Supreme Court stated:

We hold that the defense of sovereign immunity is not available, in the absence of a statute providing immunity, to a municipal corporation in an action for damages alleged to be caused by the negligent operation of a sewage treatment plant. A municipal corporation, unless immune by statute, is liable for its negligence in the performance or nonperformance of its acts.

This holding was further explained in a subsequent Ohio Supreme Court case involving the statutory construction of R.C. 701.02, which in part provides immunity from liability to fire department members for negligence while engaged in performing a governmental function. In Dougherty v. Torrence (1982), 2 Ohio St. 3d 69, the majority opinion, without any reference to the Haverlack decision, held that a volunteer fireman, who was negligently involved in a collision with another vehicle while on route to the fire station in his private pick-up truck,

OHIO
Municipal Liability
1979



OHIO LEGISLATIVE SERVICE COMMISSION

03561

R-113-1009

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June 1, 1979

LIMITING MUNICIPAL LIABILITY

You recently requested research with respect to the following matters:

- (1) trends in other states "with respect to limiting municipal liability";
- (2) constitutional and/or practical problems that could arise by requiring that suits under section 723.01 of the Revised Code against municipal corporations be commenced in the Court of Claims with a limit on the recoverable damages in such actions.

From our recent telephone conversation, I ascertained that the civil action against the City of Dayton prompting your request was apparently predicated upon a violation of section 723.01 of the Revised Code. That section reads as follows:

Municipal corporations shall have special power to regulate the use of the streets. The legislative authority of such municipal corporation shall have the care, supervision, and control of public highways, streets, avenues, alleys, sidewalks, public grounds, bridges, aqueducts, and viaducts within the municipal corporation, and shall cause them to be kept open, in repair, and free from nuisance.

The City of Dayton's liability purportedly derived from the failure to replace a stop sign at a particular intersection of public highways after being informed that the sign was "down". You also indicated that the judgment in the case (\$1,000,000) suggests the need for legislation limiting the damages recoverable in actions under section 723.01 and that you would like to know whether such legislation could be drafted "without restoring sovereign immunity".

I. Trends in other states

I have had occasion in recent months to research issues concerning municipal corporation sovereign immunity in Ohio and our sister states. In the course of that research, I obtained various articles and materials focusing upon trends in

OREGON
1980 Self-Insurance for State Tort Liability

OREGON

LPE

04972

STUDY OF THE TORT LIABILITY SELF-INSURANCE PROGRAM:
A Report by the Legislative Fiscal Office
November, 1980

Introduction

The State of Oregon began self-insurance for tort liability October 1, 1975. The 1979 Legislative Assembly, the Department of General Services, and local government representatives, all felt the need for a comprehensive program review. The following were the primary expressed concerns:

1. Is the program actuarially sound? Are claims reserves adequate and does premium assessment fairly represent exposure and experience?
2. Is the program organized and operated in an efficient manner consistent with industry standards?
3. Should the current underwriting program be expanded to a risk management and risk control program?
4. Are the current distinctions between local government units and state agency underwriting appropriate?
5. Is the current legislative role regarding claim review still appropriate?

The 1979 Legislative Assembly appropriated additional funds to the Department of General Services to contract a study of the tort liability program and the Legislative Fiscal Office identified this area for interim study. Recognizing the technical expertise available from the consultant, the Legislative Fiscal Office report will not duplicate the consultant report but rather will expand upon it and pursue several issues outside of the consultant's work plan.

The following is a summary of the Legislative Fiscal Office recommendations regarding the state's self-insurance program:

1. Consolidate the General Services insurance management program and the Attorney General's claims management function in a new risk management division within the Executive Department.
2. Develop a plan and retain necessary actuarial assistance to convert the state's self-insurance program from a pre-loss funding on a cash basis to a pre-loss funding on an incurred basis.
3. Institute a mandatory loss deductible program for state agencies and a mandatory or optional loss deductible program for local public body participants.
4. Establish a formal division between the state agency and local public body liability funds.

SOUTH CAROLINA
1985 Amendments to Tort Claims Act
[Tort Reform]

House: Sheheen
Attorney: Draffin
Stenographer: Yonce
Date: February 28, 1985
No.: 1713C

H 2541

A BILL

TO AMEND SECTION 1-11-140, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO THE AUTHORITY OF THE STATE BUDGET AND CONTROL BOARD TO PROVIDE TORT LIABILITY INSURANCE FOR PUBLIC ENTITIES AND EMPLOYEES SO AS TO DELETE LANGUAGE WHICH PROVIDES THAT THE PROCUREMENT OF TORT LIABILITY INSURANCE IN THE MANNER PROVIDED IN THE SECTION IS THE EXCLUSIVE MEANS FOR THE PROCUREMENT OF THIS INSURANCE, AND TO PROVIDE THAT POLITICAL SUBDIVISIONS OF THIS STATE MAY ALSO PROCURE THIS INSURANCE FROM ANY OTHER SOURCE AND IN ANY OTHER MANNER AS THEY MAY CHOOSE.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Section 1-11-140 of the 1976 Code, as last amended by Act 424 of 1984, is further amended to read:

"Section 1-11-140. The State Budget and Control Board, through the Division of General Services, is authorized to provide insurance for the State, its departments, agencies, institutions, commissions, boards, and the personnel employed by the State in its departments, agencies, institutions, commissions, and boards so as to protect the State against tort liability and to protect these personnel against tort liability arising in the course of their employment. The insurance may also be provided for physicians or dentists employed by the State, its departments, agencies, institutions, commissions, or boards against any tort liability arising out of the rendering of any professional services as a physician or dentist for which no fee is charged or professional services rendered of any type whatsoever so long as any fees received are directly payable to the employer of a covered physician or dentist; provided, any insurance coverage

1 INTRODUCED
2 May 30, 1985

H. 2266

Introduced by Judiciary Committee

8 S. Printed 5/30/85--S.
9 Read the first time May 30, 1985.

A BILL

15 TO AMEND TITLE 15, CODE OF LAWS OF SOUTH CARO-
16 LINA, 1976, BY ADDING CHAPTER 78, SO AS TO ENACT
17 THE SOUTH CAROLINA TORT CLAIMS ACT; TO AMEND ACT
18 182 OF 1977, RELATING TO CERTAIN CHARITABLE AND
19 SOVEREIGN IMMUNITY SO AS TO REVISE THE LIMITS OF
20 THIS IMMUNITY, TO AMEND SECTION 59-67-710,
21 RELATING TO INSURANCE ON SCHOOL BUSES AND THE
22 LIMITS OF LIABILITY INVOLVING ACCIDENTS THEREOF
23 SO AS TO REVISE CERTAIN OF THESE LIMITS, AND TO
24 REPEAL ARTICLE 3, CHAPTER 77 OF TITLE 15;
25 ARTICLE 13, CHAPTER 5, OF TITLE 57; ARTICLE 9,
26 CHAPTER 17, OF TITLE 57; SECTION 5-7-70 OF THE
27 1976 CODE, ALL RELATING TO CERTAIN DAMAGE CLAIMS
28 OR SUITS THEREON.

30 Be it enacted by the General Assembly of the
31 State of South Carolina:

32 SECTION 1. Title 15 of the 1976 Code is
33 amended by adding:

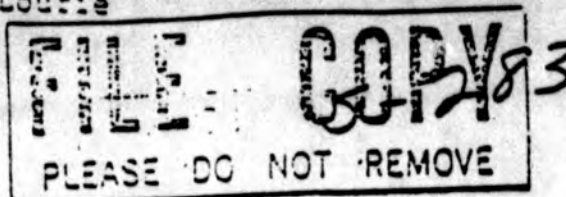
"CHAPTER 78

South Carolina Tort Claims Act

36 Section 15-78-10. This chapter may be cited as
37 the 'South Carolina Tort Claims Act'.

38 Section 15-78-20. (a) The General Assembly
39 finds that while a private entrepreneur may
40 readily be held liable for negligence of his
41 employees within the chosen ambit of his activ-
42 ity, the area within which government has the
43 power to act for the public good is almost with-
44 out limit and, therefore, government should not

Senate: Saleeby, Holland, Lourie
Attorney: Draffin
Stenographer: Yonce
Date: February 12, 1985
No.: 1325C



A BILL

TO AMEND TITLE 15, CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING CHAPTER 73, SO AS TO ENACT THE SOUTH CAROLINA TORT CLAIMS ACT; TO AMEND ACT 182 OF 1977, RELATING TO CERTAIN CHARITABLE AND SOVEREIGN IMMUNITY SO AS TO REVISE THE LIMITS OF THIS IMMUNITY, TO AMEND SECTION 59-67-710, RELATING TO INSURANCE ON SCHOOL BUSES AND THE LIMITS OF LIABILITY INVOLVING ACCIDENTS THEREOF SO AS TO REVISE CERTAIN OF THESE LIMITS, AND TO REPEAL ARTICLE 3, CHAPTER 77 OF TITLE 15; ARTICLE 13, CHAPTER 5, OF TITLE 57; ARTICLE 9, CHAPTER 17, OF TITLE 57; SECTION 5-7-70 OF THE 1976 CODE, ALL RELATING TO CERTAIN DAMAGE CLAIMS OR SUITS THEREON.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Title 15 of the 1976 Code is amended by adding:

"CHAPTER 73

South Carolina Tort Claims Act

Section 15-78-10. This chapter may be cited as the 'South Carolina Tort Claims Act'.

Section 15-78-20. (a) The General Assembly finds that while a private entrepreneur may readily be held liable for negligence of his employees within the chosen ambit of his activity, the area within which government has the power to act for the public good is almost without limit and, therefore, government should not have the duty to do everything which might have been done. Consequently, it is declared to be the public policy of the State of South Carolina that the State, and its political subdivisions, is only liable for torts within the limitations of this chapter and in accordance with

As Liability-Insurance Squeeze Hits Everyone—

Are courts going too far? Did insurers take foolish risks? Whatever the reason, we all pay the piper.

Doctors in Manhattan and building contractors in Indiana, architects in Tennessee and truckers in New Jersey, small towns in Maryland and subway systems in Chicago—all are bound together in their troubles with liability insurance. Either they can't buy it at all or they pay exorbitant sums.

Sky-high verdicts by juries and far-reaching court decisions, say liability insurers, have made their business intolerably risky. To stem multibillion-dollar losses, they are canceling thousands of commercial-liability policies and hiking premiums on many others to mind-boggling levels. Entire industries and professions are being declared off limits.

The impact on businesses is wrenching. These are not firms that did something wrong or became embroiled in thousands of product-liability suits, like Manville Corporation or A. H. Robins Company, to the point of bankruptcy. They merely got caught in the crunch, like Tiger Transit. This Bartlesville, Okla., company has one client: Phillips Petroleum. Tiger moves Phillips's cars, trucks and aircraft refuelers across the country. Recently, Arkansas General Insurance canceled coverage on vehicles that Tiger moves.

Despite only two "fender benders" in the last three years, more than 20 companies refused to cover Tiger. Without insurance, revenues were one tenth of what they had been, because the company had to play it safe. Even when it tried to solicit new clients, says President Dick Horton, "people saw we had no insurance, and they wouldn't do business with us." Horton's woes eased on September 27, when his carrier reinstated his coverage with only a 10 percent rate hike.

Truckers everywhere are targets for cancellations and big rate hikes. Insurers blame deregulation. Explains Andre Maissonpierre, president of the

Reinsurance Association of America, which represents companies that absorb some of the higher risks: "To maintain market shares, some truck companies do foolish things—cut corners. Drivers drive longer hours, and there are accidents." Replies Fred Favors of American Trucking Associations: "The real reason is the financial needs of underwriters."

ICC action. Rocque Dameo, owner of a New Jersey truck company that hauls building materials, says premiums for excess coverage above his policy limits rose nearly 700 percent. The Interstate Commerce Commission has revoked the operating authority of 3,400 carriers for failure to have insurance.

Schools and local governments can't get insurance, either. Until recent years, they were protected against liability claims by the doctrine of sovereign immunity, which means the ruler can do no wrong. But statutes and court rulings have eroded that principle and made it easier for people to seek damages from local governments.

So insurers are canceling thousands of policies on local governments and schools. Says Utica Mutual President Jack Riffle, whose firm quit writing municipal-liability insurance in New York: "Our impression is every time there was an accident or a fire or a kid getting bit by a dog, there would be a lawsuit. There's a time bomb out there."

The City Council president and three members of the zoning board in Sykesville, Md., 20 miles west of Baltimore, resigned in September after that ham-



let's liability insurance for its unpaid public officials was canceled. They feared that their personal assets would be vulnerable if there were a judgment against the town. "We do a very good job," says Mayor Lloyd Helt. "We pick up the garbage, we keep up the street lights. We aren't local yokels, but we are being forced out of existence."

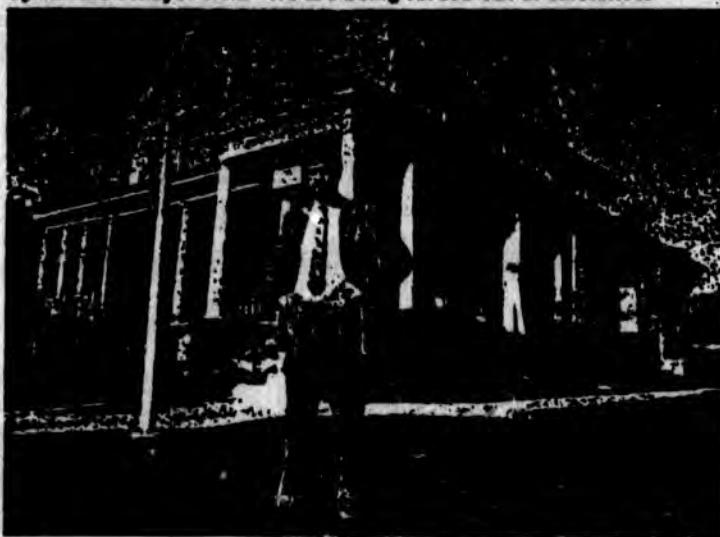
The town found a new policy for a 700 percent premium increase and sharply reduced limits. But the town still is facing a crisis: Liability coverage for its 14 paid workers has been revoked.

Utica Mutual also canceled policies of 585 Ohio schools. "Our losses have been extraordinary," Riffle says. He cites recent settlements or judgments: An 18-year-old pole vaulter severely injured in missing the mat received 1.6 million. The death of a student's father in a fall from a ladder while stringing balloons for a high-school prom was worth 1.4 million.

Staggered by a quote for a 600 percent increase and a 10-million-dollar deductible on its disaster coverage, the Chicago Transit Authority extended its self-insurance by establishing a 9-million-dollar reserve. The American Public Transit Association reports that insurance premiums of bus and subway operators are rising 300 to 1,200 percent now.

Loss of liability insurance threatens the careers of professionals. Coverage for 6,500 Los Angeles lawyers was slated to lapse on October 1. Obstetricians

Sykesville's Mayor Helt: "We are being forced out of existence."



New York, California, Florida and elsewhere are refusing to deliver babies following loss of liability insurance. Oral arguments in Detroit pay \$28,000 a year for liability coverage that cost \$10,000 in 1984. A typical neurosurgeon on Long Island saw premiums jump this year from \$66,000 to \$101,000.

Some architects and engineers who work with chemicals or hazardous waste find liability coverage all but unobtainable. Ronald Gobbell's Nashville firm was a national leader in planning removal of cancer-causing asbestos from interiors of public buildings and apartments. But his policy was canceled in March, and 75 other insurers refused to pick it up if the firm continued its asbestos work. So Gobbell fired seven of his 21 architects, canceled all asbestos jobs in progress and reverted to general architectural work. Says a shaken Gobbell: "It was quite a shock to the system."

Drinking woes. Insurers are clacking down on restaurants and bars, particularly in states where laws hold proprietors responsible for subsequent acts of drunken customers. Richard Vincent paid \$25,000 last year for liability coverage at his Traffic Jam & Snug in Detroit. This year's cost: \$80,000. "It makes us wonder if we should serve alcoholic beverages at all," says Vincent. Restaurant owners in Michigan are mindful of a \$1-million-dollar suit filed against a café in Jackson by families of three youngsters. They were killed in an accident caused by a driver who drank beer at the café—6 hours before the crash.

Insurance problems extend even to day-care centers. Lawsuits stemming from sexual-abuse complaints against a handful of centers or individuals caused premiums to skyrocket from about \$7 per child to as much as \$70. Some 17 percent of child-care centers have had their policies canceled or not renewed.

Many centers now operate without insurance, but that makes some day-care providers nervous. Deborahlyn Phillips of Randolph, Mass., who takes care of five children, was insured only through September. "I had to consider whether I'd operate or close," she says. "We just bought a home.... I would need to protect that. I wouldn't want someone to sue and take our home."

Asked how this mess came about, insurers like to blame lawyers, juries and the courts. Everyone, it seems, is suing. Federal product-liability suits more than doubled from 1978 to 1984, reaching 10,745. Judges and juries are generous to plaintiffs, too. Courts are broadening the theory of "strict liability." This means that businesses and their insurers can be made to pay for mishaps even if fault can't be proved. These legal trends, says Crum & Forster Vice Presi-

dent Leslie Cheek, "wreak havoc with insurers that depend on predictability."

The insurance industry also brought trouble on itself. Fierce price competition in the late 1970s led to imprudent policies and rock-bottom premiums. While premiums could be placed in high-interest investments, everything rolled along. But interest rates collapsed in 1984, just as underwriting losses swelled. In 1984, property and casualty insurers had 21 billion in underwriting losses and 3.8 billion in net losses—the first net losses since 1906, the year of the San Francisco earthquake.

Losses and dwindling surpluses cre-

ate new problems. Insurance regulators don't like a company to write more business if the ratio of premiums to surplus funds needed to satisfy claims exceeds 3 to 1. This causes an insurer to abandon some clients to reserve capacity for its best risks.

Lloyd's of London played a key role, too. Lloyd's syndicates, made up of "names"—wealthy investors who accept unlimited liability in exchange for a chance to realize hefty profits—underwrite risks that U.S. insurance firms are unwilling to take. Although they are smaller than insurers, reinsurers in effect can call the shots because without them, insurers cannot easily operate.

Earlier this year, Lloyd's names in syndicates that underwrote high risks suffered 165 million dollars in losses, threatening as many as 100 names with bankruptcy. That prompted Lloyd's to put pressure on U.S. insurers. Warned Lloyd's Chairman Peter Miller in September: "Virtually all our losses come from [the U.S.], which generates 12 percent of our income. As a businessman, I say to myself, 'Why carry on?'"

New basis. Lloyd's syndicates now insist that insurance they underwrite be on a "claims made" basis. This limits coverage to claims made the year the policy is in force. Most policies had been open ended, tied to when an injury occurred. But asbestos claims and other risks with a "long tail" that might not surface for decades have ballooned in recent years. This change in language is now written into commercial general-liability policies in a majority of the states. Almost all pollution-related claims are excluded, and legal-defense costs may soon be included in policy limits. The industry's legal bill in 1983 for commercial general liability—just for defending suits—was 2.9 billion, or about a quarter of each premium dollar.

State insurance offices are trying to help those caught in the crunch. Market-assistance plans put buyers in touch with those who are still selling. Self-insurance pools are being formed, and insurers' midterm cancellations are being challenged. In extreme cases, insurers are forced to accept certain risks.

No one expects this crisis to ease soon. More likely, it will worsen in coming months. Businesses that are hurt could take a page from Tiger Transit's Horton. While operating without insurance, he hauled just enough vehicles to eke out a living and stay in business until the storm lifted. "They can kill you," says the 60-year-old Horton, "but they can't eat you." □



Want to Pay This Insurance Premium?

...the two most litigious firms in the industry... this means... the two most litigious firms in the industry... this means... the two most litigious firms in the industry... this means...

By CLEMENS P. WORK with JEANNYE THORNTON, MICHELLE MAYNARD and the magazine's domestic bureau

★ call for liability reforms

By David Mott

A WARNING that major reform is needed to preserve general liability cover for industry in the Lloyd's and United States insurance markets was given yesterday by Mr Peter Miller, chairman of Lloyd's.

Mr Miller told the Houston Marine Insurance Seminar three things needed to happen to arrest the decline of a class of business which, for Lloyd's, produced 12% of premium income yet was responsible for "virtually 100%" of all losses.

These were:

- More realistic rates.
- US tort law reform.
- New policy wordings.

The chairman said the new wordings should include a claims made basis and an overall limit, including legal costs.

Without progress in all three areas it should not be wondered at if underwriters — who Mr Miller felt did not get reasonable treatment in many US courts — increasingly withdrew from liability business.

High on the chairman's list of pressing reforms were a cap on the US system of contingency fees — at present insurers pay out \$2.71 for every \$1 received by the plaintiff — and changes to the process of punitive damages.

He also called for reform of the products liability law.

Mr Miller said the consequences of wide-scale withdrawal of general liability cover were job and product losses, trade disruption and ultimate bankruptcy for many firms.

The large increase in the cost of cover in a contracted market would place US companies in an uncompetitive position.

For underwriters in general the international "name of the game" for the last five years had been to accept large lines and then lay off 95% of the risk at 15% to 20% of the premium.

But the contraction in the reinsurance market meant this was no longer possible.

insurance tax relief

By Richard Thomson

Thousands of life assurance policy-holders could find their monthly premiums rising by 15 per cent, the Association of British Insurers said yesterday. The policies affected would be those issued in the hours before midnight of March 13 last year, when life assurance premium relief was abolished.

The Life Insurance Council of the ABI met yesterday to discuss the Inland Revenue's refusal to allow tax relief on the policies concerned.

Mr Michael Oppé, secretary general of the council, said: "The meeting considered bringing a test case to the courts on the issue but rejected it. More life offices will now be writing to policy-holders to warn them of what is happening and in many cases this will be a prelude to asking policy-holders to pay premiums gross."

About 100,000 policies are in dispute, involving £60 million of potential tax relief. Since March 13 last year most insurance companies have been paying the extra 15 per cent to the policy-holders from their own funds in the hope that the revenue would relax its stance.

There is a growing recognition in the insurance industry that life companies have underestimated the revenue's determination to deny tax relief on disputed policies.

When the Chancellor announced in last year's budget that life assurance premium relief would disappear, thousands of investors rushed to take out policies. The revenue claims that many contracts were not completed before the midnight deadline and do not therefore qualify for tax relief.

on liquidation committee

BY ROGER SCOTTON IN BERMUDA

THE FIRST meeting of creditors of Mentor Insurance, the Bermuda-based subsidiary of Ocean Drilling and Exploration of New Orleans, has failed to reach agreement on the make-up of a committee of inspection to oversee Mentor's liquidation.

More than 200 banks and reinsurance companies attended the four-hour meeting in Bermuda late last week but were unable to settle differences over who should be allowed to sit on the committee.

The creditors are claiming about \$178.5m from Mentor, which was ordered into liquidation in June this year after the Bermuda Government found that the company's capital and

surplus position was \$7.9m short of the statutory minimum solvency margin.

Funds available to meet the debts amount to about \$14m leaving an estimated deficit of \$30.5m.

The creditors include six major American banks believed to be owed between \$50m and \$60m. The five are Manufacturers Hanover Bank, America, Irving Trust, Morgan Guaranty and First City National Bank of Houston.

It is understood that the banks each wanted a place on the committee but that this was firmly resisted by reinsurance industry creditors.

The meeting ended with a ballot of nominations for the committee.

Cost of insurance skyrockets

Continued from page C-1

body — including local taxpayers.

"We've got the same insurance problems as everybody else — prices, availability, predictability, stability," said Scott Burgess, executive director of the Alaska Municipal League.

"The insurance industry has a problem because its premium-to-loss ratio has changed," he said Wednesday. "The other side of the coin is the sharp (legal) awards being given."

"The problem with municipalities is liability insurance," Burgess said. "There's this 'deep pocket theory' that seems to operate with people who sue the

cities, figuring if the cities lose they'll pass the costs on to the taxpayers."

"So they're (municipalities) seen as high risks by insurance companies and they're subject to cancellations or high premiums," he said.

John Pugh, commissioner of the Department of Health and Social Services, said a number of day-care centers around the state have reported they'll close soon if they can't find insurance.

"Some carriers are saying they won't move to insure a center without a sexual-abuse exclusion clause, meaning they wouldn't insure unless they could exclude sexual-abuse claims," Pugh said.

A number of solutions are

being suggested by various groups. Among them:

- Tighten procedures for filing liability suits, including requiring plaintiffs to file an affidavit laying out the merits of the case before heading to court.

- Establish a cap between \$100,000 to \$250,000 for compensation given victims for pain and suffering.

- Set limits on lawyer fees.
- Repeal a law allowing the plaintiff to add 10 percent onto the settlement to cover legal fees.

- Pass legislation providing for "liability insurance pools," a self-insurance idea being pushed by the Alaska Municipal League.

Insurance costs jump in Alaska

by Dean Feidick
Anchorage Press Writer

Juneau — Legislative leaders are predicting that next session's big sleeper issue will involve trying to resolve the insurance crisis, and they're rushing to gather as much information as they can about availability and premium price problems.

But this much already is known: Liability and property insurance policies either are being canceled in large amounts or premium rates are rising from 35 to 500 percent around Alaska for such groups as surgeons, day-care centers, the liquor industry, commercial fishermen, truckers and airline operators and municipalities.

That threatens to drive a lot of people out of business or at least put them in an uncomfortable money bind. And it has prompted calls for immediate relief and reforms.

"Physicians have been feeling the effects of this (insurance costs) for years, but it's the little guys this time," said Dr. David A. McGuire, an orthopedic surgeon and leader of a group called the Citizens Coalition for Tort Reform.

"It's happened so suddenly and so unexpectedly that they can't pass the costs along to their customers," McGuire said Wednesday. "I've gotten a letter from a guy who operates a business with a couple of trucks, and he told me he's up against the wall."

The coalition wants to scale down the size of the awards being handed out in cases involving legal claims for damages.

"The system will work when it's fair to the injured party, when it's efficient and when it restores the perception that the system is equitable," he said.

McGuire cited his eight-physician clinic in midtown Anchorage as an example of a business where insurance rates have gone crazy.

The clinic's liability policy soared from \$149,054 a year through the end of August to \$360,102 for the current year, McGuire said, adding he was told to expect premiums in the neighborhood of \$500,000 next year.

A combination of factors are at cause.

The nation's insurance companies have suffered some major losses in recent years because of a variety of catastrophes and lawsuits resulting from those catastrophes. They've also seen interest rates and the stock market fall, affecting their earnings.

Predictability, however, is the major problem, according to Dick Block, a former state insurance director and now president of Alaska National Insurance in Anchorage.

"The insurance industry is faced with having entered into a contract to provide industry protection, but then having the rules changed," Block said. "The courts are changing the definition and limits of indemnity — expanding the limits of responsibility for bodily injury to others."

"Insurance companies are being required to pay for things they didn't count on," he said. "So they increase the price of the insurance to cover their payments. And in some cases, they don't sell policies at all."

That kind of cost-coverage ripple affects every-

See Cost, page C-4

Sunday Business

Anchorage Daily News, Sunday, September 15, 1980

Insurance costs soar High premiums threaten Alaska businesses

Lee Robertson operates her day-care center for 22 children between 6 weeks and 12 years of age. She says she's never had a serious complaint about the quality of care at her center.

But on Sept. 1, she says she had to raise her monthly rates by 10 percent to cover the cost of a new liability insurance policy that is three times more expensive than her old one.

The new policy is good only for six months. Once it expires, Robertson says her insurance rates could rise still higher.

Bob Bunch knows the cost of chartering a plane from his Gulfstream Air Taxi is getting to be higher than a lot of his would-be customers can afford. But there's one big chunk of his costs he's powerless to control: liability insurance.

This year, Bunch's insurer says he never had a serious accident, will pay \$48,000 in premiums to insure his planes. To recoverable insurance premiums Bunch must tack on an extra \$46 an hour in the \$150-an-hour charge for chartering one of his fleet planes.

Bunch says he pays his insurance company \$5 an hour more than he has to pay his pilots. He says the cost of liability insurance is the only way he can protect himself.

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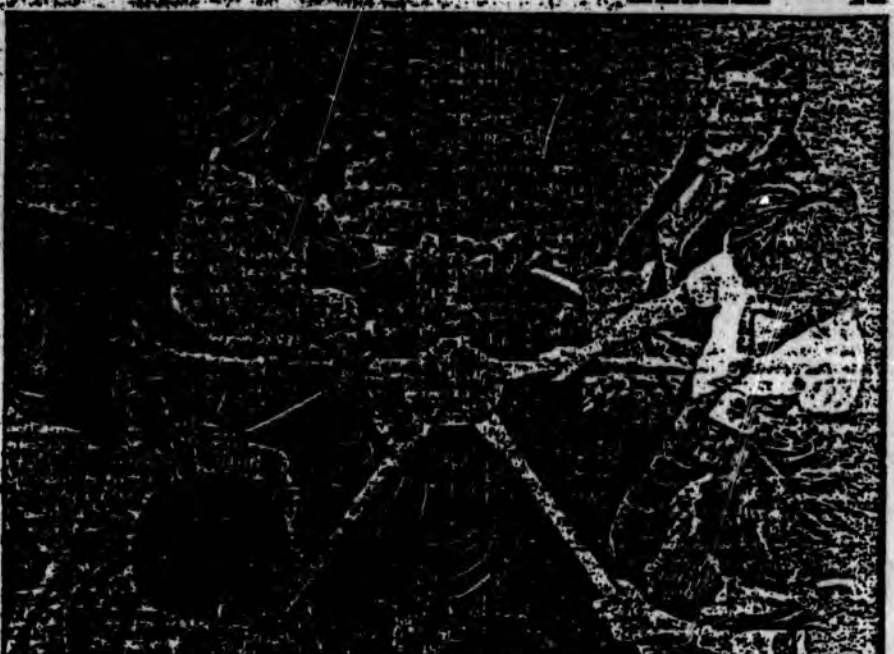
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Five big Alaska settlement awards

Year	Amount	Reason
1976	\$1.5 million	Jury awarded the amount to a widow whose husband was killed in a helicopter crash.
1977	\$1.5 million	A dentist received the award after being paralyzed from the neck down after a seat belt failed to work properly.
1981	\$1.5 million	Jury awarded the amount to the parents of a child who suffered brain damage after nearly drowning in a swimming pool.
1984	\$1.5 million	Jury found that an improperly designed and manufactured aircraft seat was an off-by error.
1984	\$1.5 million	The amount was awarded to the widow of a 58th man who was pushed into the underwater intake of a hydroelectric project.

Source: Jury Verdict Research Inc., James A. Layton Co., L. James Lott, and Jim Young. Daily News staff.

arise from the spate of recent airplane crashes and industrial disasters.

A major cause of the skyrocketing premiums is the soaring costs of settling such mega-claims, as well as thousands of smaller claims, in an increasingly litigation-minded America.

As long as claims keep rising, so will premiums, say insurance industry officials, who have launched a nationwide campaign to lobby for changes in state laws that guide juries in making damage awards.

But Mears says part of the blame for the abrupt rise in premiums lies with the major underwriters, who seriously underpriced their policies throughout much of the late 1970s and early 1980s.

The (insurance) companies' losses aren't adequate to pay current claims, let alone future claims," Mears says.



Source: American Medical Association, 1980.

Story by Hal Samton
Daily News business report

claims litigation. By year's end, 6 underwriters had paid out \$21 billion more than they collected in premiums, according to Don Koch, chief market surveillance division for state Division of Insurance.

Koch's agency approves the many insurance companies in Alaska may charge. The agency also tries to make sure the companies have enough cash reserves to make good on all claims.

For every premium dollar property and casualty insurers took in during 1984, they paid out a where from \$1.20 to \$1.50 in claim settlements, according to Koch.

And (insurance) underwriters offer coverage to back up the cash reserves of many major insurance companies, told their clients to their houses in order.

Many insurers who remain active have so few cash reserves left they are unable to write many new policies. This has created a severe shortage of coverage for many insurance markets, according to Koch.

Charles Hart says he'd like to

See Page C-2, UNDER

Underwriters say higher premiums still don't cover cost of huge damage settlements

Continued from Page D-1

his fishing boat — the 150-foot Duna Genova — out in the Bering Sea this fall, cashing in on a king crab harvest that looks like it just may be on the rebound. But after a long hard look at his 1985 insurance premiums, he decided to sit this harvest out.

Hart already is paying \$250,000 to insure his boat for the 1985 bottom fishing season, five times the cost of his 1980 policy. Hart says he can't afford the extra \$50,000 for crabbing.

"It's just like being guillotined in the back," says Hart, whose boat has an excellent safety record. "We are in terrible trouble."

Insurance industry officials readily admit the price wars of the past few years helped create their present cash crunch. But they say their own pricing blunders aren't the primary cause of this year's massive round of rate increases.

Instead, they point the finger at the U.S. tort system — the complex web of state statutes that help determine the size of damages awarded to plaintiffs harmed by negligent actions.

The number of claims being filed against insurance companies is constantly on the increase. And since 1982, damage awards have risen at five times the rate of increases in the federally calculated consumer price index, according to statistics compiled by Marsh & McLennan Inc., one of the nation's largest insurance companies.

Alaska jury awards and out-of-court settlements have mirrored the national trends, according to Jeanine Schmoll, research director of the Ohio-based Jury Verdict Research Inc.

On Tuesday, insurance industry plans to reform the state tort system will be reviewed at a seminar at an Anchorage hotel.

The seminar is expected to attract industry analysts, brokers and representatives of professions hardest hit by the latest round of premium increases. It is sponsored by the Defense Counsel of Alaska, an association of attorneys who specialize in representing defendants in insurance litigation.

Korb, of the state's Division of Insurance, predicts the seminar will produce a "ground swell for reform" of Alaska tort laws.

That kind of talk makes attorneys for plaintiff's victims nervous.

"Tort reform is a code word for immunity from prosecution, among certain segments of the community,"

says L. Ames Luce, an Anchorage attorney who serves on the board of governors of the American Trial Lawyers Association.

The tort system has its roots in common law developed in 18th century England as society accepted the notion that a person should be held responsible for negligent, as well as willful, acts causing violence or suffering to others.

Over the last two centuries, U.S. juries have expanded the English tort concepts to include new ideas about liability, compensation and punitive damages awards for victims of negligent acts.

In recent years, enterprising plaintiff's attorneys have sought to use the U.S. tort system as a powerful weapon for obtaining social justice for Americans who feel they have been wronged by corporate negligence.

In 1978, for example, Ford Motor Co. was slapped with a \$125 million damages verdict after a jury found the corporation's officials failed to fix unsafe gas tanks in Fords they knew could cause dozens of people to die.

More recently, millions of dollars in damages have been awarded as a result of more than 15,000 civil suits filed against Manville Corp., an insulation maker that tried to cover up information about the devastating health effects of asbestos.

Joe Young, one of Alaska's most successful plaintiff's attorneys, says such awards help deter other corporations from similar acts of negligence.

He says Alaska's tort system is doing a good job and shouldn't be tampered with.

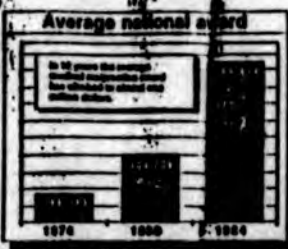
"My experience with juries are that they usually do what's right and punish outrageous conduct," Young says. "It's the same system that we have had for 300 years and it appears to be doing what it intended to do, compensate people for other people's negligence."

But insurance industry critics of the U.S. tort system now say it is careening out of control.

Insurance companies try to use past settlements reached under a state's tort code as a basis for setting premium rates that will let them pay off future claims and still make a profit.

But the unpredictable size of the jury verdicts and pretrial settlements, as well as the enormous litigation expenses involved in defending policy holders, has made it difficult to predict liability costs, says Dick Block, president of Alaska National Insurance Co.

Block says plaintiff's attorneys are



constantly creating new theories of liability to go after "deep pockets" with big insurance policies. Many times, these deep pockets end up being municipal or state governments.

