

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
1752 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990

STUDY: TORT REFORM "ONLY IDENTIFIABLE FACTOR" IN LOWER RATES

A study of mature claims-made premiums charged by 46 physician-owned professional liability companies, released late in 1987, reveals that premiums charged by all four of the MD-owned carriers in the state are substantially lower than those in other populous states, and lower than some less populous states.

"This data provides further concrete evidence that California's tort reform measures are working," says Ron Neupauer, underwriting manager for Medical Insurance Exchange of California, which conducted the study.

"California is unique among populous states because of MICRA (Medical Injury Compensation Reform Act)," Neupauer said.

Quality of care and practice patterns are not different in this state and the legal climate and liberal appellate court decisions all would tend to drive up professional liability claims costs and premiums as they have in other states, Neupauer said.

"MICRA appears to be the one identifiable California only factor which has contributed to its lower rates," he theorized.

Neupauer said that 12 years ago, California's premiums were among the highest. Now the differences are dramatic.

"An obstetrician would pay as much as \$152,881 in Miami, compared to \$45,868 in Los Angeles. Obstetricians' rates in Michigan, Maryland

INTERNAL MEDICINE

	A	B
1	MICH (MPMLC)	\$19,279
2	NEW YORK	\$18,533
3	FLORIDA (FPIC)	\$17,402
4	FLORIDA (FPIT)	\$14,770
5	FLORIDA (PPTF)	\$14,663
6	ALASKA (MICA)	\$12,030
7	MARYLAND	\$11,725
8	ALASKA (MIEC)	\$11,256
9	MICH (PICOM)	\$10,223
10	NEVADA	\$9,480
11	ILLINOIS	\$9,020
12	ARIZONA	\$8,248
13	MISSOURI (MMIC)	\$7,932
14	HAWAII	\$7,629
15	NEW JERSEY	\$7,436
16	PENNSYLVANIA	\$7,234
17	WYOMING	\$6,156
18	OHIO (PICO)	\$5,909
19	CALIF (MIEC)	\$5,908
20	GEORGIA	\$5,898
21	CALIF (DOCTORS)	\$5,896
22	CALIF (SCPIE)	\$5,864
23	MONTANA	\$5,788
24	MISSOURI (MDA)	\$5,522
25	MAINE	\$5,414
26	CALIF (NORCAL)	\$5,412
27	DIST COLUMBIA	\$5,365
28	TENNESSEE	\$5,340
29	TEXAS (TMLT)	\$5,256
30	CONNECTICUT	\$5,254
31	OREGON (NPMIC)	\$4,951
32	WASHINGTON	\$4,756
33	IDAHO	\$4,740
34	WISCONSIN	\$4,189
35	KENTUCKY	\$4,156
36	ALABAMA	\$4,124
37	LOUISIANA	\$4,032
38	IOWA	\$3,700
39	COLORADO	\$3,660
40	NORTH CAROLINA	\$3,427
41	MINNESOTA	\$3,181
42	NEW MEXICO	\$3,104
43	UTAH	\$3,071
44	MISSISSIPPI	\$2,659
45	OKLAHOMA	\$1,751
46	INDIANA 100/300	\$1,356

OBSTETRICS/GYNECOLOGY

	E	F
1	FLORIDA (FPIC)	\$152,881
2	FLORIDA (FPIT)	\$137,399
3	FLORIDA (PPTF)	\$134,496
4	MICH (MPMLC)	\$124,635
5	MARYLAND	\$99,244
6	NEW YORK	\$94,113
7	ALASKA (MIEC)	\$76,536
8	MISSOURI (MMIC)	\$67,419
9	MICH (PICOM)	\$66,412
10	NEVADA	\$64,448
11	ALASKA (MICA)	\$64,253
12	ARIZONA	\$57,068
13	MISSOURI (MDA)	\$55,804
14	HAWAII	\$51,360
15	TEXAS (TMLT)	\$50,278
16	DIST COLUMBIA	\$43,280
17	PENNSYLVANIA	\$46,196
18	CONNECTICUT	\$47,521
19	GEORGIA	\$46,791
20	ILLINOIS	\$46,648
21	CALIF (SCPIE)	\$45,868
22	COLORADO	\$42,644
23	WYOMING	\$42,172
24	OREGON (NPMIC)	\$41,062
25	OHIO (PICO)	\$40,377
26	CALIF (DOCTOR)	\$40,368
27	IDAHO	\$40,260
28	CALIF (MIEC)	\$40,156
29	CALIF (NORCAL)	\$40,136
30	MAINE	\$40,115
31	MONTANA	\$39,660
32	ALABAMA	\$37,267
33	WASHINGTON	\$36,329
34	KENTUCKY	\$34,117
35	UTAH	\$32,938
36	IOWA	\$31,828
37	NEW JERSEY	\$31,476
38	WISCONSIN	\$31,412
39	LOUISIANA	\$29,235
40	NORTH CAROLINA	\$28,626
41	MISSISSIPPI	\$22,788
42	TENNESSEE	\$20,992
43	MINNESOTA	\$18,640
44	NEW MEXICO	\$16,153
45	INDIANA 100/300	\$11,526
46	OKLAHOMA	\$11,393

GENERAL SURGERY

	C	D
1	FLORIDA (FPIC)	\$91,730
2	FLORIDA (PPTF)	\$80,698
3	MICH (MPMLC)	\$73,961
4	FLORIDA (FPIT)	\$68,538
5	MARYLAND	\$55,621
6	NEW YORK	\$55,295
7	MISSOURI (MM)	\$51,557
8	PENNSYLVANIA	\$45,635
* 9	ALASKA (MIEC)	\$40,520
10	MICH (PICOM)	\$39,549
* 11	ALASKA (MICA)	\$37,565
12	MISSOURI (MD)	\$34,601
13	ARIZONA	\$34,272
14	NEVADA	\$34,120
15	OHIO (PICO)	\$33,327
16	CALIF (SCPIE)	\$33,024
17	ILLINOIS	\$31,256
18	CONNECTICUT	\$29,700
19	KENTUCKY	\$28,494
20	TEXAS (TMLT)	\$28,360
21	GEORGIA	\$28,308
22	HAWAII	\$27,453
23	MAINE	\$27,059
24	DIST COLUMBIA	\$26,823
25	OREGON (NPMI)	\$26,504
26	NEW JERSEY	\$25,208
27	COLORADO	\$24,356
28	CALIF (NORCAL)	\$24,024
29	WASHINGTON	\$23,360
30	WYOMING	\$22,360
31	CALIF (DOCTOR)	\$21,380
32	MONTANA	\$21,500
* 33	CALIF (MIEC)	\$21,250
34	LOUISIANA	\$21,185
35	ALABAMA	\$20,934
36	IOWA	\$19,908
37	UTAH	\$19,735
38	WISCONSIN	\$18,951
39	IDAHO	\$17,052
40	MINNESOTA	\$15,609
41	MISSISSIPPI	\$15,192
42	NORTH CAROLINA	\$15,182
43	TENNESSEE	\$15,096
44	NEW MEXICO	\$12,534
45	OKLAHOMA	\$8,702
46	INDIANA 100/3	\$7,119

