

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
1749 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990

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MUNICIPAL INSURANCE POOLS

-An Appropriate Alternative for Local Governments?

New York State Legislature
Assembly Ways and Means Committee*

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*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 and 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.

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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:

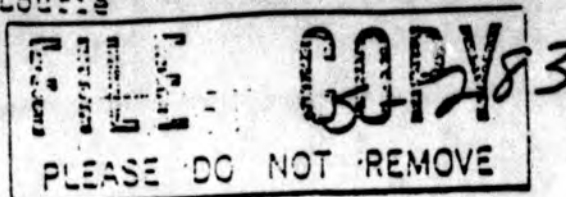
"CHAPTER 78

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 markets: 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."

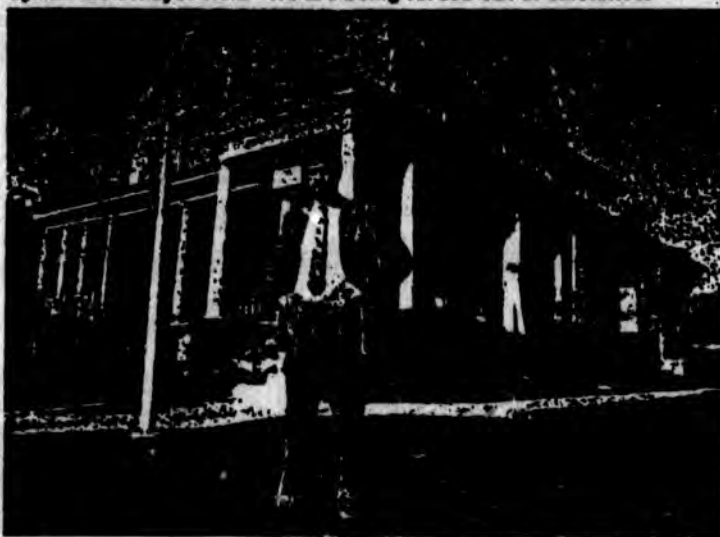
The town found a new policy for a 700 percent premium increase and sharply reduced limits. But the town still is facing a crisis: Liability coverage for its 14 paid workers has been revoked.

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." □

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 exclusionary 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 Feilich
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 recover his insurance premiums, Bunch must tack on an extra \$46 an hour to 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.

Robertson says she's never had a serious complaint about the quality of care at her center, but her premiums have tripled.

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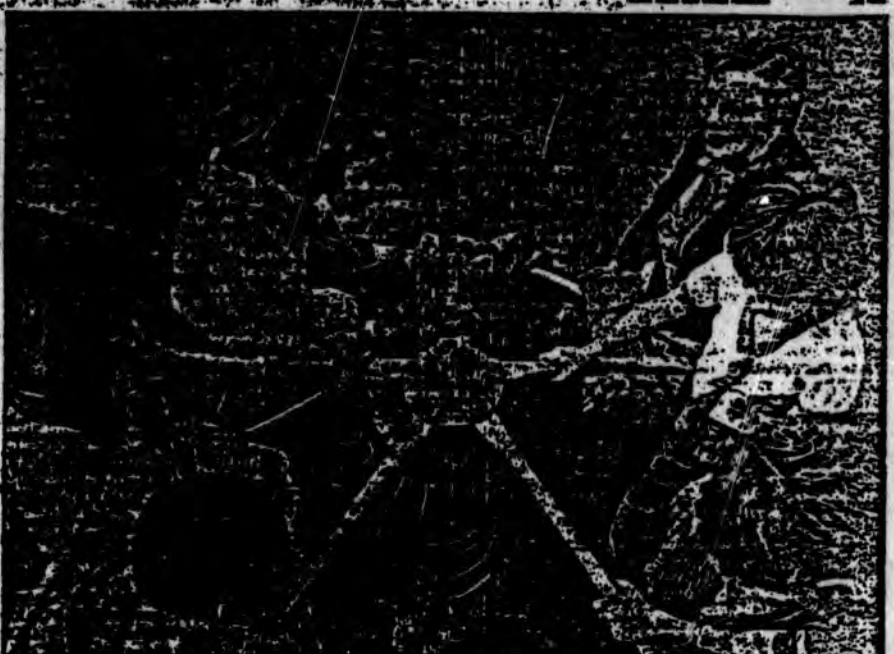
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Anchorage Daily News photo.