A recent Business Week magazine survey found that a woman in Torrington, Conn. was awarded \$1.6 million because police failed to protect her from an attack by her estranged husband. A California teenager collected \$300,000 after falling through a school skylight while playing high-intensity lights. And Newport Beach, Calif. was ordered to pay \$5 million to a man who dove into the water at the beach, hit a sandbar and became a paraplegic.

When the suits are finally settled, plaintiff's attorneys routinely get at least a third of the damage awards, and sometimes more, according to Block, a former director of the state Division of Insurance.

Young says insurance companies shouldn't try to pin the blame on plaintiffs.

"They are going to be right and left. Things are in a jam but it's not the fault of the plaintiffs," Young says. "The way the industry has failed to adequately police itself is a time bomb waiting to explode."

Block believes that a victim or his survivors should receive adequate compensation for economic losses caused by the negligent acts of others. "I think any punitive damages awards should go to the state or non-profit agencies, if not collected at all."

And he advocates placing caps on the amount of money plaintiffs can receive for certain types of damages awards, such as pain and suffering.

Dr. Caroline Brown has practiced obstetrics in Palmer for 20 years, but she's not sure what she'll be doing in a few months time.

In November, she expects her malpractice insurance premiums to jump from \$10,000 to more than \$50,000 annually. Rather than jack up her

fees to cover the premium costs, Brown, who operates a clinic with her husband Dr. George Brown, is thinking of quitting a practice that now serves more than 10,000 Matanuska Valley residents.

"My husband and I are involved in non-profit medical practice," Brown says. "We take care of a lot of wonderful people who don't have a lot of money. If I had to pass those (premium) fees on, I would have to seriously consider if I can stay in medicine."

Art Stanford, manager of the Medical Indemnity Corporation of Alaska, also thinks the state tort system needs some major changes.

The legislature created the corporation in 1976 to provide liability coverage for state physicians (who then were finding privately funded policies almost impossible to obtain).

Today, the company insures more than 300 physicians — and is the largest malpractice insurer operating in Alaska. But the corporation, like its counterparts in private industry, also is in serious financial trouble, as an escalating number of malpractice claims have drained its cash surplus to low levels.

In 1984, 33 percent more malpractice claims were reported to the company than in 1983, and the size of average settlements is also on the rise, Stanford says.

The unexpectedly high cost of claims settlements has drained cash reserves and placed the state insurance corporation in a serious jam with reinsurers.

To hang on to reinsurers, the corporation had to raise its physician malpractice liability premiums by an average of 31 percent this year, Stanford says. He expects "more dramatic" premium increases next year.

Stanford says many of the claims reported to his agency have merit and should be compensated justly. But he's disturbed by the attitude of some patients who believe "that there are never any bad results" when doctors try to cure them of their ills. "That is just not realistic. There are bad results," he says.

Obstetricians, who are pioneering the rapidly developing field of neonatology, have been particularly hard hit by malpractice suits, Stanford says.

Even with the aid of new medical technology, some premature infants die and bereaved parents sue doctors for malpractice. If a case goes to trial, a jury is allowed to compensate the parent for the net lifetime loss

to the baby might have earned if it had survived, according to Stanford.

"That just doesn't make any sense," he says.

Sometimes, a malpractice suit is not settled for more than a decade after the initial doctor error, Stanford says. When the interest is calculated, the cash value of the settlement may be inflated more than five-fold over the actual damages awarded. Stanford would like to see this prejudgment interest reduced or eliminated.

Luce says he opposes most of the tort reforms proposed by the insurance industry. And he believes the state's malpractice laws are already heavily weighted in favor of physicians. "When you try to win a jury verdict against a doctor in this town, it's damn near impossible," Luce says.

He says the net earning potential of an infant is only one of many elements of a malpractice damages award that a plaintiff's attorney can propose to a jury. If the jury doesn't think that compensation is needed, it doesn't have to include the money in a damages award.

And statistics indicate most of the malpractice suits filed against physicians are not frivolous, he says.

He says the state law allowing prejudgment interest awards should remain intact because it forces insurance companies to try to settle claims quickly, rather than delay them for years through litigation.

"It's an extremely important tool to try and expedite resolution of suits," Luce says.

State Sen. Pat Rodey, an attorney who chairs the Senate Judiciary Committee, says he's sensitive to rights of victims, but he is willing to take up the issues of tort reform at the next legislative session.

"We have not spent a significant amount of time defining tort laws in the state of Alaska and I am not at all opposed to an inquiry," says Rodey, D-Anchorage. "The system is slow, and unpredictable."

"I am a businessman and understand the problem at a pocketbook level. There has to be a mechanism for just compensation."

"Nothing we can do will satisfy everybody."

NORTHERN LIFE

Tuesday, September 17, 1985-9

Day care: Alaskan parents are facing higher costs thanks to an increase in insurance rates

By DEBBIE CARTER
Staff Writer

Backing nature's example, bad news from the south is migrating north. Expensive lawsuits against day-care operators Outside are translating into bigger day-care bills for Alaskan parents.

Day-care insurance costs here are going sky high, in some instances quadrupling in the past six months.

The reason? Child abuse cases and million-dollar lawsuits against day-care operators Outside have marked them as a risky crowd to insure. Rather than risk big lawsuits, some insurance companies have already deserted the day-care market. Other companies are imposing stricter standards on centers than those required by the state.

The troubles are rising now, because many day-care policies are renewed in late August or September to conform to the school year. Under state law, day-care centers must have liability insurance.

As a side light to this trouble, day care is going to be harder to find for children under the age of 2.

Ken Murray Insurance Inc. is one of the few remaining companies that will insure day-care centers in town. The company recently switched to a policy that requires centers to hire more day-care workers for children under 2.

In order to be insured by Ken Murray, a day-care center must have one staff person for every three children under the age of 2. The state requires a 1:5 ratio for the same age group.

The result is that day-care centers just can't afford to take in children under 2, says Turrey Maxwell, who owns two centers called Little White House Day Care.



DAY ROMP—Kids are at play in Little White House Day Care center on a rainy day. The center recently stopped taking in children younger than 2 because of an insurance squeeze.

(Staff photo by Mike Brown)

up on employees, to have more eyes around," she says.

Faced with vastly higher rates or with meeting the strict guidelines, she is phasing all children under 2½ years out of her Seventh Avenue center, which is licensed for 14, and a larger center near the intersection of University Avenue and Geist, which is licensed for 45.

If she gets the coverage with Ken Murray, she plans to let go of the rest of the children under 2½. She also expects to start charging \$5 to \$10 more a week.

Under Ken Murray's rules, employers also must also have to be trained in early childhood development before they start work. That annoys Maxwell.

\$5,000. Neither has agreed to insure her. Her last insurance bill was for \$270. Her center is licensed for 15 children.

The insurance situation is getting as bad in the state that apparently no company in Juneau will provide coverage to the town's day-care centers. Centers there are calling Fairbanks looking for coverage, according to Gayle Miller, an agent for Frank B. Hall.

Frank B. Hall used to have five or six companies it worked with to provide a variety of coverages for centers. The number has dwindled to one during the past six months.

Besides raising its rates substantially the past six months, the company will only provide for six months coverage at a time, instead of a year.

The first she heard about the insurance trouble was about six months ago, Miller recalls, when a company official informed her that they would not be renewing insurance policies for centers when they lapsed. When she said she was told it had to do with lawsuits in the Lower 48, her reaction was: "Who cares what is going on Outside?"

Apparently, the insurance companies do. During her 10 years with Frank B. Hall, Miller said no client has ever sought damages under a day-care policy.

According to Miller, the insurance companies have figured out that they must provide coverage to 4,000 children to pay for one million-dollar judgment.

The rates for one center insured by Frank B. Hall have jumped more than 100 percent—from \$18 to \$1,100. Another center, which is licensed for more than 100 kids, was paying \$2,000 a year for coverage. They are now faced with a \$3,000

One crowd that has been hardest hit by the insurance squeeze is military day-care homes licensed for up to six children. The federal government requires day-care home operators to get \$500,000 liability coverage. Their annual rates have hopped from around \$150 to \$500 and higher.

Linda Gostack, a worker with the day-care licensing office at Elmendorf, said that increase is translating into higher rates. She only knows of one day-care home that is closing down because of the insurance woes.

Alan Carrick, who runs Childcraft 1 and 11 in Hamilton Acres, says the insurance problem is only the latest squeeze in a business with a low-profit margin. One of his centers is licensed for 170 and the other is rated for 40 children.

He also is negotiating for insurance now, but the cheapest of the estimates will quadruple his insurance bill.

Childcraft's rates are increasing 5 percent, and parents are being charged an annual "re-registration" fee, designed specifically to pay the insurance, says Carrick.

Carrick says he believes the price hikes are only a temporary solution to the problem of the extreme cost squeeze on day-care centers. The squeeze comes from competition, the drive to provide quality care and the reality of what parents can afford.

He expects eventually the state or federal government will have to intervene to provide support. A group of day-care operators are banding together to look for relief.

"We run so close to the margin,"

Small Firms Face Sharp Cost Hikes For Insurance—If They Can Get It

By DAVID E. HILSON

Staff Reporter of THE WALL STREET JOURNAL

Three weeks ago, Heinz Popp was just a few days away from having to shut down his Porsche-Audi dealership in Brooklyn, N.Y. The insurance policy for the dealership was about to expire, and two insurance brokers told him they couldn't find a company that would issue a new policy.

Finally, through a car dealer's group, Mr. Popp found an insurance company willing to sell him a policy—but with a catch. Mr. Popp would have to pay whatever premium the company decided upon after it investigated his dealership. Desperate, Mr. Popp agreed.

"I needed insurance," Mr. Popp explains. "In the auto business, if you're without insurance, you're out of business."

Mr. Popp has last week was told his new policy will cost \$116,000, or nearly three times the old premium of about \$40,000 to insure about 22.5 million of new cars and auto-parts inventories against loss or damage.

Across the country, businesses of all sizes are facing premium increases ranging from 25% to more than 1,000% for property and liability insurance—when they can get any coverage at all. And small businesses such as Mr. Popp's are being squeezed the hardest.

Bars, restaurants, liquor stores, day-care centers and nursing homes—all experiencing or expecting increased claims—have been among the small concerns hardest hit by soaring insurance rates. Professionals, including midwives, doctors, accountants, architects and lawyers, also face skyrocketing insurance bills because of increasing malpractice suits.

Property-casualty insurance rates historically follow a boom-or-bust cycle: three years of falling rates followed by three years of increases. But insurance brokers, executives and regulators say the current surge is the most pronounced in this century.

The reason is that commercial insurance rates plunged for six straight years as companies battled fiercely for business, hoping to invest the premiums at high interest rates before claims had to be paid. But premiums were driven too low, the industry had a \$3.5 billion pre-tax operating loss last year, and now insurers are trying to compensate by raising prices and getting out of types of business that have resulted in big claims.

The White Sale's Over

There's still a veneer of calm between industry premiums and underlying costs, says David Crawford, vice president of Insurance Services Office, a trade group that collects data from the nation's insurers and suggests rates. "For the past six years, insurance buyers have been the beneficiaries of policies that have been priced at bargain levels. Now the white sale's coming to a close."

Businesses that can raise prices will pass some or all of the higher premiums along to customers. But some businesses

can't do that and are seeing their earnings eaten away by higher insurance costs. "In many cases, it's going to wipe out their annual profit," says Lawrence J. Barwin, a Great Neck, N.Y., insurance broker. He cites a New York sprinkler contractor who paid \$12,000 last year for a \$10 million liability policy but this year is paying \$125,000 for a \$5 million policy.

The conventional ways of controlling premiums aren't always available to small businesses. Many can't afford to absorb casualty losses by taking higher deductibles, solutions being adopted by larger companies such as setting up their own insurance subsidiaries or forming group-term insurance organizations, usually are too expensive or cumbersome. And many small businesses, unlike big industrial companies, weren't warned last year by their insurance brokers about the size of premium increases in store this year.

"It was really a shock to us," says Timothy L. Cross, president of Surgical Spe-

Hard-to-Get Insurance

The following types of insurance are the most difficult to buy:

1. Pollution risks
2. Liquor liability
3. Day-care center coverage
4. Medical malpractice
5. High-limit coverage (above \$50 million) for industrial firms
6. Asbestos removal from schools
7. Commercial fishing boat coverage
8. Municipal liability

Source: Insurance Information Institute

cialties Instrument Co., a Crofton, Md., wholesaler of surgical implants and instruments. Mr. Cross says he budgeted for a 10% to 15% premium increase from last year's \$4,722 for \$1 million of product liability coverage.

But the first two quotes he received were for \$120,000 and \$70,000 for similar coverage. Finally, his insurer, Vitamar, Ltd., renewed the policy for \$61,000.

"We're glad just to have coverage," Mr. Cross says. "We went down to the last day not knowing what was going to happen." Still, he says, the higher premium "really cuts the profits. Most of our prices are dictated by the manufacturers."

The insurance market's sharp turn has created other problems around year-to-year comparisons. Last year, Garland Flaherty, a restaurant owner in Louisville, Ky., paid a \$50 premium for \$500,000 of liquor liability insurance, which protects against lawsuits stemming from accidents involving patrons who had been drinking.

When the policy expired May 1, Mr. Flaherty was confronted with a \$1 million policy for a \$10,000 premium. "A jump from \$50 to \$10,000 is rough on any business," he says. By June, he found another company willing to write a similar policy

for \$3,000—still a 7,500% rise for a 225% increase in the amount of coverage.

Some insurers are demanding a percentage of a company's revenue. One Connecticut crane operator is paying \$18,000 a year plus 10% of his gross revenue over \$175,000 for \$500,000 of liability insurance. Last year, the crane operator paid \$3,000 for \$1 million of coverage.

Buying Loss Coverage

By choice or necessity, many small businesses are buying less coverage. Regular liability coverage, which pays the cost of defending or settling lawsuits, that, in turn, leaves them vulnerable to a lawsuit or jury award. And it ultimately could hurt those who have claims against the businesses by reducing the amount they can collect.

Joe Fiore, a South Windsor, Conn., insurance agent, cites an auto-parts wholesaler for whom he could find only \$10 million of fire-insurance coverage to replace a \$30 million policy that expired May 31. The new premium was \$156,000 compared with \$80,000 the year before, but Mr. Fiore says the reduced coverage was of more serious concern.

Richard Merrill, a San Francisco insurance broker with the firm of Rollins Burdick Hunter, says two clients will drop earthquake insurance rather than pay annual premiums up to \$750,000 for \$30 million of coverage. Last year, Mr. Merrill says, his clients had up to \$100 million of coverage for premiums one-tenth as much.

Because of Surgical Specialties' premium increase, Mr. Cross says the firm couldn't afford to buy an additional policy covering losses caused by interruptions in supplies from manufacturers. "If we put back on coverage anymore, we'd really be exposing ourselves to some financial losses," he says. "We just don't want to take that chance."

Business owners are beginning to turn to insurance regulators for help in finding coverage. Regulators can enforce laws against policy cancellations in some states, and some are circulating lists of companies willing to issue policies. But regulators can't force companies to write business they don't want, nor can they generally restrict premium increases.

We're here to ask questions and make sure the reaction to insurance-rate increases isn't excessive, says New York Insurance Superintendent James P. Moran, whose office is surveying businesses to determine the extent of the insurance shortage.

The tightening insurance market has already prompted at least one legislative remedy proposed by lawmakers in Massachusetts, where liquor liability insurance and other several court decisions upheld the liability of liquor stores and restaurants to patrons' auto accidents, the state enacted a bill forcing insurers to write liquor liability coverage. The bill would require the state. The rates will be subject to state approval.

Sunday, October 4, 1992, The Anchorage Times

Business

Section K

Insurance crisis takes a turn for the worse

by Chris Swaney

Times Business Writer

The rocketing price of liability and property insurance has created a precarious and stormy atmosphere for most every type of business, as well as governments, in Alaska and throughout the country.

Anchorage doctors, high schools, day care owners, contractors, land developers and air taxi services are among those being hit hard by soaring premiums as insurers nationwide scramble to cut some \$3.8 billion in losses last year alone — the largest pre-tax operating loss in the industry's history.

The crisis threatens to worsen. The Insurance Services Office, an industry advisory group, predicts that insurers will suffer a "capacity shortfall" of \$62 billion from now through 1997, the Dallas Morning News reported recently. That means that thousands of people who want to start businesses or expand into new products will be denied coverage, the newspaper said.

Already, some insurers are pulling out of Alaska, cutting off many businesses and leaving them with the risk of closure, bankruptcy or at the very least a financial squeeze if they eventually encounter a large lawsuit.

"This is one of the most serious issues the

Anchorage community has ever been faced with," said Dr. David A. McGuire, an Anchorage orthopedic and arthroscopic surgeon.

McGuire, who heads the newly formed Citizens Coalition for Tort Reform, said that in the end, citizens and consumers will pay the bill in the form of higher taxes and retail prices.

The coalition, which last met Saturday at the Tower Club, now represents about 10 different occupations in the state and is garnering support from others. The group plans to lobby the state legislature for new laws and revised legislation on legal claims for damages.

"We are living in litigious times where juries grant exorbitant awards," McGuire said. "There seems to be no limit."

During its meetings in the past two months, the coalition drafted 13 possible solutions. Among them are:

- Tighten procedures for filing liability lawsuits and require plaintiffs to file an affidavit outlining the merit of their case before filing suit.
- Require alleged victims itemize potential earned income losses.
- Establish a cap of between \$100,000 and \$200,000 on "non-economic" awards — compensation awarded a victim for pain and suffering.

- Limit awards for punitive damages.
- Allow the court to assess a percentage of responsibility and damages even if only one party being sued.
- Revise the concept of "wrongful" death to include potential income compensation in cases involving the death of an infant.
- Set a sliding scale for attorneys' fees based on award to the victim.
- Repeal the law that allows the plaintiff to add percent onto his settlement fee to cover legal expenses.

Many of the proposals came from laws enacted in other states. The coalition's suggested list may change during upcoming meetings, but area starting point, McGuire said.

"Without a concerted effort by all sectors of the Alaskan economy — both public and private sectors — more insurance companies will probably reconsider their coverage policies and the difficulties Alaskans face today will substantially worsen," the draft report said.

An example of the high cost of insurance is McGuire's own office of eight doctors. His policy ballooned from \$149,000 annually through the end of August to \$300,102 for the next 12 months. He was told to expect his premiums to jump next year to \$500,000.

Some doctors have faced premiums high enough to make them think again about their career choices. An estimated 18 percent of obstetricians in the United States will switch to other specialties this year because coverage against malpractice suits now runs as high as \$72,000 a year, according to the American Medical Society.

Businesses of all types have been hit just as hard, suffering premium hikes of 500 percent or even 1,000 percent. Alaskan fishermen, for example, have seen their vessel liability insurance go up an average of 500 percent in the past three years, according to Craig Weiss, business law specialist for the University of Alaska Marine Advisory Program.

Even firms that have never had a claim against them are having difficulty getting insurance, local business men and women said.

Day care centers have become a high risk business because of sexual abuse cases. Liquor stores have been denied coverage because they are sometimes liable for death and injury caused by drunken drivers.

The airline industry is facing higher premiums due in part to the string of fatal crashes this year. That Japan Airlines crash in August in Japan, which killed more than 500 people, is expected to

See Coalition, page K-10

Coalition works for solution

Continued from page K-1

cost the carrier and its insurance company more than \$200 million in compensation to victims' families.

Bill Fisher, president of Harold's Air based in Fairbanks, an air taxi serving the Bush, said escalating insurance costs cannot all be passed onto the consumers "because they can hardly bear what's being charged now."

As a result, premiums are cutting into the taxi services' profits, already low due to a sluggish economy.

"Anytime, the successful air carrier is not judged by the bottom line but rather by an ability to hang on," he said.

Margaret Wolfe, owner of the Midtown Day Care Center in Anchorage, fears that bloated insurance premiums would make it impossible for some centers to stay open.

Wolfe pays \$4,500 a year for insurance now. Within the next 24 months, she expects her rates to double.

The insurance shock wave has even rippled into the school districts. When the Anchorage School District's insurance programs for property, general liability and workmen's compensation for fiscal year 1989-1990 were up for renewal July 1, administrators found it had soared from \$880,000 to nearly \$1.7 million.

Property insurance for Carr-Gottstein Co. Inc. also has doubled. "We're hoping the Citizens Coalition for Tort reform will help address the alarming increases," said Mary Pierce, a risk insurance manager for the firm.

Pierce said part of the reason for increases comes from the insurance company's notoriously liberal financial portfolio.

"Instead of stockpiling some of its premiums, the insurance companies invested the money, and then didn't have what they needed when large lawsuits developed," she said.

When interest rates were high and the stock market boomed, insurers invested their money, making enough to finance current premiums for some six years. When interest rates fell, investment income failed to cover losses.

Recent court rulings and newly created areas of liability also worked against the insurance companies.

"It's really getting frightening out there," said Linda Chase, president of Chase-Int., a construction company in Anchorage.

Chase said she is trying what she can to shave expenses and has developed a "wellness program" for employees, which she hopes will reduce her medical insurance premiums for employees.

"Employees who don't use their sick days will be com-

pensated for not missing work," she said. "We hope it will help slash costs."

To complement local business efforts, Gov. Bill Sheffield earlier this month appointed a Cabinet-level task force to study the problem of escalating insurance

costs. The report is due next month.

Meanwhile, the task force, State Division of Insurance and the University of Alaska are planning a seminar Nov. 14-15 at the Anchorage International Airport Inn on the rising cost of vessel insurance for fishermen.

Alaska State Legislature

Advisory Council Members
 Senator Bennett, Chairman
 Senator Kerttula
 Senator Abood
 Senator Sackett



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 State Capitol
 Juneau, Alaska 99811
 Phone: (907) 465-3114

SENATE ADVISORY COUNCIL

MEMORANDUM

TO: Senator Bennett

FROM: Carol R. Berryhill *CRB*
 Research Assistant

DATE: June 17, 1985

RE: Medical Malpractice: Limitations on Liability

In response to your request, according to the American Medical Association, there are approximately 20 different categories of tort reform measures that have been enacted in the United States with wide variations within those categories. Six of the most strongly recommended and most widely adopted are: (1) pretrial screening, (2) collateral source rule, (3) attorney fee regulation, (4) statute of limitation changes, (5) periodic payment of damages, and (6) limitations on liability.

As of November, 1984, seventeen states had enacted legislation placing limitations on liability awards. These limitations generally take three forms; one places a limit on certain kinds of damages, one places a fixed cap on amount of damages recoverable, and one places a fixed cap on the liability of the physician.

1. California - provision exists.
2. Idaho - provision has been repealed or has sunset.
3. Illinois - provision found unconstitutional by highest state court.
4. Indiana - provision found constitutional by highest state court.
5. Kentucky - provision not severable from an act found unconstitutional by highest court.
6. Louisiana - provision exists, enacted 1975, amended 1976.
7. Nebraska - provision found constitutional by highest state court.
8. New Hampshire - provision found unconstitutional by highest state court.
9. New Mexico - provision exists, enacted 1976.
10. North Dakota - provision found unconstitutional by highest state court.
11. Ohio - provision exists, enacted 1976.

Senator Bennett
June 17, 1985
Page 2

12. Oregon - provision exists, enacted 1975.
13. South Carolina - provision exists, enacted 1978 (See NOTE).
14. South Dakota - provision exists, enacted 1976.
15. Texas - provision exists, enacted 1977.
16. Virginia - provision exists, enacted 1976.
17. Wisconsin - provision exists, enacted 1975.

NOTE: Limitations on liability have been found unconstitutional (Spring 1985) by the lower courts in South Carolina. To date, no determination has been made by the higher courts.

Limitations on liability have been extremely vulnerable to constitutional challenge. Indiana is the only state thus far whose courts have upheld the statutes on liability limits when challenged. Nearly all reform measures that have been found unconstitutional apply only to medical liability cases and no other kind of lawsuits. Thus, plaintiffs argue that the laws violate their constitutional rights to equal protection of the laws. Tort reform provisions have also been challenged because they are special legislation, that is, legislation enacted solely to benefit physicians.

Attached are copies of the statutes of eight states whose statutes contain limitations on liability and court decisions from seven states that have found such statutes unconstitutional. The Legislative Reference Library is in the process of moving their office. They are the only local agency that maintains codes and statutes of other states. I was unable to obtain a hard copy of the California Code and the South Carolina Statute that pertains to recovery limits on liability. As soon as the reference material becomes available I will forward you a copy.

If I may be of further assistance, please contact me.

Attachments:

#55-CC 2673

Alaska State Legislature

Advisory Council Members
Senator Bennett, Chairman
Senator Kerttula
Senator Abood
Senator Sackett



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Juneau, Alaska 99811
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SENATE ADVISORY COUNCIL

MEMORANDUM

TO: Senator Bennett
FROM: Carol R. Berryhin *CRB*
Research Assistant
DATE: September 17, 1985
RE: Medical Malpractice

In June, 1985, at your request, I prepared a brief report on "Medical Malpractice: Limitations on Liability". The Senate Advisory Council has received a report on Medical Malpractice prepared by the National Conference of State Legislatures. I thought it might be of interest to you so I am forwarding a copy.

Enclosure:

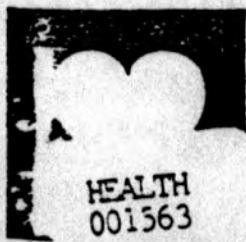
What Legislators Need to Know About Medical Malpractice



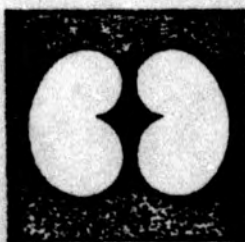
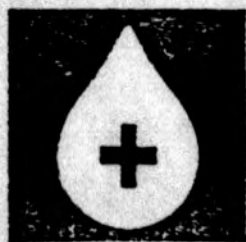
National Conference
of State Legislatures



Foundation for
State Legislatures



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What Legislators Need to Know About Medical Malpractice was written by Robert Pierce, senior research analyst, National Conference of State Legislatures (NCSL). Randall R. Bovbjerg of The Urban Institute, Professor Clark C. Havighurst of the Duke University School of Law, and Ellen Hekman, formerly of NCSL, made significant contributions.

This booklet is based in part on presentations made at a national conference sponsored by The Urban Institute, February 1985, in Washington, D.C. The conference—entitled "Medical Malpractice: Can the Private Sector Find Relief?"—offered a forum for discussion of malpractice issues by academicians, providers, insurers, lawyers, and public policymakers. The conference was chaired by Randall R. Bovbjerg and Clark C. Havighurst. Eleven state legislators participated in the conference, including Senator Dempsey J. Baron of Florida, Senator Prescott Bloom of Illinois, Senator Chuck Chvala of Wisconsin, Senator David Helbach of Wisconsin, Senator Anne Lindeman of Arizona, Senator C. R. Montgomery of Mississippi, Representative Paul Starnes of Tennessee, Assemblyman James Tallon of New York, Representative Louise M. Tesmer of Wisconsin, Senator Jerome Van Sistine of Wisconsin, and Representative Joseph E. Wimmer of Wisconsin.

The following individuals made presentations at the conference:

Patrick Atiyah, Oxford University; Patricia M. Danzon, Ph.D., Center for Health Policy Research and Education, Duke University; Richard A. Epstein, University of Chicago Law School; Max Fine, Max Fine Associates, Inc., Washington, D.C.; William H. Ginsburg, Esquire, Wood, Lucksinger & Epstein, Los Angeles; James Lewis Griffith, Esquire, Griffith & Burr, P.C., Philadelphia; James A. Henderson, Cornell Law School; John S. Hoff, Esquire, Swidler, Berlin & Strelow, Washington, D.C.; John Harty, Esquire, Harty, Springer & Mattern, Pittsburgh; Sylvia Law, New York University School of Law; Arthur J. Mannix, M.D., Medical Liability Insurance Co., New York; Don Harper Mills, M.D., J.D., University of Southern California School of Medicine; Hon. W. Henson Moore, U.S. House of Representatives; Jeffrey O'Connell, University of Virginia School of Law; Joseph N. Onek, Esquire, Onek, Klein & Farr, Washington, D.C.; James R. Posner, Ph.D., Marsh & McLennan, Inc., New York; Elvay Raines, J.D., American Society of Law and Medicine, Boston; John B. Reiss, Esquire, Dechert, Price & Rhoads, Philadelphia; Glen O. Robinson, University of Virginia School of Law; Peter Sweetland, The Medical Inter-Insurance Exchange of New Jersey; Laurence R. Tancredi, M.D., J.D., University of Texas Health Science Center at Houston; and James S. Todd, M.D., Trustee, American Medical Association Ridgewood, New Jersey.

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Senate Advisory Council

In early 1986, papers from the conference proceedings will be published in a symposium of the journal, *Law and Contemporary Problems*, a publication of the Duke University School of Law.

Funds for the organization of The Urban Institute conference were provided by General Reinsurance Corporation, the Hospital Corporation of America Foundation, and St. Paul Fire and Marine Insurance Company.

This booklet also draws on materials from the American Medical Association, the Association of Trial Lawyers of America, The Rand Corporation, and the Health Policy Analysis Program of the University of Washington.

Reviewers of the booklet were Gordon Anderson, Wisconsin Legislative Council; Nancy Bannon, American Medical Association; Patricia Danzon, Duke University; Thomas Goddard, Association of Trial Lawyers of America; Steve Krafchick, Medical Legal Consultants of Washington, Seattle; Doug Reese, Intergovernmental Health Policy Project; and Carl Tubbesing, Lanny Proffer, Cindy Simon, Candace Romig, and Barbara Yondorf of the National Conference of State Legislatures.

In addition, Sharon Bjorkman's editing and Michelle Polchow's word processing led to the successful completion of this project.

What Legislators Need to Know About Medical Malpractice was made possible by a grant from the Hospital Corporation of America Foundation to NCSL's Foundation for State Legislatures. NCSL and the Foundation appreciate continuing support for those projects designed to help legislators understand today's health care issues.

July 1985

Introduction

Medical malpractice is once again prominent on the legislative agenda—just 10 years after a crisis in the availability of malpractice insurance inspired reform legislation in almost every state in 1975 and 1976.

Providers of medical care and malpractice insurers are lobbying for new legislation to address the problem of a growing number of malpractice lawsuits and increasingly large damage awards and settlements. The American Medical Association (AMA) has described the current malpractice situation as a crisis, not of availability as in 1975-76, but of affordability. Among the social costs of the system, say the critics, are the costs of "defensive medicine."

Attorneys who represent those filing malpractice actions challenge the assumption that there is a crisis. They argue that malpractice settlements reflect provider negligence and fair compensation for injuries. They also argue that the system raises the standards of medical practice and that most of what is called "defensive medicine" reflects taking desirable precautions.

The issues in the malpractice debate once again are being discussed before state legislatures. This booklet provides an overview of the issues, some relevant data, and a review of possible legislative and private sector actions to improve or replace the medical malpractice system.

From: [illegible]
 Date: [illegible]

Question One:

What Is Medical Malpractice?

Medical malpractice is negligent care by a health care provider that causes injury to a patient. A bad treatment result, no matter how severe, is not grounds for malpractice action unless the provider was at fault.

Medical malpractice actions are brought by injured parties who believe that they are the victims of negligence. Relatives or dependents of the claimant also may be party to the lawsuit. Suits may be brought against a doctor, other health care personnel, a hospital, equipment manufacturers, pharmaceutical companies, and others involved directly or indirectly in patient care.

To be compensated for medical malpractice, the injured party must establish a breach of the legal standard of care, compensable injury to the patient, and a causal connection between such breach and such injury.

Malpractice law has two major goals: a) to provide compensation to victims of malpractice, and b) to deter substandard care through the threat of legal action. It does not seek to cover all injuries that occur in the course of medical care. Nor does it systematically police all poor-quality care.

Question Two:

How Does the Medical Malpractice System Function?

The medical malpractice system encompasses both the formal legal process and the mechanisms of liability insurance. Although most incidents are resolved without full recourse to the legal system, legal doctrine and institutions determine which claims will be brought, whether settlements will be reached, and at what level of payment.

The Legal Process

Medical malpractice lawsuits are resolved through the tort system. Plaintiffs usually seek compensation for both economic and noneconomic damages. Economic damages include the cost of medical and rehabilitative care and lost wages. Noneconomic damages include pain, suffering, and impairment of the quality of life.

Providers and insurers usually are notified of a claim before a lawsuit is actually filed. A study by The Rand Corporation showed that one-half of all claims are dropped without any payment and that two-thirds of those are dropped before a lawsuit is filed.¹ In 22 states, a screening panel reviews claims that result in formal lawsuits before they can go to trial.

A majority of lawsuits that are filed are settled without a trial; many others are settled during trial. A Rand Corporation review of 6,000 national malpractice claims closed in 1974 and 1976 found that less than 10 percent were tried all the way to verdict.² Lawsuits involving more severe injuries and those likely to win larger settlements are more apt to be tried to verdict. The probability of the plaintiff's winning is greater if the case involves a permanent or fatal injury and if there are multiple defendants. Of those cases resolved by a jury verdict, The Rand Corporation analysis showed that such verdicts favored providers (defendants) 75 percent of the time; a 12-year review of California Superior Court records showed that verdicts favored providers in 60 to 74 percent of malpractice cases.³

The Patient as Plaintiff

Whether any claim will be made depends upon a patient's initiative in identifying possible malpractice and seeking redress. Estimates are that only one in 10 victims of malpractice files a claim.⁴ A 1972 study for the U.S. Department of Health, Education and Welfare found that 7.5 percent of discharged patients had been injured in some way as a result of their medical treatment and that 29 percent of these injuries were due to demonstrable malpractice or negligence.⁵ But injured people may not recognize the malpractice, may consider the result merely unfortunate, may accept a provider's remedial efforts, or may simply elect not to become involved in a lawsuit debilitating to the provider.

Most commonly, lawsuits are filed because of bad treatment results, injuries resulting from medical treatment, misdiagnosis, failure to treat or improper treatment, or a fall in a hospital or a doctor's office. A patient also may sue a provider for failing to obtain "informed consent"—that is for withholding information that probably would have led the patient to refuse the injurious treatment.

For the most part, a patient may pursue a claim without concern for paying an attorney in advance because malpractice lawyers usually are paid on a contingent fee basis. In such an arrangement, the attorney agrees to accept a percentage of the settlement or award, if any, as a fee. The plaintiff is still responsible for other expenses such as court costs and the cost of obtaining evidence.

The Liability Insurance System

Doctors and hospitals purchase malpractice insurance to protect themselves from malpractice claims. Premium costs for doctors are based on the experience rating for their medical specialty and geographic area. Surgeons, obstetricians, and anesthesiologists are more likely than other specialists to pay high premiums. On Long Island, New York, some neurosurgeons reportedly pay as much as \$101,000 and obstetricians \$82,000 for malpractice coverage.

Malpractice insurance is offered by several national liability insurers and by provider-owned and -operated companies. Self insurance is also an option for large hospitals and other entities; a few physicians have elected to practice without insurance.

Although there was a fear in the 1970s that malpractice insurance would become unavailable, availability is not a significant problem now, in part because, beginning in the 1970s, providers formed their own insurers. These "bedpan mutuals" insured more than 87,000 physicians in 1983. States also have established joint underwriting associations to guarantee availability.