NEUROSURGERY

	G	H
1	FLORIDA (PPTF)	\$170,363
2	MICH (MPMLC)	\$159,190
3	FLORIDA (FPIC)	\$152,881
4	FLORIDA (FPIT)	\$137,399
5	NEW YORK	\$115,240
6	MARYLAND	\$100,118
* 7	ALASKA (MICA)	\$89,809
* 8	ALASKA (MIEC)	\$76,536
9	MICH (PICOM)	\$73,128
10	MISSOURI (MMIC)	\$71,390
11	PENNSYLVANIA	\$69,877
12	NEVADA	\$64,448
13	ILLINOIS	\$63,752
14	ARIZONA	\$59,744
15	GEORGIA	\$58,855
16	MISSOURI (MDA)	\$55,804
17	OHIO (PICO)	\$53,835
18	TEXAS (TMLT)	\$53,303
19	DIST COLUMBIA	\$52,903
20	HAWAII	\$51,860
21	KENTUCKY	\$48,577
22	MAINE	\$47,948
23	CONNECTICUT	\$47,521
24	LOUISIANA	\$46,606
25	OREGON (NPMIC)	\$44,540
26	CALIF (NORCAL)	\$43,976
27	UTAH	\$43,862
28	NEW JERSEY	\$41,698
29	CALIF (MIEC)	\$40,156
30	WYOMING	\$39,972
31	IOWA	\$39,820
32	WISCONSIN	\$39,796
33	CALIF (SCPIE)	\$38,964
34	COLORADO	\$38,584
35	CALIF (DOCTORS)	\$38,260
36	WASHINGTON	\$38,150
37	MONTANA	\$37,596
38	ALABAMA	\$37,267
39	IDAHO	\$32,208
40	NORTH CAROLINA	\$31,515
41	MISSISSIPPI	\$30,388
42	TENNESSEE	\$22,511
43	MINNESOTA	\$19,470
44	NEW MEXICO	\$16,158
45	INDIANA 100/300	\$11,526
46	OKLAHOMA	\$11,393

and New York also are at or over the \$100,000 threshold," he said.

Subsequent success in California in enacting and upholding such tort reforms as caps on non-economic damages, limits on contingent fees, periodic payment of future damages, and collateral source rule changes all have contributed to the moderation of doctors' premiums. This should provide sound support for similar reforms in other states, Neupauer suggested.

In looking at the data collected, Neupauer pointed out that in some states, rates would be higher but for the intervention of state regulatory agencies, which in some cases may imperil certain companies' solvency.

"Claims that these insurance companies are 'profiteering' or overcharging are insupportable," he concluded.

NEXT MONTH: A report on proposed rates sought by some commercial carriers. Also, an update on tort reform and a surprising report from the United Kingdom.

The study of doctor-owned companies premium comparisons includes four representative specialties. It shows premiums for \$1 million limit coverage except for Indiana, Michigan and Wisconsin where only lower limits are offered, and Ohio, where the limit is \$1.4 million. It is reprinted with permission of MIEC.

Medical Liability Monitor

August 12, 1988

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Vol. 13

Number 8

ANALYSIS OF LATEST MD-COMPANY PREMIUM INCREASES REFLECTS TRENDS

Are medical insurance premiums finally leveling off? MLM's 1988 mid-year national survey of physician-owned companies reveals that premiums increased this year about 10% on average. Seventeen including four in California, reported no increases or increases less than 10%. Largest increases were reported by American Physicians Insurance Exchange of Texas (49.8%); Arizona (34.6%); Colorado (28.3%); Alaska (23.0%) and Georgia (21%).

Significant state tort reforms and a nationwide decline in the number of new claims filed in several regions may have contributed to the lower premium increases. The relatively modest overall increases, however, will nevertheless add some \$150 million to the aggregate annual insurance bill for some 170,000 physicians insured by these companies.

Next month MLM talks with some doctor-company leaders to find out whether this is a temporary or permanent downtrend--and why.

MLM 1988 MEDICAL MALPRACTICE INSURANCE RATE SURVEY

Doctor-companies offering \$1 million or more coverage

STATE/COMPANY	DATE CHANGE	PERCENTAGE INCREASE
Alabama	8/88	21.4 (Request filed)
Alaska	1/88	23.0
Arizona	4/88	34.6 (Request filed)
Arkansas	1/88	15.4
California		
MIBC	8/88	None
NORCAL		None
SCPIE	1/88	8.3
DOCTORS	4/88	None
Colorado	1/88	28.3
Connecticut	10/87	17.2
Dist. of Columbia	6/88	None (New renewal date: 1/1/89)
Florida		
FFIC	1/88	.5
FFIT	1/88	18.0
Georgia	5/88	21.0
Illinois	7/88	7.0
Iowa	2/88	17.7
Kentucky	4/88	10.0
Louisiana	7/88	None
Maine	9/87	25.0
Maryland	7/88	None (New renewal date: 1/1/89)
Michigan		
MMIC	4/88	9.8
Minnesota	1/88	8.0
Mississippi	1/88	15.0
Missouri		
MEMEDICO	9/87	15.0
New Jersey	2/88	None
New York	7/88	5.0
North Carolina	2/88	9.5
Ohio	8/88	10.0 (Request filed)
Oklahoma	1/88	5.0
Oregon	1/88	10.0
Tennessee	5/88	5.6
Texas		
APIE	1/88	49.8
Utah	12/87	4.5
Washington	1/88	9.0

Several physician-owned companies do not write coverage at \$1 million or more levels. They are not included in this report.

KANSAS PHYSICIANS, LAWYERS OFFER MODEL BILL... (Cont. from page 1)

panel conclusions strongly persuasive in determining the presence or absence of injury, the presence or absence of sub-standard practice, and the presence or absence of causation of such injury by substandard practice," the Kansas cardiovascular surgeon said.

Appeals from board decisions within the scope of the act go to state district courts and appellate courts, which must "act expeditiously by giving preference to the consideration of com-

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two or three providers, are convened as needed to help the board evaluate claims."

"Although the board can make decisions independently, it is mandated to

FLORIDA INSURANCE COMMISSIONER ANNOUNCES FOR U.S. SENATE

It never was a secret that Florida Insurance Commissioner Bill Gunter had political ambitions. He now has announced that he will run for the U.S. Senate seat held by retiring Lawton Chiles. He will post-date his resignation until January, 1989, to prevent the Republican governor from appointing his successor.

PIE MUTUAL EXPANDS WESTWARD INTO MISSOURI: SEES RIGHT MIX

PIE Mutual Insurance Company, Cleveland, OH, has announced that it has been authorized to offer professional liability insurance to Missouri physicians through independent agents, beginning this month. PIE writes medical protection for 8,000 physicians, surgeons and dentists in Ohio, West Virginia and Kentucky.

"Missouri offers us the mix of ingredients which have worked well for our physicians in other states," said Larry E. Rogers, PIE's president and CEO. "The state has more than 11,000 physicians in a sophisticated medical community with a good track record of controlling costs."

The company will offer up to \$7.2/\$7.6 million in modified claims-made coverage. Rates have not yet been finalized.

CONGRESSIONAL BILL, REPORT FOCUS ON QUALITY CARE MEASURES

Congress currently appears to be taking a long and positive look at ways of improving the quality of medical care available to consumers.

Seeking to facilitate effective emergency medical treatment on certain commercial flights, Rep. William Broomfield (R-MI) has introduced legislation that would enable a physician to render care to a fellow passenger suffering a heart attack or similar life-threatening condition without fear of a malpractice suit. HR 4924, entitled the In-Flight Medical Emergency Assistance Act, would free a licensed MD from constraining malpractice liability when treating an in-flight emergency.

In addition, the Congressional Office of Technology Assessment last month issued a report offering possible guidelines that individuals and organizations can use to evaluate the quality of health care. Some yardsticks for measuring quality have become necessary, said Rep. James Scheuer (D-NY) in introducing the report, because of recent changes in physician and hospital reimbursement to hold down health costs.