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 air vent caused an off-duty worker to die.
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 J. 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.

Stock 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 \$1.30 in claims 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.

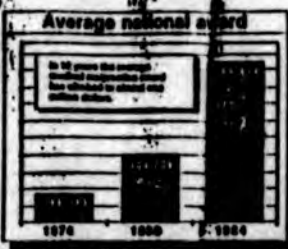
"My experience with juries are that they usually do what's right and punish outrageous conduct," Young says. "It's the same system that we have had for 300 years and it appears to be doing what it intended to do, compensate people for other people's negligence."

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 shambles 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

Following 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 Eielson, 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 choice or necessity, many small
paying Loss Coverage
last year, the crane operator paid \$5,000
\$150,000 for \$500,000 of liability insurance.
over plus 10% of his gross revenue over
the next crane operator is paying \$15,000
coverage of a company's revenue. One com-
pany's revenues are dropping a per-
centage in the amount of coverage.

...of defendant or settling lawsuit. That
...of this award, and it is...
...and that those who have claims...
...be satisfied by making the amount...

Joe Pore, a South Windsor, Conn., insurance agent, cites an auto-pays whole-dollars for whom he could find only \$15 million of fire-insurance coverage to replace a \$25 million policy that expired May 31. The new premium was \$156,000 compared with

Richard Merrill, a San Francisco insurance broker with the firm of Rollins Burdette Hunter, says two clients will drop earthquake insurance rather than pay an-
nually.

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.

...the chance. "We just don't want to expose ourselves to some kind of back on coverage, anymore, we don't happen from manufacturers. If we put something out of any additional policy

Business owners are beginning to turn to insurance regulators for help in finding overzealous, arbitrary policy cancellation and enforcement actions. Regulators can enforce the "bad faith" law, which prohibits insurers from cancelling a policy without a legitimate business reason. In some states, bad faith is a criminal offense.

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the following insurance market has been determined, the extent of the influence

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It was really a shock to me," says Tully. "I, of course, presided at Simpson's funeral. I was in charge of the service. I was really a shock to me."

Hard-to-Get Insurance
The following types of insurance are the most difficult to buy:
1. Pollution liability

2. Liquid liability	
3. Day-care center coverage	
4. Medical malpractice	
5. High-limit coverage (above \$50 million) for individual firms	

6. Allocation of assets to the various trusts
7. Commercial fishing boat coverage
8. Municipal liability
Source: Insurance Information Institute

But the firm does not believe that the new product will be a major success. It is expected to be a "niche" product, says a company spokesman. The firm is expected to be a "niche" product, says a company spokesman. The firm is expected to be a "niche" product, says a company spokesman.

... Still, he says, the further down the road they go, the more they are going to find out about the situation. He says, "We are going to have a very good idea of what is going on in the future."

The insurance market's sharp turn has
inspired other companies around year-
round comparisons. Last year, Garland Pl.
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Ky., paid a \$50 premium for \$100,000 of li-

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U.S. DEPARTMENT OF AGRICULTURE
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Small businesses such as Mr. Pop's are being squeezed the hardest.

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 13. *Elodea canadensis* (Mill.) B. S. P.
 14. *Hydrilla verticillata* (L.) Rostk Schmidt
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hoping to meet the premium at least in-
terest rates before claims had to be paid.
don't had a \$2.5 billion payout operating
loss last year, and now insurers are trying
to compensate by raising prices and get-
ting out of lines of business that have re-

THE WHITE SWAN OVAL

For the past six years, Immigration inspectors have been the beneficiaries of policies that have been designed to bring in more people. For the past six years, Immigration inspectors have been the beneficiaries of policies that have been designed to bring in more people.

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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 \$885,000 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 portfolios.