Two-thirds of insurance claims are resolved within two years of filing. Of the cases that receive compensation, settlements vary widely. Five percent of paid claims account for half of the dollars paid to plaintiffs and another 50 percent of paid claims account for only 4 percent of dollar outlays. Settlements and awards, however, do appear to reflect the severity of injuries.⁶

Until recently, most medical malpractice policies were written on an occurrence basis. Occurrence-based insurance holds the insurance company financially responsible for claims resulting from treatment rendered during the coverage period, regardless of when the claim was filed. This results in a "long tail" of exposure to unfilled malpractice claims. For example, the St. Paul Fire and Marine Insurance Company, the nation's largest malpractice insurer, found that 30 percent of claims are

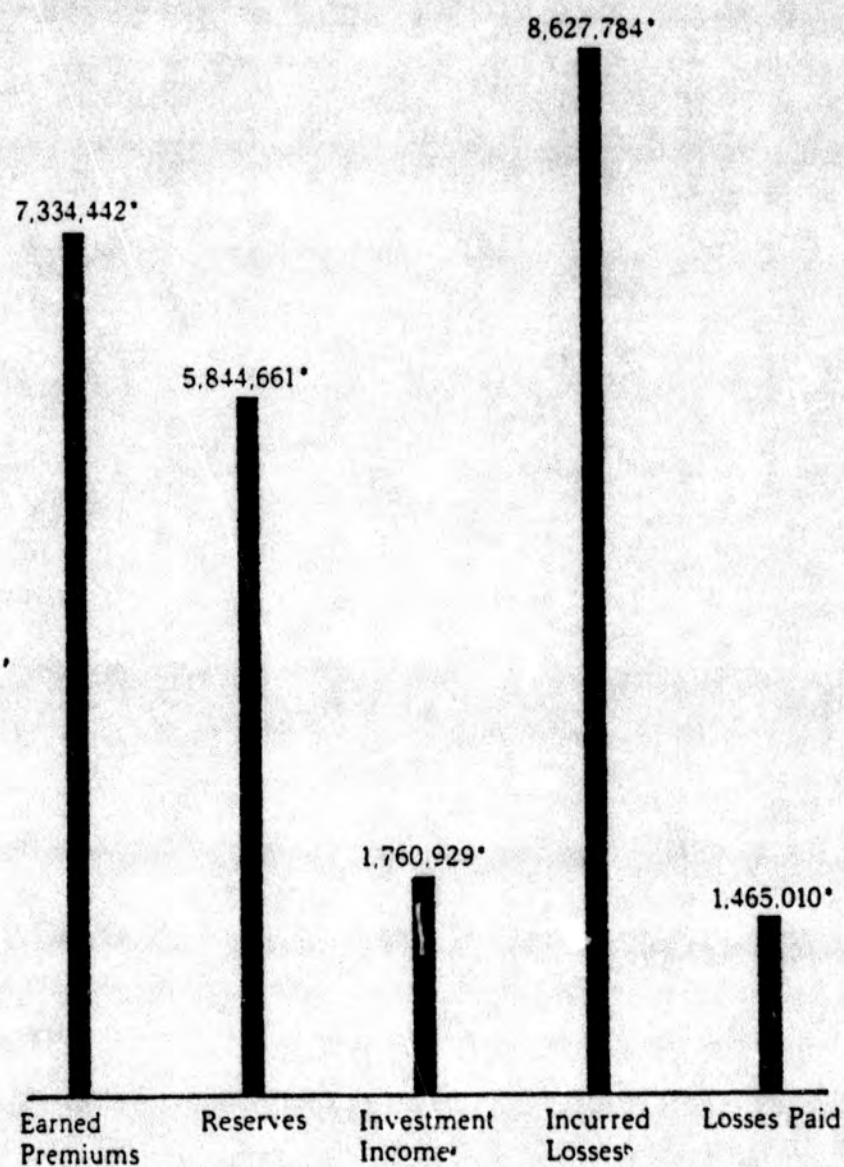
filed in the year of treatment, 30 percent in the year after treatment, 25 percent in the third year, 7 percent in the fourth year, and 8 percent in years five through 10. This long lag time makes it difficult to determine appropriate premiums and necessary reserve levels.

Because of these problems, the malpractice insurance market is moving to a claims-made system, under which insurers are contractually responsible for claims filed only during the coverage year. Thus insurers can better set premium levels and reserves. Providers, however, bear the risk of suits filed late and must carry insurance even after retiring from practice. Claims-made policies now account for about half of the total premiums written.

The profitability of malpractice insurers can be measured either by using loss ratios or by comparing actual losses to premium income. In either case, a backlog of unresolved claims complicates the actuarial determination necessary to estimate profitability.

Loss ratios compare a company's actual and estimated future losses and expenses to its premium income. The industry-wide loss ratio over the last five years is estimated at 111.4, or a loss payment of \$1.11 for each \$1.00 of premium income. In 1982, major malpractice underwriters had a loss ratio of 122.

**Figure 1: Medical Malpractice Insurance
for 75 Selected Companies (94 Percent
of Industry), 1978-1983**



*000's omitted

* Estimate based on 10% return on investments.

* Paid losses and estimate of future payments and expenses.

Some important considerations, however, are not reflected in loss ratios. First, these ratios are based on *estimated* future claims losses and often are revised up or down later. Second, this measure does not consider investment income from sizable reserves held against future losses.

Comparing actual losses paid to premium income is another way to measure the industry's economic performance, and critics

of malpractice insurers prefer to cite these figures. From 1977 through 1982, major malpractice insurers earned net premiums of \$7.2 billion. Since 1977, they have paid incurred losses of \$1.7 billion. Insurers maintain that the reserves they have built up reflect appropriate actuarial estimates of future liabilities, while critics cite investment income earned from these large reserves.

Question Three:

What Are the Trends in Medical Malpractice Premiums, Claims, and Awards?

The number of malpractice claims (frequency), the size of awards (severity), and the cost of insurance have increased steadily. Some data, some possible explanations, and some speculations on future trends are presented here.

Frequency of Claims

After the deluge of claims in the mid-1970s, their frequency declined briefly, from 24,240 in 1975 to 17,238 in 1978. In 1979, however, frequency once again began to rise rapidly. Physician-owned malpractice insurers experienced an increase in claim frequency from 12.17 cases per 100 physicians in 1979 to 20.3 cases per 100 physicians in 1983. The St. Paul Company saw hospital claims rise from 1.75 per 100 beds in 1979 to 3.0 per 100 beds in 1983. The figures vary greatly by provider specialty

from state to state, and even within a state. In 1978, for example, the state with the most claims activity had 12 times the claims frequency of the state with the least.

Size of Awards

Malpractice awards and settlements have been increasing even more dramatically in amount than in number. The St. Paul Company has seen its average loss per hospital claim, including allocated loss expense, grow from less than \$5,000 in 1975 to more than \$12,000 in 1983. Data compiled by the AMA from physician-owned insurers show the average paid loss going from \$20,396 in 1979 to \$72,243 in 1983.⁷

Although juries resolve only a small percentage of malpractice claims, jury awards influence the level of settlements and give patients and attorneys incentive to pursue claims. According to one reporting service, the average malpractice jury award grew more than fivefold, from \$166,165 in 1974 to \$888,285 in 1983.⁶ Only four jury awards of \$1 million or more were voluntarily reported to the service in 1974, compared with 70 in 1983. The size of malpractice claims also varies greatly between states with a thirtyfold range between the most and least litigious states.

Insurance Costs

The growth in average malpractice premium costs has been much more moderate than the growth in frequency of claims or size of awards. In just the past year, however, indicators are that premiums have jumped suddenly.

Between 1976 and 1983, average physician premium expenses grew only 51 percent (from \$4,700 to \$7,100)—well below the nearly 100 percent increase in the Medical Care Price Index for this same period. According to the AMA, physicians' average malpractice premium expenses equaled 4.4 percent of gross income in 1976, and 3.7 percent in 1983. Recently, however, insurance rates have risen markedly. A New York insurer received approval to raise rates more than 50 percent. Many physician-owned malpractice insurers increased rates 10 to 39 percent in 1984, with more increases expected in 1985.

Malpractice insurance rates for the higher-risk specialties, such as surgery, obstetrics and anesthesiology, have gone up more than for other specialties. The average rate for obstetricians went from \$8,300 in 1978 to \$14,100 in 1983, and surgeons saw their average rates increase from \$7,187 to \$10,900. Rates for internists and general practitioners rose from approximately \$2,400 to \$4,400.

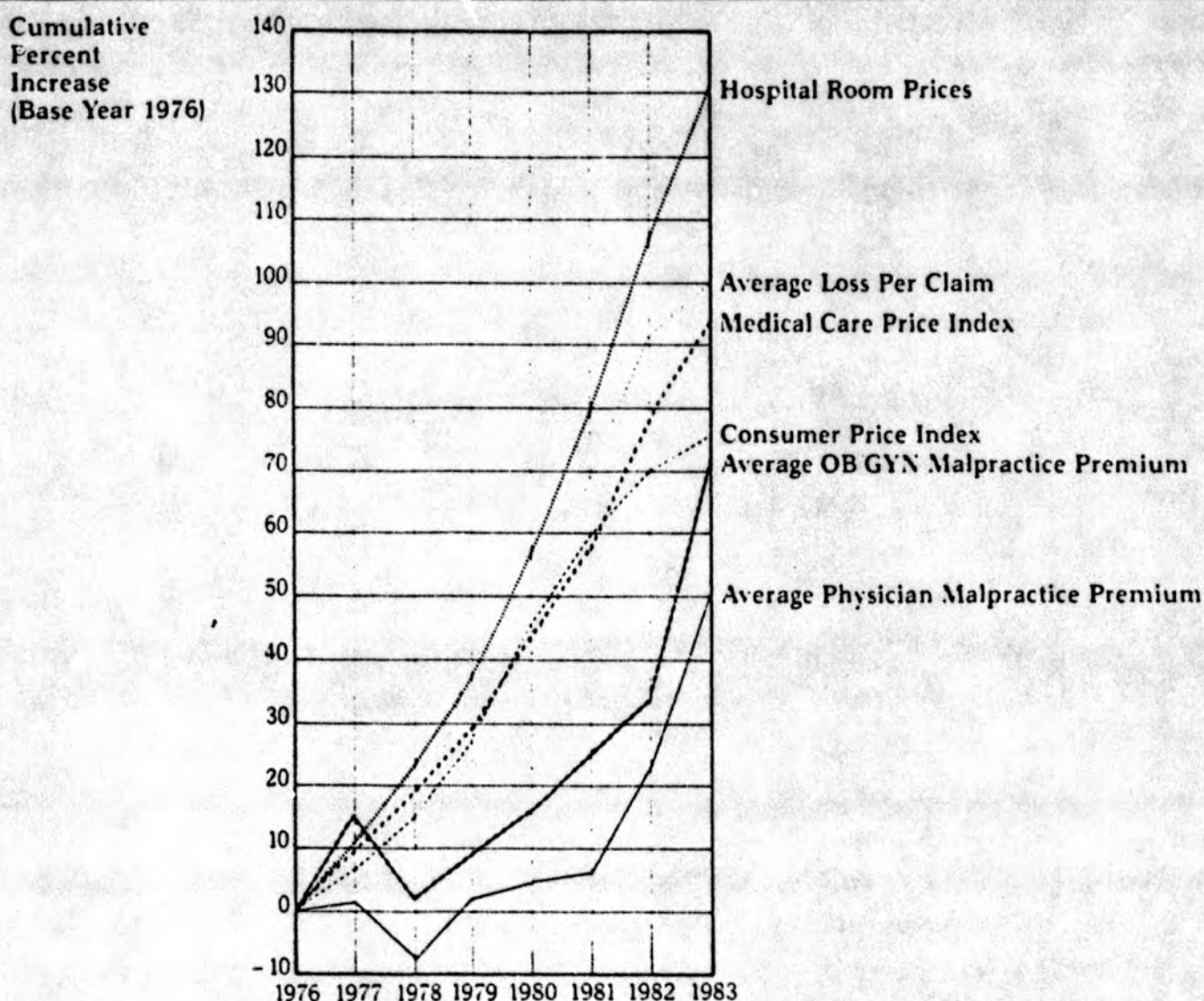
Insurance costs vary greatly by geographic region. Average physician premiums for physician-owned companies, for example, ranged from \$1,200 in Indiana to \$12,500 in New York, in 1984. Hospital premium rates also vary widely. The St. Paul Company's data showed that 1984 hospital premiums ranged from \$378 per bed in South Carolina to \$2,178 per occupied bed in Dade and Broward Counties of Florida. Individual hospital rates differ according to the institution's actual malpractice experience.

Explanations of the Trends

The growth in the number of claims, size of awards, and costs of malpractice insurance has been attributed to many factors, some of which are difficult to evaluate and control. They include:

- Rapid rises in health care costs which are reflected in damage awards (between 1975 and 1983 the Medical Care Price Index nearly doubled).
- Rising expectations by patients and jurors of success in medical treatment.

**Figure 2: Comparative Trends
in Malpractice and Health Care Costs**



Sources:

Consumer Price Index, Medical Care Price Index, Hospital Room Prices: *Statistical Abstract of the United States, 1985.*

Average physician malpractice premium, average OB GYN malpractice premium: American Medical Association.

Average loss per claim: National Claims Frequency and Severity Indices for Physicians and

- Changes in health care technology that have increased the use of dangerous and invasive treatments and diagnostic procedures;
- Increased incidence of malpractice claims for adverse birth-related outcomes, which may entail supporting a victim for an entire life;
- Impaired doctor/patient communication and trust resulting from the increasing depersonalization of health care;
- Increased willingness to sue in general and urbanization in particular, which explains much of the difference in the frequency of claims between areas;
- Liberalization of legal doctrine governing malpractice; and
- Increased sophistication of malpractice attorneys.

Future Prospects

Several factors may slow the rising costs of the malpractice system over the next few years. As the costs of malpractice continue to rise, hospitals and other health care organizations have a greater financial incentive to select their doctors carefully and scrutinize their actions to avoid liability. Risk management programs being introduced in hospitals may help improve the quality of care, prevent injuries, limit the extent of harm, settle claims on a realistic basis, and change patient expectations through education and disclosure.

Much of the difficulty in determining negligence results from wide variations in medical practice and lack of consensus on treatment standards. Current health care cost containment efforts, however, may bring more agreement on appropriate standards of care. The adoption of prospective payment systems, especially the Medicare diagnosis-related group (DRG) reimbursement system, has increased attention to cost-effectiveness. Utilization review systems, such as Medicare's Peer Review Organizations (PRO), also may effect greater agreement on medical standards.

Another factor that may help standardize care and improve quality is the expansion of health maintenance organizations (HMOs), primary care networks, and preferred provider organizations. These mechanisms often incorporate utilization review, quality controls, and incentives to avoid unnecessary care.

Although changes in organizational patterns and incentives may improve quality and better define the standard of care, many doctors and others are concerned that the DRG system and other cost containment measures may result in a two-tier system of care, exposing providers who economize to the risk that courts will penalize them for not adhering to higher standards.

As already noted, however, evidence exists that only a small percentage of negligent medical injuries result in malpractice claims. Thus, even if the incidence of injuries remains the same or declines,

changes in patient attitudes and provider/patient relations, increased awareness of possibilities for legal action, and other factors could trigger more claims.

Question Four: What Are the Major Criticisms of the Existing Medical Malpractice System?

Critics of the system have a long list of complaints. These criticisms are reviewed here together with the responses of the system's defenders.

- *The system's administrative costs are excessive.* Estimates are that only 28 to 40 cents of each premium dollar ultimately goes to injured parties.⁹ Administration, claims evaluation, and litigation costs, including plaintiff attorneys' contingent fees and defense attorneys' hourly fees, absorb more than half of each premium dollar. Defenders of the system believe that such costs are worth incurring because of the deterrence to malpractice that the system achieves. Dr. Patricia Danzon of Duke University argues, for example, that a 20 to 30 percent reduction in the incidence of negligent injury would justify the present cost of the fault-based system

- *The resolution of medical malpractice claims is too slow.* One-third of all claims takes more than two years to resolve. The injured party often does not receive compensation when it would be most helpful in repairing his injuries. The present malpractice system sometimes discourages early settlement offers because that might be interpreted as a sign that one's case is weak. Defenders point out, however, that it is not clear that malpractice litigation is any more drawn out than other insurance and legal disputes and that defendants can avoid litigation costs through prompt, reasonable settlement offers.

■ *Damage awards are often excessive.* A small percentage of cases account for the bulk of dollar payouts. Many of these and other awards are questioned as larger than necessary to compensate the patient. Damage awards sometimes duplicate amounts already reimbursed by other sources, such as health or disability insurance. Critics argue that awards for pain and suffering and other forms of noneconomic loss are highly subjective, and that emotional appeals result in awards that vary greatly in otherwise similar cases. Defenders argue that large awards for noneconomic loss, such as disfigurement or injuries that confine the victim to a wheelchair, are not inappropriate and that a patient's own insurance should not reduce the liability of a negligent provider. Finally, defenders believe that excluding or limiting these damages would weaken the system's deterrent effect.

■ *The system encourages costly defensive medicine and inhibits responsible cost containment.* Defensive medicine consists of additional diagnostic tests, treatment procedures, and administrative costs incurred primarily to improve the provider's defense to a

possible future malpractice action. It also may include avoiding some high-risk or potentially litigious patients and forgoing desirable, but risky, procedures out of a fear of litigation if success is not achieved.

The most commonly quoted estimate of the cost of defensive medicine is \$15.1 billion per year. The AMA derived this figure from its Socioeconomic Monitoring System. In the AMA's 1983 survey, 40.8 percent of responding physicians said they prescribed additional tests out of concern about possible lawsuits, 27.2 percent said they provided additional treatment procedures, 34.6 percent said they do not accept certain types of cases, and 31.4 percent said they increased their fees because of malpractice premium costs.¹⁰

Whatever the costs associated with defensive medicine, not everyone believes these costs are unwarranted. Dr. Danzon points out that "some defensive medicine is precisely the increased care which the malpractice system is intended to encourage."¹¹ She also notes that it is not possible to distinguish defensive medicine from the overutilization that results from the economic incentives inherent in fee-for-service medicine.

- *Malpractice insurance is overpriced.* Plaintiffs' attorneys in particular feel that the rising costs of malpractice coverage are more a problem with the insurance mechanism than with the legal system. They make three major points in arguing that premiums are too high: a) Premium income far exceeds paid losses. From 1977 through 1982, insurers received net premium income of \$7.2 billion, and reported loss and loss expense payments of \$1.7 billion. b) Premium rates fail to reflect income from investment of insurers' sizable reserves. c) Actuarial estimates of malpractice losses from claims not yet paid or filed are too high.

The insurers and others who disagree make the following points: a) Premium increases and large reserve amounts are necessary to meet expected losses from 186,000 pending claims.¹² b) Actuarial estimates are appropriate, although subject to change. Estimates of incurred losses since 1977 have been raised for some years, lowered for others. c) Malpractice insurers expect to pay claims that exceed premium income, and so they depend upon investment income. d) Physician-owned companies have experienced similar premium increases and have made similar actuarial estimates, although they have no incentive to earn large profits. e) Commercial insurance company rates are competitive with those of the bedpan mutuals.

Question Five:

What Were the Effects of the Medical Malpractice Reform Measures?

The perceived crisis of the mid-1970s prompted state legislatures to enact many reforms. These reforms were meant to ensure the availability of insurance, to encourage settlements before trial, to limit recoveries, to improve the quality of care, and to alter the legal process.

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

Research on the effects of reforms has been complicated by the difficulty of accurately characterizing reforms. Not every state reforming a specific element of malpractice law made precisely the same change. In addition, the complexity of reforms, typically mixing many different elements in one package, has hampered researchers' efforts to isolate the effect of any single element. Finally, studies may have been undertaken too early to assess reforms; not only might reforms take time to influence behavior, but also many pre-reform claims continued in the system.

Economist Frank Sloan of Vanderbilt University analyzed the reforms' impact on malpractice premiums. He concluded that "the empirical results of this study give no indication that individual state legislative actions, or actions taken collectively, have had their intended effects on premiums. The publicity resulting from considerable legislative activity may have made juries more aware of the cost consequences of malpractice suits."

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

- Limits on the dollar amount of awards, including caps and provisions for periodic rather than lump-sum payments, appeared to cut average settlements by 25 percent, to raise the proportion of cases dropped from 43 to 48 percent, and to reduce slightly the share of cases going to verdict.
- Relaxation of the ban on introducing evidence of collateral sources of compensation available to the plaintiff appeared to reduce settlements although the statistical significance of this finding was low.
- Limits on attorneys' contingent fees cut average settlements by 9 percent, somewhat raised the number of cases dropped without payment, and slightly reduced the percentage of cases going to verdict.

Question Six:

What Issues Should Legislators Consider in Examining Medical Malpractice?

Provider groups and malpractice insurers are looking to state legislatures for additional changes in the malpractice system. Plaintiffs' attorneys and others dispute the need for change and seek different reforms. As legislators examine the malpractice system and the wide range of reform proposals, they will need to determine whether changes are needed, whether adjustments should be made in the tort system, or whether more fundamental changes are called for.

As noted earlier, legislators should be aware that the frequency and size of malpractice claims and the affordability of malpractice insurance vary greatly by state and by region. There are also shortcomings in malpractice data. Studies by the federal government and the National Association of Insurance Commissioners (NAIC) in the 1970s have not been continued or expanded in the 1980s. Much of the available data is proprietary and supplied by interested parties. Data for a specific state may be incomplete and inadequate as a basis for policymaking.

As legislators examine alternative approaches to the malpractice issue, they may want to consider the following objectives:

- *Assuring equitable patient redress for negligent injury.* The malpractice system should not discourage meritorious claims or encourage inadequate compensation. Patients have few other ways to effectively register their grievances about substandard care.

- *Detering negligent practice and improving the quality of medical treatment.* This point is particularly important because current health care cost containment pressures may encourage providers to inappropriately cut corners.
- *Controlling health care costs.* Injuries resulting from medical malpractice are a significant cost of medical care. Awarding reparations for such injuries creates no new costs but merely shifts to providers and the public costs that otherwise would be borne privately. Making these costs explicit is not objectionable in itself. On the other hand, shifting costs through the tort system is itself expensive. Moreover, by inhibiting responsible economizing and encouraging wasteful defensive medicine, the tort system may add to the overall cost of health care.
- *Promoting reasonable expectations.* Medical malpractice suits are appropriate only in cases where negligence by providers results in patient injury. Medical care is an inherently risky activity and all undesirable treatment outcomes cannot be made compensable. The standard of care used in judging provider negligence should not curb reasonable economizing efforts, stifle innovation, or encourage inefficient treatment practices.

- *Assuring consumer access to needed care.* The increasing cost of malpractice insurance for providers undertaking high-risk activities has caused those in some geographic areas to leave certain activities or retire early. In a few places, patient access to services (e.g., obstetrics) is being curtailed.
- *Encouraging timely resolution of suits.* The length of time involved in settling malpractice cases fuels costs, inconveniences providers and patients, and saddles in-

surance companies with uncertainties about future claims.

- *Discouraging nonmeritorious lawsuits.* Competent doctors deserve to have their reputations protected from adverse publicity caused by nonmeritorious suits.
- *Developing legislation that can withstand legal challenges.* As noted later, state courts found a number of malpractice reforms passed in the 1970s unconstitutional. Great care needs to be taken in drafting new reforms.

Question Seven: How Can States Encourage Claims Resolution Without Trial?

Pretrial screening panels and arbitration are reforms that can speed resolution of disputes and limit litigation costs. Unlike pretrial screening panels, arbitration is an alternative designed to replace the judicial system altogether.

Pretrial Panels

Currently operating in 23 states, such panels encourage early settlements and weed out frivolous claims. In many states the panel must review a claim before the action can be tried in court. Panels usually consist of physicians, lawyers, and public members. Decisions by pretrial screening panels are nonbinding. Panel decisions are admissible in court in some states and inadmissible in others.

In Florida, Illinois, Missouri, and Pennsylvania, state courts have invalidated pretrial panels on the grounds they unduly impeded access to courts and a jury trial, were arbitrary and capricious in their operation, or violated equal protection guarantees by treating medical malpractice differently from other negligence actions.

Proponents of panels argue that they not only will weed out less meritorious claims and encourage early out-of-court settlements but also will lessen the cost of litigation. Opponents believe that panels may increase costs by requiring an additional level of litigation (before the panel) that provider

representation on some state panels introduces a bias against claimants, and that panels whose decisions are admissible in court should not be conducted under different evidentiary and procedural rules.

Arbitration

Unlike screening panels, arbitration may provide a total substitute for a court proceeding—although substantive tort rules still govern. State law may permit patients and health care providers to agree in writing to submit a malpractice claim to binding arbitration and thus to have the issues of liability and damages resolved by mutually acceptable arbitrators rather than by a jury. Because some courts historically refused to enforce agreements to replace courts with arbitrators, most legislatures have passed arbitration acts.

Eleven states have statutes specifically allowing arbitration of medical liability cases. Such statutes generally provide that patients who do not sign an arbitration agreement may not be denied treatment or otherwise discriminated against. It is also common to allow a revocation period (usually 30 to 60 days after treatment) in which a patient may rescind the agreement.

In Michigan, institutional providers are required to offer all patients a voluntary agreement to arbitrate any future disputes. A booklet explaining the arbitration statute and process must be given to a patient along with the agreement. Arbitration panels include a public member, an attorney, and a health care provider of the same specialty as the defendant. Hearings

are not open to the general public. Decisions are binding on all parties involved, and only in cases where there is alleged unfairness or bias of the arbitrators is an appeal available. The claimant is not responsible for the costs of the arbitration proceedings. The Michigan act has been upheld by the state supreme court.

Proponents of binding arbitration argue that expert arbitrators are better than juries at dealing with the complexities of medical treatment, law, and damages, and that results are therefore more predictable and equitable. They also believe that through this process claims may be resolved more promptly than in the court system and that lessened formality and reduced likelihood of appeals will reduce litigation costs. Finally, arbitration provides confidentiality for the parties.

Opponents of binding arbitration argue that individuals may be unaware of the meaning of the arbitration agreement they sign and the arbitration may be prejudiced against the plaintiff because the panel includes a provider. Critics also point out that the plaintiff forfeits his right to a jury trial and to appeal the panel's decision. Finally, they believe that plaintiffs may not be adequately compensated for their injuries, since panel awards tend to be lower than jury awards.

Table 1:
Tort Reform Provisions

	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky
Ad Damnum	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1
Arbitration	1	1			1					1			1				
Attorney Fees			1		1	1		1	1		1			2	1	1	
Awarding Costs						1			1				1			1	
Collateral Source		1	2		1			1	2				1		2	1	
Expert Witness								1	1			2					
Limits on Liability					1								3	2			
Patient Compensation Fund									2		1			2		1	3
Periodic Payment	1	1		1	2			1	1							1	
Pre-Trial Screening Panel		1	2	1			1	1	3		1	1	3	2		1	
Res Ipsa Loquitur		1			1			1	1				1				
Statute of Limitations	2		1		1	2		1	1	1	1		2	2	1	2	1
Special Statute of Limitations for Minors	2		1		1	1		1						2		1	
Standards of Care	1	2	1	1				1	1			1					

Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	Missouri	Montana	Nebraska	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming	
2	1	1	1			1	1		1			1	1	1		1					1			1	1	1			1		1	
1				2												1						1				1	1					
		1		1					2		3	1		1			1	1					1					1		1	1	
			2						1											1												
									2		3			1		3	1			3	1		1	1				1				
1				1						1	3					2	1						1				1					
1									2		3		1		3	1		1				1	1		1		1				1	
2									2				1		1				1	1		1									1	
		1		1							3		1					1				1							1		2	
2	1	1	2				3	2	2		1	2	1	1		2			3									1			2	
										1					3		1				1			1	1							
1	1	1	1	1	1	1	1	1	1	1	3		1	1	1	1	1	1			1	1	1	2	1	2		1		1	1	
1		1	1			1	1				3		1	1	1		3						1		3	1					1	1
1				1					1	1					1		1	1					1			1	1	2				

Key:

1. Provision exists.
2. Provision found constitutional by highest state court.
3. Provision found unconstitutional by highest state court.

Notes:

This chart does not include all of the court rules that affect these provisions.
Chart reflects state actions through 1983.

Data source: AMA Division of Legislative Activities Department of State Legislation, Chicago, November 1984.
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Question Eight: What Can States Do to Limit the Extent of Provider Liability?

In the 1970s, several state legislatures acted to reduce awards and settlements in medical liability cases by limiting specific types of damages, placing caps on total recoveries, changing the rules on collateral sources, and providing for periodic payment of damages. A few states established state patient compensation funds to cover liability in excess of some specific dollar amount.

Limits on Specific Types of Damages

Some states, such as California, Louisiana, New Mexico, Ohio, South Dakota, and Texas, have enacted limits on the amounts recoverable for noneconomic losses such as pain and suffering, disfigurement, and impairment of the quality of life. The most common recovery limit is \$500,000, although California has a \$250,000 limit, and Ohio a \$200,000 limit.

In 1980, the New Hampshire Supreme Court found unconstitutional a \$250,000 limit on noneconomic loss, saying that "it is only the award above the out-of-pocket loss that is available to compensate in some way for the pain, suffering, physical impairment or disfigurement that the victim must endure until death." The court also felt that treating a malpractice tort differently from other torts violated equal protection under the law. The California Supreme Court, however, recently upheld that state's limit.

Proponents of limits on specific types of damages argue that noneconomic damages are subjective, resulting in widely differing awards in similar situations. Therefore, they argue, limits will provide more equity between awards as well as reduce malpractice premiums.

Opponents contend that it is inequitable to treat malpractice torts differently from other torts and that limits will prevent some victims from receiving fair compensation, especially for legitimate pain, suffering, and disfigurement.

Caps on Total Recoveries

Indiana, Nebraska, and Virginia have placed caps on the total recovery amount that malpractice victims may receive. Indiana's limit is \$500,000, while Virginia's and Nebraska's is \$1 million.

Illinois and North Dakota have ruled caps on total recoveries unconstitutional. The Illinois Supreme Court found this limit arbitrary and in violation of a state constitutional ban on "special laws" when a general law can be made applicable. The court said there was no societal "quid pro quo" whereby the loss of recovery potential for some victims was offset by lower insurance premiums and medical care costs for all citizens. The North Dakota Supreme Court held that the limit on recovery did not promote the legislative purposes of assuring the availability of medical services at reasonable costs and encouraging physicians to remain in practice, and that the limitation violated the state's equal protection clause.

Courts in Indiana and Nebraska have upheld the limits, ruling that they do serve a broad societal purpose, namely to ensure availability of liability insurance, and hence of all health care services, "to the benefit of the entire community including the badly injured plaintiff."

Proponents of caps believe that they would reduce costs to benefit all consumers and make insurance rating somewhat easier. Opponents argue that caps result in some consumers being unable to meet medical and living expenses and shift costs from the negligent party to the victim.

Changes in the Collateral Source Rule

The traditional collateral source rule in medical malpractice and other tort cases forbids evidence that the plaintiff has received compensation from other sources such as health insurance. Thus, a patient may receive compensation from more than one source for a single element of loss, such as medical expenses. Twenty states have modified the rule either by allowing evidence of collateral payment to be considered in setting a malpractice award or by requiring that payments be deducted from awards. Such changes have met with judicial approval except in New Hampshire, North Dakota, and Pennsylvania, where courts accepted the argument that it is unreasonable to single out malpractice cases for special reduction of personal injury awards. A New Hampshire decision said this provision "arbitrarily and unreasonably discriminated in favor of the class of health care providers."

Those who agree that collateral source evidence should be permitted feel that this will prevent double compensation and free up insurance resources to cover other losses or to cut prices. Opponents of revealing collateral sources argue that victims of malpractice should not be penalized because they have purchased insurance, that collateral sources are not designed to compensate for negligence, and that insurance companies may have subrogation rights. Finally, they feel this change in the rule may weaken deterrence.

Periodic Payment of Damages

Traditionally, settlements in medical malpractice cases have been awarded in lump sums. Most states allow periodic payments only under court mandate or by arrangement of all parties; most plaintiffs (and their lawyers) want full payment immediately.

Sixteen states by statute allow structured awards—damages paid in installments throughout the plaintiff's period of disability, up to a lifetime. The frequency of installments varies and may be discretionary with a supervising court.

Courts in California and Wisconsin have upheld structured payments, saying that malpractice victims benefit from assured availability of funds to meet future medical and other needs. New Hampshire and North Dakota courts, to the contrary, saw these provisions as violations of equal protection guarantees.

Proponents of periodic payments argue that they eliminate speculation on future medical care and earnings while guaranteeing necessary funds. They also eliminate windfalls to the heirs of plaintiffs who die earlier than a judgment anticipated. Advocates also expect lower overall payouts.

Opponents argue that periodic payments involve higher administrative and court costs and that malpractice victims should get the use of and interest from settlements; the victim, not those liable or the court, should benefit from control of settlement amounts.

Patient Compensation Funds

These are state-sponsored excess liability funds, usually paid for by assessments on providers, liability insurers, and sometimes by state general revenues. Patient

compensation funds generally require covered providers to carry malpractice insurance for losses up to \$100,000; settlements above this amount are paid for out of the fund. Patient compensation funds in Indiana and Nebraska are coupled with caps on the total recovery amount malpractice victims may receive.

Proponents of patient compensation funds argue that they help ensure insurance availability by making it easier for insurers to estimate liability since the maximum cost per claim is capped. Opponents point out that if providers are assessed to pay for the fund, there is little or no reduction in malpractice insurance costs. They also cite the large deficits facing patient compensation funds in several states, where assessments have been inadequate to cover fund liabilities.

Question Nine:

What Other Reforms of the Tort System Might States Consider?

Statutes of Limitations

Statutes of limitations define the time period within which medical liability actions must be commenced. A typical law might allow a lawsuit to be filed up to three years after the injury occurred or within one year after the injury's late discovery. Twenty-three states have adopted such statutes of repose specifically for malpractice actions, thus shortening the long tail of malpractice claims. Special provision usually is made for situations

where the injury could not have been discovered, such as where a foreign object was left in the body or where the injury was fraudulently concealed.

A separate issue is the appropriate period of limitation applicable to minors. Some states provide that the limitation period does not begin to run until the minor reaches the age of majority, but others have enacted shorter

limits. Although court decisions usually have upheld statutes of limitations, special statutes for minors have been thrown out in three states as violations of minors' due process rights.

Proponents of shorter limitation periods argue that they will help ensure that pertinent evidence and witnesses are available, will allow insurers to better estimate awards and claims, and will protect providers against changes in legal doctrine and the risk of being judged on the basis of new medical knowledge. Opponents argue that very few claims are filed late and that injuries or the existence of negligence sometimes are not immediately discoverable.

The Legal Standard of Care

The legal standard of care is the law's measure of acceptable practice. In order to prove malpractice, this basic level of accountability must be established. Although the standard of care may be defined generally by statute or judicial decision, it must be established in more specific terms in each case. The applicable standard usually is drawn from observation of customary practice and that usually is established by expert testimony.

Eighteen states have statutes establishing a medical standard of care. Some of the issues involved in defining that standard include:

- Should physicians adhere to a local, state, or national standard of care? Should the standards of a

- Should adherence to prevailing standards be absolutely required? Or should good faith deviations from customary standards be permitted?
- Should cost concerns enter into the definition of the appropriate standard of care?

Qualifications of Expert Witnesses

Ten states have established qualifications for the use of expert witnesses in medical malpractice actions. The following are some of the issues concerning expert witnesses:

- Should it be necessary that an expert witness practice in the defendant's medical specialty?
- Should states require that expert witnesses be familiar with the standard of care in the particular locality? (Concern frequently is expressed about the so-called "conspiracy of silence" that makes it difficult for some plaintiffs to find a physician willing to testify against a peer.)
- Should legislatures or the courts determine witnesses' qualifications?
- Should provision be made for calling impartial experts to supplement the testimony of the parties' possibly biased experts?

Informed Consent

The doctrine of informed consent requires physicians to inform patients of the risks of treatment procedures, alternative treatments and their risks, and to obtain the patient's consent to the agreed-upon treatment. If a physician does not do this, he may be liable for adverse results. A physician need not inform a patient of commonly known or unforeseeable risks, or medical emergency procedure risks.

Because of the amorphous nature of informed consent doctrine, it is subject to varying applications. Some states have attempted to clarify and limit this aspect of tort law by requiring evaluation based on the "same or similar community" rule or by using a test of reasonableness. Also, doctors sometimes require written proof of informed consent to protect themselves from lawsuits. Some states consider written proof of informed consent conclusive or presumptive, but subject to rebuttal.

Question Ten:

What Other Actions Have Legislatures Taken That Affect the Malpractice System?