"These payment changes have raised concerns that physicians and hospitals facing restricted budgets and low payment rates will skimp on services to the detriment of patients' health and that third-party payors will seek low cost providers with not enough regard for their quality of care," Rep. Scheuer, Chairman of the House Subcommittee on Natural Resources, Agriculture, Research and Environment, said.

OTA evaluated many possible quality care indicators and concluded that these were best: formal disciplinary actions by state medical boards; hospital accreditation standings; physicians practicing within the confines of their training; hospital mortality rates; adverse events, such as hospital-acquired infections; and sanctions imposed by the Department of Health and Human Services based on recommendations of peer review organizations. Amount of malpractice compensation also may be an indicator. Consumers' own ratings also have good validity, the report said, but patients should combine information from more than one indicator and draw information from more than one year. OTA also said high priority should be given to identifying and improving below-par performance of MDs and hospitals.

EXECUTIVE SUMMARY

Who Should Be Liable?

A Guide
To Policy For
Dealing
With Risk

This Executive Summary is
based on a Statement on
National Policy by the
Research and Policy
Committee of the Committee
for Economic Development

 CED

Who Should Be Liable?

A Guide To Policy For Dealing With Risk

In 1985 and 1986, our economy experienced what many called a "liability crisis." This crisis reverberated throughout the economy, raising prices and disrupting the supply of a wide range of goods, services, and activities. Today the crisis has eased to some degree, but that is not grounds for complacency. The root cause of the crisis — expanding and unpredictable standards of tort liability — has not yet been resolved.

Under our American system of governance, the tort liability system is intended to perform two functions: to deter the imposition of excessive risks on others and to compensate others for injuries received as a result. But new demands on the system have strained it to the point that in some circumstances it now neither effectively deters nor efficiently compensates. Designed in a simpler age, the tort system is neither prepared to resolve many of the increasingly complex issues and disputes that now confront it, nor is it designed to adapt efficiently to society's evolving standards of acceptable risk and fair compensation. **Consequently, we believe that the United States needs to develop a more balanced approach to risk management.** Such a balanced approach requires:

- Using the tort system, better structured to handle current issues, where it is most cost-effective.
- Putting increased reliance on other more cost-effective methods to control risk and provide compensation where the tort system is ill matched to the circumstances.

For purposes of controlling risk, the two most important alternatives to tort liability are **market forces** and **government regulation**. Greater reliance on market forces and government regulation can in some areas provide better **deterrence** than the liability system. For purposes of compensation, private insurance, social insurance, and workers' compensation are often far more efficient than liability and should play a greater role.

Our challenge is two-fold: first, to achieve the best balance between risk reduction and other social goals, such as more vigorous economic growth, higher standards of living, and greater job creation; second, to design the most cost-effective mix of institutions for controlling risk and providing compensation. Achieving these goals will not be possible, however, until we accept the need to modify our current practices.

DIMENSIONS OF THE PROBLEM

While the overall number of liability claims has grown only modestly in recent years, there has been an enormous increase in some types of cases. Between 1974 and 1985, for example, the number of product liability suits in federal courts increased more than seven-fold. At the same time, the number of suits involving professional and municipal liability has also grown dramatically. The largest growth has occurred in the area of so-called mass toxic torts, cases involving thousands of claims against a single product, notably asbestos, Agent Orange, and the Dalkon Shield. By 1986, for example, more than 350,000 Dalkon Shield claims had been submitted.

The size of awards has also skyrocketed. Since 1960, the typical award for product liability and medical malpractice suits has more than doubled, after adjusting for inflation, with much larger increases for the very highest awards.

Averages, however, do not tell the full story. Unpredictable variation in liability standards and awards from case to case and jurisdiction to jurisdiction greatly magnifies the sheer uncertainty confronting consumers, corporations, professionals, municipalities, not-for-profit organizations, and others who interact with the general public.

Because the potential scope and duration of liability and the size of awards have become virtually unbounded, those engaged in producing or delivering goods and services face extraordinary difficulties in taking such risks into account in their resource allocation and pricing decisions. For similar reasons, the insurance industry to which individuals and organizations typically come for liability coverage has had a difficult time pricing risk, and liability insurance rates have increased sharply. Medical malpractice rates have increased 25 to 40 percent a year since 1985. Rates have increased several hundred percent in the space of one or two years for some groups of insureds, while other buyers report being unable to obtain the amount of coverage they would prefer.

Plaintiffs receive only a fraction of the total dollars expended through the tort system. Of the \$19.5 billion spent on non-auto cases in 1985, \$11 billion went to litigation costs, including attorneys' fees and time costs of the litigants, leaving only \$8.2 billion in compensation to plaintiffs. On average, the litigation process for non-auto cases absorbs roughly 57 percent of total expenditures.

The costs of lawsuits and liability insurance premiums are only a fraction of the total costs of the liability system. Much harder to measure are the indirect costs of loss of productivity and international competitiveness, and the loss to consumers from goods and services that are withdrawn or simply not produced. Many U.S. firms incur much greater insurance costs than their foreign competitors. Total U.S. liability insurance costs, for example, exceed those of Japan by a factor of fifteen. Such high costs have forced some American companies out of certain high-risk markets. Moreover, nearly half of the large firms and two-thirds of small firms which responded to a recent Conference Board survey report that the increased threat of liability had significantly curtailed their provision of products and services.

Unfortunately, the available data are inadequate to measure the full costs and the benefits of the liability system. Some withdrawal of risky products is expected—indeed intended—under a well-functioning liability system, and some expenditures on dispute resolution are inevitable. But in our judgment, there is good reason to believe that the current drift in liability rules leads to distortions in production, withdrawal of products that optimally should be marketed, and wasteful litigation costs. We believe the partial data and practical experience available today permit us to reach reasonable judgments on ways of improving our systems of risk management and deterrence.

CAUSES OF THE PROBLEM

Chiefly through a succession of court cases, liability for personal injury has been expanded from a fault-based standard to strict and increasingly to absolute liability. Manufacturers can be held liable for risks that were scientifically unknowable at the time of production. Furthermore, they can be found liable if the plaintiff wantonly misused the product, if other parties contributed to the injury, and even if no connection was established between a defendant's actions and a plaintiff's injury. Employees covered by workers' compensation have been allowed to sue in tort even though participation in the program was originally intended to be a bar to such suits.

Imposing liability where a defendant has taken all reasonable precautions serves no positive deterrent function—on the contrary, it undermines the incentive for other parties to take appropriate care and may lead to the withdrawal of products that cannot be designed to prevent misuse.

Risk reduction has been one goal driving the expansion of liability. But in setting standards of liability or regulation, it is essential to recognize that zero risk is neither technically possible nor financially feasible due to our limited resources. Because of these resource constraints, we need to make more clear-cut and rational decisions on the trade-

offs we will accept between risk reduction and other social goals we also hold dear. It is also essential to recognize that when more than two parties can reduce or aggravate risk, optimal risk management requires providing all with incentives to take appropriate care.

More complete **compensation** has been another goal driving the expansion of liability. But expanding liability in order to compensate is grounded in the mistaken belief that defendants can spread this risk at minimal cost. In fact, the costs of increased tort compensation are largely passed on to consumers through higher prices, and in some cases, through the decreased availability of useful products and services.

But providing compensation through the courts is extremely inefficient. Lawsuits provide less compensation per dollar spent than any form of insurance: plaintiffs receive only 40 cents per dollar spent on lawsuits while workers' compensation pays the injured party roughly 60 cents per cost dollar and private health insurance pays over 80 cents per cost dollar. Moreover, lawsuits often take months or years to settle before any award is made. In addition, tort compensation is a poor form of insurance because awards are highly uncertain in amount and timing and often simply duplicate other private and social insurance payments.