"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 cut-rate 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



Pouch V
 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



Pouch V
State Capitol
Juneau, Alaska 99811
Phone: (907) 465-3114

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:

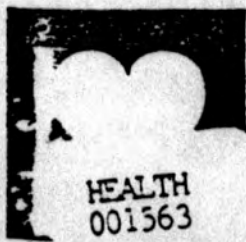
What Legislators Need to Know About Medical Malpractice



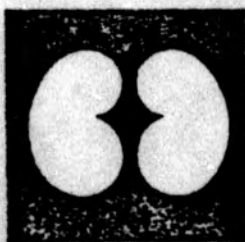
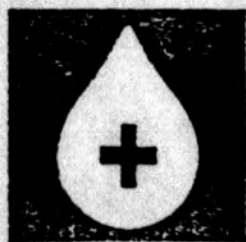
National Conference
of State Legislatures



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

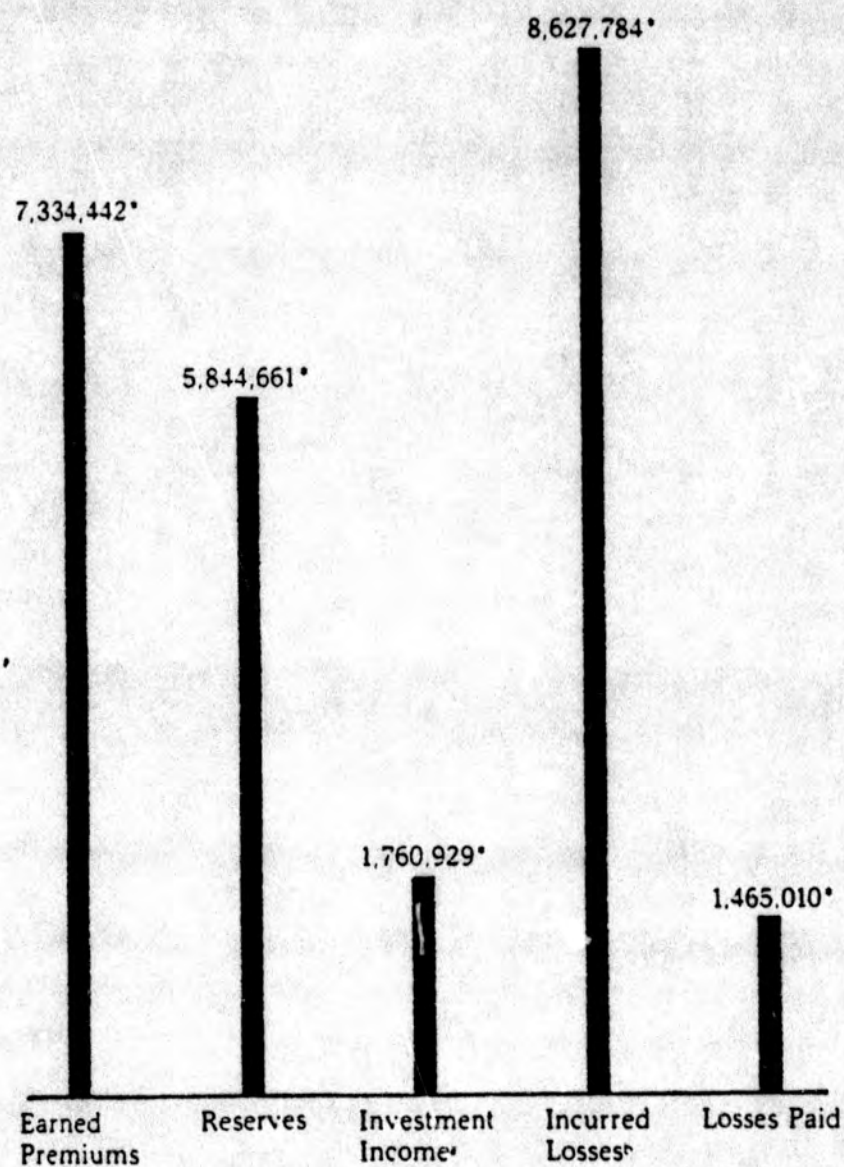
filed in the year of treatment, 30 percent in the year after treatment, 25 percent in the third year, 7 percent in the fourth year, and 8 percent in years five through 10. This long lag time makes it difficult to determine appropriate premiums and necessary reserve levels.

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.