Attorney Fee Regulation

Some states regulate the contingent fee arrangements of attorneys representing patients in medical malpractice cases. Several approaches have been used. California, Delaware, and New York use a sliding fee scale. The maximum fee percentage decreases as the amount of the award increases. Delaware allows 35 percent of the first \$100,000; 25 percent of the next \$100,000; and 10 percent of the balance.

In nine states, the court must review all fees and may approve only "reasonable fees." In Tennessee, a reasonable fee may not exceed one-third of the award. Statutes in Indiana, Oregon, and Utah state that the plaintiff's attorney fees may not exceed a certain percentage of the amount awarded.

Florida's statute authorizes courts to award a "reasonable" attorney's fee in medical malpractice cases. To discourage weak cases and promote settlements, however, Florida makes the losing party liable for the winner's legal fees. This loser-pays-all rule is unique in U.S. tort law and resembles the British approach.

Courts in California, Indiana, and Nebraska have upheld limitations on attorney fees. The limitations were deemed to be reasonable and logically related to the state goal of holding down health care costs. The New Hampshire and Pennsylvania supreme courts, however, have declared such fee limits to be unconstitutional. The limits were found to violate equal protection guarantees and indirectly

Proponents of attorney fee regulation argue that it ensures that reasonable amounts go to the injured plaintiff without denying attorneys fair compensation. They believe that regulation will encourage earlier settlements by removing incentives to pursue jury verdicts with potentially larger awards and therefore larger fees. They also expect that fee limits will reduce lawyers' incentives to take cases that have doubtful merits but hold hope for a huge recovery.

Opponents of fee regulation argue that contingent fees are not meant solely as reasonable compensation for work on a particular case but also must cover the costs of unsuccessful cases. They also argue that, on average, plaintiffs' lawyers earn no more than defense lawyers. Moreover, they observe, if regulation actually lowers previous fees, it will discourage lawyers from taking smaller and harder-to-prove, but meritorious cases. Finally, an official contingent fee statute also could discourage price competition among lawyers as all adopt the official schedule of maximum fees as the minimum. In general, defenders of the contingent fee system argue that it facilitates access to the legal system and provides a strong incentive for lawyers not to pursue doubtful cases.

Malpractice Insurance Data Collection

Several states require insurance companies and self-insurers to submit basic information on their malpractice experience. This information can give a better understanding of the frequency and severity of claims and the adequacy of premiums, as well as provide feedback on the effect of financial

For example, a 1985 Washington law requires submission of insurance data for physicians, surgeons, hospitals, and other health care professions and facilities. Malpractice insurers must submit data concerning claims, settlements, premiums, investment income, reserves, and estimates of incurred claims.

Improved Discipline of Negligent Providers

Improved state discipline of physicians might reduce the incidence of malpractice and hence of claims and premiums. A few negligent providers may cause disproportionate problems. A 1977 study by the Washington State Medical Disciplinary Board found that physicians who had been subject to previous disciplinary review presented more than 10 times the risk of malpractice claims presented by a control group.

Because physicians with bad experiences tend to move their practices, a need exists for coordination across state lines. The AMA has recognized this need and is notifying state licensing boards of adverse actions against a physician licensed in several states.

State legislatures can affect medical discipline by:

- Expanding immunity from civil actions for members of medical review committees, witnesses, investigators, and proceeding reporters.

- Requiring reports of malpractice claims filed against a facility;
- Requiring medical facilities to report disciplinary actions against providers; and
- Expanding medical disciplinary boards' access to facility and patient records needed to investigate allegations of negligence.

Reviewing the Operation of State Malpractice Insurance Mechanisms

States established several mechanisms in the 1970s to help ensure the availability of malpractice insurance. Some examples are patient compensation funds, joint under-

writing authorities, and reinsurance funds. Recently, many of these funds have had major problems. New Jersey, whose fund was disbanded, has an estimated deficit of \$42 million. Florida's fund went bankrupt in 1984, largely as a result of a few large awards. And Wisconsin has a projected 1985 deficit of \$48 million.

Legislators may want to review the operation of these insurance mechanisms to ensure that they are actuarially sound. Kansas, for example, has authorized its insurance commissioner to increase surcharges on insurance companies to ensure the soundness of the state's patient compensation fund.

Question Eleven:

What New, Untried Proposals Have Been Made Regarding Medical Malpractice?

A number of innovative proposals to revise or revamp the existing malpractice system, have been made. These proposals include corporate liability for malpractice, scheduled damage awards, experience rating of physician malpractice premiums, a no-fault approach, and patient/provider contracts. No state has enacted any of these proposals as yet, but some of them are under study.

Corporate Liability and Risk Management

Physicians were once considered wholly independent contractors, not subject to hospital control. Today, the trend of case law is to hold the hospital liable to injured patients for negligence in selecting physicians or in monitoring their performance.

Proposals for hospital liability differ. Some would have hospitals share liability with the physician, while others would assign liability solely to the hospital. Under sole hospital liability, patients

would bring suit against the hospital, and it would purchase insurance to cover malpractice actions against physicians with staff privileges. These approaches presumably would strengthen hospital review of physician actions and efforts to revoke or curtail staff privileges. This development would mesh with the new emphasis on hospital review of physician actions brought about by Medicare's DRG-based reimbursement system and hospital risk management programs.

Proponents of hospital liability argue that it is best to impose liability at the point where quality of health care can best be monitored. Eighty percent of all malpractice claims and almost all settlements over \$100,000 arise out of events that occur in hospitals. Advocates argue that corporate liability would simplify malpractice actions and that concentrating insurance coverage at this level would produce economies of scale.

Opponents believe that hospitals do not have sufficient control of providers to assume this responsibility. In addition, critics fear that, if hospitals should assume such control, there would be a serious loss of professional independence and of the physician's direct accountability and responsibility to the individual patient. They also believe that a hospital might be better able to cover up negligence and "stonewall" patients if physicians were brought under hospital control.

Scheduled Damage Awards

Dr. Danzon recommends that malpractice damage awards be based on pre-established schedules, just as injuries are handled for some other coverages, including workmen's compensation. Benefits for economic loss would follow a schedule based on age and severity of injury rather than being determined on a case-by-case basis. Pain and suffering damages would be eliminated with the exception of modest, fixed payments for permanently disabling injuries.

Proponents of this approach insist that eliminating most disputes over the extent of loss would save litigation costs while improving overall patient compensation and eliminating disparities in outcomes. Opponents point out that administrative difficulties in determining severity of injury and compensation levels would remain. Moreover, such award schedules would tend to become outdated and thus undercompensate victims. Finally, settlement amounts under this system may be inadequate to allow patients to purchase new health care technologies that may better repair their injuries.

Experience Rating

Although most hospitals and HMOs pay premiums based on their malpractice experience, physicians—even groups of physicians—pay a rate based only on location, specialty, and operative procedures performed. Thus, a doctor with poorer than average malpractice experience does not pay more for liability insurance than, for example, a doctor with no malpractice suits brought against him.

Some experts believe that requiring such experience rating would improve quality incentives. Opponents of experience rating point out that insurers have not moved in this direction partly because of the difficulty of translating experience into an actual rating system. In addition, because insurers usually can settle a claim without a physician's permission, they could increase his premiums despite the lack of a legal finding of negligence.

No-Fault Proposals

Some reformers would replace today's malpractice system in whole or in part by introducing some type of "no-fault" approach. Like arbitration, no-fault might be tried on a voluntary basis rather than legislated as an across-the-board solution. Legislatures might consider how they could encourage private experimentation with these new ideas.

The more serious no-fault proposals stop short of making providers and their insurers pay for every adverse outcome of medical care. Rather, the idea is to limit the number of cases in which fault would be the dominant issue, requiring extensive claims evaluation and use of the legal process.

One proposal would provide automatic payment of prescribed amounts (presumably excluding noneconomic losses) for adverse outcomes appearing on a list of "designated compensable events." For outcomes not on this list, the patient would be free to bring an action under traditional

tort principles. The list, however, would incorporate many of the injuries that are currently the subject of tort claims, and these would be paid without reference to provider fault in the particular circumstances. Providers' incentives to avoid injuries could be maintained through experience rating of premiums for no-fault insurance coverage. Such a system would pay many more claims than the prevailing system but might not cost appreciably more if administrative costs and compensation amounts were less.

A somewhat different no-fault approach has been proposed by Professor Jeffrey O'Connell, coauthor of early proposals for no-fault auto insurance. He suggests that providers get their insurers to make a pre-accident commitment to make prompt post-accident offers to pay victims' net economic losses. This offer, which would be made irrespective of fault, would be conditioned on the victim's release of his malpractice claims. This approach leaves the fault-based tort system in place but is designed to produce more prompt, fair settlements than are being reached today. O'Connell bets that few injured persons would sue if such an offer were made.

Proponents of no-fault approaches argue that they would provide fair and prompt compensation to more injured persons and would redirect to victims money that is now spent on lawyers' fees. They also believe that no-fault compensation could be designed to preserve deterrence of negligent practice and even to improve the quality of health care by giving providers

compares with that of others. They also see opportunities to improve trust between doctors and patients by reducing the necessity for assigning blame. The apparent high cost of compensating people for more injuries is deceptive, they say, because patients already bear these costs; the social costs would be less, advocates allege, because of the administrative cost savings and improved deterrence.

Opponents fear that a no-fault system would allow more awards because most injuries currently do not result in lawsuits; therefore, the no-fault system might be more costly than the tort system. They also doubt that litigation costs could be avoided in a no-fault system, observing that workers' compensation is a highly litigious area even though fault is not an issue. They also fear that a no-fault system would reduce deterrence by reducing payouts and the stigma associated with tort liability.

Reform Through Private Contract

An emerging idea is that medical malpractice reform might be undertaken, not through legislation, but by the private sector through contractual agreements under which patients accept limitations on their tort rights in exchange for compensating benefits. Most prominently advanced by Duke University law professor Clark Havighurst, this proposal envisions consumers agreeing to such changes as binding arbitration; various limits on potential

recoveries; alterations in the applicable legal standard of care; surrender of their right to sue for any but gross negligence; and no-fault rather than tort-based compensation for designated compensable events.

The benefits to consumers who surrender some of their tort rights might include reduced costs for their medical care, which would reflect cutbacks in inappropriate defensive medicine and lower malpractice premiums and litigation costs. Under some arrangements, consumers might gain assurance of prompt, more certain payment for certain injuries.

Critics of malpractice reform by private contracts doubt that courts will enforce them and that consumers are able to make sound judgments on these issues.

In the past, court decisions have struck down contractual arrangements surrendering patients' malpractice rights in the following circumstances:

- Where consumer consent was deemed not to have been freely given—for example, where the patient was coerced or unaware of the restriction in question;
- Where public policy was violated—for example, where an exculpatory clause undercut a statutory requirement that a professional be liable for his torts; or
- Where the contract was unfair on its face—for example, where it amounted to a total surrender rather than a reasonable modification of the patient's right to sue.

It appears that, although courts can and do protect against provider overreaching in such contracts, there may be room for reasonable reforms to be adopted in this fashion.

Courts are most likely to uphold contracts limiting patients' tort rights in the following circumstances:

- Where the agreement is expressly authorized by statute—for example, where a state expressly allows arbitration of malpractice claims;
- Where the agreement was negotiated at arm's length by a sophisticated entity bargaining on

behalf of consumers—as in the case of an employer's group health benefits plan; or

- Where the agreement appears fair on its face—for example, where the restriction seems reasonable and there is reason to believe that both sides made concessions.

Because courts still may be hostile to contracts that change tort rules, legislators should consider whether legislation is needed or desirable to facilitate private reforms. Such legislation might simply indicate that courts should not refuse to enforce agreements for this purpose (other than pure exculpatory clauses), or it might expressly authorize specific agreements.

Question Twelve: 'What Is the Federal Government Doing?

Two major proposals at the national level are of interest to state lawmakers. H.R. 5400, sponsored in 1984 by Congressmen Henson Moore (La.) and Richard Gephardt (Mo.), would preempt state malpractice laws in cases concerning services provided through Medicare, Medicaid, and other federally funded programs. States would have several years to establish an alternative medical liability system conforming to the bill's requirements to avoid preemption. This bill would give providers

the right to foreclose a patient's right to sue in tort by promptly offering to pay his net economic loss. The Moore-Gephardt proposal is being revised for reintroduction in this session.

The AMA has called for a different federal initiative. This proposal would leave the fault system intact and would "provide monetary and other incentives for states to pass specified tort and judicial reform legislation." The specific reforms, not yet outlined in detail, would concern "refining the way in which damages are awarded" and "improving the

Notes

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10. Stephen Zuckerman, "The Costs of Medical Malpractice," *Health Affairs* 3, no. 3 (Fall 1984): Exhibit 3.
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National Conference of State Legislatures

The National Conference of State Legislatures is the official representative of the nation's 7,461 state legislators and their staffs. It is the only national legislative organization governed and funded directly by the states.

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- To improve the quality and effectiveness of state legislatures;
- To foster interstate communication and cooperation; and
- To assure state legislatures a strong, cohesive voice in the federal system.

The conference operates from its headquarters in Denver, Colorado, and an Office of State-Federal Relations in Washington, D.C.

The Foundation for State Legislatures

The Foundation for State Legislatures was established in 1982 to provide a forum for the exchange of views between state legislators and the private sector, and to support the programs and objectives of the National Conference of State Legislatures. It is funded by tax-deductible contributions from individuals, groups, and corporations. It is governed by an 11-member Board of Directors consisting of officers and members of the NCSL Executive Committee and executive officers from the private sector.

The Series on State Health Policy Issues

What Legislators Need to Know is a series of booklets on state health policy issues prepared for legislators. *What Legislators Need to Know About Medical Malpractice* is the second in this series. The first booklet examined the issue of uncompensated hospital care. Booklets may be ordered from: Marketing, National Conference of State Legislatures, 1125 Seventeenth Street, Suite 1500, Denver, Colorado 80202. 303/292-6600.



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Alaska State Legislature

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SENATE ADVISORY COUNCIL

MEMORANDUM

TO: Senator Bennett
FROM: Carol R. Berryhill *CRB*
Research Assistant
DATE: September 17, 1985
RE: Medical Malpractice

In June, 1985, at your request, I prepared a brief report on "Medical Malpractice: Limitations on Liability". The Senate Advisory Council has received a report on Medical Malpractice prepared by the National Conference of State Legislatures. I thought it might be of interest to you so I am forwarding a copy.

Enclosure:

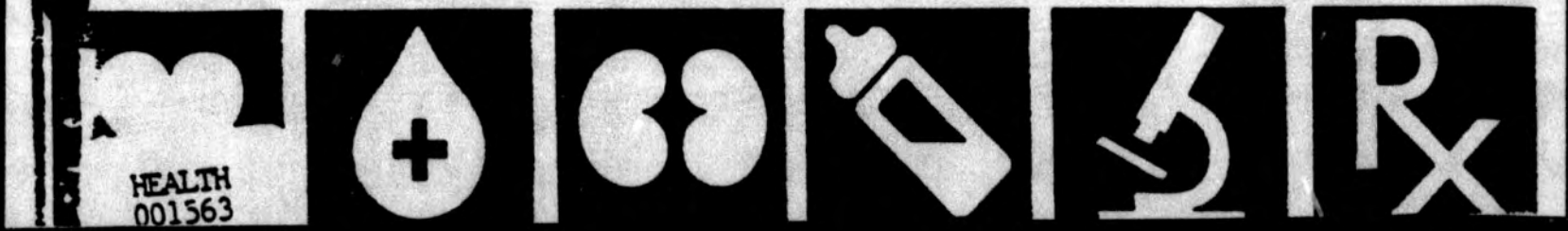
What Legislators Need to Know About Medical Malpractice



National Conference
of State Legislatures



Foundation for
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Senate Advisory Council

In early 1986, papers from the conference proceedings will be published in a symposium of the journal, *Law and Contemporary Problems*, a publication of the Duke University School of Law.

Funds for the organization of The Urban Institute conference were provided by General Reinsurance Corporation, the Hospital Corporation of America Foundation, and St. Paul Fire and Marine Insurance Company.

This booklet also draws on materials from the American Medical Association, the Association of Trial Lawyers of America, The Rand Corporation, and the Health Policy Analysis Program of the University of Washington.

Reviewers of the booklet were Gordon Anderson, Wisconsin Legislative Council; Nancy Bannon, American Medical Association; Patricia Danzon, Duke University; Thomas Goddard, Association of Trial Lawyers of America; Steve Krafchick, Medical Legal Consultants of Washington, Seattle; Doug Reese, Intergovernmental Health Policy Project; and Carl Tubbesing, Lanny Proffer, Cindy Simon, Candace Romig, and Barbara Yondorf of the National Conference of State Legislatures.

In addition, Sharon Bjorkman's editing and Michelle Polchow's word processing led to the successful completion of this project.

What Legislators Need to Know About Medical Malpractice was made possible by a grant from the Hospital Corporation of America Foundation to NCSL's Foundation for State Legislatures. NCSL and the Foundation appreciate continuing support for those projects designed to help legislators understand today's health care issues.

July 1985

Question One:

What Is Medical Malpractice?

Medical malpractice is negligent care by a health care provider that causes injury to a patient. A bad treatment result, no matter how severe, is not grounds for malpractice action unless the provider was at fault.

Medical malpractice actions are brought by injured parties who believe that they are the victims of negligence. Relatives or dependents of the claimant also may be party to the lawsuit. Suits may be brought against a doctor, other health care personnel, a hospital, equipment manufacturers, pharmaceutical companies, and others involved directly or indirectly in patient care.

To be compensated for medical malpractice, the injured party must establish a breach of the legal standard of care, compensable injury to the patient, and a causal connection between such breach and such injury.

Malpractice law has two major goals: a) to provide compensation to victims of malpractice, and b) to deter substandard care through the threat of legal action. It does not seek to cover all injuries that occur in the course of medical care. Nor does it systematically police all poor-quality care.

Question Two:

How Does the Medical Malpractice System Function?

The medical malpractice system encompasses both the formal legal process and the mechanisms of liability insurance. Although most incidents are resolved without full recourse to the legal system, legal doctrine and institutions determine which claims will be brought, whether settlements will be reached, and at what level of payment.

The Legal Process

Medical malpractice lawsuits are resolved through the tort system. Plaintiffs usually seek compensation for both economic and noneconomic damages. Economic damages include the cost of medical and rehabilitative care and lost wages. Non-

Providers and insurers usually are notified of a claim before a lawsuit is actually filed. A study by The Rand Corporation showed that one-half of all claims are dropped without any payment and that two-thirds of those are dropped before a lawsuit is filed.¹ In 22 states, a screening panel reviews claims that result in formal lawsuits before they can go to trial.

Malpractice insurance is offered by several national liability insurers and by provider-owned and -operated companies. Self insurance is also an option for large hospitals and other entities; a few physicians have elected to practice without insurance.

Although there was a fear in the 1970s that malpractice insurance would become unavailable, availability is not a significant problem now, in part because, beginning in the 1970s, providers formed their own insurers. These "bedpan mutuals" insured more than 87,000 physicians in 1983. States also have established joint underwriting associations to guarantee availability.

Two-thirds of insurance claims are resolved within two years of filing. Of the cases that receive compensation, settlements vary widely. Five percent of paid claims account for half of the dollars paid to plaintiffs and another 50 percent of paid claims account for only 4 percent of dollar outlays. Settlements and awards, however, do appear to reflect the severity of injuries.⁶

Until recently, most medical malpractice policies were written on an occurrence basis. Occurrence-based insurance holds the insurance company financially responsible for claims resulting from treatment rendered during the coverage period, regardless of when the claim was filed. This results in a "long tail" of exposure to unfilled malpractice claims. For example, the St. Paul Fire and Marine Insurance Company, the nation's largest malpractice insurer, found that 30 percent of claims are

filed in the year of treatment, 30 percent in the year after treatment, 25 percent in the third year, 7 percent in the fourth year, and 8 percent in years five through 10. This long lag time makes it difficult to determine appropriate premiums and necessary reserve levels.

Because of these problems, the malpractice insurance market is moving to a claims-made system, under which insurers are contractually responsible for claims filed only during the coverage year. Thus insurers can better set premium levels and reserves. Providers, however, bear the risk of suits filed late and must carry insurance even after retiring from practice. Claims-made policies now account for about half of the total premiums written.

The profitability of malpractice insurers can be measured either by using loss ratios or by comparing actual losses to premium income. In either case, a backlog of unresolved claims complicates the actuarial determination necessary to estimate profitability.

Loss ratios compare a company's actual and estimated future losses and expenses to its premium income. The industry-wide loss ratio over the last five years is estimated at 111.4, or a loss payment of \$1.11 for each \$1.00 of premium income. In 1982, major malpractice underwriters had a loss ratio of 122.

Question Three:

Some important considerations, however, are not reflected in loss ratios. First, these ratios are based on *estimated* future claims losses and often are revised up or down later. Second, this measure does not consider investment income from sizable reserves held against future losses.

Comparing actual losses paid to premium income is another way to measure the industry's economic performance, and critics

of malpractice insurers prefer to cite these figures. From 1977 through 1982, major malpractice insurers earned net premiums of \$7.2 billion. Since 1977, they have paid incurred losses of \$1.7 billion. Insurers maintain that the reserves they have built up reflect appropriate actuarial estimates of future liabilities, while critics cite investment income earned from these large reserves.

What Are the Trends in Medical Malpractice Premiums, Claims, and Awards?

The number of malpractice claims (frequency), the size of awards (severity), and the cost of insurance have increased steadily. Some data, some possible explanations, and some speculations on future trends are presented here.

Frequency of Claims

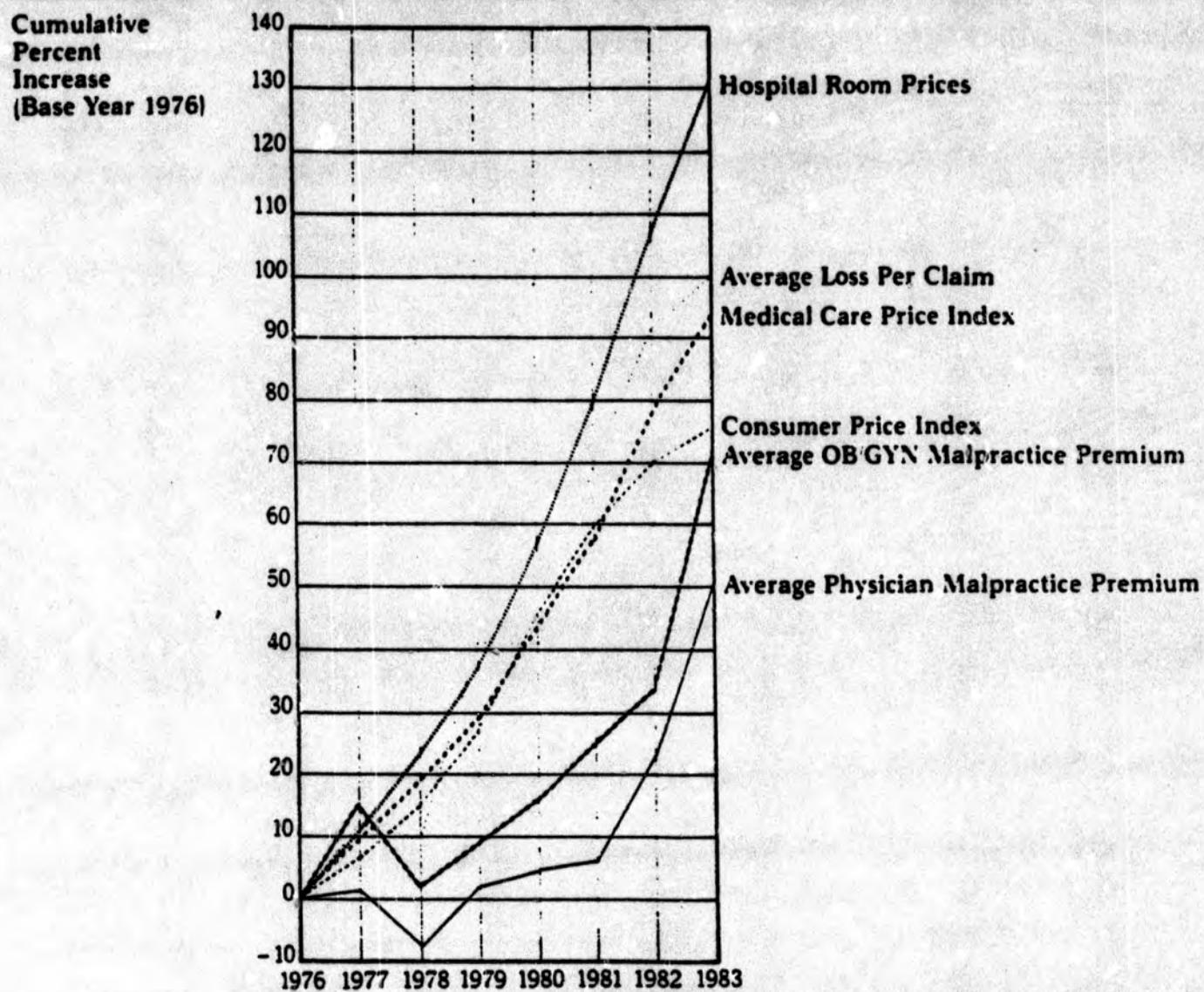
After the deluge of claims in the mid-1970s, their frequency declined briefly, from 24,240 in 1975 to 17,238 in 1978. In 1979, however, frequency once again began to rise rapidly. Physician-owned malpractice insurers experienced an increase in claim frequency from 12.17 cases per 100 physicians in 1979 to 20.3 cases per 100 physicians in 1983. The St. Paul Company saw hospital claims rise from 1.75 per 100 beds in 1979 to 3.0 per 100 beds in 1983. The figures vary greatly by provider specialty

from state to state, and even within a state. In 1978, for example, the state with the most claims activity had 12 times the claims frequency of the state with the least.

Size of Awards

Malpractice awards and settlements have been increasing even more dramatically in amount than in number. The St. Paul Company has seen its average loss per hospital claim, including allocated loss expense, grow from less than \$5,000 in 1975 to more than \$12,000 in 1983. Data compiled by the AMA from physician-owned insurers show the average paid loss going from \$20,396 in 1979 to \$72,243 in 1983.⁷

**Figure 2: Comparative Trends
in Malpractice and Health Care Costs**



Sources:

Consumer Price Index, Medical Care Price Index, Hospital Room Prices: *Statistical Abstract of the United States, 1985.*

Average physician malpractice premium, average OB/GYN malpractice premium: American Medical Association.

Average loss per claim: National Claims Frequency and Severity Index for Physicians.

Question Four:

As already noted, however, evidence exists that only a small percentage of negligent medical injuries result in malpractice claims. Thus, even if the incidence of injuries remains the same or declines,

changes in patient attitudes and provider/patient relations, increased awareness of possibilities for legal action, and other factors could trigger more claims.

What Are the Major Criticisms of the Existing Medical Malpractice System?

Critics of the system have a long list of complaints. These criticisms are reviewed here together with the responses of the system's defenders.

- *The system's administrative costs are excessive.* Estimates are that only 28 to 40 cents of each premium dollar ultimately goes to injured parties.⁹ Administration, claims evaluation, and litigation costs, including plaintiff attorneys' contingent fees and defense attorneys' hourly fees, absorb more than half of each premium dollar. Defenders of the system believe that such costs are worth incurring because of the deterrence to malpractice that the system achieves. Dr. Patricia Danzon of Duke University argues, for example, that a 20 to 30 percent reduction in the incidence of negligent injury would justify the present cost of

- *The resolution of medical malpractice claims is too slow.* One-third of all claims takes more than two years to resolve. The injured party often does not receive compensation when it would be most helpful in repairing his injuries. The present malpractice system sometimes discourages early settlement offers because that might be interpreted as a sign that one's case is weak. Defenders point out, however, that it is not clear that malpractice litigation is any more drawn out than other insurance and legal disputes and that defendants can avoid litigation costs through prompt, reasonable settlement offers.

■ *Malpractice insurance is overpriced.* Plaintiffs' attorneys in particular feel that the rising costs of malpractice coverage are more a problem with the insurance mechanism than with the legal system. They make three major points in arguing that premiums are too high: a) Premium income far exceeds paid losses. From 1977 through 1982, insurers received net premium income of \$7.2 billion, and reported loss and loss expense payments of \$1.7 billion. b) Premium rates fail to reflect income from investment of insurers' sizable reserves. c) Actuarial estimates of malpractice losses from claims not yet paid or filed are too high.

The insurers and others who disagree make the following points: a) Premium increases and large reserve amounts are necessary to meet expected losses from 186,000 pending claims.¹² b) Actuarial estimates are appropriate, although subject to change. Estimates of incurred losses since 1977 have been raised for some years, lowered for others. c) Malpractice insurers expect to pay claims that exceed premium income, and so they depend upon investment income. d) Physician-owned companies have experienced similar premium increases and have made similar actuarial estimates, although they have no incentive to earn large profits. e) Commercial insurance company rates are competitive with those of the bedpan mutuals.

Question Five:

What Were the Effects of the Medical Malpractice Reform Measures?

The perceived crisis of the mid-1970s prompted state legislatures to enact many reforms. These reforms were meant to ensure the availability of insurance, to encourage settlements before trial, to limit recoveries, to improve the quality of care, and to alter the legal process.

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

Question Six:

What Issues Should Legislators Consider in Examining Medical Malpractice?

Provider groups and malpractice insurers are looking to state legislatures for additional changes in the malpractice system. Plaintiffs' attorneys and others dispute the need for change and seek different reforms. As legislators examine the malpractice system and the wide range of reform proposals, they will need to determine whether changes are needed, whether adjustments should be made in the tort system, or whether more fundamental changes are called for.

As noted earlier, legislators should be aware that the frequency and size of malpractice claims and the affordability of malpractice insurance vary greatly by state and by region. There are also shortcomings in malpractice data. Studies by the federal government and the National Association of Insurance Commissioners (NAIC) in the 1970s have not been continued or expanded in the 1980s. Much of the available data is proprietary and supplied by interested parties. Data for a specific state may be incomplete and inadequate as a basis for policymaking.

As legislators examine alternative approaches to the malpractice issue, they may want to consider the following objectives:

- *Assuring equitable patient redress for negligent injury.* The malpractice system should not discourage meritorious claims or encourage inadequate compensation. Patients have few other ways to effectively register their grievances about substandard care.

- *Detering negligent practice and improving the quality of medical treatment.* This point is particularly important because current health care cost containment pressures may encourage providers to inappropriately cut corners.
- *Controlling health care costs.* Injuries resulting from medical malpractice are a significant cost of medical care. Awarding reparations for such injuries creates no new costs but merely shifts to providers and the public costs that otherwise would be borne privately. Making these costs explicit is not objectionable in itself. On the other hand, shifting costs through the tort system is itself expensive. Moreover, by inhibiting responsible economizing and encouraging wasteful defensive medicine, the tort system may add to the overall cost of health care.
- *Promoting reasonable expectations.* Medical malpractice suits are appropriate only in cases where negligence by providers results in patient injury. Medical care is an inherently risky activity and all undesirable treatment outcomes cannot be made compensable. The standard of care used in judging provider negligence should not curb reasonable economizing efforts, stifle innovation, or encourage inefficient treatment practices.

representation on some state panels introduces a bias against claimants, and that panels whose decisions are admissible in court should not be conducted under different evidentiary and procedural rules.

Arbitration

Unlike screening panels, arbitration may provide a total substitute for a court proceeding—although substantive tort rules still govern. State law may permit patients and health care providers to agree in writing to submit a malpractice claim to binding arbitration and thus to have the issues of liability and damages resolved by mutually acceptable arbitrators rather than by a jury. Because some courts historically refused to enforce agreements to replace courts with arbitrators, most legislatures have passed arbitration acts.

Eleven states have statutes specifically allowing arbitration of medical liability cases. Such statutes generally provide that patients who do not sign an arbitration agreement may not be denied treatment or otherwise discriminated against. It is also common to allow a revocation period (usually 30 to 60 days after treatment) in which a patient may rescind the agreement.

In Michigan, institutional providers are required to offer all patients a voluntary agreement to arbitrate any future disputes. A booklet explaining the arbitration statute and process must be given to a patient along with the agreement. Arbitration panels include a public member, an attorney, and a health care provider of the

are not open to the general public. Decisions are binding on all parties involved, and only in cases where there is alleged unfairness or bias of the arbitrators is an appeal available. The claimant is not responsible for the costs of the arbitration proceedings. The Michigan act has been upheld by the state supreme court.

Proponents of binding arbitration argue that expert arbitrators are better than juries at dealing with the complexities of medical treatment, law, and damages, and that results are therefore more predictable and equitable. They also believe that through this process claims may be resolved more promptly than in the court system and that lessened formality and reduced likelihood of appeals will reduce litigation costs. Finally, arbitration provides confidentiality for the parties.

Opponents of binding arbitration argue that individuals may be unaware of the meaning of the arbitration agreement they sign and the arbitration may be prejudiced against the plaintiff because the panel includes a provider. Critics also point out that the plaintiff forfeits his right to a jury trial and to appeal the panel's decision. Finally, they believe that plaintiffs may not be adequately compensated for their injuries, since panel awards tend to be lower than jury awards.

Louisiana	Maine	Maryland	Massachusetts	Michigan	Minnesota	Mississippi	Missouri	Montana	Nebraska	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming	
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Key:

1. Provision exists.
2. Provision found constitutional by highest state court.
3. Provision found unconstitutional by highest state court.

Notes:

This chart does not include all of the court rules that affect these provisions.
 Chart reflects state actions through 1983.

Data source: AMA Division of Legislative Activities. Department of State Legislation. Chicago. November 1984.
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Courts in Indiana and Nebraska have upheld the limits, ruling that they do serve a broad societal purpose, namely to ensure availability of liability insurance, and hence of all health care services, "to the benefit of the entire community including the badly injured plaintiff."

Proponents of caps believe that they would reduce costs to benefit all consumers and make insurance rating somewhat easier. Opponents argue that caps result in some consumers being unable to meet medical and living expenses and shift costs from the negligent party to the victim.

Changes in the Collateral Source Rule

The traditional collateral source rule in medical malpractice and other tort cases forbids evidence that the plaintiff has received compensation from other sources, such as health insurance. Thus, a patient may receive compensation from more than one source for a single element of loss, such as medical expenses. Twenty states have modified the rule either by allowing evidence of collateral payment to be considered in setting a malpractice award or by requiring that payments be deducted from awards. Such changes have met with judicial approval except in New Hampshire, North Dakota, and Pennsylvania, where courts accepted the argument that it is unreasonable to single out malpractice cases for special reduction of personal injury awards. A New Hampshire decision said this provision "arbitrarily and unreasonably discriminated in favor of the class of health care providers."

Those who agree that collateral source evidence should be permitted feel that this will prevent double compensation and free up insurance resources to cover other losses or to cut prices. Opponents of revealing collateral sources argue that victims of malpractice should not be penalized because they have purchased insurance, that collateral sources are not designed to compensate for negligence, and that insurance companies may have subrogation rights. Finally, they feel this change in the rule may weaken deterrence.

Periodic Payment of Damages

Traditionally, settlements in medical malpractice cases have been awarded in lump sums. Most states allow periodic payments only under court mandate or by arrangement of all parties; most plaintiffs (and their lawyers) want full payment immediately.

Sixteen states by statute allow structured awards—damages paid in installments throughout the plaintiff's period of disability, up to a lifetime. The frequency of installments varies and may be discretionary with a supervising court.

Courts in California and Wisconsin have upheld structured payments, saying that malpractice victims benefit from assured availability of funds to meet future medical and other needs. New Hampshire and North Dakota courts, to the contrary, saw these provisions as violations of equal protection guarantees.

limits. Although court decisions usually have upheld statutes of limitations, special statutes for minors have been thrown out in three states as violations of minors' due process rights.

Proponents of shorter limitation periods argue that they will help ensure that pertinent evidence and witnesses are available, will allow insurers to better estimate awards and claims, and will protect providers against changes in legal doctrine and the risk of being judged on the basis of new medical knowledge. Opponents argue that very few claims are filed late and that injuries or the existence of negligence sometimes are not immediately discoverable.