RECOMMENDATIONS

Using the liability system is only one of several approaches to achieving the goals of efficient and equitable risk management, injury compensation, and dispute resolution. Market incentives, public regulation, private health and disability insurance, social insurance, and workers' compensation all have important roles to play in how the United States deals with risk. **Our goal should be to improve the cost-effectiveness of each of these mechanisms and to ensure their efficient integration.**

Achieving these goals will require extensive efforts by Congress, state legislatures, the courts, the legal profession, manufacturers, and insurers. If well-designed, our courts, regulatory agencies, and social and private insurance programs can mesh with one another and with market forces to jointly control risk and compensate injury appropriately. But if they remain poorly designed and uncoordinated, these potentially useful corrective forces can generate wasteful and draining distortions on our economy.

The following is a summary of our key recommendations to prevent such waste. Other changes are also needed; they are discussed in greater detail in our full report. We have included a limited glossary at the end explaining some of the legal terms used below.

A. CHOICE OF INSTITUTIONS

We strongly believe that when consumers and workers are reasonably well informed, market forces can provide appropriate incentives to control risk. However, when market forces produce insufficient incentives for safety—either because risks are latent or third parties are affected—the control of excessive risk by tort* liability or regulation should be considered. Managing risk by regulation is more appropriate than tort liability in circumstances that call for uniform standards based on technical expertise beyond the competence of the typical consumer and the typical juror, or where damages are highly diffuse or distant in time or place from the harmful activity.

- Courts should honor contractual agreements between well informed parties. This would include disallowing suits where risks were obvious to the parties and adhering to liability insurance and other contractual agreements.
- Standard setting by existing regulatory agencies such as OSHA, EPA, and the FDA should be the main instrument for controlling environmental and chemical hazards, pharmaceuticals, and medical devices.
- Compliance with regulatory standards of product design or warning should be a bar to tort liability, except in cases of fraud or suppression of evidence.
- The workers' compensation (WC) system should be the sole remedy for work-related injuries and diseases where occupational exposure is the predominant cause. Tort actions should be disallowed, because market forces, regulation, and the WC system provide strong incentives for risk control. To assure fair compensation for work-related injuries, WC benefits should provide for full replacement of after-tax earnings and reasonable medical and rehabilitation expense, and should be indexed to keep pace with inflation.

B. REFORM OF THE TORT SYSTEM

The primary goal of tort liability, when used, should be to create efficient incentives to all relevant parties to control risk. Deterring excessive risk should override concern for compensation if these two goals conflict, because of the greater cost to society of not deterring risk properly and because other insurance mechanisms are more cost-effective if compensation is the main concern. To the extent possible, tort standards should be gov-

*See Glossary

erned by clear and predictable rules. This is essential for efficient deterrence and compensation and to reduce expenditure on litigation. Several of our recommendations apply to all areas of tort liability. Others are specific to product liability.

1. GENERAL RECOMMENDATIONS

- Liability should be based on a notion of fault or failure to take cost-justified precautions.
- Joint and several liability* should be eliminated. Joint and several liability violates the deterrent principle of assessing costs to responsible parties. It encourages the frivolous naming of deep pocket* defendants who can now be held fully liable even if only minimally responsible. It also limits the ability of insurers to perform accurate risk assessment.
- A state-of-the-art defense* and a reasonable statute of repose* are required to prevent retroactive application of new knowledge and new standards of liability. Liability imposed retroactively for unknowable risk cannot usefully deter.
- Compensatory awards should be modeled along the same lines as private and social insurance. Specific guidelines (indexed for inflation) should be set by statute for both monetary and nonmonetary loss. Narrowing the discretion of the courts would make awards more equitable, reduce incentives for litigation, and reduce uncertainty for all parties concerned.
- Compensatory awards for monetary loss should aim to replace after-tax wages (with special provisions for persons not in the labor force) and cover appropriate medical, rehabilitation, and special educational expenses. Payments for nonmonetary loss should be reasonable and made according to a schedule based on the plaintiff's age and severity of injury.
- Tort and nontort insurance coverages need to be better coordinated, but more fact-finding and study is needed to determine the best method of coordination.
- Punitive damages should be awarded only in cases of willful misconduct* and should be limited to a modest multiple of the compensatory awards. Punitive damages should be coordinated across different cases relating to the same issue.
- Aggressive judicial management should be used to prevent strategic abuse of pretrial tactics. Judges should not allow unsubstantiated testimony of expert witnesses, should be more willing to grant summary judgment, should send to the jury only those issues that are truly within the jury's realm of expertise, and should consider reducing excessive awards.

*See Glossary

2. PRODUCT LIABILITY

- A federal product liability statute should be enacted. The current diversity of state standards generates costly and inefficient uncertainty.
- Courts should disallow or modify liability if a product is unreasonably misused, altered, or used in a way contrary to explicit warnings.

3. INTERNATIONAL RIGHTS AND RESPONSIBILITIES

- All U.S. courts should deny access to foreign litigants for injuries occurring outside of the United States, as most federal courts already do. Foreign sellers of products in the United States should be subject to financial responsibility requirements as stringent as those applied to U.S. firms. These principles will assure both U.S. and foreign consumers the same tort rights against foreign-based suppliers as against domestic firms.

4. NONOCCUPATIONAL MASS TORTS

- Further study is needed to determine the best way to handle the unique and highly complex problems raised by mass tort cases. Our tentative recommendation is that such claims should be permitted only where the contribution to injury by the defendant exceeds some threshold. Alternatively, damages paid by the defendant could be reduced by the percentage contribution of other factors.

C. STANDARD SETTING THROUGH REGULATION

- The goal of regulatory standards should be to achieve roughly equal marginal benefits in terms of life-years saved per dollar spent for all types of hazards.
- Performance standards should be set in terms of target quality or risk levels. Regulations requiring specific process standards destroy incentives for developing new methods that can achieve the desired result at lower cost.

D. ALTERNATIVE DISPUTE RESOLUTION

There are abundant opportunities for reducing the costs and delay of dispute resolution through one or another of various alternatives to court trials that are being developed around the country. We recommend:

- Parties should be permitted and encouraged to contractually adopt alternative systems of dispute resolution (ADR) such as arbitration, mediation, and mini-trials, provided that such contracts clearly state where rights to a jury trial are being waived.

E. ALTERNATIVE COMPENSATION PROGRAMS

- Because the tort system has much higher overhead costs than other insurance programs, it should be used for purposes of compensation only where it can also perform a useful deterrent function.
- For those without adequate coverage for injury, expanding existing private or social insurance programs is preferable to creating new programs targeted at specific injuries.

Our current mix of institutions for risk control and injury compensation has evolved in an uncoordinated fashion that entails much wasteful duplication and even inconsistent standards, and at the same time leaves many legitimate needs inadequately attended. Correcting these large-scale inefficiencies and inequities requires statutory, judicial, and regulatory changes, as well as private initiatives. It also requires more comprehensive coordination among these public and private systems. A more systematic approach is essential to halt the trends which lead the liability system to attempt to perform functions it is not designed to perform and which can be achieved far more efficiently through other means. We believe this study points the way to such a goal.

GLOSSARY

Deep pocket defendant: A defendant with relatively large financial assets or insurance.

Joint and several liability: A rule that permits a plaintiff to collect the full amount of damages from any single defendant, in cases where multiple defendants are found to have contributed to the injury, regardless of the relative fault of each defendant.