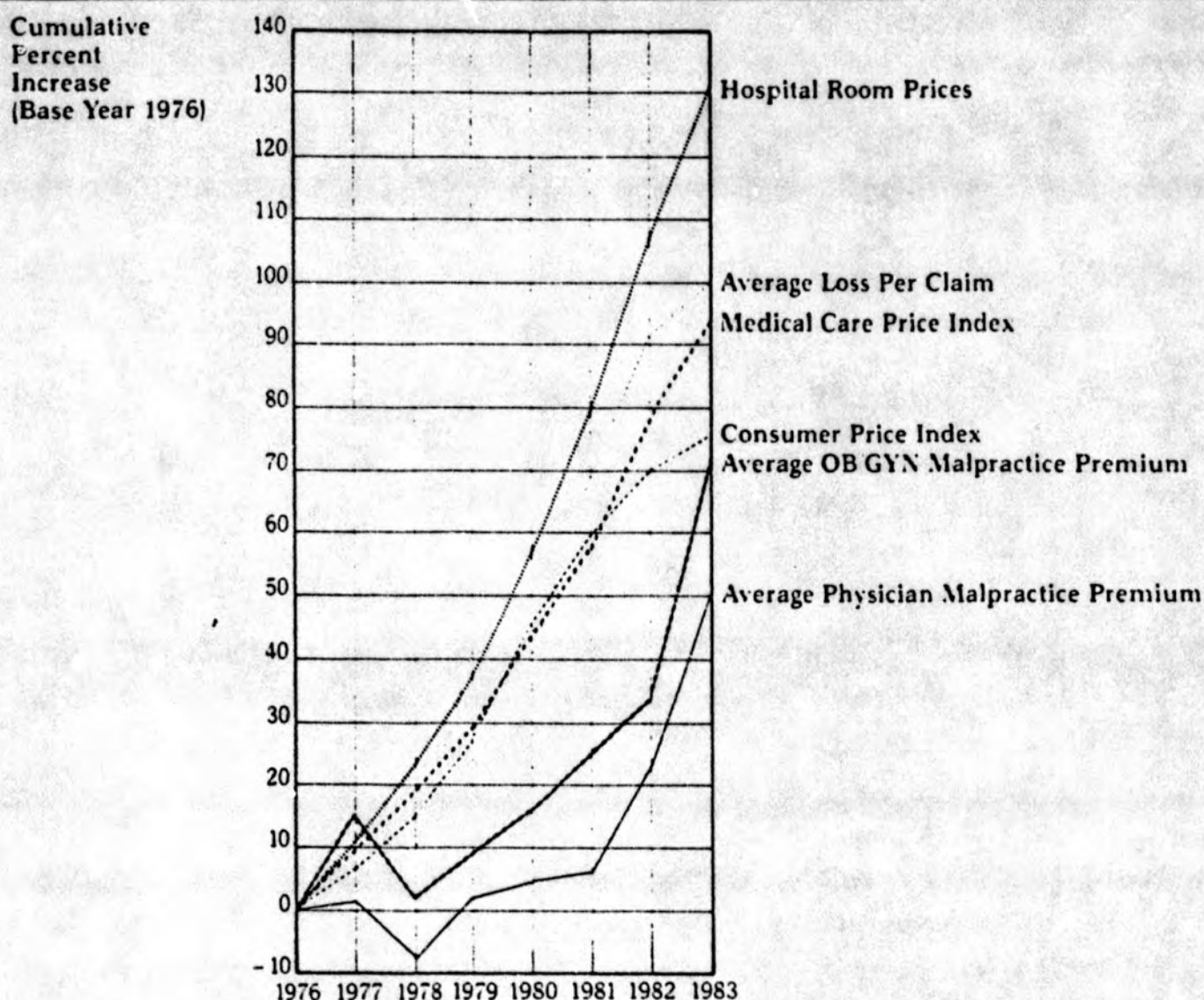
Insurance costs vary greatly by geographic region. Average physician premiums for physician-owned companies, for example, ranged from \$1,200 in Indiana to \$12,500 in New York, in 1984. Hospital premium rates also vary widely. The St. Paul Company's data showed that 1984 hospital premiums ranged from \$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

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

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.

NCSL was created in January 1975 from the merger of three organizations that served or represented state legislatures. NCSL is a nonpartisan organization with three basic objectives:

- 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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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

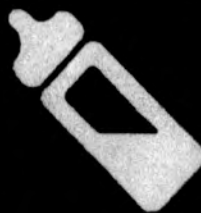
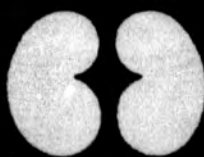
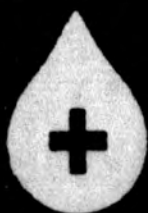


National Conference
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In early 1986, papers from the conference proceedings will be published in a symposium of the journal, *Law and Contemporary Problems*, a publication of the Duke University School of Law.