The Legal Standard of Care

The legal standard of care is the law's measure of acceptable practice. In order to prove malpractice, this basic level of accountability must be established. Although the standard of care may be defined generally by statute or judicial decision, it must be established in more specific terms in each case. The applicable standard usually is drawn from observation of customary practice and that usually is established by expert testimony.

Eighteen states have statutes establishing a medical standard of care. Some of the issues involved in defining that standard include:

- Should physicians adhere to a local, state, or national standard of care? Should the standards of a

- Should adherence to prevailing standards be absolutely required? Or should good faith deviations from customary standards be permitted?
- Should cost concerns enter into the definition of the appropriate standard of care?

Qualifications of Expert Witnesses

Ten states have established qualifications for the use of expert witnesses in medical malpractice actions. The following are some of the issues concerning expert witnesses:

- Should it be necessary that an expert witness practice in the defendant's medical specialty?
- Should states require that expert witnesses be familiar with the standard of care in the particular locality? (Concern frequently is expressed about the so-called "conspiracy of silence" that makes it difficult for some plaintiffs to find a physician willing to testify against a peer.)
- Should legislatures or the courts determine witnesses' qualifications?
- Should provision be made for calling impartial experts to supplement the testimony of the parties' possibly biased experts?

Proponents of attorney fee regulation argue that it ensures that reasonable amounts go to the injured plaintiff without denying attorneys fair compensation. They believe that regulation will encourage earlier settlements by removing incentives to pursue jury verdicts with potentially larger awards and therefore larger fees. They also expect that fee limits will reduce lawyers' incentives to take cases that have doubtful merits but hold hope for a huge recovery.

Opponents of fee regulation argue that contingent fees are not meant solely as reasonable compensation for work on a particular case but also must cover the costs of unsuccessful cases. They also argue that, on average, plaintiffs' lawyers earn no more than defense lawyers. Moreover, they observe, if regulation actually lowers previous fees, it will discourage lawyers from taking smaller and harder-to-prove, but meritorious cases. Finally, an official contingent fee statute also could discourage price competition among lawyers as all adopt the official schedule of maximum fees as the minimum. In general, defenders of the contingent fee system argue that it facilitates access to the legal system and provides a strong incentive for lawyers not to pursue doubtful cases.

Malpractice Insurance Data Collection

Several states require insurance companies and self-insurers to submit basic information on their malpractice experience. This information can give a better understanding of the frequency and severity of claims and the adequacy of premiums, as well as

For example, a 1985 Washington law requires submission of insurance data for physicians, surgeons, hospitals, and other health care professions and facilities. Malpractice insurers must submit data concerning claims, settlements, premiums, investment income, reserves, and estimates of incurred claims.

Improved Discipline of Negligent Providers

Improved state discipline of physicians might reduce the incidence of malpractice and hence of claims and premiums. A few negligent providers may cause disproportionate problems. A 1977 study by the Washington State Medical Disciplinary Board found that physicians who had been subject to previous disciplinary review presented more than 10 times the risk of malpractice claims presented by a control group.

Because physicians with bad experiences tend to move their practices, a need exists for coordination across state lines. The AMA has recognized this need and is notifying state licensing boards of adverse actions against a physician licensed in several states.

State legislatures can affect medical discipline by:

- Expanding immunity from civil actions for members of medical review committees, witnesses, investigators, and proceeding reporters.

would bring suit against the hospital, and it would purchase insurance to cover malpractice actions against physicians with staff privileges. These approaches presumably would strengthen hospital review of physician actions and efforts to revoke or curtail staff privileges. This development would mesh with the new emphasis on hospital review of physician actions brought about by Medicare's DRG-based reimbursement system and hospital risk management programs.

Proponents of hospital liability argue that it is best to impose liability at the point where quality of health care can best be monitored. Eighty percent of all malpractice claims and almost all settlements over \$100,000 arise out of events that occur in hospitals. Advocates argue that corporate liability would simplify malpractice actions and that concentrating insurance coverage at this level would produce economies of scale.

Opponents believe that hospitals do not have sufficient control of providers to assume this responsibility. In addition, critics fear that, if hospitals should assume such control, there would be a serious loss of professional independence and of the physician's direct accountability and responsibility to the individual patient. They also believe that a hospital might be better able to cover up negligence and "stonewall" patients if physicians were brought under hospital control.

Scheduled Damage Awards

Dr. Danzon recommends that malpractice damage awards be based on pre-established schedules, just as injuries are handled for some other coverages, including workmen's compensation. Benefits for economic loss would follow a schedule based on age and severity of injury rather than being determined on a case-by-case basis. Pain and suffering damages would be eliminated with the exception of modest, fixed payments for permanently disabling injuries.

Proponents of this approach insist that eliminating most disputes over the extent of loss would save litigation costs while improving overall patient compensation and eliminating disparities in outcomes. Opponents point out that administrative difficulties in determining severity of injury and compensation levels would remain. Moreover, such award schedules would tend to become outdated and thus undercompensate victims. Finally, settlement amounts under this system may be inadequate to allow patients to purchase new health care technologies that may better repair their injuries.

Experience Rating

Although most hospitals and HMOs pay premiums based on their malpractice experience, physicians—even groups of physicians—pay a rate based only on location, specialty, and operative procedures performed. Thus, a doctor with poorer than average malpractice experience does not pay more for liability insurance than, for example, a doctor with no malpractice

compares with that of others. They also see opportunities to improve trust between doctors and patients by reducing the necessity for assigning blame. The apparent high cost of compensating people for more injuries is deceptive, they say, because patients already bear these costs; the social costs would be less, advocates allege, because of the administrative cost savings and improved deterrence.

Opponents fear that a no-fault system would allow more awards because most injuries currently do not result in lawsuits; therefore, the no-fault system might be more costly than the tort system. They also doubt that litigation costs could be avoided in a no-fault system, observing that workers' compensation is a highly litigious area even though fault is not an issue. They also fear that a no-fault system would reduce deterrence by reducing payouts and the stigma associated with tort liability.

Reform Through Private Contract

An emerging idea is that medical malpractice reform might be undertaken, not through legislation, but by the private sector through contractual agreements under which patients accept limitations on their tort rights in exchange for compensating benefits. Most prominently advanced by Duke University law professor Clark Havighurst, this proposal envisions consumers agreeing to such changes as binding arbitration; various limits on potential

recoveries; alterations in the applicable legal standard of care; surrender of their right to sue for any but gross negligence; and no-fault rather than tort-based compensation for designated compensable events.

The benefits to consumers who surrender some of their tort rights might include reduced costs for their medical care, which would reflect cutbacks in inappropriate defensive medicine and lower malpractice premiums and litigation costs. Under some arrangements, consumers might gain assurance of prompt, more certain payment for certain injuries.

Critics of malpractice reform by private contracts doubt that courts will enforce them and that consumers are able to make sound judgments on these issues.

In the past, court decisions have struck down contractual arrangements surrendering patients' malpractice rights in the following circumstances:

- Where consumer consent was deemed not to have been freely given—for example, where the patient was coerced or unaware of the restriction in question;
- Where public policy was violated—for example, where an exculpatory clause undercut a statutory requirement that a professional be liable for his torts; or
- Where the contract was unfair on its face—for example, where it amounted to a total surrender

Notes

1. Patricia Munch Danzon and Lee A. Lillard, *The Resolution of Medical Malpractice Claims. Research Results and Policy Implications* (Santa Monica: The RAND Corporation, 1982), p. xi.
2. Danzon and Lillard, *The Resolution of Medical Malpractice Claims*, p. xiii.
3. Insurance Information Institute, "California Superior Court Verdicts—Medical Malpractice Cases 1973-1983" (As cited in materials from The Urban Institute's national medical malpractice conference, "Can the Private Sector Find Relief?," Washington, D.C., February 21-22, 1985).
4. Don Harper Mills (Presentation at The Urban Institute's national medical malpractice conference, "Can the Private Sector Find Relief?," February 21-22, 1985).
5. Leon S. Pocincki et al., *The Incidence of Iatrogenic Injuries* (Washington, D.C.: U.S. Department of Health, Education and Welfare, 1973), p. 50.
6. Danzon and Lillard, *The Resolution of Medical Malpractice Claims*, p. xiv.
7. American Medical Association Special Task Force on Professional Liability, *Professional Liability in the 80s, Report 1* (Chicago: American Medical Association, 1984), p. 17.
8. Jury Verdict Research, *Current Award Trends* (Solon, Ohio: Jury Verdict Research, January 1985), pp. 18-99.
9. Jeffrey O'Connell, "The Case Against the Current Malpractice System" (Presentation at The Urban Institute's national medical malpractice conference, "Can the Private Sector Find Relief?," February 21-22, 1985); and Patricia Danzon, "Evaluation of the Current Malpractice System" (Presentation at The Urban Institute's national medical malpractice conference, "Can the Private Sector Find Relief?," February 21-22, 1985).
10. Stephen Zuckerman, "The Costs of Medical Malpractice," *Health Affairs* 3, no. 3 (Fall 1984): Exhibit 3.
11. Danzon, "Evaluation of the Current Malpractice System."
12. James Reuter, *Defensive Medicine and Medical Malpractice* (Washington, D.C.: Congressional Research Service, 1984), p. 23.



National Conference of State Legislatures

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SENATE ADVISORY COUNCIL

MEMORANDUM

TO: SENATOR FRED ZHAROFF
FROM: ELIZABETH J. HICKERSON
SUBJECT: MEDICAL MALPRACTICE AWARDS
DATE: APRIL 24, 1985

MAY 01 1985

In response to your request for information regarding medical malpractice awards, Rob Nauheim provided your office a memorandum on the general issues involved on this matter. I have been tracking three recent California Supreme Court decisions on the California 1975 Medical Injury Compensation Reform Act. Information on these cases has been difficult to obtain, and I apologize for the delay. The following is a summary of the California act and the recent court decisions.

MEDICAL INJURY COMPENSATION REFORM ACT OF 1975 (MICRA)

In May 1975, the Governor of the State of California convened the Legislature in an extraordinary session to consider measures aimed at remedying the rapid increase in medical malpractice insurance premiums. In response, the Legislature enacted the Medical Injury Compensation Reform Act of 1975 (Stats. 1975, Second Ex. Sess. 1975-1976, chs. 1, 2, pp. 3949-4007). This is a lengthy statute which:

1. attempted to reduce the incidence and severity of medical malpractice injuries by strengthening governmental oversight of the education, licensing and discipline of physicians and health care providers;
2. sought to curtail unwarranted insurance premium increases by authorizing alternative insurance coverage programs and by establishing new procedures to review substantial rate increases; and,
3. attempted to reduce the cost and increase the efficiency of medical malpractice litigation by revising a number of legal rules applicable to such litigation.

Following the adoption of the MICRA, three law suits were filed challenging the constitutionality of the act. By a slim majority, the court upheld the statutes in all three

cases. It is unclear at this time whether or not the cases will be appealed to the U. S. Supreme Court. It may be years before an answer to the constitutionality of the California act is finally decided.

AMERICAN BANK AND TRUST COMPANY v. COMMUNITY HOSPITAL OF LOS GATOS-SARATOGA, INC. (July 9, 1984)

This case involves a constitutional challenge to one provision of MICRA affecting medical malpractice lawsuits (section 667.7 of the Code of Civil Procedure). This section provides that when a plaintiff in a medical malpractice case has sustained "future damages" of \$50,000 or more, compensation for those future damages is to be paid periodically over the course of time the plaintiff incurs the losses, rather than in a lump sum payment at the time of judgement.

Plaintiff brought suit against the hospital for damages caused by severe burns that she suffered as a result of overheated water when she fainted or fell in a shower stall on the eve of her scheduled operation. The plaintiff died while this appeal was pending and the American Bank and Trust Company, special administrator of her estate, was substituted as plaintiff in this action. Plaintiff attacked this provision on the grounds that it violated the state and federal constitutional guarantees of due process, equal protection and the right to jury trial.

The court in a 4-3 decision held that the provision was not unconstitutional since it was rationally related to legitimate state interest of reducing cost of medical malpractice insurance; the statute could be construed to require a jury to designate a portion of its verdict that is intended to compensate a plaintiff for future damages; and the statute is not void for vagueness, ambiguity, and unworkability.

The Dissent stated in part:

Today's majority opinion ignores the lessons of history. This is not the first time that tort victims have, in the face of a "crisis," been deprived of their constitutional rights. In the late 1920's and 1930's, many states, including California, enacted panic legislation restricting the right of automobile guest passengers to obtain relief from negligently inflicted harm. It was not until 1973 that this court recognized this constitutional violation and invalidated the automobile guest statute as applied to negligently injured guests. With today's majority opinion, it appears that once again years will pass and many victims of negligence will undergo injury without adequate relief before their constitutional rights will

be recognized and respected. The periodic payment provision of the Medical Injury Compensation Reform Act violates the constitutional guarantees of trial by jury and equal protection of the law.

American Bank and Trust Company v. Community Hospital of Los Gatos-Saratoga, Inc., (1984) 204 Cal.Rptr. 671, 689-690.

BARME v WOOD (November 8, 1984)

This case involves a constitutional challenge to another provision of MICRA, which provides that no source of collateral benefits introduced shall recover any amount against the plaintiff nor shall it be subrogated to the rights of a plaintiff against a defendant. The purpose of this section has generally been viewed as an attempt to eliminate the so-called "double recovery" obtained by plaintiffs who have their medical expenses paid by their own health insurance and still obtain damages for such expenses from defendant tortfeasors.

The plaintiff, Barme, a police officer employed by the City of Huntington Beach, suffered a heart attack while on duty. He underwent open heart surgery at St. Francis Hospital, during which he sustained brain damage. The plaintiff brought action against the hospital and staff alleging that the brain damage was caused by their negligence. The City of Huntington Beach, a self-insured workers' compensation carrier, intervened seeking to recover from defendants the expenses it had incurred, and was continuing to incur in providing workers' compensation benefits to Barme. The lower court denied the City's complaint in intervention. The City appealed, challenging that the due process clause prohibits the Legislature from arbitrarily eliminating this right and maintains that this provision is arbitrary because it bears no rational relation to a legitimate public purpose, and it shifts some of the cost of medical malpractice from negligent health care providers to innocent employers or insurers.

The Supreme Court of California in a 4-2 decision held that the statute, which precludes a "collateral source" that has provided medical expenses or other benefits to a medical malpractice plaintiff from reimbursement of those expenses from medical malpractice defendant, does not violate due process or equal protection. This decision was based on the conclusion that the provision reduces the potential liability of defendants and that the Legislature could rationally conclude that this would lead to lower malpractice insurance premiums.

The Dissent stated in part:

In American Bank & Trust Co. v. Community Hospital
(1984) 36 Cal.3d 359, 204 Cal. Rptr. 671, 683 P.2d.
670, a slim majority of this court approved the
shifting of a substantial part of the burden of damages
from the tortfeasor to the innocent victim. The
purported reason was the desire to reduce premiums for
medical insurance and by that means to lower medical
and hospital costs. In my dissent in that case I
pointed out how vain that purpose had then proved to
be. The passage of time has further vindicated my
view. In the nine years since adoption of the
so-called Medical Injury Compensation Reform Act of
1975, medical and hospital costs have continued to rise
astronomically. The only "reform" had been to
magnanimously bestow on health providers a generous
insulation from much of the responsibility for their
more egregious negligence.

Now the majority compound their error by permitting yet
another shift of the burdens of malpractice, this time
from medical malpractice defendant to the plaintiff's
employer or workers' compensation carrier. Why the
plaintiff's employer or compensation carrier should
bear any of the responsibility for the defendant's
malpractice defies rational explanation. Once again
the only purpose suggested by the majority is a
hoped-for reduction in medical malpractice insurance
premiums. That the result will be an increase in
workers' compensation insurance premiums appears to be
ignored. As between the two, which should logically
shoulder the burden: the carrier of the tortfeasor or
the carrier of the innocent employer? The answer is
obvious.

Barme v. Wood (1984) 689 P.2d 446, 451.

ROA v. MICRA MEDICAL GROUP, INC. (February 7, 1985)

This final case involves a provision of the MICRA which
limits the amount of fees an attorney may obtain in a
medical malpractice action when he or she represents a party
on a contingency fee basis. This provision places the
following limits on contingency fees:

- 40% of the first \$50,000 recovered,
- 33 ¹/₃ % of the next \$50,000 recovered,
- 25% of the next \$100,000, and
- 10% of any amount exceeding \$200,000.

Plaintiffs challenged the provision on the grounds that it was a violation of due process, equal protection and separation of powers.

The California Supreme Court in a 4-3 decision held that the provision was constitutional. This was based on the determination that due process was not violated because the statute does not impermissibly infringe on the right of medical malpractice victims to retain counsel in malpractice actions, but limits the compensation that an attorney may obtain when he/she represents an injured party under a contingency fee arrangement. With regard to the equal protection claim, it held that the Legislature did not act arbitrarily in selectively imposing the statute's attorney fee limits only in medical malpractice action because of the rational relationship to the objectives of MICRA, which was enacted to reduce the high cost of malpractice insurance premiums. The court held that separation of powers was not violated because the appropriateness of attorney fees is not a matter committed solely to the judicial branch.

The Dissent stated in part:

In effect, section 6146 prohibits severely injured victims of medical negligence from paying the general market rate for legal service, while permitting defendants to pay whatever is necessary to obtain high quality representation.

Out of practical necessity, virtually all plaintiffs use contingent fee arrangements in medical malpractice cases. In fact, for clients of limited means "the contingent fee arrangement offers the only realistic hope of establishing a legal claim."

Section 6146 imposes heavy burdens on the ability of severely injured plaintiffs to obtain adequate legal representation. It sets forth a sliding scale of fee limits--the greater the recovery, the lower the allowable percentage. The effect of this approach is to impose drastically low limits on fees in precisely those cases which require a large recovery to make the plaintiff economically whole.

Roa v. Lodi Medical Group, Inc., (1985) 37 Cal.3d 920, 934-935.

ATTACHMENTS

California Code:

<240.5 (Action against health care provider)
<667.7 (Action against health care provider; periodic payments of future damages)
<1714.8 (Liability of health care provider)
<6146 (Limitations; periodic payments)

California Cases:

American Bank and Trust Company v. Community Hospital of Los Gatos-Saratoga, Inc.

Barme v. Wood

Roa v. Lodi Medical Group, Inc.

Articles:

The Limitation on Recovery in Medical Negligence Cases in Virginia, University of Richmond Law Review

Validity and Construction of State Statutory Provisions Relating to Limitations on Amount of Recovery in Medical Malpractice Claim and Submission of Such Claim to Pretrial Panel

Validity of Statute Establishing Contingent Fee Scale for Attorneys Representing Parties in Medical Malpractice Actions

California Fee Cap Draws Protests, National Law Journal

Alaska State Legislature

Advisory Council Members
Senator Bennett, Chairman
Senator Kerttula
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SENATE ADVISORY COUNCIL

MEMORANDUM

TO: Senator Fred Zharoff
FROM: Rob Nauheim *Rob Nauheim*
DATE: March 28, 1985
RE: Additional medical malpractice information.

Please find enclosed a copy of a publication from the American Medical Association which we recently received. The comments in this article seem to concur with the findings of the interim report which our office prepared for you.

The review of the situation in Indiana seems particularly interesting in light of the relatively low malpractice insurance rates in that state (see attached chart). The success of the awards cap statute in Indiana may be more closely related to a local perspective in the courts than to a unique statutory approach. However, a closer look at the Indiana statute might be warranted.

I hope you will find this information useful.

Please call if you should have additional questions.

RCN
enclosures:

*From "Professional Liability in the '80s" Report 2
American Medical Association, Nov. 1984*

lenges to address in the next five years, but I don't think we are going to be blown away by the problem. Physicians must realize that they can't be passive participants—they must take a strong stand and get out and do some work if any legislative reforms are to be enacted. Physicians must participate actively in those physician-company functions that require their involvement.

Dion - Some people have suggested that the insurance industry is incapable of dealing with the current professional liability problem effectively. Is federal intervention needed?

Sweetland - Maybe some assistance to the states in their efforts to reform their own laws might be helpful, but I don't think that the government has a satisfactory solution to the professional liability insurance problem.

Morse - I agree. Federal proposals to date are very vague and haven't been studied appropriately. Furthermore, the professional liability problem is a product of 50 different social, legal and economic climates in the states. I'm not sure that uniform, across-the-board federal legislation is the answer.

Phillips - The insurance industry has not failed and the medical profession has not failed to deal with the professional liability problem. We are working with a flawed system. We are trying to deliver a product to compensate patients for things that happened to them through a system that puts only 20% to 25% of the money generated into the hands of the victim. In many cases, a true victim gets nothing, and in others, a claimant able to win the sympathy of the court gets a great deal of money when there was no physician liability. If we need federal intervention, it is to restrain the whole litigious atmosphere in this nation today.

Professional Liability Tort Reform

After the professional liability crisis reached its peak in 1975, physicians and other health care providers and institutions took several steps to solve the problem. One of the most important of these steps was an aggressive campaign to reform state laws affecting medical professional liability lawsuits. The goal was to change state laws governing tort litigation in two general ways: first, to make it harder for plaintiffs to bring groundless lawsuits, and second, to limit the impact of the costs of successful suits on defendants, insurers, and the medical profession as a whole.

In one sense, the campaign for tort law reforms was immensely successful. Every state in the union, except West Virginia, enacted some reform proposals. Some states, including those with the most serious professional liability problems—such as New York, California, Florida, and Illinois—enacted comprehensive packages of legislation over the vigorous and well-organized opposition of plaintiffs' trial lawyers.

But in another sense, the campaign appears to have failed.

The expected reduction in the number and severity of professional liability suits against physicians and hospitals never happened. In the past two or three years the situation has become worse than it was before. More professional liability claims are filed now and jury verdicts against physicians are higher on the average.

According to American Medical Association figures, before 1978 an average of 3.3 professional liability claims were filed for every 100 physicians. From 1978 through 1983, an average of 8 professional liability claims were filed for every 100 physicians. For physician-

owned companies in 1983 the average frequency was 20.3 claims for every 100 physicians. In those cases that go to trial and result in an unfavorable jury verdict, the size of the damages awarded has skyrocketed and the number of million-plus awards has increased each year (See Report 1-Special AMA Task Force on Professional Liability and Insurance.)

Are tort reforms effective?

An obvious conclusion that the wave of tort reform legislation in the 1970s was a failure may well turn out to be partly or wholly inaccurate. First, without the reforms enacted, the situation might be far worse than with the reforms in place. Second, the publicity generated by the first professional liability crisis may have made the public and the legal profession more aware of the vulnerability of the medical profession to successful lawsuits.

Thus, the impact of the wave of tort reforms of the late 1970s on medical liability costs is unclear. Yet it is undeniable that these reforms have not had the effect that their supporters hoped, or at least not yet. This has been true for at least two reasons.

First, some of the reform measures have not been as effective in reducing litigation volume or severity as hoped. Some measures passed during the crisis were poorly thought out, and either had no effect at all on medical liability costs, or in a few cases had an opposite effect. For example, recovery of costs legislation designed to reduce suits without merit by requiring losers to pay costs, including attorney's fees, has

increased outlays for awards in some states

Second, many of the potentially most effective reforms have been successfully challenged on constitutional grounds in the courts. With the exception—thus far—of contractual binding arbitration, every single major tort reform measure has been found unconstitutional by at least one state supreme court. In many states, lower courts have reached conflicting conclusions about the same statutes, and plaintiffs and defendants in many states are still awaiting higher court determinations on the validity of important provisions. Because it often takes several years for a liability case to wind its way from the trial courts through at least one intermediate appeal stage, and finally to the supreme court in the state, many tort reforms passed by state legislatures in the mid-1970s have been subject to supreme court scrutiny only in the last two to four years.

Of course, the view expressed by plaintiffs' lawyers is that physicians and hospitals are guilty of professional negligence far more often than even the latest flood of litigation indicates. These lawyers generally believe that while the tort reforms of the 1970s make their work somewhat more difficult, and treat some injured patients harshly, the tort law changes have no effect on "good" medical liability cases, either in terms of chances of success or in size of eventual settlement or verdict awards.

Whether that view is accurate or not, it does appear that some plaintiffs' attorneys are becoming more proficient at winning bigger settlements or verdicts for their medical liability clients. In recent years, many courts have taken a broader view of what constitutes adequate compensation for an injured plaintiff. The traditional goal of "making the plaintiff whole" has expanded from

merely paying for medical expenses and lost wages to include lifelong compensation for rehabilitation, counseling, physical or occupational therapy and training, and lifestyle changes.

Vulnerability to constitutional challenge

The single greatest legal weakness of nearly all reform measures that have been found unconstitutional is that they apply only to medical liability cases, and no other kind of lawsuit. Plaintiffs are thus able to argue that the laws violate their constitutional rights to "equal protection of the laws." Both state and federal constitutions contain the equal protection provisions, which guarantee that no class of persons can be treated differently from the rest of the population unless there is a very good reason for doing so. When an equal protection claim arises in a case, the court first decides if there is in fact an unequal impact on one class of people. If so, then the court decides whether the unequal burden on the complaining party is justified or outweighed by the reasons given for the different legal treatment.

In the case of medical liability tort reforms, plaintiffs argue that equal protection guarantees are violated because certain measures make it harder for them to file and win a lawsuit, or limit the damages recoverable, while plaintiffs in other kinds of lawsuits faced no such barriers. The courts must determine whether the reasons for that unequal treatment of one class of people (medical liability plaintiffs) compared to other similarly situated classes (other kinds of tort plaintiffs) justify the distinction.

It is not an easy formula to apply, and it is virtually impossible to predict how courts will treat such claims.

Courts may apply different standards of review. One level of review presumes that the law in question is a valid one, as long as there is any rational and proper explanation for it. A stricter level of review makes no such presumption, but instead examines the statute, its legislative history, and its current impact, to determine what its actual purpose is and whether that purpose could be achieved with a less harsh law. This latter level of scrutiny is usually applied when the person raising the issue can show that a "fundamental right" of all citizens is affected. Fundamental rights usually involve issues such as freedom of speech, freedom of assembly, and racial discrimination. Courts generally do not classify medicolegal issues as fundamental rights. The tort reform provisions have been challenged because they are special legislation; that is, legislation enacted solely to benefit physicians. This analysis is similar to the equal protection arguments.

The kinds of tort reforms most susceptible to equal protection challenges have been limitations or "caps" on liability (when the amount of money a victorious plaintiff can collect is limited) and mandatory pretrial screening panels for medical liability claims.

In tort reform challenges, the concept of free and equal access to the courts is considered by some courts to be a very important right, almost to the level of a "fundamental right." But even in those situations, different courts may reach different results. For example, both the Indiana and New Hampshire supreme court applied the stricter standard to their states' respective liability reform acts; Indiana's court upheld its entire act, while New Hampshire's struck down its entire act.

In some cases, the imposition of mandatory pretrial screening panel review, or other kinds of reforms,

have been invalidated because they were determined by the courts to violate plaintiffs' right to due process of law, or the right to a jury trial of civil claims; both rights are protected under both state and federal constitutions.

In a few cases, laws have been invalidated, or so modified by the courts as to eliminate their effectiveness, for reasons having nothing to do with unconstitutional rights. For example, many attempts to modify statutes of limitation have been blunted by court decisions on the basis of traditional common-law interpretations. The most unusual invalidation occurred in North Dakota. That state's supreme court invalidated all of the state's new medical malpractice act, primarily on equal protection grounds (much as the New Hampshire court did), but also ruled that the legislature's attempt to modify rules of evidence was beyond its authority in the first place. The high court said that matters of pleading and evidence were court rules, and only the supreme court had the authority under the state constitution to determine such rules.

It is important to note that in a few states tort reforms have been invalidated only because they were part of a comprehensive package of statutory changes. Most such statutes contain a "severability clause," which provides that if any section is struck down, the others will remain in force. However, in New Hampshire and North Dakota, for example, high courts invalidated entire medical liability reform acts despite such clauses, under the reasoning that the measures were so interrelated that it was impossible for any part of the law to stand if one part were unconstitutional. Parts of Pennsylvania's comprehensive act received similar treatment.

Some of the tort reform measures that have survived constitutional

challenges have done little to control the medical liability crisis. For example, a widely adopted reform—in at least 20 states—was the imposition of limitations on contingency fees for lawyers who win medical liability cases. Where the fee regulation generally fixed limits on the percentage of awards that plaintiffs' attorneys could claim as fees, the ultimate effect on the size of awards is probably very limited, if any. Indeed, where strict limits on fee percentages were enacted, there may have been a tendency on the part of plaintiffs' lawyers to push for higher verdicts and settlements to maximize their own fees.

Similarly, pretrial screening panels, while considered successful in many states, have been regarded as ineffective and even counterproductive in other states, in deterring the filing of frivolous claims or in making medical liability litigation quicker and more efficient. One reason for this could be the reluctance of plaintiffs' lawyers to use them.

However, other tort reforms have proved to be very effective in achieving the ultimate goal of the whole campaign: reduction of total costs of medical liability litigation. The Rand Corp.'s Institute for Civil Justice rates limitations on "caps" on awards and changes in the collateral source rule as the most effective law changes in terms of reducing the size of jury verdict and settlements. Also, changes in the laws that permit courts to order periodic payments of damages rather than lump-sum payments have been viewed as substantially reducing costs for insurance companies. A Pennsylvania study has estimated potential saving to be between 7% and 14% while a New York study suggests that potential savings might be approximately 5%. Where these reforms have passed constitutional muster, they appear to have played an important role in keeping the cost of medical liability

litigation at a more reasonable level, though not necessarily affecting the number of claims filed.

Tort reforms: a closer look

The single most popular tort reform measure, in terms of the number of states which have adopted it, is a shortening of the statute of limitations for filing medical liability claims; 41 states have modified their statutes of limitation for such cases in recent years. Other popular tort reforms include elimination of "ad damnum" clauses in complaints (statements which specify, sometimes in inflated terms, the amount of money sought in damages), approved in 32 states, and the institution of pretrial screening panels for medical liability claims in 30 states.

The tort reforms most vulnerable to invalidation on constitutional grounds have been those placing limits on liability and pretrial screening panels.

While approximately 20 different categories of tort reform measures have been enacted in the United States with wide variations within those categories—six of these reforms have been most strongly recommended and most widely adopted:

(1) Pretrial screening panels.

This reform was strongly recommended by the secretary of HEW's Malpractice Commission in 1973 as the primary method for speeding resolution of medical liability claims and eliminating non-meritorious suits. Many states adopted varying forms of the model system, which requires review of all medical liability claims by a panel composed of physicians, lawyers, and laypersons. The panel is not required to follow formal rules of evidence. After a pan-

el's decision is given, either party can proceed to a jury trial. Usually, a panel's conclusions can be introduced as evidence at trial.

A critical factor is whether review by the panel is mandatory or voluntary. Where it is mandatory, the plan may be declared an unconstitutional bar to free access to the courts or an impermissible limitation on the right to trial before a jury, as was the case in Missouri and Illinois. In Missouri, mandatory pretrial screening was struck down as an equal protection violation, since medical liability plaintiffs were required to go through a prerequisite before going to court not required of other tort plaintiffs.

Another important issue is whether the pretrial panel is considered to be "judicial" or not—that is, whether the panel's conclusions determine liability or whether they serve as a form of expert evidence that can be relied on later by a trial court. Illinois' pretrial panel plan was struck down as being an unconstitutional usurpation of judicial power because the panels rendered judgments on liability and damages. In Nebraska, the state supreme court said that state's screening system was constitutional since its role was merely to provide evidence to the trial court.

Where pretrial screening is voluntary, it is likely to pass constitutional muster—but according to a 1980 study by a George Washington University health policy group, voluntary panels must be mandatory to achieve the desired goal of speedy disposition of claims. The report of the Intergovernmental Health Policy Project said, "In the six states with voluntary screening panels they either have been under-utilized or are completely inactive." In Arkansas, the voluntary system is essentially inactive; in New Jersey, an under-utilized voluntary system was changed to a compulsory system, resulting in an almost

immediate drop in the number of liability claims filed.

Another potential problem with pretrial screening lies in its administration. While systems in some states work efficiently and quickly, other states' systems have resulted in long delays and other problems. In Florida, for example, a pretrial screening system was originally upheld by the state supreme court in 1976. Four years later, the same court struck down the panels as "arbitrary and capricious," and violative of due process rights because more than half of all cases did not get panel hearings before expiration of the statutory time limit. The screening statute was constitutional as written, but unconstitutional in the way it operated, the court declared.

Variations exist in both structure and operation of panels and these variations have determined the success or failure of the provision when it was challenged in many state courts. Pretrial panels were originally adopted in 30 states, and have been upheld by 10 state supreme courts, struck down by four, and repealed or permitted to expire by four state legislatures.

(2) **Collateral source rule.** This rule of evidence prevents a jury from learning that a plaintiff has been compensated from another source, such as health insurance or worker's compensation, for the injury. This rule often results in a windfall for plaintiffs with insurance, since they recover twice for the same injury: although in some cases the insurer has a right of subrogation against any judgment—that is, the right to get its money back. So far, 19 states have changed the collateral source rule in an effort to reduce this potential double recovery. The changes have been upheld in four states, struck down in three, and allowed to expire in one.

Two general kinds of changes have been made. The first, adopted

originally in nine states, eliminated the collateral source rule and gave either the judge or the jury discretion to consider a plaintiff's other sources of compensation in determining damages. The second kind of change, enacted in ten states, left the rule in place, but required a mandatory offset of the amount of other compensation against the award of damages. That is, the amount of any insurance benefits received by the successful claimant must be deducted from the judgment awarded by the jury.

The mandatory offset of collateral benefits against damage awards is considered by the Rand Corporation's Institute for Civil Justice to be one of the two tort reforms with the greatest impact on the size of awards (a ceiling or "cap" on awards is the other). The Institute reports that in states where a mandatory collateral offset is imposed, the severity of awards drops by 50%, on average, within two years' time.

A Kansas statute permitted evidence of insurance or other compensation, but not of "gratuitous" compensation, such as money from a family member. A federal court declared in 1981 that the distinction did not have a reasonable relationship to the law's stated purpose, and was therefore unconstitutional.

Collateral source rule changes have generally survived court tests, but how the changes are applied can cause problems.

(3) **Attorney fee regulation.** Some form of limitation or control of attorneys' fees has been adopted in 23 states, although these include a wide variety of approaches. The most common general approach is to require court review of proposed attorneys' fees in medical liability cases to determine whether they are "reasonable," but there are several variations within that category.

Several states provide that the lawyer in a medical liability suit must pa-

the winner's "reasonable" attorney fees and costs, if the loser did not appear to have a reasonable chance of winning. The theory is that the attorneys and plaintiffs will more carefully screen cases with such a provision in place.

The other general approach is to set fixed limits on the percentage of

an award that a successful attorney may claim as a fee. Most commonly a sliding scale ensures that as the amount of an award increases, the attorney's share of it decreases. For example, in Delaware, the claimant's attorney's fee may not exceed 35% of the first \$100,000, 25% of the next \$100,000, and 10% of the balance

over \$200,000. Four states place fixed ceilings on fees, declaring that any fee exceeding from 33% to 40% of an award is presumed unreasonable and not enforceable.

Generally, limitations on attorney fees have been upheld by the courts. Only in New Hampshire has attorney fee regulation itself been declared

Florida

Florida's tort reform experience has been tumultuous. The state legislature in the mid-1970s approved a broad range of medical liability reforms, including attorney fee regulations, changes in the collateral source rule, establishment of a patient compensation fund and medical screening panels, periodic payment provisions, and changes in statutes of limitations, among others.

Most of these provisions remain in effect, despite vigorous opposition from Florida's 2,600-member trial lawyers' organization both in the legislature and the courts. Existing and proposed liability reforms remain in constant jeopardy as the result of what some physicians term "open warfare" between the medical profession and trial lawyers.