State-of-the-art defense: A defense which bars suits if the defendant complied with standards of care or a product was not defective, given the state of knowledge and what was reasonably knowable at the time of the defendant's action.

Statute of limitation: A statute prescribing a specified period of time in which a lawsuit can be filed, sometimes running from the date at which the plaintiff discovered (or should have discovered) the injury.

Statute of repose: A limit on the time within which a suit may be brought, with the limit defined from the date of the defendant's alleged harmful act, as opposed to the date the plaintiff discovered the injury (see statute of limitation).

Tort: A private or civil wrong or injury other than breach of contract, for which redress in the form of damages can be sought under common law.

Willful misconduct: Conduct which intentionally and voluntarily disregards the safety of others, such as failure after knowledge of an impending danger to exercise ordinary care to prevent it.

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Official Title and Summary Prepared by the Attorney General

INSURANCE RATES, REGULATION, COMMISSIONER. INITIATIVE STATUTE Requires minimum 20-percent rate reduction from November 8, 1987, levels, for automobile and other property/casualty insurance. Freezes rates until November 8, 1989, unless insurance company is substantially threatened with insolvency. Thereafter requires every insurer offer any eligible person a good-driver policy with 20-percent differential. Requires public hearing and approval by elected Insurance Commissioner for automobile, other property/casualty insurance rate changes. Requires automobile premiums be determined primarily by driving record. Prohibits discrimination, price-fixing, unfair practices by insurance companies. Requires commissioner provide comparative pricing information. Authorizes insurance activities by banks. Summary of Legislative Analyst's estimate of net state and local government impact: Would increase Department of Insurance administrative costs by \$10 to \$15 million in first year, varying thereafter with workload, to be paid by additional fees on the insurance industry. State and some local governments would have unknown savings from lower insurance rates. Gross premium tax reduction of approximately \$125 million for first three years offset by required premium tax rate adjustment. Thereafter, possible state revenue loss if rate reductions and discounts continue but gross premium tax is not adjusted.

Analysis by the Legislative Analyst

Background

Various types of insurance are sold in California, including automobile, liability, fire, health and life. In 1987, companies collected about \$50 billion in premiums from the sale of insurance. In turn, the state received about \$1 billion from a tax on these premiums.

Motor vehicle insurance is one of the major types of insurance purchased in the state. It accounted for about \$12 billion (24 percent) of all premiums collected during 1987. Additionally, fire and liability insurance premiums totaled about \$10 billion, or 21 percent, of all premiums.

Rate Setting by Insurance Companies. Currently, insurance companies set rates for various types of insurance, using a number of factors. For motor vehicle insurance, these factors generally include the age, sex, marital status, driving record, type of vehicle and home address of the insured. The insurance companies also take into consideration other factors such as their claims experience, income and expenses. Insurance companies are not required to tell the public what relative weight they give to these factors when setting rates. In addition, insurance companies are not subject to the state's anti-trust laws.

Role of the Department of Insurance in Reviewing Rates. Currently, the Department of Insurance does not review and approve insurance rate changes before they take effect. Instead, the Department of Insurance can request insurance companies to justify such rates *after* they take effect, as part of the rate examination process or in response to complaints from consumers. Historically, the scope and frequency of rate examinations has been limited.

Proposal

In summary, this measure:

- Requires insurance companies to reduce rates for various types of insurance, including motor vehicle, fire and liability.
- Requires insurance companies to offer a "Good Driver Discount Plan" and makes other changes regarding automobile insurance.

- Requires the Insurance Commissioner to review and approve rate increases—for various types of insurance—before they can take effect.
- Requires that the Insurance Commissioner be elected.

This measure changes the laws that regulate insurance rates for certain types of insurance. It applies to motor vehicle, fire and liability insurance, but not to life, mortgage and disability insurance.

Rate Reductions

1. Rate Reduction. This measure requires that rates for motor vehicle, fire and liability insurance issued or renewed on or after November 8, 1988, be reduced by 20 percent from their levels on November 8, 1987.

2. Rate Freeze. The measure requires that the rates be kept at the reduced levels until November 8, 1989. During this period, the rates can be increased only if the Insurance Commissioner determines that the affected insurance company is threatened with insolvency.

Review and Approval of Insurance Rate Filings

Beginning November 8, 1989, the measure requires the Insurance Commissioner to review and approve rate changes before they go into effect. Insurance companies are required to file information with the commissioner to justify the new rates. In general, the commissioner is required to hold a public hearing on the proposed rate change whenever it exceeds certain percentages. Additionally, the commissioner is authorized to hold a hearing when requested by a consumer.

Good Driver Discount Plan and Other Automobile Provisions

1. "Good Driver" Discount. This measure requires insurance companies to offer motor vehicle insurance to good drivers at reduced rates. These rates would take effect November 8, 1989, (one year after the general rate reduction) and would be 20 percent below the rate which would otherwise have been paid for the same coverage.

Continued on page 140

Text of Proposed Law

This initiative measure is submitted to the people in accordance with the provisions of Article II, Section 8 of the Constitution.

This initiative measure adds and repeals sections of the Insurance Code, and adds a section to the Revenue and Taxation Code; therefore, existing sections proposed to be deleted are printed in *strikeout type* and new provisions proposed to be added are printed in *italic type* to indicate that they are new.

PROPOSED LAW

SECTION 1. Findings and Declaration.

The People of California find and declare as follows:

Enormous increases in the cost of insurance have made it both unaffordable and unavailable to millions of Californians.

The existing laws inadequately protect consumers and allow insurance companies to charge excessive, unjustified and arbitrary rates.

Therefore, the People of California declare that insurance reform is necessary. First, property-casualty insurance rates shall be immediately rolled back to what they were on November 8, 1987, and reduced no less than an additional 20%. Second, automobile insurance rates shall be determined primarily by a driver's safety record and mileage driven. Third, insurance rates shall be maintained at fair levels by requiring insurers to justify all future increases. Finally, the state Insurance Commissioner shall be elected. Insurance companies shall pay a fee to cover the costs of administering these new laws so that this reform will cost taxpayers nothing.

SECTION 2. Purpose.

The purpose of this chapter is to protect consumers from arbitrary insurance rates and practices, to encourage a competitive insurance marketplace, to provide for an accountable Insurance Commissioner, and to ensure that insurance is fair, available, and affordable for all Californians.

SECTION 3. Reduction and Control of Insurance Rates.

Article 10, commencing with Section 1861.01 is added to Chapter 9 of Part 2 of Division 1 of the Insurance Code to read:

Insurance Rate Rollback

1861.01. (a) For any coverage for a policy for automobile and any other form of insurance subject to this chapter issued or renewed on or after November 8, 1988, every insurer shall reduce its charges to levels which are at least 20% less than the charges for the same coverage which were in effect on November 8, 1987.

(b) Between November 8, 1988, and November 8, 1989, rates and premiums reduced pursuant to subdivision (a) may be only increased if the commissioner finds, after a hearing, that an insurer is substantially threatened with insolvency.

(c) Commencing November 8, 1989, insurance rates subject to this chapter must be approved by the commissioner prior to their use.

(d) For those who apply for an automobile insurance policy for the first time on or after November 8, 1988, the rate shall be 20% less than the rate which was in effect on November 8, 1987, for similarly situated risks.

(e) Any separate affiliate of an insurer, established on or after November 8, 1987, shall be subject to the provisions of this section and shall reduce its charges to levels which are at least 20% less than the insurer's charges in effect on that date.