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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

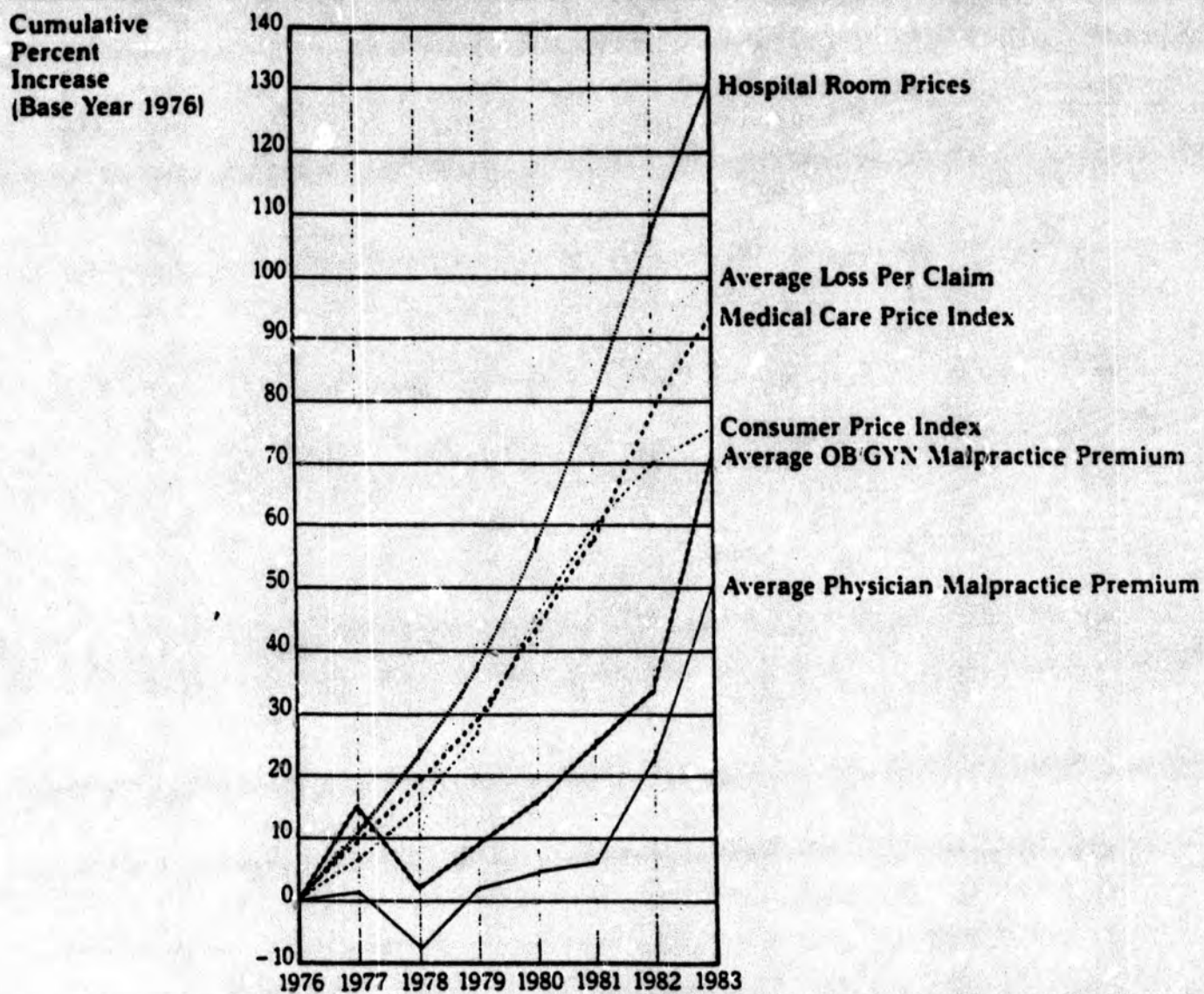
After the deluge of claims in the mid-1970s, their frequency declined briefly, from 24,240 in 1975 to 17,238 in 1978. In 1979, however, frequency once again began to rise rapidly. Physician-owned malpractice insurers experienced an increase in claim frequency from 12.17 cases per 100 physicians in 1979 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 and

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 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

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