In 1980, the Florida Supreme Court declared the state's pretrial screening panels to be unconstitutional, since they were "arbitrary and capricious" in their operation. Four years earlier, the same court had upheld the reform. However, since that time the panel system had become bogged down, and fewer than half of all medical liability claims received hearings before panels before expiration of a statutory 10-month deadline. Thus, the statute was

constitutional as written, but unconstitutional in its operation and effect, the court said.

A year later, the high court upheld the constitutionality of changes in the collateral source rule that mandated offsetting of any court-awarded damages by the amount of other compensation received by the successful plaintiff. The provision did not violate equal protection guarantees, the court said; the professional liability crisis affecting health care in the state justified the limitation.

A constitutional attack on the state's patient compensation fund in 1981 came from an unexpected source: 57 hospitals in the Miami area objected to a special \$10.7 million extra assessment against hospitals to pay claims against the fund. A lower court held the compensation fund unconstitutional—as an improper delegation of legislative power—in early 1983. But the state supreme court reversed in June, 1983, holding that the law setting up the fund provided the state insurance department with sufficient guidelines to carry out the legislature's intent. Even so, the PCF, overwhelmed by costly claims, has stopped writing new business.

After Florida's panel system was struck down, Florida's legislature passed a unique attorney fee law, requiring that in all medical liability cases, the loser, whether

plaintiff or defendant, must pay the winner's "reasonable" attorney's fees. (In some recent Florida cases, the fees ran into the millions.) Fees may not be assessed, however, against poor or insolvent parties. The measure is designed to encourage continual negotiation and reevaluation before trial of the merits of each case. The law has not been tested before the state supreme court.

Florida physicians attempted to bypass the legislature and place a general tort reform referendum on the ballot in 1984. The referendum could have required mandatory summary judgment (a decision by the judge on legal issues when no material facts were in dispute), abolished joint and several liability (when there are multiple defendants, each one can be liable for the entire amount if the other can't pay), and limited non-economic damages, such as pain and suffering and mental anguish, to \$100,000.

The referendum was challenged in court by Florida trial lawyers because, according to Florida law, a referendum may only raise one issue and the challenged referendum contained three. The Florida supreme court upheld this challenge on October 3, 1984. Florida physicians have not ruled out legislative proposals or another referendum attempt in 1986.

constitutionally invalid: the state supreme court ruled that the state's sliding-scale fee limit interfered with the freedom of contract between plaintiffs and lawyers, and unfairly made medical liability cases unattractive to lawyers.

Whether such limitations have had any effect on the number and severity of medical liability claims is problematic. Some experts suggest that limiting an attorney's percentage of a liability award only encourages plaintiffs' attorneys to seek even larger awards. Although the contingency fee system has been the subject of acrimonious criticism by physicians, the HEW Medical Malpractice Commission in 1973 found, and lawyers have argued, that the contingency fee arrangement operates as an effective screening device against groundless liability suits—since the lawyer who loses collects nothing. In its survey the Commission found that plaintiffs' lawyers believed that medical liability cases were the most difficult of all personal injury suits. The prospect of spending a great deal of time pursuing a suit that would ultimately be lost caused medical liability attorneys to reject 88% of all prospective plaintiffs. Since that study was done, however, physician-owned insurance companies have observed that plaintiffs' lawyers have become more proficient in developing and pressing professional liability cases.

Therefore, limiting attorneys' fees may not reduce the number or severity of suits; however, it may lead to a more equitable allocation of awards among plaintiffs and their attorneys.

(4) Statute of limitation changes. Statutes of limitation are fixed limits on the length of time following an injury that a person has to file a lawsuit. Every state has a statute of limitations applicable to all tort actions. Some states enacted laws shortening or clarifying these statutes for medical liability claims.

This provision is the most common tort reform, adopted in 40 states. In addition, 23 of these states have modified statutes of limitation claims by minors. Claims by minors have been cited by professional liability insurers as a serious problem in setting premium rates. The primary purpose of these statutes is to require that a claim be asserted when the pertinent evidence and witnesses are available. It is generally accepted that the specter of a lawsuit should not continue for an indefinite time. The shorter statute of limitations makes writing professional liability insurance policies more actuarially predictable.

At issue is the potential "long tail" on such claims. In the past, the time period started running once the patient actually discovered the injury; for minors, the statute started running once the child reached the age of majority. But in recent years, state legislatures began changing the laws to require that claims had to be brought, for example, within two years of the injury, or within two years of the point at which the injury should have been discovered with reasonable diligence. Other state laws require that an action must be filed within a specified number of years after the injury occurred or should have been discovered, but impose a maximum time period within which the action must be brought. For minors, the usual change is to start the regular statutory time after the child reaches a certain age. For example, when a state had adopted a two-year statute of limitations, the law might provide that if a child under the age of six incurs injuries, the child has until the eighth birthday to file suit.

In general, efforts to shorten the statute of limitations have withstood court scrutiny. However, in three states the courts have struck down special rules for minors, stating that the limitations for children arbitrarily

denied their right to seek redress for injuries. Further, even where statutes have not been declared unconstitutional, courts in many states have construed the statutes to mean that the "discovery rule" (when the statute only begins running after the patient has discovered the injury) still applies, either across the board or at least in regard to "foreign body" claims—such as when a sponge is left in the patient after surgery.

A change in the statute of limitations may limit the open-endedness of professional liability suits while still allowing claimants a right to redress for injuries.

(5) Limitations on liability. These limitations, adopted in 17 states, take two forms: one places a limit on certain kinds of damages and one places a fixed cap on a physician's liability. The former generally limits the amount a jury can award for "non-economic damages," which usually means a limit on damages for pain and suffering. No limit is placed on what can be awarded for actual monetary losses because of medical expenses or lost wages, nor are amounts available for punitive damages limited, though punitive damages are rare and awarded only where the defendant's conduct was grossly negligent or reckless. A common belief is that pain and suffering damages are the primary source of inflated awards, and these statutes attempt to control such awards by imposing a limit of, for example, \$250,000 in California.

The second kind of limit on liability involves a fixed cap on awards against physicians. These caps are usually tied to a patient compensation fund, under which amounts over the statutory cap—usually \$100,000 to \$300,000—are paid out of a state-operated fund in which all physicians may participate. A total of 10 states have both a patient compensation fund and a statutory limit on physician liability. Where there is

a patient compensation fund the cap on physician liability is not always absolute. For example, a physician (or physician's insurer) is liable up to the cap amount, \$200,000; the patient compensation fund is liable for any amount of a judgment which exceeds \$200,000 but does not exceed \$600,000. The remainder of an award larger than \$600,000 must be paid by the physician. A few states, however, such as Illinois and Indiana, place an absolute limit on physician liability; regardless of the circumstances, no award for medical liability may be greater than \$500,000.

A 1982 Rand Institute for Civil Justice report found that states with caps had an average drop of 19% in the severity of awards within two years of enactment. Liability limits generally have been extremely vulnerable to constitutional challenges. In the 17 states where liability limits were enacted, five state supreme courts have declared the limits to be invalid because they arbitrarily limited the rights of injured plaintiffs to recover for their injuries; Kentucky's provision was held to be part of an unconstitutional scheme.

Where caps on awards remain, they are still vulnerable to attack. For example, in Maryland, a governor's commission on medical liability rejected limits on liability as a solution to professional liability insurance cost problems; such limits were regarded as placing the burden of cost control on a small number of the most seriously injured plaintiffs.

Caps on awards may be one of the most effective tort reforms in reducing their size.

(6) Periodic payment of damages. Seventeen states have passed statutes which require or permit courts to award damage payments periodically, rather than in a lump sum. Under these statutes, courts specify that losing defendants must pay medical expenses as they

Indiana

Indiana's medical malpractice act was the first comprehensive medical liability tort reform package in the nation when it went into effect in 1975. The act established pretrial medical review panels, shortened the statute of limitations, limited physicians' liability to \$100,000 per claim, established a patient's compensation fund to pay the balance of awards over \$100,000 but not more than \$400,000, and limited attorney's fees to 15% of any award from the compensation fund. It did not include changes in the collateral source rule, in evidence or procedural law, or provision for periodic payment.

The act was held constitutional by the Indiana Supreme Court in 1980 in *Johnson v. St. Vincent Hospital*. The plaintiff had challenged several aspects of the act on equal protection grounds. The court agreed that the law's interference with trial by jury, right of recovery, and freedom of contract for medical liability plaintiffs was sufficient to trigger close scrutiny of the act's purposes and effects in relation to the state constitution.

It was unusual for such a strict test to be applied on behalf of medical liability plaintiffs. The stricter standard required that the separate treatment for medical in-

jury plaintiffs must be reasonable not arbitrary, and rest on some ground of difference having a fair and substantial relation to the object of the legislation, and all similarly situated persons must be treated alike.

The court ruled that the legislature's purpose, to prevent a loss of health care services in the state because of the crisis in insurance cost and availability, justified the law. The act's provisions were a reasonable and non-arbitrary manner of addressing the problem. The court dealt specifically with challenges to the attorney fee controls and medical review panels, finding each to be a valid and reasonable limitation on plaintiffs' rights.

Indiana's experience is widely regarded as a success story, since the act has worked well and all potential constitutional challenges to it seem to have been decisively dealt with in the *Johnson* case. Two constitutional challenges to the patient's compensation fund thus far have been rejected by state appellate courts. Although there has been some criticism that the fund system and review panels have produced larger awards than expected, insurance premiums in the state have remained moderate, despite a steady increase in the number of claims filed.

are incurred, rather than speculating on the total future costs and awarding a lump sum. Criticism of lump-sum awards has been that where a plaintiff dies earlier than predicted, the heirs may receive a windfall from the portion of the award based on future damages, or the plaintiff may squander funds needed for future expenses.

The biggest battle over periodic

payment legislation has occurred in California, where the state supreme court first declared the provision unconstitutional, and then a year later, in June, 1984, on rehearing the same case, declared the law valid. California law requires that compensation for future damages awards of \$50,000 or more is to be paid in periodic payments. Plaintiffs argued that the law was an un-

TORT REFORM PROVISIONS

	Alabama	Alaska	Arizona	Arkansas	California	Colorado	Connecticut	Delaware	Florida	Georgia	Hawaii	Idaho	Illinois	Indiana	Iowa	Kansas	Kentucky	Louisiana	Maine	Maryland	Massachusetts	Michigan
Ad Damnum	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	2	1	1	1
Arbitration	1	1			1					1			1					1	5			2
Attorney Fees			1		1	1		1	1		1	5		2	1	1					1	1
Awarding Costs						1			1				1			1						2
Collateral Source		1	2		1			1	2			5	1		2	1						
Expert Witness								1	1			2						1				1
Limits on Liability					1							5	3	2			4	1				
Patient Compensation Fund						6			2		1		1	2		1	3	2				
Periodic Payment	1	1		1	2			1	1				1			1				1		1
Pre-Trial Screening Panel		1	2	1			1	1	3		1	1	3	2		1		2	1	1	2	
Res Ipsa Loquitur		1			1			1	1				1									
Statute of Limitations	2		1		1	2		1	1	1	1		2	2	1	2	1	1	1	1	1	1
Special Statute of Limitations for Minors	2		1		1	1		1							2	1		1		1	1	
Standards of Care	1	2	1	1				1	1			1						1				1

EXPLANATION OF CHART

1. Provision exists
2. Provision found constitutional by highest state court
3. Provision found unconstitutional by highest state court
4. Provision not severable from an act found unconstitutional by highest state court, although provision not specifically reviewed by the court
5. Provision has been repealed or has sunset
6. Provision exists but not in effect

constitutional violation of equal protection and due process, thus an impermissible limitation on their right to redress for injuries. The NORCAL Mutual Insurance Company, a Northern California physician-owned insurance company, states that the periodic payment provision of the state's liability reform act has saved the company about \$2 million.

Therefore, periodic payment provisions may lessen professional

liability costs because insurers can fund them at a substantially lower cost than a lump sum payment and savings can be passed to providers in the form of lower professional liability premiums or at reduced rates that may translate into lower fees for the patient.

Other tort reform measures have focused primarily on the procedural or evidentiary structure of trials, with little noticeable effect. For example,

12 states have abolished the res ipsa loquitur doctrine, which permits a plaintiff to argue that under certain circumstances specific injuries are presumptively the result of negligence on the part of the physician or hospital; the defendant must prove that negligence did not occur. However, abolishment of this doctrine does not appear to have had a measurable impact on the number or severity of liability awards against

Minnesota	Mississippi	Missouri	Montana	Nebraska	Nevada	New Hampshire	New Jersey	New Mexico	New York	North Carolina	North Dakota	Ohio	Oklahoma	Oregon	Pennsylvania	Rhode Island	South Carolina	South Dakota	Tennessee	Texas	Utah	Vermont	Virginia	Washington	West Virginia	Wisconsin	Wyoming
1	1			1		4		1	1	1		1	1				1		1	1	1	1		1		1	1
				2		3	1		1			5	1		1	1	4	5		1			1	1		1	1
				1		4										1	5										
				2		3			1		3	1				3	1		1	1				1			
					1	3						2	1						1				1				
→				2		3		1			3	1		1			1	1		1			1			1	
				2				1		1	4				1	1		1								1	1
						3		1			4				1			1						1		2	
			3	2	2	5	1	2	1	1		5	2			3	5			5				1		2	
					1	4					3		1			1			1	1							
1	1	1	1	1	1	1	3		1	1	1	1	1	1	1		1	1	1	2	1	2			1	1	1
		1	1				3		1	1	1		3				5		1		3	1					1
					1	1	4				1	4		1	1					1			1	1	2		

This chart does not include all of the court rules that affect these provisions.

Data source: AMA Division of Legislative Activities, Department of State Legislation.

physicians. Similarly, changes in the requirements for approval of expert witnesses or in the standard of care required for physicians defending themselves against negligence actions have been approved in many states, but with little apparent effect.

Moreover, where these changes in evidentiary or procedural law are limited to cases involving medical liability, they are vulnerable to constitutional attacks. Such tort law

changes are widely regarded by the legal profession as "special interest" legislation that is not likely to survive. As University of Pennsylvania law professor Arnold J. Rosoff said in testimony to Congress in July, 1984, such "doctors' legislation" is one-sided and unfair, since it is intended "simply to make it harder for aggrieved patients to sue and recover for their injuries."

In general, the tort reform legisla-

tion of the middle and late 1970s has survived in some states but has been and remains vulnerable to attack in other states. Some laws are not likely to face constitutional tests for some years. In addition, trial lawyers are beginning to organize and mount aggressive attacks on some of the earlier reforms; already, 12 states have repealed or let expire some of the reforms of the previous decades, at least partly as a result of trial lawyers' lobbying.

Tort reform legislation that applies to all types of torts may be more likely to survive a constitutional challenge. However, the national awareness of the need to contain health care costs and the unique nature of medical services, such as reliance upon sophisticated new technology and the fact that every patient is different, makes a strong argument for reform that specifically applies to the medical profession.

New Hampshire

In 1977, the New Hampshire legislature approved one of the most comprehensive professional liability reform packages in the nation, including limits on liability, periodic payment provisions, attorney fee regulations, abolition of the collateral source rule, and changes in rules regarding statutes of limitation, expert witnesses, *ad damnum* clauses, *res ipsa loquitur*, and awarding of costs.

In 1980, the New Hampshire Supreme Court invalidated the entire act in *Carson v. Maurer*. The consolidated appeal challenged several sections of the act on equal protection grounds. The court determined that the right to sue and recover for injuries was not a "fundamental right" under the constitution, but was important enough that the same standard of review should be applied to the statute in question. That is, was the statutory classification (medical liability claims versus other kinds of cases) reasonable, not arbitrary, and actually based upon a difference having a "fair and substantial" relation to the purpose of the legislation? The court stated that law must be set up so that all similarly situated persons are treated equally. This standard was the one applied by the Indiana supreme court in the *St. Vincent* case.

The court then declared each challenged section of the statute to be unconstitutional. Attorney

fee limits, abolition of the collateral source rule, expert witness qualifications, limitations on non-economic damages, periodic payment of damages, and changes in the statute of limitations were all unconstitutional, primarily because they were unfair burdens on medical liability plaintiffs.

All other sections of the act were also declared invalid, despite the presence of a "severability clause." The court reasoned that the legislature had intended to create an entirely new and separate comprehensive system of recovery for medical liability claims. Therefore, the valid provisions of the act could not be separated from the invalid provisions, and the entire act was declared unconstitutional. Included in the provisions declared valid but struck down were abolition of the *ad damnum* clause, reforms in the standard of care rule, evidentiary changes, and provisions awarding costs to defendants in frivolous cases.

The effect of the decision was devastating. Fortunately for New Hampshire physicians, the state has not been a hotbed of liability lawsuits and juries are regarded as conservative. According to Jury Verdict Research, Inc., the state is one of only four (the others are Maine, Idaho, and South Dakota) that has not yet had a medical liability verdict of \$1 million or more.

TORT REFORM GLOSSARY

Ad damnum clauses - The *ad damnum* clause is that part of a plaintiff's initial pleadings which states the amount of monetary damages and other relief requested by the plaintiff in a court action. Most of the legislation on this subject provides for the elimination of the *ad damnum* clause altogether. Legislation also often provides that the defendant be apprised of the precise amount sought by the plaintiff through the normal course of pre-trial discovery.

Arbitration - Arbitration statutes relate to voluntary procedures whereby patients and health care providers may enter into written agreements for the submission of any medical liability claims to binding arbitration. This procedure is an alternative to and in lieu of trial by jury. This procedure provides for limited judicial review of the arbitration decision.

Medical liability claims can currently be arbitrated in at least 30 states under the general arbitration statutes in those states. The chart only lists those states with arbitration legislation specifically for medical liability claims.

Most of the medical liability arbitration statutes provide that written arbitration agreements may cover present and future medical injury claims. All of the statutes generally provide that a person's right to treatment shall not be prejudiced in any way by the decision whether or not to enter into an agreement for arbitration of medical liability claims. In other words, the agreement must truly be voluntary to be binding. Also, most statutes which permit arbitration agreements to cover future medical injury claims provide for a certain period of time, either following execution of the contract or provision of the services, in which the patient may reject the arbitration agreement.

Attorney fee regulation - The most common arrangement for payment of plaintiff attorney fees in medical liability cases is the "contingent fee." Under this type of arrangement the attorney receives as his fee an agreed upon percentage (commonly 30% to 50%) of any final award or settlement made to the plaintiff.

Legislation enacted during the last few years regulating attorney fees in medical liability cases has taken several different approaches: a sliding scale for the plaintiff attorney fees in terms of a percentage of the award; court review of the proposed fees or approval of what it considers to be a "reasonable fee"; or limiting attorneys' fees to a certain percentage of the amounts recovered by the plaintiff.

Awarding costs, expenses and fees. - A few states have provisions designed to deter the pursuit of frivolous medical injury claims. These statutes generally provide that where one party to the action has been found to have acted frivolously in bringing the suit, the party may be found liable for payment of the other party's reasonable attorney and expert witness fees and court costs. These provisions differ from the usual civil trial situation in which payment for attorney fees and expert witness fees are normally paid by the party who incurs them.

Collateral source provisions. - The collateral source rule is a rule of evidence that prohibits the introduction into evidence at trial of any indication that a patient has been compensated or reimbursed for the injury from any source other than the defendant.

Legislation modifying the collateral source rule has taken several approaches: permitting consideration of compensation or payments received from some or all collateral sources; requiring the mandatory offset against any award in the amount of some or all collateral source payments received by the plaintiff; or allowing the defendant to introduce evidence of the plaintiff's compensation from collateral sources. The jury is instructed to make a mandatory reduction of the award for economic loss by a sum equal to the difference between the total benefits received and the total amount paid by the plaintiff to secure such benefits.

Expert witness. - Expert witnesses are required to explain many of the complex and difficult issues in a medical negligence case. Legislation affects the qualifications and use of expert witnesses.

Limits on liability. - Some states have enacted legislation that limits the liability of defendants in medical liability lawsuits. These statutes limit liability in one of several ways: limiting recovery of a particular type of damages; placing an absolute cap on the amount of damages recoverable; or placing an absolute cap on physician liability under a patient compensation fund.

Patient compensation fund. - A patient compensation fund is a governmentally operated mechanism established to pay that portion of any judgment or settlement against a health care provider in excess of a statutorily designated amount. A fund may pay the remainder of the award or it may have a statutory maximum (e.g. one million dollars).

Patient compensation funds are generally funded through an annual surcharge assessed against health care providers, with such surcharge often being a specified percentage of the provider's annual insurance premium. Patient compensation funds are also known as "excess recovery funds."

Periodic payments. - In most states, unless otherwise agreed on by the parties or mandated by the court, judgments can only be lump-sum awards. Under a periodic payments system, the payments are made over the actual lifetime of the plaintiff or for the actual period of disability.

Pre-trial screening panels. - Pre-trial screening panels are prerequisites to trial. Procedures for panels usually require a mandatory pre-trial hearing to be conducted by a panel comprised of members as mandated by statute. In some states the pre-trial hearing is voluntary. The composition of the panel and its scope of inquiry vary greatly from state to state.

All statutes establishing pre-trial screening procedures provide that the panel's decision is not binding on the parties and that it does not preclude a plaintiff from initiating a lawsuit. Although some states permit the decision of the panel to be introduced into evidence in a subsequent lawsuit, the panel's decision is not binding upon a judge or jury.

Res ipsa loquitur. - *Res ipsa loquitur* ("the thing speaks for itself") is a common law doctrine which applies when a plaintiff can demonstrate that the injury occurred while the instrumentality causing the injury was under the exclusive control of the defendant and which, if operated in a non-negligent fashion, does not normally cause injury. In recent years, a number of state courts have expanded the application of *res ipsa loquitur*, and increased the effect of its applicability from that of a mere inference to that of a presumption, which if not rebutted, will allow the jury to reach no finding other than liability.

Legislation enacted in several states has codified the doctrine in regard to medical liability cases by delineating those circumstances when the doctrine may be applied, such as when a foreign object has been left in a body or the patient has suffered radiation burns. However, these statutes have sought to make it clear that the mere fact of injury is not sufficient to invoke the doctrine.

Standard of care. - The standard of care in a medical negligence action is that level of care to which a health care provider is held accountable to a patient, and is based upon the prevailing level of care practiced within locality (community, state, or national).

Statute of limitations. - A statute of limitations is a law that bars a cause of action after the expiration of a specified time period. In many states the statute of limitations for medical liability actions begins to run only upon discovery of the injury. Injuries may be discovered several years after the treatment was provided, so the time period for filing an action may be uncertain. Some states have sought to eliminate the "long tail" by placing an absolute maximum time period within which medical liability suits may be brought. An exception to the time period is provided in some of these statutes where foreign objects are left in the body, or where the health care provider has fraudulently concealed the fact of injury.

Most state statutes of limitations provide that if an injury is incurred by a minor, the statute is tolled (i.e., stops running) on the minor's cause of action until he reaches the age of majority. Changes in the statute of limitations for a minor's actions usually provide that the statute will begin running prior to the age of majority.

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1984 Report on physician/owned medical society created liability insurance companies

Company	Insureds	Limits	Coverage	Premium range	Average premium
Alabama	2,850	\$1M/1M; 5M/5M	CM* O	\$1,159-13,555/466-3,080 1,237-14,729	\$ 4,900
Arizona	3,010	1M/1M; 5M/5M	CM*	3,064-22,252/1,308-8,328	8,500
MIEC, CA	2,900	1M/3M	CM*	4,996-31,848/994-6,294	6,500
NORCAL, CA	5,800	1M/3M; 2M/4M	CM*	2,604-28,520/872-7,116	NA
SCPIE, CA	7,331	1M/3M; 5M/5M	CM*	3,404-29,184/1,288-10,496	6,700
Colorado	2,200	1M/1M; 5M/5M	O	1,200-14,000	5,000
D.C.	1,100	1M/3M; 10M/10M	CM*/O	1,563-26,185/513-11,385/ 1,666-26,382	7,300
Florida	4,360	500/1M; 1.5M	CM*	4,363-42,348/781-7,582	7,700
Georgia	2,400	1M/1M; 5M/5M	CM*	1,147-25,307/380-9,895	5,800
Illinois	7,986	1M/3M; 5M/5M	O	3,944-42,700	9,400
Indiana	430	100/300	O	630-5,048	1,200
Kentucky	1,723	1M/1M; 5.2M/5.6M	CM*/O	1,592-12,196/533-3,631/ 1,691-12,982	3,300
Louisiana	2,000	1M/1M; 5M/5M	O	1,841-15,284	4,500
Maine	895	1M/3M; 5M/7M	CM*	2,858-25,305/752-6,659	5,600
Maryland	2,900	1M/3M; 5M/7M	CM*/O	656-12,400/200-6,200 1,562-19,690	6,000
Michigan	4,585	1M/1M	O	3,935-44,669	5,100
Minnesota	2,203	1M/3M; 4M/7M	CM*	939-13,688/311-4,013	4,700
Mississippi	2,050	1M/1M; 5M/5M	CM*/O	1,501-17,011/461-5,222/ 2,011-22,795	5,000
Missouri	1,254	1M/2M; 2M/3M	O	2,153-21,535	4,291
New Jersey	6,850	1M/3M; 5M/7M	O	3,373-24,272	6,700
New Mexico	1,500	100/300	O	956-6,197	3,250
New York	15,830	1M/3M	O	4,541-63,311	12,500
N. Carolina	3,805	1M/1M; 5M/5M	CM*	1,600-17,129/556-7,330	2,600
Ohio	4,541	1.1M/1.3M 5M excess	O	2,047-17,944	4,080
Oklahoma	3,603	1M/1M; 5M/5M	O	922-5,234	2,903
Pennsylvania	6,200	200/600	CM*/O	2,304-19,351/648-5,443/ 2,400-20,158	4,700
Tennessee	4,830	1M/3M; 10M/12M	CM*	1,933-16,436/649-4,456	4,740
Texas	3,200	1M/2M; 2M/3M	O	1,200-16,500	4,000
Utah	1,325	1M/3M; 5M/7M	O	910-13,674	3,600
Washington	1,803	1M/3M; 5M/7M	RO**	1st 891-7,148 2nd 2,005-16,083 3rd 2,785-22,339	2,800

CM—Claims Made O—Occurrence
 *First year claims made range
 **Report occurrence

Premium range based on \$1 million coverage except when maximum available is less. Maximum limits available are indicated also. Average premiums are estimated. Financial data based on 1983 year end statements.

Data source: AMACO

Alaska State Legislature

Advisory Council Members
Senator Bennett, Chairman
Senator Kerttula
Senator Abood
Senator Sackett



Pouch V
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Phone: (907) 465-3114

SENATE ADVISORY COUNCIL

MEMORANDUM

TO: Senator Fred Zharoff
FROM: Rob Nauheim, Researcher
DATE: March 1, 1985 *Rcn*
RE: Medical Malpractice Awards Cap, Other Alternatives

You have requested that the Senate Advisory Council research the feasibility of a statute which would place a cap on the amount of a monetary award in medical malpractice cases. You also indicated that you are interested in other potential alternatives to an awards cap statute which might help to solve some of the problems to which the article in the Bristol Bay Times, January 15, 1985, alluded.

Since the problem of increasing medical malpractice insurance rates and the associated costs born by the health care provider and ultimately the patient, is a complicated financial and legal problem, an in-depth report has not been prepared. In the interest of providing a prompt response to your request, an interim report has been prepared which should serve to touch upon the most important aspects of this matter.

In order to provide a more meaningful response to your request, it seems appropriate to outline the major components of the medical malpractice insurance crisis. In this manner, potential solutions can be better evaluated in terms of their effectiveness.

During the early and mid 1970s, medical malpractice insurance rates increased dramatically. As a result, many physicians found that they could not afford malpractice insurance or they simply chose not to purchase it. In addition, many insurance companies terminated their malpractice insurance operations because of uncertain risk and potential future losses. Not only did malpractice insurance become more expensive, it also occasionally became unavailable.

While the direct cause of rate increases and insurance unavailability was related to an ever increasing number of malpractice claims and higher awards, an evolution of basic social and legal thought has provided the impetus. In addressing the Alaska Bodily Injury Reparations Advisory Committee in 1979 (BIRAC), Professor William Cohen of Stanford University asserted,

"Twentieth Century law has moved steadily in the direction of modifying or eliminating the limitations upon the defendant's liability -- eliminating immunities and defenses, establishing full duties of care, lowering standards of proof, and allowing juries more latitude for decision."

Other more specific causes include 1) the changing doctor-patient relationship, 2) the legal rights explosion, 3) the impact of the media, 4) the increased proficiency of trial lawyers, and 5) the belief that insurance companies have an unlimited source of funds (Keene 1976).

By 1975 and 1976, many state legislatures were addressing the difficult problems posed by skyrocketing insurance rates and the resultant prospect of increasing medical costs born by the patient. In an effort to reduce the costs of medical malpractice insurance, a variety of measures were passed in state legislatures. The following list identifies some of the kinds of statutory approaches which were adopted in the mid and late 1970s.

Elimination of "Ad Damnum" Clauses

This kind of legislation eliminates the "ad damnum" inclusion of dollar amounts in malpractice suits. The amount of award is determined by the jury and cannot be specified in the suit.

Limits on Attorneys' Fees

Various approaches have been used which limit a portion of the incentive to obtain large settlements by reducing the contingency fee percentage of attorneys as the amount of the award increases.

Liability Limits

- a) limits on the liability of the physician or insurer
- b) limits on the amount of an award for noneconomic loss
- c) limits on the total amount recoverable for any injury or death

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Compensation Funds

Some states have established patient compensation funds in order to supplement awards to successful plaintiffs when the award exceeds the statutory maximum liability of the defendant or of the defendant's insurer.

Elimination of "No Collateral Source" Rules

This kind of statute requires the reduction of award by an amount equal to the amount of certain insurance benefits received by the plaintiff.

Counterclaims Against Frivolous Cases

The assignment of court costs to unsuccessful plaintiffs, punitive damages to plaintiffs/attorneys whose case is determined to have no action and is frivolously filed, is a method of reducing the number of court cases.

Arbitration

These are provisions which call for mandatory or voluntary binding arbitration in order to reduce court costs and the time spent in litigation.

Pre-Trial Screening Panels

Statutes of this type require the use of expert panels which determine if a case has merit and should proceed to trial.

Statutes of Limitation

Statutes of limitation usually limit the period of time after the discovery of the alleged act of malpractice in which cases would be heard.

In Alaska, where insurance availability was perhaps a more serious problem than the escalating costs of premiums, the Medical Indemnity Corporation of Alaska was established by an act of the state legislature in 1976 in order to provide health-care providers with adequate insurance against liability for medical negligence. The act also calls for the use of a pre-trial expert advisory panel in order to review the merits of the case. Additional provisions prohibit "ad damnum" clauses, allow for the reduction of an award by the amount equal to certain insurance benefits received by the plaintiff, and outline conditions by which arbitration might proceed (A.S.09.55.530-560).

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Since it is apparent that the problems associated with malpractice insurance have again become acute, it seems reasonable to suggest that the remedies as provided in legislation heretofore have not been sufficient.

According to John George, Director of the Division of Insurance, Department of Commerce and Economic Development, there are four reasons for the current high rates for medical malpractice insurance in Alaska.

1. The number of malpractice awards has increased substantially in recent years.
2. The dollar amount of individual awards is up.
3. The investment climate which insurance companies enjoyed in the late 1970s and early 1980s has changed. During this period of time, insurance company losses which outstripped revenue from premium payments could be partially offset by high earnings on reserves. Since interest rates are now significantly lower than in the late 1970s and early 1980s, earnings on reserves are much lower.
4. Insurance companies are finding it increasingly difficult to make realistic projections of actuarial risk. Some companies are leaving the market. Recently, the Medical Indemnity Corporation of Alaska (MICA) has had difficulty in securing adequate reinsurers. Reinsuring is a method by which insurance companies spread the risk of loss.

The net result of the above factors and other less important factors is that malpractice insurance rates are up substantially. The insurance premium increase for 1985 is approximately 90% for physicians as a group (MICA).

AWARDS CAPS

In a report from the Governor's Medical Malpractice Insurance Commission, 1975, the Commission rejected arbitrary limits on awards. The rationale can be summarized by the following:

1. The amount of potential reduction of an insurance company's exposure to loss is speculative at best.
2. There was concern that arbitrary limits might serve as a minimum target for potential recovery rather than a maximum.
3. The Commission recognized that certain cases involving serious injury might not be adequately compensated.

The feasibility of legislation which would have the effect of establishing a maximum allowable award is complicated by the constitutional questions involved. The constitutional issues raised in cases wherein a state's award cap statute has been challenged usually relate to 1) equal protection and 2) due process arguments. According to Richards (1982), at least eight of the eleven states which, at that time, had statutes limiting the total amount of damages recoverable in malpractice suits, had been challenged on constitutional grounds. While it appears that the courts have failed to reach a consensus on the matter, the benefit of reduced actuarial risk has not been achieved because of the prospect of unfavorable rulings in the future.

Nevertheless, some states have passed legislation which placed a cap on malpractice awards. Indiana has a statute which limits the total amount of damages recoverable for any injury or death of a patient to \$500,000. The statute also limits the liability of the health care provider to \$100,000 (I.C. 16-9.5-2-2). The constitutionality of this statute was upheld in 1979 and 1980. However, other states have seen their awards cap legislation struck down.

In the BIRAC report to the Governor in 1979, the committee failed to approve any recommendation regarding liability limits or awards caps. However, Arnt Van Hippel, M.D., and Michael Armstrong, M.D., stated in a minority report on professional malpractice of the BIRAC report,

"There seems little merit or justice in any protocol that values death or injury differently depending on the offending agent (airplane or scalpel) or on the popularity or wealth of the party found liable. It seems evident that there must be a recovery limit for death/personal injury from any cause beyond which additional recovery or even unfulfilled liability becomes socially counterproductive due to the rising expectations and legal costs."

A view which contrasts that of many doctors is perhaps best summarized by the past president of the Association of Trial Lawyers, Robert E. Cartwright (1976).

"We have felt that if one person wrongs another that he should have to pay, regardless of whether he is a doctor, lawyer, engineer or private citizen. The reason for this is twofold:

1. The victim who is injured by the wrongful actions of another should be entitled to recover the full amount of his damages, and,

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2. There is a strong therapeutic and prophylactic effect in holding wrongdoers responsible for their actions--the so-called deterrent effect of tort law."

Thus, the problem seems to be associated with certain incompatibilities of the insurance and tort law systems. The feasibility of any statute which would place a cap on the amount of damages recoverable in a malpractice suit seems to be predicated upon a clear consensus from the courts which weighs the rights of the individual to recover damages against the externalization of the costs of recovery on society as a whole.

At this time, our office is awaiting the arrival of information pertaining to the current status of awards cap statutes from other states. In addition, I will compare the malpractice rates of those states which have withstood constitutional challenges with rates from states where no such statute exists. Though there may not necessarily be a statistically meaningful cause-effect relationship, some comparison might help to identify differences in successful approaches. We will continue to build a resource file on this subject and I will send you additional background material as it comes in.

If you should have any questions regarding this matter, please do not hesitate to call.

RN/rcn
enclosures:

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LIMITS ON LIABILITY

Some states have enacted legislation which functions as a limit on physician liability in medical injury lawsuits. These statutes may limit liability by: 1) limiting recovery of a particular type of damages; 2) placing an absolute cap on the amount of damages recoverable; or 3) placing an absolute cap on physician liability under a patient compensation fund. In some instances two types of limits on liability may be present. For example, New Mexico law places a limit on all damages except punitive damages and medical care, and also limits physicians' personal liability under the patient compensation fund. Nebraska and Indiana limit physician liability and place an absolute cap on the amount of damages which may be recovered.

Statutes which limit recovery of a particular type of damages most often limit recovery of noneconomic or general damages while permitting unlimited recovery for damages related to medical care. The California statute provides that in no action for injury against a health care provider, based on professional negligence, shall the amount of damages for noneconomic losses exceed \$250,000. South Dakota law provides that the total general damages which may be awarded shall not exceed the sum of \$500,000 but, "no limitation is placed on the amount of special damages which may be awarded." In Texas, the limit on civil liability for damages of a physician or health care provider is an amount not to exceed \$500,000, however, this limit does not apply to damages awarded on a health care liability claim for the expenses of necessary medical, hospital and custodial care received before judgment or required in the future for treatment of the injury.