Automobile Rates & Good Driver Discount Plan

1861.02. (a) Rates and premiums for an automobile insurance policy, as described in subdivision (a) of Section 660, shall be determined by application of the following factors in decreasing order of importance:

(1) The insured's driving safety record.

(2) The number of miles he or she drives annually.

(3) The number of years of driving experience the insured has had.

(4) Such other factors as the commissioner may adopt by regulation that have a substantial relationship to the risk of loss. The regulations shall set forth the respective weight to be given each factor in determining automobile rates and premiums. Notwithstanding any other provision of law, the use of any criterion without such approval shall constitute unfair discrimination.

(b) (1) Every person who (A) has been licensed to drive a motor vehicle for the previous three years and (B) has had, during that period, not more than one conviction for a moving violation which has not eventually been dismissed shall be qualified to purchase a Good Driver Discount policy from the insurer of his or her choice. An insurer shall not refuse to offer and sell a Good Driver Discount policy to any person who meets the standards of this subdivision. (2) The rate charged for a

Good Driver Discount policy shall comply with subdivision (a) and shall be at least 20% below the rate the insured would otherwise have been charged for the same coverage. Rates for Good Driver Discount policies shall be approved pursuant to this article.

(c) The absence of prior automobile insurance coverage, in and of itself, shall not be a criterion for determining eligibility for a Good Driver Discount policy, or generally for automobile rates, premiums, or insurability.

(d) This section shall become operative on November 8, 1989. The commissioner shall adopt regulations implementing this section and insurers may submit applications pursuant to this article which comply with such regulations prior to that date, provided that no such application shall be approved prior to that date.

Prohibition on Unfair Insurance Practices

1861.03. (a) The business of insurance shall be subject to the laws of California applicable to any other business, including, but not limited to, the Unruh Civil Rights Act (Civil Code Sections 51 through 53), and the antitrust and unfair business practices laws (Parts 2 and 3, commencing with section 16600 of Division 7, of the Business and Professions Code).

(b) Nothing in this section shall be construed to prohibit (1) any agreement to collect, compile and disseminate historical data on paid claims or reserves for reported claims, provided such data is contemporaneously transmitted to the commissioner, or (2) participation in any joint arrangement established by statute or the commissioner to assure availability of insurance.

(c) Notwithstanding any other provision of law, a notice of cancellation or non-renewal of a policy for automobile insurance shall be effective only if it is based on one or more of the following reasons: (1) non-payment of premium; (2) fraud or material misrepresentation affecting the policy or insured; (3) a substantial increase in the hazard insured against.

Full Disclosure of Insurance Information

1861.04. (a) Upon request, and for a reasonable fee to cover costs, the commissioner shall provide consumers with a comparison of the rate in effect for each personal line of insurance for every insurer.

Approval of Insurance Rates

1861.05. (a) No rate shall be approved or remain in effect which is excessive, inadequate, unfairly discriminatory or otherwise in violation of this chapter. In considering whether a rate is excessive, inadequate or unfairly discriminatory, no consideration shall be given to the degree of competition and the commissioner shall consider whether the rate mathematically reflects the insurance company's investment income.

(b) Every insurer which desires to change any rate shall file a complete rate application with the commissioner. A complete rate application shall include all data referred to in Sections 1857.7, 1857.9, 1857.15, and 1864 and such other information as the commissioner may require. The applicant shall have the burden of proving that the requested rate change is justified and meets the requirements of this article.

(c) The commissioner shall notify the public of any application by an insurer for a rate change. The application shall be deemed approved sixty days after public notice unless (1) a consumer or his or her representative requests a hearing within forty-five days of public notice and the commissioner grants the hearing, or determines not to grant the hearing and issues written findings in support of that decision, or (2) the commissioner on his or her own motion determines to hold a hearing, or (3) the proposed rate adjustment exceeds 7% of the then applicable rate for personal lines or 15% for commercial lines, in which case the commissioner must hold a hearing upon a timely request.

1861.06. Public notice required by this article shall be made through distribution to the news media and to any member of the public who requests placement on a mailing list for that purpose.

1861.07. All information provided to the commissioner pursuant to this article shall be available for public inspection, and the provisions of Section 6254(d) of the Government Code and Section 1857.9 of the Insurance Code shall not apply thereto.

1861.08. Hearings shall be conducted pursuant to Sections 11500 through 11528 of the Government Code, except that: (a) hearings shall be conducted by administrative law judges for purposes of Sections 11512 and 11517, chosen under Section 11502 or appointed by the commissioner; (b) hearings are commenced by a filing of a Notice in lieu of Sections 11503 and 11504; (c) the commissioner shall adopt,

Continued on page 140

Argument in Favor of Proposition 103

There are important differences between the five insurance initiatives on the November ballot which you should be aware of before voting.

Proposition 103—Voter Revolt to Cut Insurance Rates—is the only insurance initiative written and paid for exclusively by consumers. It alone reduces all of your automobile, home and business insurance premiums to November 1987 prices. Then, it alone cuts them another 20%.

Proposition 103 will also end the insurers' exemption from the antimonopoly laws, allow people to elect the Insurance Commissioner, require a special 20% discount for good drivers, and stop unfair price increases in the future. It specifies that a permanent, independent consumer watchdog system will champion the interests of insurance consumers.

Proposition 103 is written in plain language. There are no loopholes or fine print. Unlike the other propositions, nonlawyers can read it.

Because the polls showed that the insurance industry could not defeat Voter Revolt's 103 directly, the insurance companies came up with a plan to defeat it indirectly. They are pushing Proposition 104—the so-called "no-fault" proposition—and are spending tens of millions of dollars to advertise that it is better for consumers than Proposition 103.

Privately, insurance executives have admitted that their Proposition 104 would actually raise auto insurance premiums for many drivers. Worse, Proposition 104 rewrites the entire California Insurance Code to benefit insurance companies. The 24,000 words of obscure legalese in Proposition 104 turn the law into a "your fault" system. Their fine print cancels out every consumer reform in Voter Revolt's Proposition 103.

Some insurance companies disagree with "no fault," so they're financing Proposition 101, which claims to make the biggest cut in auto insurance. But the big cut they boast about affects only one portion of your auto insurance—they could raise premiums for the rest of your coverage as much as they want. In return, Proposition 101 allows insurance companies to avoid full payment for accidents. It, too, cancels many of the auto insurance reforms in Proposition 103.

Insurance companies are also financing Proposition 106, which restricts your right to quality legal counsel. The insurance companies claim Proposition 106 will cut their costs. In fact, it will limit your ability to make the insurance companies pay up.

Proposition 100, which is paid for by trial lawyers and bankers, simply does not go far enough to protect consumers' interests. Unlike Proposition 103, it does not automatically and immediately cut insurance rates. Nor does it enable consumers to permanently unite to fight against insurance abuse, as Voter Revolt's Proposition 103 does.

Proposition 103 is the only initiative written and paid for exclusively by consumers. It will save you the most money.

To guarantee that every reform in Voter Revolt's Proposition 103 becomes law, it must get more "Yes" votes than any other proposition. Every vote in favor of another insurance proposition cancels your vote for Proposition 103. That's why we advise you to vote "Yes" *only* on Proposition 103.

RALPH NADER
Consumer Advocate

HARVEY ROSENFELD
*Chair, Voter Revolt to Cut Insurance Rates/
Proposition 103*

Rebuttal to Argument in Favor of Proposition 103

Proponents of PROP 103 claim that their initiative includes no "fine print," but IT'S FULL OF UNINTENDED CONSEQUENCES THAT WILL WIPE OUT ANY BENEFITS IT PROMISES YOU. VOTE NO ON PROP 103.

The most glaring example of this "fine print" allows for massive government intervention into the insurance industry. A GOVERNMENT-RUN INSURANCE SYSTEM IS NOT THE ANSWER.

In New Jersey, where the government intervened in the insurance business under circumstances similar to those mandated in PROP 103, every driver is paying a surcharge to help foot a \$2.5-billion deficit racked up by the state-run insurance system.

PROP 103 advocates also tell you their initiative contains no loopholes. Look again. It's loaded with them.

- **RATES WILL INCREASE** by an average 22% for two-thirds of the state's drivers, according to the State Department of Insurance, because PROP 103

eliminates rating based on the driving safety record of your neighborhood and forces suburban and rural drivers to subsidize motorists in high-risk areas.

- **DRUNK DRIVERS** who haven't lost their licenses can qualify for "good driver" discounts.

A MASSIVE BUREAUCRACY IS NOT THE SOLUTION. Only fundamental reform of our auto insurance system will hold down insurance premiums. We need to reduce the cost of litigation, fraud and subsidizing uninsured motorists.

PROP 103 DOES NOT REFORM OUR SYSTEM. IT DOES NOT GUARANTEE YOU LONG-TERM RATE REDUCTIONS.

Vote NO on PROP 103.

ALISTER MCALISTER
Former Chair, Assembly Finance and Insurance Committee

ED DAVIS
State Senator, 19th District

KIRK WEST
President, California Chamber of Commerce

Argument Against Proposition 103

KEEP BIG GOVERNMENT OUT OF THE AUTO INSURANCE BUSINESS.

You might think PROP 103's auto insurance rate reductions seem too good to be true. You're right.

Vote NO on PROP 103; it does not enact any cost-cutting reforms. Instead, it attacks the symptoms of our failing auto insurance system. It does not address, let alone begin to grapple with, the real problem—the cost of uninsured motorists, fraud and, most importantly, *run-away auto accident litigation*.

PROP 103 might seem well-intentioned but, unfortunately, it inevitably would lead to a huge, state-run insurance system costing millions of dollars.

Hidden provisions of this measure give the state unprecedented authority to enter the insurance business. If you think lines are long and the bureaucracy impenetrable at government offices today, just wait until you have to deal with the state to purchase insurance.

This sloppily drafted measure will:

- *Raise insurance premiums, in the long term, for the majority of California drivers.* PROP 103 forces insurers to ignore the driving safety record of where you live and, instead, forces you to subsidize drivers in areas that have the highest insurance losses. For example, a 55-year-old suburban driver will end up paying more for insurance so that a young urban driver can pay less. A State Department of Insurance study recently predicted that this aspect of PROP 103 will raise rates for two-thirds of the state's drivers

by an average 22%!

- *Allow convicted drunk drivers who have not lost their licenses to win an additional rate discount for "good driving."*
- *Make the Insurance Commissioner an elected official with enormous new powers.* This "insurance czar" would be a politician first, and a regulator second. As a politician, this official would be preoccupied with raising campaign money from special interests all too willing to "buy" influence.
- *Create a huge government bureaucracy that does nothing to make auto insurance more affordable.* Instead, PROP 103 would add time, expense and lots of lawyers to enact a price-control policy that has failed miserably in New Jersey and other states. To carry out this price-control policy, the measure increases the Department of Insurance's budget by 33% and its staff by at least 100 new bureaucrats.

VOTE NO on PROP 103. Lowering auto premiums for California drivers is a laudable goal, but this measure's flawed methods are not the answer. Please VOTE NO on PROP 103.

KIRK WEST

President, California Chamber of Commerce

WILLIAM CAMPBELL

State Senator, 31st District

Chairman, Joint Legislative Budget Committee

DAVID DAVREUX

Author, Consumers' Guide to Auto Insurance

Rebuttal to Argument Against Proposition 103

The insurance companies want to divert your attention away from the fact that Prop 103 will save *everyone* 20% on their auto insurance as well as their home and business insurance. That's why the statement above employs confusing and often ridiculous arguments against it.

Here are the facts:

- 103 is the *only* initiative that will immediately cut *everyone's* premiums by 20%.
- 103 forces insurance companies to base your rates on your driving record first, rather than on where you live. That means good drivers throughout the state will pay less than they do now, while bad drivers will pay more.
- 103 eliminates the insurance industry's unfair exemption from the antitrust laws. This will reduce rates permanently.
- 103 involves no new government bureaucracy—just a

new set of rules to create a competitive marketplace and prohibit excessive rates.

- 103 will actually save money for taxpayers, according to the official California State Legislative Analyst.
- And no wonder the insurance companies don't want an elected Insurance Commissioner—in the states where people elect insurance commissioners, rates average 30% lower than in California.

Voter Revolt's Proposition 103 is the *only* insurance reform initiative written and paid for exclusively by consumers. That's why it is the *only* initiative endorsed by Ralph Nader.

103 will lower insurance rates for everyone. That's why the insurance industry is against it. Don't buy their misleading advertising. Vote YES on Proposition 103.

HARVEY ROSENFELD

Chair, Voter Revolt to Cut Insurance Rates/
Proposition 103

Proposition 103: Analysis

Continued from page 98

In general, this measure defines a good driver as a person who, during the last three years, has (a) held a driver's license and (b) had no more than one conviction for a moving violation.

2. **Determining Factors for Rates.** In general, the measure requires that rates and premiums for automobile insurance be determined on the basis of the insured person's driving record, miles driven and number of years of driving experience.

Other Insurance-Related Provisions

1. **Antitrust Laws.** The measure makes insurance companies subject to the state's antitrust laws.

2. **Election of Insurance Commissioner.** The measure requires that the Insurance Commissioner be elected, the first election taking place in 1990.

3. **Consumer Assistance.** The measure requires the establishment of a nonprofit corporation to represent the interests of insurance consumers. Additionally, the measure requires the Insurance Commissioner to provide consumers—upon request and for a reasonable fee—with a comparison of the rates for each personal (that is, noncommercial) type of insurance offered in California. In general, this would include rates for private automobile, homeowner's and renter's insurance.

4. **Discounts or Rebates.** The measure permits insurance agents and brokers to give certain discounts or rebates to those who buy insurance from them. It does so, by eliminating the prohibition in current law against such discounts or rebates.

Fiscal Effect

Costs

Department of Insurance. This measure would increase the Department of Insurance's administrative costs by between \$10 million to \$15 million during 1988-89. These costs would be financed out of the Insurance Fund which is supported by fees and assessments on

the insurance industry. Given the current balance in this fund, fees and assessments would have to be increased to cover these costs.

In years following, these costs could be somewhat lower or higher, depending on workload.

State and Local Governments. While some local governments purchase insurance, most "self-insure" by relying upon their own resources to pay losses and claims. The state is generally self-insured, but does purchase some liability and fire insurance. Because this measure reduces the rates for certain types of insurance, including motor vehicle, fire and liability, it would result in unknown savings to the state and those local governments that purchase such insurance.

Revenues

Insurance companies pay a tax based on the amount of gross premiums they receive each year from insurance sold in California. These tax revenues are deposited in the State General Fund.

Starting in November 1988, this measure requires that rates for motor vehicle, fire and liability insurance be reduced. These lines of insurance account for about 45 percent of all California insurance premiums. A good driver discount takes effect a year later. The Department of Insurance's new role in reviewing and approving proposed rate changes also takes effect in November 1989. The rate reductions and the good driver discounts combined normally would reduce state insurance tax revenues by about \$125 million a year. This estimate assumes that about 50 percent of the drivers would qualify for the discount. It also assumes that no offsetting adjustments would be made in other insurance rates. The resulting state revenue loss, however, will not occur because this measure provides that for the period November 1988 to January 1991 the State Board of Equalization shall adjust the state tax rate on gross premiums to offset these premium reductions.