A few states place an absolute limit on the amount of damages recoverable. This absolute limit may be found in connection with a patient compensation fund, as mentioned above in Indiana and Nebraska, or as a "stand alone" provision as found in Virginia. The Virginia provision states that in any verdict returned against a health care provider in an action for professional negligence, the total amount recoverable for any injury to or death of a patient shall not exceed one million dollars. Illinois and Idaho had similar provisions for absolute limits on recovery, although the statutory maximums were less than Virginia's cap on awards.

The liability of a physician also may be limited under a patient compensation fund. Wisconsin law provides that if a health care provider has met the requirements of the state patient compensation fund, then the health care provider is liable for medical negligence for no more than \$200,000 per claim and \$600,000 per year or the maximum limit for which the provider is insured, whichever is higher. Oregon's patient compensation fund statute provides that the liability of a physician arising out of a claim for damages due to professional negligence shall be limited to any sum payable under the terms of the physician's professional liability insurance policy and the fund.

Note that some patient compensation fund statutes set a maximum on fund liability. In states with such fund maximums, the health care provider remains liable for any portion of a judgment or settlement above the fund maximum, unless there also is an overall cap on awards corresponding with the fund maximum or a limit on physician liability.

States which have enacted some form of limitation on liability in medical injury actions are:

- | | |
|-------------------------|--------------------|
| 1. California | 10. North Dakota* |
| 2. Idaho* (sunset 6/81) | 11. Ohio |
| 3. Illinois* | 12. Oregon |
| 4. Indiana* | 13. South Carolina |
| 5. Kentucky* | 14. South Dakota |
| 6. Louisiana | 15. Texas |
| 7. Nebraska* | 16. Virginia |
| 8. New Hampshire* | 17. Wisconsin |
| 9. New Mexico | |

Court Decisions: Limits on Liability

Idaho

In Jones v. State Board of Medicine, an Idaho trial court found unconstitutional the state's Hospital-Medical Liability Act using a reasonable relationship standard of review. The act included a provision which set a ceiling on recoverable damages for actions against physicians and hospitals of \$150,000 per claim and \$300,000 per occurrence. On appeal, the Idaho Supreme Court stated that for purposes of an equal protection claim, the standard of review should be a "means-focus" or "means scrutiny" test. Under this intermediate standard of review, in order for a statute to be found constitutional, it must be shown that the legislative means used substantially further some specifically identifiable legislative end. The supreme court stated that it was unable to substantively rule on the case based on the facts before it. The case was remanded to the trial court with directions to apply the "means scrutiny" test. On remand, the trial court found that the limits on recovery did not substantially affect the availability of a liability market for physicians and hospitals at reasonable expense or the continued availability of health care facilities. As a result, the trial court held that the legislation did not meet the means scrutiny equal protection test and so was unconstitutional. [555 P.2d 399 (Idaho 1976); Case No. 55527, No. 55586 Fourth Judicial District]

Illinois

In Wright v. Central Du Page Hospital Association, a decision striking down several parts of the Illinois medical liability law, the Illinois Supreme Court held that the provision limiting recovery in medical injury actions to \$500,000 was arbitrary and constituted a special law in violation of the state constitution. The court noted that other statutes, such as the state dramshop act, limit recovery where

there originally had not been a common law cause of action for damages. The court also distinguished the medical injury limit on awards from the state workers' compensation act, stating that the workers' compensation act provides a quid pro quo in that the employer assumes a new liability without fault but is relieved of the prospect of a large damage judgment while the employee, whose monetary recovery is limited, is awarded compensation without regard to the employer's negligence. The court found that the medical liability limit on recovery abolished no common law defenses, nor did it purport either to alter the essential elements of a cause of action for medical injury or lessen the burden of proof. Furthermore, the very seriously injured patient might be unable to recover all the medical expenses incurred because of the recovery limitation, in which event he would recover nothing for any other loss suffered. The court stated that although it did not find or even imply that under no circumstances may the legislature abolish a common law cause of action without a concomitant quid pro quo, the court had consistently held that to the extent that recovery is permitted or denied on an arbitrary basis, a special privilege had been granted in violation of the state constitution. [347 N.E.2d 736 (Ill. 1976)]

Indiana

In Johnson v. St. Vincent Hospital, the Supreme Court of Indiana addressed the constitutionality of the Indiana Medical Malpractice Act. The court stated that in considering the constitutional challenges, the act was to be accorded every reasonable presumption supporting its validity and the burden was on the party challenging it to show unconstitutionality. Before the court would declare a statute repugnant to the federal and state constitutions, any fatal constitutional defects had to be clearly apparent. The court held that the Indiana Medical Malpractice Act did not violate the federal and state constitutions.

The court reviewed a provision of the act which limits total recovery of a patient to \$500,000 and limits the liability of any health care provider to \$100,000. The limit on total recovery was challenged as violative of the due process and equal protection guarantees of the fourteenth amendment of the federal constitution.

In reviewing the claim of unconstitutionality under the due process clause, the court found that the limitation on recovery was a natural consequent of the establishment of an insurance type program (the state patient compensation fund). The limitation, the court stated, provides a factor for calculating premiums and charges to the insured so that the insurance operation remains sound and the funds collected are sufficient to meet the obligations incurred. The court also stated that it must be accepted that the badly injured plaintiff who may require constant care will not recover full damages. It was impressed, however, with the large amount which is recoverable and the probability of fully compensating a large proportion of injured patients. The court noted that the badly injured patients would have little or no chance of recovering large sums of money if an environment developed in Indiana in which private or public liability insurance were unavailable or unused -- a development the act was intended to prevent. The court also attributed some relevance to the fact that after suit and recovery against a health care

provider is completed, there continues to be a lifetime dependency upon other health care providers for treatment of illness due to the prior negligence, as well as for new and unrelated illnesses. Thus, to the extent that the limitation on recovery is successful in preserving the availability of health care services, it does so to the benefit of the entire community, including the badly injured plaintiff. Also, there was evidence in the record that the act with its limit on recovery was achieving its intended goal. As a result, the court held that the limit on patient recoveries was not arbitrary or irrational, but rather furthers the public purpose of the act in a manner consistent with due process of law guaranteed by the state and federal constitutions.

The limit on recoveries was also challenged on equal protection grounds. The court found that while the statute does impose a special burden on those persons with medical injury damages in excess of \$500,000, the statute was consistent with the provisions of the state constitution which prohibit special privilege legislation and consistent with the equal protection guarantees of the fourteenth amendment.

The standard of review used for equal protection analysis was that the classification not be arbitrary or unreasonable and that a "fair and substantial relationship exist between the classification and the purpose of the legislation creating it." The court found that there was good reason to believe that the interests of patients in ultimately transforming valid claims into money is furthered by the availability to the health care industry of some risk spreading mechanism at reasonable cost. Evidence was presented for constitutional purposes that part of the private insurance industry had ceased to make professional liability insurance available to some health care providers in the state. The court found that curtailment very important as a reality that the legislature was responding to in creating the state patient compensation fund. The court found that the legislature reasonably could have considered a set limitation upon recoveries to be an essential part of any operable plan to spread the risk of loss to participating health care providers and to regulate the cost to them, and thereby meet the danger it perceived to the public welfare. The classifications of health care providers and injured patients were held to be composite parts of the limitation itself and likewise justified.

The Indiana court distinguished its decision from the Illinois Supreme Court decision in Wright v. Central Du Page Hospital Association, stating that unlike that court, the Indiana court found a rational justification for the difference in treatment accorded various groups within the rationality of the legislative program to protect vital societal interests. [404 N.E.2d 585 (Ind. 1980)]

Kentucky

In McGuffey v. Hall, the Kentucky Supreme Court reviewed the constitutionality of several provisions of the act establishing the Kentucky Patients' Compensation Fund. The act created the fund as an agency within the state department of insurance and provided: that every physician and hospital be a member of the fund; that every member of the fund carry professional liability insurance with minimum coverage of \$100,000 per occurrence and \$300,000 annual aggregate (or must be

similarly self-insured); that each member of the fund pay an annual assessment; that financial resources of the fund were to be used for payment of judgments and settlements in excess of the basic insurance coverage; and that a claimant could collect from the fund that portion of a judgment or settlement which exceeded \$100,000 and if the fund became exhausted, such claims were to be paid out of the general fund of the Commonwealth. Moneys drawn from the general fund were to be repaid with interest by the fund at the earliest practicable time. The court found that the provision regarding recourse to the state general fund violated that state constitution's prohibition against commitment of future general revenues without a vote of the people and the state constitution's prohibition against the state loaning or giving its credit to any person or corporation for any purpose. The court also held that the provision for compulsory professional liability insurance was not shown to be a justified exercise of police power and so was in violation of the state constitution. The court found that those provisions held unconstitutional were so essential to the patient compensation fund statute that the remaining sections of that statute, including the limit on physician liability, could not stand without them. As a result, the patient compensation fund statute was held invalid in its entirety. [537 S.W.2d 401 (Ky. 1977)]

Nebraska

In Prendergast v. Nelson, the Nebraska Supreme Court considered and upheld the constitutionality of the state Hospital-Medical Liability Act. The act includes provision for the establishment of the Excess Liability Fund (patient compensation fund) under which physician liability is limited to \$100,000 per occurrence and \$300,000 annual aggregate liability. The act also places a \$500,000 overall limit on recovery (one million dollar limit after 12/31/84). The court held that the legislature, consistent with the dictates of the state and federal constitutions, may pass a law which seeks to distinguish between different types of tort actions. The legislature's ability to do this is conditioned upon the distinctions being reasonable and grounded upon real differences inherent in those tort actions.

The ceiling on judgments was challenged as a special privilege for health care providers and an undue restriction on the seriously injured patient. The court indicated that it must be remembered that the Excess Liability Fund procedure is an elective one, (a patient may elect not to come under the terms of the Hospital-Medical Liability Act prior to treatment). It went on to note that under an election, the act guarantees the prevailing claimant an assured fund of \$500,000 for the payment of any medical injury claim, while under the common law remedy a claimant has no such guarantee. If a health care provider had been unable to acquire medical liability insurance, the likelihood of collecting a substantial judgment would be quite remote. The court also noted that under the act, the claimant is assured of a procedure which will provide him access to an impartial medical review panel to determine whether the health care provider met the applicable standard of care and in return the claimant by his election agrees to the \$500,000 ceiling.

The court held that there was no merit to the argument that if a common law right is taken away something must be given in return. Nevertheless, the act was found to provide quid pro quo in that the claimant receives assurance of collectibility and the benefit of the opinion of a panel of experts.

The court also found that the classifications under the act rest on public policy reasons and a substantial difference between medical care providers and other tortfeasors. The court would only find constitutional safeguards had been offended if the classification rested on grounds wholly irrelevant to the achievement of the state's objective. The legislature is presumed to have acted within its constitutional power despite the fact that in practice its laws may result in some inequality. The court stated that it would not set aside a statutory discrimination if any facts reasonably existed to justify it. The court held that a legitimate legislative objective was being furthered by the act and the classification was proper. The court found of paramount importance the fact that the enactment was, and appeared to the court to be, in the public interest. [256 N.W.2d 657 (Neb. 1977)]

New Hampshire

In Carson v. Maurer, several aspects of the New Hampshire medical liability statute were challenged. The state supreme court in Carson found that the right to recover for personal injuries is not a "fundamental right" but is nevertheless an important substantive right. It concluded that the rights involved were sufficiently important to require that the restrictions imposed on those rights be subjected to a more rigorous judicial scrutiny than allowed under the rational basis test. The court applied the "substantial relationship" test in reviewing the statute, i.e., the statutory classifications must be reasonable, not arbitrary and must rest upon some ground of difference having a "fair and substantial" relation to the object of the legislation in order to satisfy state equal protection guarantees. (The U.S. Supreme Court has restricted use of the "substantial relationship test" in federal constitutional cases to classifications based upon gender and illegitimacy.)

The provision limiting liability in the New Hampshire statute provided that "compensation for noneconomic losses shall in no event exceed the sum of \$250,000." The court noted that the purpose of this section was to stabilize insurance risks and reduce medical liability insurance rates by providing that insurers would not have to pay out damages for "pain and suffering" in excess of the stated amount. The plaintiffs in Carson challenged this provision as a denial of equal protection of law, in that it created an arbitrary damage limitation and thereby precluded only the most seriously injured from receiving full compensation for their injuries. The court agreed with plaintiffs' argument, finding that the necessary relationship between the legislative goal of rate reduction and the means chosen to attain that goal was weak because paid-out damage awards constitute only a small part of total insurance premium costs and because all individuals suffer noneconomic damages in excess of \$250,000.

The court also found that the limit on recovery distinguishes not only between medical injury claimants and other tort claimants but also between medically injured claimants with noneconomic losses which exceed \$250,000 and those with less egregious noneconomic losses. It held that it was unfair and unreasonable to impose the burden of supporting the medical care industry solely upon those persons who are most severely injured and therefore most in need of compensation. The limit on noneconomic damages was found to deny medical liability plaintiffs the equal protection of law guaranteed by the state constitution. [424 A.2d 825 (N.H. 1980)]

North Dakota

The North Dakota Supreme Court found that state's Medical Malpractice Act unconstitutional in Arneson v. Olson. The court, in considering the constitutionality of provisions of the act, applied a test similar to the substantive due process standard of scrutiny. This test requires that there be a "close correspondence between the statutory classification and the legislative goals"; this is a stricter standard of scrutiny than the rational basis test. In examining the act, the court noted that although there need not always be a quid pro quo when a right is limited or withdrawn, any limitation or elimination of a preexisting right may not be arbitrarily imposed.

The act provided that, in conjunction with the Patient Trust Fund (patient compensation fund), a health care provider's liability for all claims of professional negligence was limited to \$300,000 from any one occurrence; \$100,000 to be paid by the health care provider's personal insurance, the remainder of damages to be paid by the fund. The court reviewed the limit on recovery to determine whether the limit was arbitrary and unreasonable and violative of due process, or whether there was a sufficiently close correspondence between statutory classification and legislative goals so as not to violate the equal protection requirements of the state and federal constitutions. The court found that the limit on recovery did not promote the stated legislative purposes of assurance of availability of medical services at reasonable cost, elimination of nonmeritorious claims, and encouragement of physicians to enter into and remain in practice in the state. In addition, the court found no evidence of an availability or cost crisis in the state. As a result, the court held "the drastic limitation on recovery to be a violation of the equal protection clause of the state constitution and the fourteenth amendment of the federal constitution."

The court went on to hold that although some of the provisions of the act individually would not violate due process, the cumulative effect was to violate the right of medical patients in the state to due process of law. It found that the act was arbitrary, unreasonable and discriminatory, and that the methods adopted had no reasonable relation to the attainment of the results desired. As a result, the court found the entire act unconstitutional because the provisions were so connected and dependent upon each other that it could not be presumed that the legislature would have enacted the valid sections without the unconstitutional sections. [270 N.W.2d 125 (N.D. 1978)]

* See Concluding

FEB 22 1985

Statutes Limiting Medical Malpractice Damages

J. KENT RICHARDS*

I.

INTRODUCTION

In some states, the amount of damages recoverable by victims of medical malpractice is limited by statute. These statutes were enacted in the middle 1970s in response to a crisis in the availability and cost of medical malpractice insurance. The crisis, headlined by skyrocketing premiums and the outright withdrawal of many insurance companies from the medical malpractice insurance market,¹ led to the passage of some sort of medical malpractice reform in nearly every state.² These reforms varied widely from state to state but the ultimate goal invariably was to stabilize medical malpractice insurance premiums by controlling damage awards and reducing actuarial uncertainty.³ Toward this end, some states decided to encourage or mandate settlement of medical malpractice lawsuits outside the tort system by instituting medical malpractice litigation

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¹ Waxman, *Spiraling Costs: A Health Care Slide*, 11 TRIAL 23 (May/June 1975); Gibbs, *Medical Malpractice Insurance Crisis*, 80 CASE & COMMENT 5 (July/Aug. 1975). One commentator noted "we are in a medical malpractice panic, and that no one can deny." Hirsh, *Malpractice Crisis: Fact or Fiction*, 80 CASE & COMMENT 3 (July/Aug. 1975). Some state courts have been openly skeptical that there was a medical malpractice insurance crisis in their state, insinuating that the state legislature had panicked when it passed responsive legislation. See note 68 *infra* and accompanying text. In addition, many commentators have suggested that though the crisis was real, its causes were outside the tort system. It has been suggested that poor investment practices by insurers, the "Marcus Welby" syndrome, the high incidence of actual medical malpractice, and the increasing complexity of medicine were root causes of the crisis. See Note *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 SO. CAL. L. REV. 829, 849-52 (1979).

² See AMERICAN INSURANCE ASSOCIATION, STATUTES AFFECTING LIABILITY INSURANCE (1981). "There has never been such dramatic and immediate response by the state legislatures to the pressure for any reform such as the reaction of all fifty state assemblies to the demands made by and on behalf of the medical profession in 1975." Fuller, *The Insurance Crisis in Medical Malpractice*, MEDICAL MALPRACTICE 10-1, 10-14 (Illinois Institute for Continuing Legal Education ed. 1975).

³ *Carson v. Maurer*, 120 N.H. 928, 941, 424 A.2d 525, 536 (1980). See Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 SO. CAL. L. REV. 829, 846 (1979).

screening panels⁹ and mandatory, though nonbinding, arbitration. Other states chose to modify the tort system by abrogating the collateral benefits rule¹⁰ eliminating the "double recovery" barrier, or limiting the amount of damages recoverable.¹¹ Another popular reform was to limit attorneys' fees in medical malpractice cases through statutory controls on contingency fees.¹² A few states instituted only one or two of these reforms. As a rule, however, most states enacted a hodgepodge of reforms combining several changes within and without the tort system.

Most of these reforms have been controversial.¹³ One of the more interesting and continuing controversies revolves around the constitutionality of statutes putting an absolute limit on the amount of damages that victims of medical malpractice may recover.¹⁴ These statutes limiting the amount recoverable fell into one of three categories. First, some states chose to limit the amount recoverable in a medical malpractice action by simply limiting the liability of medical care providers to a specific dollar amount -- typically \$500,000.¹⁵ A second way in which states limited the amount recoverable in a medical malpractice action was by limiting the medical care provider's liability to a modest amount -- typically \$100,000 -- and establishing some kind of patient compensation fund to pay judgments in excess of the provider's liability. However, many of the patient compensation fund provisions also place a ceiling on the amount that can be paid out of the fund so that it is possible that a judgment could exceed the amount payable

by the provider and the limited pool amount to be placed in the fund, and suffering from the distinction will be in statutes because the determining the con-

These three different common the fact the malpractice may be recovered in the ab- statutes limiting the grounds. At least the limits on the amount actions.¹⁵ At least a tionally challenged the state courts have ality of these laws, been upheld. Thus, s. stabilized insurance cannot be achieved

The purpose of the selective implemen dollars recoverable on equal protection

⁹ E.g., ARIZ. REV. STAT. ANN. §12-567 (1982) upheld against equal protection challenge in *Eastin v. Broomfield*, 116 Ariz. 570, 582-83, 570 P.2d 744, 770-51 (1977).

¹⁰ E.g., ALASKA STAT. §9.55.535 (Supp. 1981).

¹¹ E.g., R.I. GEN. LAWS §9-19-24 (Supp. 1981).

¹² E.g., MASS. GEN. LAWS ANN. ch. 231, §20C (West Supp. 1980).

¹³ See notes 12-14 *infra*.

¹⁴ E.g., DEL. CODE ANN. tit. 18, § 6565 (Supp. 1980) (Contingent Fees limited to 35% of first \$100,000, 25% of next \$100,000, 10% of balance).

¹⁵ See Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759 (1977); Comment, *Recent Medical Malpractice Legislation — A First Checkup*, 50 TEX. L. REV. 655 (1976); Comment, *An Analysis of State Legislative Responses to the Medical Malpractice Crisis*, 1975 DUKEL. J. 1417; Annotation, 80 A.L.R.3d 583 (1977).

¹⁶ In a broad sense the controversy is caused by a conflict between the insurance system and the tort system. The goal of insurance is to protect the assets of policyholders. In contrast, the goal of the tort system is just compensation for victims to be achieved by reaching the assets of tortfeasors.

¹⁷ IDAHO CODE § 39-4204 (1977); ILL. REV. STAT. ch. 70, § 101 (1975) (held unconstitutional in *Wright v. Central DuPage Hospital Assoc.*, 65 Ill. 2d 313, 347 N.E.2d 704 (1976) and repealed by P.A. 51-28, § 18 N.D. CENT. CODE § 26-40.1-11 (1978) (held unconstitutional in *Arneson v. Olson*, 270 N.W.2d 123 (1978); VA CODE § 8.01-581.15 (1977).

¹⁸ IND. CODE ANN. § 1-1-1 (West 1977); N.E. REV. S.

¹⁹ CAL. CIV. CODE § 38 (1979); OHIO REV. CODE trial court in *Grady v. S. LAWS § 21-3-11 (1979).*

²⁰ See notes 12-14 *supra*.

²¹ *Fein v. Permanent Jones v. State Bd. of M.* 914 (1977); *Wright v. C.* *Johnson v. St. Vincent* N.W.2d 125 (N.D. 1978); *Carson v. Maurer*, 120 1255 (La. 1978). In additionality of Ohio's dam: N.E.2d 532 (1976); *Sim* 903 (1976).

²² This article does malpractice reform le; with limits on recover attack." Note, *California Challenge*, 52 So. 1 to lesser degrees. *Id.*

by the provider and the fund combination.¹⁴ A final way that some states limited the amount that medical malpractice victims can recover was by placing absolute limits such as \$250,000 on the recovery of pain and suffering general damages.¹⁵ For purposes of this discussion no distinction will be made among the three types of damage limitation statutes because the courts have not relied on such distinctions when determining the constitutionality of these laws.

These three different approaches to limiting recoveries have in common the fact that the most seriously injured victims of medical malpractice may be unable to recover as much as they would have recovered in the absence of the limitation. Not surprisingly, these statutes limiting damages have been challenged on constitutional grounds. At least eleven states have passed statutes placing absolute limits on the amount of damages recoverable in medical malpractice actions.¹⁶ At least eight of those eleven statutes have been constitutionally challenged in reported state supreme court cases.¹⁷ However, the state courts have failed to reach any consensus on the constitutionality of these laws. Some have been struck down while others have been upheld. Thus, ironically, the lower actuarial risk and resulting stabilized insurance premiums that the acts were intended to procure cannot be achieved because their constitutionality is still in doubt.

The purpose of this article is to examine the constitutionality of the selective implementation of tort reform by limiting the amount of dollars recoverable in medical malpractice actions.¹⁸ The focus will be on equal protection analysis, which has been the favorite and most

¹⁴ IND. CODE ANN. § 16-9.5-2-2 (Burns Supp. 1981); LA REV. STAT. ANN. § 40:1299.42(B) (West 1977); N.H. REV. STAT. § 44:250 (1978); N.M. STAT. ANN. § 41-5-6 (1978).

¹⁵ CAL. CIV. CODE § 36-33.2 (West Supp. 1979); N.H. REV. STAT. ANN. ch. 507-C:7II (Supp. 1979); OHIO REV. CODE ANN. § 2307.43 (1961) (held violative of equal protection by state trial court in *Graley v. Satayatham*, 74 Ohio Op.2d 316, 343 N.E.2d 832 (1976); S.D. COD. LAWS § 21-3-11 (1979).

¹⁶ See notes 12-14 *supra*.

¹⁷ *Fein v. Permanente Medical Group*, 121 Cal. App. 3d 135, 175 Cal. Rptr. 177 (1981); *Jones v. State Bd. of Medicine*, 97 Idaho 659, 555 P.2d 399 (1976), *cert. denied*, 431 U.S. 914 (1977); *Wright v. Central DuPage Hosp. Ass'n*, 63 Ill.2d 313, 347 N.E.2d 736 (1976); *Johnson v. St. Vincent Hosp. Inc.*, 424 N.E.2d 585 (Ind. 1980); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978); *Prendergast v. Nelson*, 195 Neb. 97, 256 N.W.2d 657 (1977); *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980); *Everett v. Goldman*, 359 So. 2d 1256 (La. 1978). In addition, two reported trial court decisions considered the constitutionality of Ohio's damage limitation law. *Graley v. Satayatham*, 74 Ohio Op.2d 316, 343 N.E.2d 832 (1976); *Simon v. St. Elizabeth Medical Center*, 3 Ohio Op.3d 164, 355 N.E.2d 903 (1976).

¹⁸ This article does not consider the constitutionality of other provisions of medical malpractice reform legislation for two reasons. First, "legislative provisions dealing with limits on recovery have consistently been the most vulnerable to constitutional attack." Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 S. CAL. L. REV. 629, 668 (1979). Other reforms have proved vulnerable to lesser degrees. *Id.* Second, the issues and arguments are likely to be very similar

...by these shall in law be treated as a recovery of damages. Plaintiffs will be required to prove that the state's decision will be deemed to be a recovery of damages. Next, the *quid pro quo* process argument that has been advanced in many of the cases will be discussed. Following that, other miscellaneous state constitutional provisions that might be relevant will be mentioned.²¹ Finally, there will be a consideration of whether the principles evident in the medical malpractice cases are likely to apply if similar legislation limiting damages in products liability actions is passed.²²

II. EQUAL PROTECTION

The most successful argument for invalidating legislation limiting damages is that the limitation violates equal protection. The courts have discerned a number of classifications in the statutes, including (1) plaintiffs with medical malpractice claims contrasted with plaintiffs bringing other tort actions, and (2) medical malpractice claimants with damages above the statutory limit on recovery contrasted with medical malpractice claimants with damages within the statutory limit.²³ The classifications are both obvious and intentional in each of the statutes limiting medical malpractice damages. Therefore, the real question in these cases is whether the classification chosen by the legislature is a permissible one.

Plaintiffs have usually asserted both federal and state equal protection claims. The federal equal protection arguments have not been a significant factor in the cases. Nevertheless, our equal protection discussion must start with an outline of federal equal protection doctrine because the states have largely drawn on the federal case law for their own doctrine.

When courts consider whether a statute or regulation violates the

regardless of the specific provision challenged. Therefore, although cases ruling on medical malpractice reform provisions other than damage limitations may be important and relevant in specific instances, they generally are not helpful here in presenting the issues that are raised by damage limitation statutes.

¹⁸ See notes 23-41 *infra* and accompanying text.

¹⁹ See notes 42-69 *infra* and accompanying text.

²⁰ See notes 70-84 *infra* and accompanying text.

²¹ See notes 85-88 *infra* and accompanying text.

²² See notes 89-93 *infra* and accompanying text.

²³ E.g., *Carson v. Maurer*, 120 N.H. 925, 931, 424 A.2d 525, 530 (1980).

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equal protection clause of the federal constitution, they normally employ a two-tier analysis: if a suspect classification²⁹ or a fundamental interest³⁰ is involved, then the legislation is subjected to the strict scrutiny test. The test is "strict" because, according to the Supreme Court, it has been accurately observed that the strict scrutiny test is "strict" in theory and fatal in fact³¹ because laws subjected to the strict scrutiny test are inevitably struck down.³² In contrast, if suspect classification or fundamental interests are not involved, then the constitutionality of the classification is determined by subjecting the legislation to the rational basis test.³³ The rational basis test asks whether there is a rational relationship between the classification drawn by the statute and the achievement of a legitimate state purpose.³⁴ In application, the rational basis test is characterized by extreme deference to the legislature.³⁵ Thus, economic or social welfare legislation that does not create a suspect classification or infringe on a fundamental interest is inevitably upheld against equal protection attack because the rational basis test is applied.

In recent years, the equal protection doctrine has been in a state of flux

²⁹ See *Developments in the Law — Equal Protection*, 82 HARV. L. REV. 1065 (1969).

³⁰ A suspect class consists of a "discrete and insular minority" that is politically powerless due to circumstances beyond its control. *United States v. Carolene Prods. Co.*, 304 U.S. 144, 153, n.4 (1938). Classifications based on race (*McLaughlin v. Florida*, 379 U.S. 184, 191-92 (1964)), alienage (*Graham v. Richardson*, 403 U.S. 365, 372 (1971)), and nationality (*Korematsu v. United States*, 323 U.S. 214, 216 (1944)) have been found to be suspect.

³¹ Fundamental rights are rights explicitly or implicitly guaranteed by the Constitution. The Supreme Court has found voting (*Dunn v. Blumstein*, 405 U.S. 330, 336 (1972)), travel (*Shapiro v. Thompson*, 394 U.S. 618, 629-30 (1969)) and marriage (*Loving v. Virginia*, 388 U.S. 1, 12 (1967)) to be among the fundamental rights guaranteed by the Constitution.

³² Nowak, *Realigning the Standards of Review Under the Equal Protection Guarantee — Prohibited, Neutral, and Permissive Classifications*, 62 GEO. L.J. 1071, 1074 (1974).

³³ *Id.*

³⁴ Gunther, *The Supreme Court, 1971 Term — Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1, 8 (1972). But see *Korematsu v. United States*, 323 U.S. 214 (1944).

³⁵ Nowak, *Realigning the Standards of Review Under the Equal Protection Guarantee — Prohibited, Neutral, and Permissive Classifications*, 62 GEO. L.J. 1071, 1073 (1974).

³⁶ In *McGowan v. Maryland*, 366 U.S. 420, 425-26, (1961), the Court stated: "The constitutional safeguard [of equal protection] is offended only if the classification rests on grounds wholly irrelevant to the achievement of the state's objective. State legislatures are presumed to have acted within their constitutional power despite the fact that, in practice, their law results in some inequality. A statutory discrimination will not be set aside if any statement of facts may be reasonably conceived to justify it."

³⁷ Comment, *Equal Protection and Due Process: Contrasting Methods of Review Under Fourteenth Amendment Doctrine*, 14 HARV. C.R.-C.L.L. REV. 529, 534-35 (1979).

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equal protection law. In a number of doctrine, the state courts have not hesitated to vary their analysis when applying the equal protection clause. ⁴³ The courts have also varied their analysis from federal constitution equal protection analysis. ⁴⁴ This is of great interest in this discussion because it accounts for the decisions holding that medical malpractice laws violate state equal protection requirements.

State supreme courts have uniformly held that medical malpractice legislation does not create suspect classifications or implicate fundamental interests. ⁴⁵ Accordingly, no state court has applied or discussed applying the strict scrutiny test to equal protection challenges to damage limitation laws.

Rather, the decisive issue in the cases has been the decision whether to apply the rational basis test or an intermediate level of review. Just as the choice between the strict scrutiny and rational basis tests is outcome determinative under traditional equal protection analysis, it appears that the choice between the rational basis test and the intermediate test will predict the result of equal protection challenges to medical malpractice damages limitations statutes. Of eight courts that have discussed the equal protection issue, three applied an intermediate test, ⁴⁶ and four applied the rational basis test. ⁴⁷ In one the standard chosen was unclear. ⁴⁸ Of the three courts that chose intermediate scrutiny, two held the statute unconstitutional ⁴⁹ and one remanded for more information. ⁵⁰ In contrast, no state court that has applied the rational basis test has failed to find the statute in question constitutional. ⁵¹

Because the choice of test is critical to the outcome, it is worthwhile

⁴³ See notes 55-62 *infra* and accompanying text. See generally Brennan, *State Constitutions and the Protection of Individual Rights*, 90 HARV L. REV. 489 (1977).

⁴⁴ E.g., *Fein v. Permanente Medical Group*, 121 Cal. App.3d 135, 175 Cal. Rptr. 177, 184-85 (1981). This has also been true in cases challenging the constitutionality of medical malpractice reforms other than damages limitations. See cases collected at Note, *California's Medical Injury Compensation Reform Act: An Equal Protection Challenge*, 52 SO CAL. L. REV. 829, 861 (1979).

⁴⁵ *Jones v. State Board of Medicine*, 97 Idaho 859, 555 P.2d 399, 407 (1976), cert. denied, 431 U.S. 914 (1977); *Carson v. Maurer*, 120 N.H. 925, 932, 424 A.2d 825, 830-31 (N.H. 1980); *Arneson v. Olson*, 270 N.W.2d 125, 133 (N.D. 1978).

⁴⁶ *Fein v. Permanente Medical Group*, 121 Cal. App.3d 135, 175 Cal. Rptr. 177, 184 (1981); *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E.2d 565, 600 (Ind. 1980); *Everett v. Goldman*, 359 So.2d 1256, 1266 (La. 1978); *Prendergast v. Nelson*, 199 Neb. 97, 113, 256 N.W.2d 657, 668 (1977).

⁴⁷ *Wright v. Central Du Page Hospital Ass'n*, 60 Ill.2d 313, 347 N.E.2d 706 (1976).

⁴⁸ *Carson v. Maurer*, 120 N.H. 925, 424 A.2d 825 (1980); *Arneson v. Olson*, 270 N.W.2d 125 (N.D. 1978).

⁴⁹ *Jones v. State Board of Medicine*, 97 Idaho 859, 555 P.2d 399 (1976), cert. denied, 431 U.S. 914 (1977).

⁵⁰ See list at note 43 *supra*.

⁵¹ See list at note 43 *supra*.

...of the court's "intermediate" factors influence the result is chosen. The traditional equal protection analysis clearly applies the rational basis test to social welfare legislation. Therefore, the courts that have applied the rational basis test to medical malpractice legislation have not necessarily indicated a violation, by noting that the law in question is social welfare legislation.⁴⁹ Nevertheless, two of the cases have specifically relied on the U.S. Supreme Court decision in *Dandridge v. Williams*⁵⁰ to support their use of the rational basis test. In *Dandridge* the Court considered the validity of a regulation that limited, irrespective of the number of children in the family, the total amount that a family could receive under the Federal Aid to Families with Dependent Children program. Finding the regulation to be economic and social, the Court applied the rational basis test, and upheld the regulation against an equal protection challenge.⁵¹ The Indiana Supreme Court followed *Dandridge* and applied the rational basis test because it found the interest of a medical malpractice victim in recovering an amount greater than the statutory limit to be "not greater than that of the children needing but being denied subsistence level support in *Dandridge*."⁵² Likewise, the Nebraska Supreme Court quoted at length from *Dandridge* before announcing that it would apply the rational basis test.⁵³

It is somewhat difficult to discern why the courts that have applied an intermediate scrutiny test chose to apply an elevated standard of review. Furthermore, several formulations of the intermediate scrutiny standard have been applied. The Idaho Supreme Court applied the "means scrutiny" intermediate standard of review. The test applied was whether "the legislative means substantially furthers some specifically identifiable end."⁵⁴ This intermediate level test, which the court derived from several U.S. Supreme Court cases, had been applied

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⁵¹ *Carson v.*

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⁵⁴ *Arneson v.*

⁵⁵ *Id.*

⁵⁶ *White & N.* 312, 330 (1977).

⁴⁹ *E.g., Prendergast v. Nelson*, 199 Neb. 97, 114, 256 N.W.2d 657, 668 (1977).

⁵⁰ 397 U.S. 471 (1970).

⁵¹ *Id.* at 485-87.

⁵² *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E.2d 585, 600 (Ind. 1980). The Indiana Supreme Court also relied on *Duke Power Co. v. Carolina Env. Study Group*, 438 U.S. 59 (1978), in which the U.S. Supreme Court applied the rational basis test to determine whether the limit on the nuclear power industry's liability contained in the Price Anderson Act violates equal protection. *Id.* at 83. However, the *Duke Power Co.* case can be distinguished on the ground that Congress has made a commitment to act if damages from a nuclear accident exceed the liability limits of the Price Anderson Act, whereas under medical malpractice damage limitations there is a "strong possibility of damage above the limitation and no legislative commitment beyond the limitation." *Arneson v. Olson*, 270 N.W.2d 125, 135, n.6 (1978).

⁵³ *Prendergast v. Nelson*, 199 Neb. 97, 113, 256 N.W.2d 657, 668 (1977).

⁵⁴ *Jones v. State Board of Medicine*, 97 Idaho 839, 667, 553 P.2d 399, 407 (1976), cert. denied, 431 U.S. 914 (1977).

in prior cases involving "obviously discriminatory classifications." The court clearly held that the discrimination in the Idaho suits between medical malpractice plaintiffs with damages exceeding the state's tort limit and those without was not obvious enough to warrant application of the intermediate test.⁵⁴

The New Hampshire Supreme Court derived its intermediate scrutiny standard elsewhere. The court found a right to recover in tort for personal injuries that, although not a fundamental right, was important enough to require heightened scrutiny.⁵⁵ The court labelled its intermediate test a substantial relationship test, under which the statute "must be reasonable, not arbitrary, and must rest upon some ground having a fair and substantial relation to the object of the legislation."⁵⁶ The court acknowledged that the Supreme Court has not extended intermediate scrutiny to economic and social welfare legislation but noted that it had done so on prior occasions and was free to apply its own test in interpreting the equal protection provisions of the New Hampshire Constitution.⁵⁷

The Supreme Court of North Dakota, the final state to apply an intermediate scrutiny test, required a "close correspondence between statutory classification and legislative goal."⁵⁸ The only apparent reason that the court applied the intermediate test was because it had applied it in judging the constitutionality of the state's automobile guest statute. That case, said the court, had "many similarities to the present case."⁵⁹

The surest way to predict which equal protection test a state court will apply may be to examine prior cases determining the constitutionality of that state's automobile guest statute.⁶⁰ Four of the above states

⁵⁴ *Id.*

⁵⁵ Nevertheless, after extensive discussion, the court did not reach the merits of the issue because there was inadequate information in the record to perform the analysis. Instead the case was remanded. *Id.* at 570, 555 P.2d at 416.

⁵⁶ *Carson v. Maurer*, 120 N.H. 925, 931-32, 424 A.2d 825, 830 (1980).

⁵⁷ *Id.* at 932-33, 424 A.2d at 831.

⁵⁸ "We recognize that recently the United States Supreme Court has restricted its application of this substantial relationship test to cases involving classifications based upon gender and illegitimacy. In interpreting our state constitution, however, we are not confined to federal constitutional standards and are free to grant individuals more rights than [sic] the Federal Constitution requires. Indeed, we have applied the 'fair and substantial relation' test not only in scrutinizing gender-based classifications but also in examining economic and social legislation and ordinances which did not involve distinctions based upon gender or illegitimacy." 120 N.H. 925, 932, 424 A.2d 825, 831 (1980) (citations omitted).

⁵⁹ *Arneson v. Olson*, 270 N.W.2d 125, 133 (N.D. 1978).

⁶⁰ *Id.*

⁶¹ White & McKenna, *Constitutionality of Recent Malpractice Legislation*, 13 FORUM 312, 330 (1977). A table showing the consistency or inconsistency of state court decisions

1977) and it should be noted when they discussed which test was applied, and each state applied the same standard to the medical malpractice law as it did to the general statute law.⁶⁷

Under the application of the rational basis test, if a plaintiff can show that the court generally will defer to the legislative judgment, reflected in the statute, that the classification is rationally related to a legitimate state purpose. For instance, in *Fein v. Permanente Medical Group*,⁶⁸ the plaintiff argued that the California statute limiting pain and suffering damages in medical malpractice cases violated equal protection because "the alleged 'crisis' pursuant to which the legislation was enacted was largely fabricated."⁶⁹ The court noted that the plaintiff was asking it to reconsider the legislature's findings, which it refused to do under the rational basis test.⁷⁰

In stark contrast, when the intermediate level test is applied, the courts are willing to scrutinize the basis for the legislative decision to limit damages far more closely. The Idaho Supreme Court was clearly skeptical that any crisis existed in Idaho and remanded for determination of whether malpractice claims had caused increased insurance rates and whether the damage limitation would actually stabilize insurance rates.⁷¹ The New Hampshire Supreme Court was unable to find the necessary relationship between the legislative goal of rate reduction and the damage limitation statute because "paid out damage awards constitute only a small part of total insurance premium costs [and] few individuals suffer non-economic damages in excess of \$250,000."⁷²

Thus, the functional difference between the rational basis test and the intermediate test is the degree to which the legislative judgment reflected in the statute will be examined. The practical difference is that under the rational basis test the statute will surely be found constitutional while the opposite result is likely if the intermediate test

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⁶⁷ *Jones v. State Board of Medicine*, 97 Idaho 859, 567, 555 P.2d 399, 407 (1976), cert. denied, 431 U.S. 914 (1977); *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E. 2d 585, 608 (Ind. 1980); *Prendergast v. Nelson*, 159 Neb. 97, 113, 256 N.W.2d 657, 666 (1977); *Arneson v. Olson*, 270 N.W. 2d 125, 134 (N.D. 1978).

⁶⁸ Cal. App.3d 123, 175 Cal. Rptr. 177 (1981).

⁶⁹ 175 Cal. Rptr. at 183.

⁷⁰ *Id.* at 184-86.

⁷¹ *Jones v. State Board of Medicine*, 97 Idaho 859, 874, 555 P.2d 399, 414 (1976), cert. denied, 431 U.S. 914 (1977).

⁷² *Carson v. Maurer*, 120 N.H. 925, 941, 424 A.2d 825, 836 (1980).

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⁷⁶ *Id.* at 2
⁷⁷ *Id.* at 2
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is applied. At any rate, the crucial issue in such cases remains which standard of review the court chooses to apply.

III. DUE PROCESS—THE *QUID PRO QUO* THEORY Analysis

Plaintiffs have invariably raised due process objections to statutes that limit their right to recover damages in medical malpractice actions. However, even when courts have struck down the statute, they have relied on equal protection, not due process grounds. When the traditional due process issue has been addressed, the test applied by the state courts has been merely whether the statute bore a rational relation to the achievement of governmental objectives.⁷⁰ Judged by this standard, there is no doubt that the statutes are constitutional.

However, a less conventional due process argument has been advanced by plaintiffs in most of the cases. They have argued that the right to recover medical malpractice damages in tort is a property interest that the state legislature cannot deprive them of unless it provides a *quid pro quo* in return.⁷¹ The *quid pro quo* theory originated with *New York Central Railroad Co. v. White*,⁷² which upheld the New York workmen's compensation law against a constitutional challenge. Although the United States Supreme Court clearly indicated in *White* that there is no vested right in common law liability rules allowing tort recovery from negligent employers, the Court implied that due process required a "reasonably just substitute."⁷³ The suggested requirement of a *quid pro quo* was expressly indicated to be dicta,⁷⁴ although the Court pointed out that the workmen's compensation law in question did in fact provide a *quid pro quo*. Workers gave up their common law tort rights in return for a guaranteed recovery while employers gave up their common law defenses in return for a limit on their potential liability.⁷⁵

The basic theory has not developed appreciably in the sixty odd years since it was first expounded in *White*. The Court has stated many

⁷⁰ *E.g.*, *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E.2d 585, 598 (Ind. 1980).

⁷¹ The argument is discussed in detail by Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981).

⁷² 243 U.S. 183 (1917).

⁷³ *Id.* at 200-01.

⁷⁴ *Id.* at 201.

⁷⁵ *Id.* 201-02.

times that there is no right to a common law cause of action.⁷⁶ Yet, at the time the *quid pro quo* argument has arisen, the Court has declined to rule on its validity while keeping the theory alive by pointing out how the challenger could establish that the law provided a *quid pro quo*.⁷⁷

The only state court discussion of the *quid pro quo* argument in relation to a statute limiting medical malpractice recovery that is not clearly dicta is found in *Carson v. Maurer*.⁷⁸ There the New Hampshire Supreme Court was considering an equal protection challenge to a statute limiting pain and suffering damages in medical malpractice actions to \$250,000.⁷⁹ The court indicated that its prior cases upholding a \$50,000 statutory limit on tort recovery for personal injury against municipalities and upholding a statute limiting recovery in wrongful death actions were inapposite because in neither case was there a common law right to recovery. Therefore the legislature could abolish or limit such actions.⁸⁰ Furthermore, the state workmen's compensation law was distinguishable because it provided a *quid pro quo* to injured workers in return for their common law rights.⁸¹ However, the court did not explicitly conclude that the limitation on pain and suffering damages was unconstitutional because no *quid pro quo* was provided.

Instead, the court held that the statute violated the equal protection clause of the state constitution. The *quid pro quo* analysis was contained within the court's equal protection discussion, following notation of the unfairness of the classification drawn by the law but preceding the court's statement that it was holding the statute violative of equal protection.⁸² Thus it is unclear exactly what the court's analysis was. It may simply have confused the due process *quid pro quo* argument with the equal protection issue. It is also possible that the court was saying that under the intermediate scrutiny test that it was applying in the case, a classification might survive scrutiny if a *quid pro quo* were provided to those in the affected class. Although the court's reasoning is unclear, what is fairly certain is that the court

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⁷⁶ "Our cases have clearly established that '[a] person has no property, no vested interest, in any rule of the common law.'" *Duke Power Co. v. Carolina Env. Study Group*, 438 U.S. 59, 85, n.32 (1977) (collecting cases).

⁷⁷ *Duke Power Co. v. Carolina Env. Study Group*, 438 U.S. 59, 86 (1977) (Price-Anderson Act limiting liability of nuclear power industry). See Learner, *Restrictive Medical Malpractice Compensation Schemes: A Constitutional "Quid Pro Quo" Analysis to Safeguard Individual Liberties*, 18 HARV. J. ON LEGIS. 143 (1981).

⁷⁸ 120 N.H. 925, 424 A.2d 825 (1980).

⁷⁹ N.H. REV. STAT. ANN. ch. 507-C:7II (Supp. 1979).

⁸⁰ 120 N.H. at 942-43, 424 A.2d at 837.

⁸¹ *Id.* at 943, 424 A.2d at 837-38.

⁸² *Id.* at 941-43, 424 A.2d at 835-38.

⁸³ *Jones v. Boe*, 431 U.S. 914 (1977).

⁸⁴ See, e.g., *Prendergast* the c
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approved of and applied the *quid pro quo* analysis.

Other state courts that have discussed the *quid pro quo* due process question have either rejected the *quid pro quo* theory, citing Supreme Court cases holding that the legislature is free to limit rights as long as it does not do so arbitrarily.⁸³ However, the majority of the courts generally have acknowledged the argument, expressed reservations about the vitality of the theory, noted that the law in question does provide a *quid pro quo*, and decided the case on other grounds.⁸⁴ Thus, the *quid pro quo* argument in cases challenging damage recovery limitations has been relatively unimportant. As long as the equal protection argument is present, it appears that the *quid pro quo* argument will not be squarely faced.

The *quid pro quo* due process analysis would assume more importance if no equal protection argument were present. That would be the case if a state legislature chose to put a damage recovery limit on all tort actions. When squarely faced with the issue, and in the absence of any further indication of the vitality of the *quid pro quo* theory from the United States Supreme Court, the state courts would likely be reluctant to apply it to challenges based on the due process clause of the federal constitution.

However, the generally favorable dicta found in the state cases suggests that individual states might choose to apply the *quid pro quo* doctrine under the due process clause of their state constitutions. That would lead to a situation similar to the present where some courts have held legislation limiting damages recoverable in tort actions to violate state but not federal equal protection provisions.

IV.

SPECIAL STATE CONSTITUTIONAL PROVISIONS

The vital role that state equal protection clauses have played in determining the constitutionality of medical malpractice damages limitation statutes has already been discussed. Other state constitutional provisions that are more unique to certain states have been argued by plaintiffs as well. For instance, it has been argued that

⁸³ Jones v. Board of Medicine, 97 Idaho 859, 869, 555 P.2d 399, 409 (1976), cert. denied, 431 U.S. 914 (1977).

⁸⁴ See, e.g., Prendergast v. Nelson, 199 Neb. 97, 120-21, 256 N.W.2d 657, 671 (1977). In Prendergast the court rejected the *quid pro quo* argument, noting that the legislature is free to abolish even common law rights. Nevertheless the court thought that the damage limitation statute did provide a *quid pro quo* because it helped make medical malpractice liability insurance available and affordable, thereby assuring that judgments would be collectible. *Id.* at 121, 256 N.W.2d at 671. The notion that a societal *quid pro quo* might be adequate was flatly rejected by the Illinois Supreme Court. Wright v. Central Du Page Hospital Ass'n, 63 Ill.2d 313, 328, 347 N.E. 2d 736, 742 (1976).

damages limitations constitute prohibited special legislation," contravene the right to jury trial, or fail to provide a complete remedy for harm suffered.⁸⁸ The only statute limiting medical malpractice damages that has been struck down on other than equal protection grounds was that of Illinois, which the Illinois Supreme Court held violated the special privilege prohibition of the state Constitution.⁸⁹ With this exception, arguments based on state Constitutional provisions have been generally treated as make weight arguments behind the equal protection analysis.

V.

THE PRODUCTS LIABILITY ANALOGY

The same type of insurance crisis that prompted major medical malpractice reforms in the 1970's appears to be brewing in the products liability area.⁹⁰ Products liability and medical malpractice are similar in that both involve insurance problems—specifically, the cost and availability of insurance.⁹¹ In addition, as in the malpractice insurance case, pressure for reform is likely to come from manufacturers and insurers rather than those who are injured.⁹² No doubt legislatures will be pressed to adopt remedial products liability legislation similar to the previous medical malpractice changes.⁹³ Thus, it would not be surprising if some states placed limits on the amount of damages recoverable in products liability actions.

Despite the similarities between medical malpractice and products liability, there are a number of distinctions that may support treating the two problems differently. The number of medical malpractice claims is significantly smaller than the number of products liability claims and products liability litigation is more expensive than malpractice litigation. Unlike medical malpractice insurance, the problem

in products liability is because of the greater extent of the damage.

Nevertheless, liability plaintiffs object to the age limitation that the lack of tort law reforms.

The case ages recover reasons for. Although it several years these cases unsettled, the substantial availability they occur, damage recoverable tort and cost and availability.

⁸⁸ *Wright v. Central Du Page Hospital Ass'n*, 63 Ill.2d 313, 326, 330, 347 N.E.2d 736, 741, 743 (1976); *Arneson v. Olson*, 270 N.W.2d 125, 136-37 (N.D. 1978).

⁸⁹ *Johnson v. St. Vincent Hospital, Inc.*, 404 N.E.2d 585, 601-02 (Ind. 1980).

⁹⁰ *Id.* at 593.

⁹¹ *Wright v. Central Du Page Hospital Ass'n*, 63 Ill.2d 313, 330, 347 N.E.2d 736, 743 (1976).

⁹² Comment, *Solving the Products Liability Insurance Crisis: A Study of the Rule of Economic Theory in the Legislative Reform Process*, 31 MERCER L. REV. 755, 756-60 (1980). See generally INTERAGENCY TASK FORCE ON PRODUCT LIABILITY, U.S. DEPARTMENT OF COMMERCE 3-7 (1977).

⁹³ INTERAGENCY TASK FORCE ON PRODUCT LIABILITY, U.S. DEPARTMENT OF COMMERCE 436 (1975).

⁹⁴ *Id.* at 419.

⁹⁵ *Id.* at 434.

⁹⁶ *Id.* at 422.

⁹⁷ See *Dagu*, Indiana law a decision upholding challenge.

in products liability insurance is more one of cost than availability because manufacturers can absorb higher costs by raising prices to a greater extent than doctors can.³³ Finally, products liability involves products while malpractice involves services.

Nevertheless, if laws limiting the amount of damages that products liability plaintiffs can recover are passed, the same constitutional objections that have been asserted against medical malpractice damage limitations would surely be raised.³⁴ One may surmise, however, that the lack of consensus on the constitutionality of medical malpractice laws would lead to similar uncertainty in regard to products liability reforms.

VI. CONCLUSION

The cases on the constitutionality of state statutes limiting damages recoverable in medical malpractice actions reveal a variety of reasons for rendering decisions and arriving at conflicting results. Although the number of such statutes passed has slowed in the last several years as the medical malpractice insurance crisis has receded, these cases are of considerable importance. As long as the results are unsettled, the issue will probably continue to be litigated. In addition, substantial premium increases in the future or restrictions on the availability of medical malpractice insurance, for whatever reasons they occur, will likely stimulate the passage of more laws restricting damage recoveries. Finally, similar legislation may be passed in analogous tort areas such as products liability in response to crises in the cost and availability of liability insurance.

³³ *Id.* at 422.

³⁴ See *Dague v. Piper Aircraft Corp.*, 513 F.Supp. 19, 29 (N.D. Ind. 1980) (applying Indiana law and citing Indiana medical malpractice limitation case in support of decision upholding ten year products liability statute of limitations against equal protection challenge).



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

April 3, 1985

MEMORANDUM

TO: Representative Mike Szymanski

FROM: Jonathan Sherwood
Legislative Analyst

RE: Regulation of the Insurance Industry in Alaska
Research Request 85-239

You requested that we provide information on current State efforts to regulate the insurance industry and on the potential need for additional regulatory controls. Title 21 of the Alaska Statutes contains numerous provisions regulating various aspects of the insurance industry in Alaska. The title includes almost 400 pages; it contains general provisions for the insurance regulation and several chapters pertaining to the regulation of specific types of insurance. This memorandum does not provide a comprehensive summary of all insurance regulation; rather, we will discuss the major directions of insurance regulation, particularly those aspects of regulation which extend across types of insurance.

Current Regulation of Insurance in Alaska

In the discussion of Alaska insurance regulation, it is important to distinguish between two distinct classes of insurers, admitted and nonadmitted. The nonadmitted (also called surplus lines) insurer is not subject to the same level of regulation that admitted insurers are; however, surplus lines insurance must be sold through a broker who posts a bond of \$200,000. Surplus lines insurance is generally used as the insurance of last resort, when coverage from admitted carriers cannot be obtained.

Authorized Insurance. To operate as an admitted insurer in Alaska, a business must obtain a certificate of authority from the Division of Insurance. By law, such insurers must meet minimum financial requirements for surplus capital, as specified in AS 21.09.070, and maintain a minimum deposit for the protection of policyholders and creditors.¹

¹Title insurance is exempted from the deposit requirement.

The Division of Insurance also regulates the rates, policies and trade practices of the insurance industry. According to AS 21.39.010, the purpose of rate regulation is:

"to promote the public welfare by regulating insurance rates in order that they will not be excessive, inadequate or unfairly discriminatory, and to authorize and regulate cooperative action among insurers in rate making and in other matter within the scope of this chapter."

Rate regulation does not apply to reinsurance, disability insurance, some types of marine insurance and aircraft insurance.

Under the provisions of AS 21.39.030, insurers must consider past and prospective loss experience, catastrophe hazards, reasonable profit and contingencies, past and prospective expenses, and all other relevant factors in developing their rates. Insurers must include in their rate submission enough information on the basis for the rates to enable the division to determine whether the rates are justified. According to John George, insurers must show that the basis on which they discriminate in their rates is based on reasonable grounds as well.

The Division of Insurance can disapprove rates filed by insurers. However, Mr. George noted that although the division can prohibit an insurer from selling a policy at a given price, it cannot require that a policy be offered at a given price. He further stated that, in the recent past, insurance regulators have tended to allow insurers to set rates which were too low to accumulate adequate funds to meet claims, rather than permitting excessive rates.

Insurers are also required to file their insurance policy or contract forms with the Division of Insurance. Under the provisions of AS 21.42.130, a policy may be disapproved if it:

- 1) is in any respect in violation of or does not comply with this title;
- 2) contains or incorporates by reference, where incorporation is permissible, an inconsistent, ambiguous, or misleading clause, or exception and condition that deceptively affects the risk purported to be assumed in the general coverage of the contract;
- 3) has a title, heading or other indication of its provision that is misleading;
- 4) is printed or otherwise reproduced in a manner that renders a provision of the form substantially illegible; and

Representative Szymanski
April 3, 1985
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The division has a consumer complaints section and a market surveillance section. Mr. George stated that a considerable amount of the division's effort is directed toward monitoring the finances and claims practices of insurers.

Mr. George noted that under Alaska law, the Director of Insurance has substantial direct authority over insurers. The director has subpoena power, an absolute right to examine insurance records, the authority to force insurers to pay claims, and the power to levy administrative penalties against members of the insurance industry.

The Need for Additional Insurance Regulation

In this section, we discuss briefly the potential for increasing the regulation of the insurance industry in Alaska. To put the regulatory scheme used by Alaska into perspective, we first discuss how regulation of insurance in Alaska compares to regulation in other states.

In the United States, state governments are the primary source of regulation for the insurance industry; the federal government does not regulate insurance. In fact, the insurance industry is exempt from federal antitrust laws. According to Art Chartrand, with the National Association of Insurance Commissioners (NAIC), although there are many specific differences between individual states, the general pattern of insurance regulation tends to be consistent among the states. All states regulate trade practices, policies, rate practices, and the financial stability of insurance companies.²

According to John George, the NAIC is responsible for some of this consistency. With representatives from all fifty states, NAIC develops model laws, coordinates examinations of insurance companies, and generally fosters cooperation among states. NAIC model laws are frequently used by the states as the foundations for their insurance statutes.

Mr. George noted that many of the differences between states result from the individual circumstances of the state's insurance industry. For example, Alaska is recognized as a leader in surplus lines regulation; it is also the state with the greatest proportion of its insurance written by surplus lines insurers. New York has become a leader in crime insurance regulation for similar reasons.

²There are structural differences in the way insurance regulatory agencies are established. Attached is a previous House Research Agency memorandum which compares the structure of the Texas State Board of Insurance to the Alaska Division of Insurance.

Representative Szymanski
April 3, 1985
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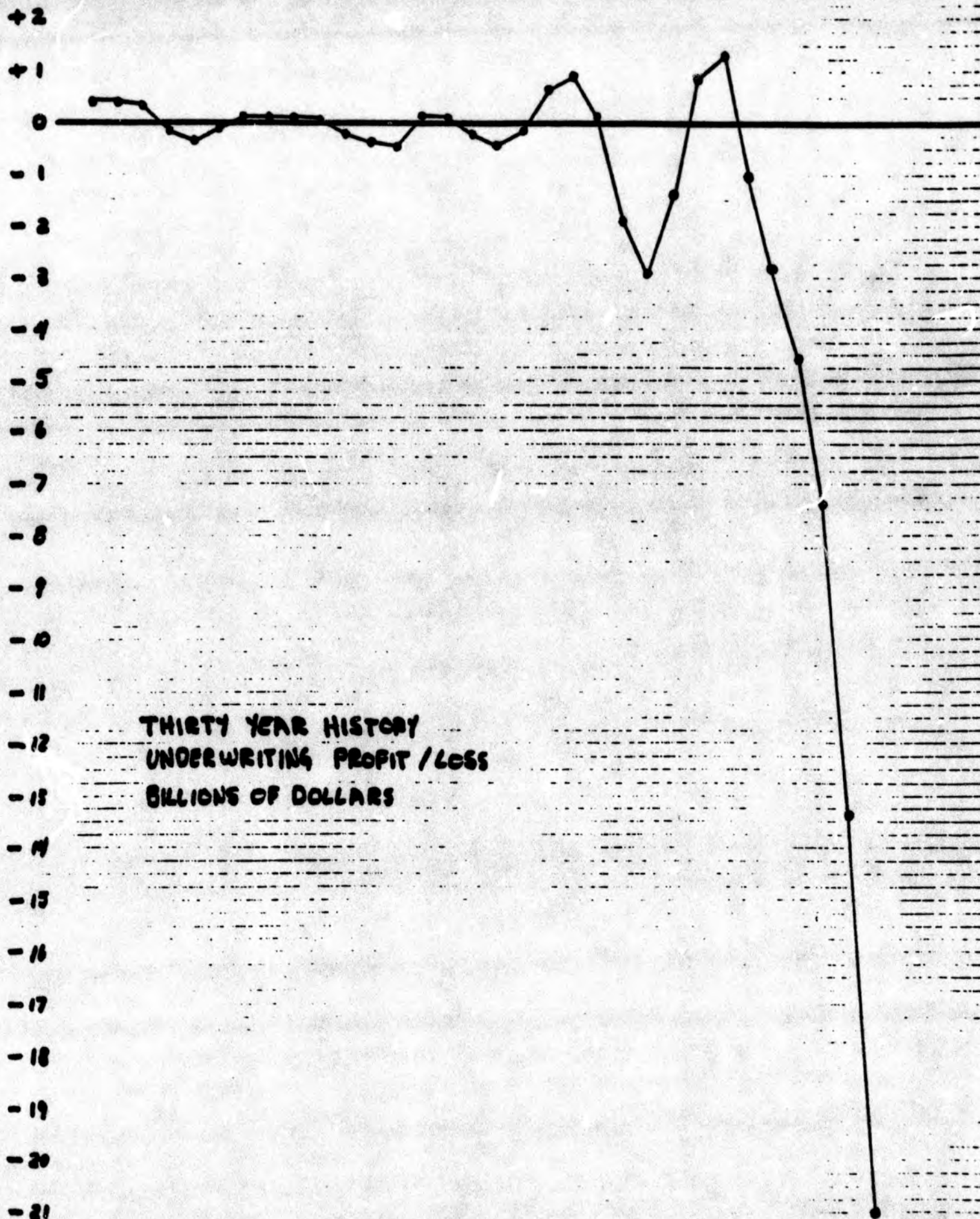
Apparently, during the period of high interest rates, insurance companies were making a high yield on their investments. In order to increase the scale of their investments to make more money, they began lowering premium rates to attract more capital to invest. However, in the last few years, the return on investments has declined; but rates have not been increased accordingly.

Attachment B shows two tables provided by the Division of Insurance illustrating this phenomenon. According to the first table, underwriting profits and losses have traditionally fluctuated around zero, but never dropping below zero for more than three consecutive years. However, beginning in 1979, underwriting has produced six straight years of increasingly large losses. In 1984, the insurance industry suffered a \$21 billion underwriting loss. The second table shows that through most of this period, underwriting losses were offset by investment income. However, in 1984, the insurance industry suffered a net loss of almost \$4 billion.

The losses suffered by the insurance industry have reduced the cash reserves that companies maintain as protection against underwriting losses. The amount of a company's cash surplus determines the amount of coverage it can sell; insurers can write less insurance when cash reserves decline. Because of underwriting losses, some insurers may currently have more insurance issued than their cash surplus would permit.

According to John George, the Division of Insurance is concerned about the financial conditions of several insurers doing business in Alaska. He noted that when looking at the financial condition of insurers, coverage of high-risk lines such as crab boats or liquor law liability is likely to have a negative impact on his evaluation.

For some lines of insurance, the public does have some protection against insurer insolvency. Under AS 21.80, all companies providing direct insurance except for life, title, surety, disability, credit, mortgage guaranty, and ocean marine insurance, are members of the Alaska Insurance Guaranty Association. If an insurer is declared insolvent, all insurers offering the same line of insurance are assessed a fee in proportion to their share of the line in the state to cover unmet claims obligations and premium refunds. Companies may not be assessed more than two percent of their surplus in any one year. Currently, there is a bill (SB 88) before the Alaska Senate which would create the Alaska Life and Disability Insurance Guaranty Association.

[illegible]



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

House of State Capitol
Juneau, Alaska 99811
(907) 465-1991

November 5, 1982

MEMORANDUM

TO: Representative Thelma Buchholdt

FROM: Leonard Steinberg, Research Staff *L. S.*

RE: Insurance Agency Organization
Research Request Number 82-183

You requested information about the organization and effectiveness of state insurance agencies in Alaska and Texas. Specifically, you asked for information about:

- 1) The functions and structure of the Texas State Board of Insurance;
- 2) How the work of the Board of Commissioners differs from the work of their staff;
- 3) How well the Texas State Board of Insurance performs its duties particularly with regard to consumer affairs; and
- 4) How the Alaska Division of Insurance compares with the Texas organization.

Texas State Board of Insurance

Insurance regulation in Texas is handled through the State Board of Insurance. The Board is composed of three full-time commissioners. The Governor, with the advice and consent of the Senate, appoints the commissioners to serve six-year terms staggered every two years. Board members must have at least ten years experience in business, professional, or governmental activities and Texas law prohibits individuals with conflicts of interests from serving on the Board.

The State Board of Insurance (SBI) is responsible for:

- 1) promulgating rates;
- 2) promulgating and adopting administrative regulations;
- 3) hearing appeals from Commissioner's decisions; and
- 4) establishing policies on insurance regulation.

The three-member Board also has general oversight responsibilities for agency performance and the power to hire and fire the Commissioner of Insurance who is the chief of staff. The Commissioner of Insurance is responsible for administering, enforcing, and carrying out the insurance provisions of Texas statutes and regulations.

The Chairman of the three member State Board of Insurance (who is designated by the Governor in odd-numbered years) is also responsible for appointing the State Fire Marshall.

Currently, there are four Deputy Commissioners reporting to the Commissioner each having responsibility for one of the following Divisions:

- 1) Business Practices and Enforcement;
- 2) Financial Monitoring;
- 3) Property Insurance; and
- 4) Casualty Insurance.

Additionally, the managers of the following eight Departments also report directly to the Commissioner:

- 1) Liquidation;
- 2) Statistical and Rate Development;
- 3) Surplus Lines;
- 4) Hearings;
- 5) Legal;
- 6) Support Services;
- 7) Personnel; and
- 8) Data Processing.

The State Board of Insurance has recently proposed two changes which are to be implemented in September 1983. First, in order to improve the efficiency and effectiveness of the way the Board deals with complaints and investigations, it is proposing to create a Legal and Compliance Division. Second, the Board is proposing to increase the number of Deputy Commissioners from four to six but reduce the number of programs and program managers reporting directly to the Commissioner.

Under the new organization, only the following programs, each headed by a Deputy Commissioner, would report to the Commissioner:

- Casualty;
- Property;
- Life;
- Administrative Services;
- Legal and Compliance; and
- Corporate and Financial Affairs.

For FY 1982, the operating budget for the State Board of Insurance was \$17.5 million and the agency employed 651 persons. Though most of the State Board of Insurance's staff is located at the state capitol in Austin, Texas, there are numerous field offices throughout the state. The State Fire Marshal has four field offices to assist in arson investigations and inspect fireworks stands and buildings for fire hazards. The Property Division also has numerous field offices to inspect buildings and assign property insurance ratings.

Claims and Complaints Section

Under the current structure, the Claims and Complaints Section is part of the Business Practices and Enforcement Division. If the proposed reorganization is implemented in September 1983, the Claims and Complaints Section will operate under the Legal and Compliance Division.

The Claims and Complaints Section responds to written inquiries or complaints regarding consumer dissatisfaction with claim benefits, underwriting practices, or questionable business practices. The State Board of Insurance examines and analyzes these complaints, determines what, if any, action should be taken pursuant to the Texas Insurance Code, and if appropriate, compiles information for legal proceedings or other actions determined necessary by the Commissioner.

The State Board of Insurance has found that when violations of policy provisions have been identified, insurance companies usually cooperate and correct claims errors. If a company chooses not to cooperate, however, the State Board of Insurance does not have the authority to require settlement of claims disputes.

When complaints result in a finding that the insurer is in violation of sections of the Texas Insurance Code, and the insurer does not respond by resolving the complaint, a recommendation is made to the Deputy Commissioner to cite the company for alleged violations. If the allegations are found by the Legal Section to be legally valid, a public hearing is held and the parties are advised in writing of the resulting findings and directives.

The Investigation Section is responsible for licensing insurance agents and adjusters and, in cooperation with the Claims and Complaints Section, also looks into alleged improper acts of insurance agents, adjusters, and companies. Violations of the Texas Insurance Code may result in the Commissioner cancelling, or suspending licenses or issuing consent orders.

In addition to the work of the Claims and Complaints and Investigation Sections, during FY 1981 more than 1100 complaints and an unknown but

significant number of inquiries were processed by other Divisions of the State Board of Insurance.

The State Board of Insurance retains data on complaints to detect patterns of problems with specific companies and agents as well as to measure the work performed by its staff. Beginning in 1981, this tracking effort has been enhanced with the aid of a computer system.

The effectiveness of the State Board of Insurance's Claims and Complaints Section is difficult to estimate. Listed below are two common indicators, the amount of dollars paid to claimants as a result of SBI action and the number of complaints received.

	Claims Paid	Complaints Recieved
1979	\$5,435,147	10,281
1980	\$7,222,082	11,791
1981	\$9,577,051	11,938

The average time required for processing a complaint is not available, but the State Board of Insurance has indicated that most claims can be settled within three weeks provided that the insurance company or agent responds promptly.¹

Alaska Division of Insurance

The Alaska Division of Insurance is a line agency within the Department of Commerce and Economic Development. The laws under which the Division operates are set forth in Title 21 of the Alaska Statutes and in Chapters 21-31 of Title 3 of the Alaska Administrative Code.

The Division's mission is to make certain that, "...insurance coverages are available to all citizens at equitable prices from solvent and reputable sources."² Additionally, the Division collects about \$12 million of insurance taxes and fees every year.

¹ Texas State Board of Insurance, Texas State Board of Insurance. Photocopied document of 13 pages plus 3 exhibits, obtained from Dianne Longley, Information Services, Texas State Board of Insurance, Austin, Texas. October 20, 1982. Most of the information about the Texas State Board of Insurance was obtained from this document.

² Division of Policy Development and Planning, Office of the Governor, State of Alaska. Alaska Report of Performance FY 81. Page 53.

The Division of Insurance is structured into three sections responsible for the following program areas:

- 1) Licensing of agents, brokers, and insurance companies (this is also the section that collects taxes);
- 2) Financial audits, reviewing company solvency and the financial ability of companies to respond to claims; and
- 3) Marketing surveillance, reviewing rates, the wording and clarity of policy forms, and trade practices.

The Division employs eighteen individuals, five in Anchorage and thirteen in Juneau. Though the Division has grown over the years, its budget is still less than \$1 million annually (\$976,800 for FY 83). The Division is, of course, much smaller in size than the Texas State Board of Insurance, but is comparable to the Texas agency in terms of the number of employees on a per capita basis.

Of the five staff positions in Anchorage, two are "consumer complaints specialists" that handle nearly all of the consumer complaints for the Division.³ The Division responds to consumer complaints by investigating cases and informally attempting to resolve problems. When necessary, the Division holds hearings, issues orders, and revokes licenses.

The Division does not involve itself in determining the liability of an insurance company or the amount of an insurance settlement; the Division's regulatory role is limited to ensuring that premium rates are fair, companies are solvent, and insurance claims are properly dealt with.

During the calendar year 1981, the Division processed 291 complaints requiring an average of 44 days each to complete. During the first nine months of the 1982 calendar year, the Division has processed 208 complaints requiring an average of 41 days to complete. On the basis of the information available to me, it appears that the Division's complaint response time is substantially longer than its Texas counterpart, although an exact comparison is difficult due to the lack of specific Texas data.

In addition to the Division of Insurance, there is also a Division of Worker's Compensation within the Department of Labor that acts as staff to the Board of Worker's Compensation; they resolve disputes

³ Interview with Division Director Ken Moore, October 19, 1982. During this interview Director Moore indicated that two staff positions are sufficient to handle the Division's workload.

Representative Thelma Buchholdt
November 5, 1982
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surrounding claims and benefits under this program. In Texas, this function is handled by the State Board of Insurance.

The attached table provides a summary comparison of some of the key elements of insurance regulation efforts in Alaska and Texas.

I hope this information is useful. Please let me know if you have any further questions or would like any additional information.

Comparison of Alaska - Texas Insurance Regulatory Programs

	<u>Alaska</u>	<u>Texas</u>
Total In-State Premium Amount	\$600 million	\$6 billion
Fees & Taxes Collected	\$12 million (1982)	\$185 million (1980)
Agency Budget	\$976,800 (FY 1983)	\$17.5 million (FY 1982)
Number of Employees	18	651
Independent Board	No	Yes
Agency Sets Rates	No	Yes
Agency May Issue Orders/ Revoke Licenses	Yes	Yes
Number of Complaints Processed	291 (1981)	11,938 (1981)
Complaint Processing Time	44 day avg. (1981)	avg. is unknown but usually within three weeks
Amount of Claims Paid Through State Intervention	unknown	\$9,577,051