Thereafter, there would be an unknown General Fund revenue loss to the extent these rate reductions and discounts continue.

Proposition 103: Text of Proposed Law

Continued from page 99

amend or reject a decision only under Section 11517 (c) and (e) and solely on the basis of the record; (d) Section 11513.5 shall apply to the commissioner; (e) discovery shall be liberally construed and disputes determined by the administrative law judge.

1861.09. Judicial review shall be in accordance with Section 1858.6. For purposes of judicial review, a decision to hold a hearing is not a final order or decision; however, a decision not to hold a hearing is final.

Consumer Participation

1861.10. (a) Any person may initiate or intervene in any proceeding permitted or established pursuant to this chapter, challenge any action of the commissioner under this article, and enforce any provision of this article.

(b) The commissioner or a court shall award reasonable advocacy and witness fees and expenses to any person who demonstrates that (1) the person represents the interests of consumers, and, (2) that he or she has made a substantial contribution to the adoption of any order, regulation or decision by the commissioner or a court. Where such advocacy occurs in response to a rate application, the award shall be paid by the applicant.

(c) (1) The commissioner shall require every insurer to enclose notices in every policy or renewal premium bill informing policyholders of the opportunity to join an independent, non-profit corporation which shall advocate the interests of insurance consumers in any forum. This organization shall be established by an interim board of public members designated by the commissioner and operated by individuals who are democratically elected from its membership. The corporation shall proportionately reimburse insurers for any additional costs incurred by insertion of the enclosure, except no postage shall be charged for any enclosure weighing less than $\frac{1}{4}$ of an ounce. (2) The commissioner shall by regulation determine the content of the enclosures and other procedures necessary for implementation of this provision. The legislature shall make no

appropriation for this subdivision.

Emergency Authority

1861.11. In the event that the commissioner finds that (a) insurers have substantially withdrawn from any insurance market covered by this article, including insurance described by Section 660, and (b) a market assistance plan would not be sufficient to make insurance available, the commissioner shall establish a joint underwriting authority in the manner set forth by Section 11891, without the prior creation of a market assistance plan.

Group Insurance Plans

1861.12. Any insurer may issue any insurance coverage on a group plan, without restriction as to the purpose of the group, occupation or type of group. Group insurance rates shall not be considered to be unfairly discriminatory, if they are averaged broadly among persons insured under the group plan.

Application

1861.13. This article shall apply to all insurance on risks or on operations in this state, except those listed in Section 1851.

Enforcement & Penalties

1861.14. Violations of this article shall be subject to the penalties set forth in Section 1859.1. In addition to the other penalties provided in this chapter, the commissioner may suspend or revoke, in whole or in part, the certificate of authority of any insurer which fails to comply with the provisions of this article.

SECTION 4. Elected Commissioner

Section 12900 is added to the Insurance Code to read:

12900. (a) The commissioner shall be elected by the People in the same time, place and manner and for the same term as the Governor.

SECTION 5. Insurance Company Filing Fees

Section 12979 is added to the Insurance Code to read:

12979. Notwithstanding the provisions of Section 12978, the commissioner shall establish a schedule of filing fees to be paid by insurers to cover any

administrative or operational costs arising from the provisions of Article 10 (commencing with Section 1861.01) of Chapter 9 of Part 2 of Division 1.

SECTION 6. Transitional Adjustment of Gross Premiums Tax

Section 12902.1 is added to the Revenue & Taxation Code to read:
12902.1. Notwithstanding the rate specified by Section 12902, the gross premium tax rate paid by insurers for any premiums collected between November 8, 1988 and January 1, 1991 shall be adjusted by the Board of Equalization in January of each year so that the gross premium tax revenues collected for each prior calendar year shall be sufficient to compensate for changes in such revenues, if any, including changes in anticipated revenues, arising from this act. In calculating the necessary adjustment, the Board of Equalization shall consider the growth in premiums in the most recent three year period, and the impact of general economic factors including, but not limited to, the inflation and interest rates.

SECTION 7. Repeal of Existing Law

Sections 1643, 1850, 1850.1, 1850.2, 1850.3, 1852, 1853, 1853.6, 1853.7, 1857.5, 12900, Article 3 (commencing with Section 1854) of Chapter 9 of Part 2 of Division 1, and Article 5 (commencing with Section 750) of Chapter 1 of Part 2 of Division 1, of the Insurance Code are repealed.

1643. No bank or bank holding company, subsidiary, or affiliate thereof, or any officer or employee of a bank, bank holding company, subsidiary, or affiliate, may be licensed as an insurance agent or broker or act as an agent or broker for insurance; in this state, or control a licensed insurance agent or broker, except that a bank or a bank holding company, subsidiary, or affiliate of a bank, may be issued a license to act as a life and disability agent limited to the transaction of credit life and disability insurance; or an agent limited to the transaction of insurance which is limited solely to securing repayment of the outstanding balance due on a specific extension of credit by a bank or bank holding company or its subsidiary in the event of the involuntary unemployment of the debtor; or both: A commercial bank may be licensed to sell insurance or act as an insurance broker as provided in Section 1208 of the Financial Code. This section shall not apply to any bank or bank holding company which, under the authorization of the Federal Reserve Board, had prior to January 1, 1976, a subsidiary or affiliate licensed to sell insurance (except that subsequent authorization to expand such activities shall be subject to this section); or to any bank holding company owning a state-chartered bank which had, prior to January 1, 1976, a subsidiary or affiliate licensed to sell insurance: This section shall not apply to any person authorized or licensed to make loans pursuant to Division 2 (commencing with Section 18000); Division 9 (commencing with Section 20000); Division 10 (commencing with Section 24000); or Division 11 (commencing with Section 26000) of the Financial Code.

For the purposes of this section, the following definitions shall apply:

(4) "Bank" means any institution in this state defined in Section 108 of the Financial Code except that such term does not include a title insurance company authorized to transact a trust business under the provisions of Article 3 (commencing with Section 16000) of Chapter 3 of Part 6 of Division 8 or a trust company controlled by or under common control with a title insurance company;

(4) "Bank holding company" means the same as the definition of that term set forth in Section 8 of the Federal Bank Holding Company Act of 1956, as amended, but limited to holding companies which control a bank authorized to accept deposits in this state;

(4) "Subsidiary" means any corporation, association, or partnership, owned in whole or in part by a bank or bank holding company;

(4) "Affiliate" means any corporation, association, or partnership connected through the ownership of a 10 percent or greater interest by a common parent;

(4) "Credit life, health, and accident insurance" means insurance on the life and health of a borrower from a bank issued to secure the repayment of the amount borrowed;

(4) "Control" means the possession, by any means, of the power to direct or cause the direction of the management or activities of a licensed insurance agent or broker;

1850. The purpose of this chapter is to promote the public welfare by regulating insurance rates as herein provided to the end that they shall not be excessive, inadequate or unfairly discriminatory; to authorize the existence and operation of qualified rating organizations and advisory organizations and require that specified rating services of such rating organizations be generally available to all admitted insurers; and to authorize cooperation between insurers in rate making and other related matters.

It is the express intent of this chapter to permit and encourage competition between insurers on a sound financial basis and nothing in this chapter is intended to give the Commissioner power to fix and determine a rate level by classification or otherwise.

1850.1. In this chapter "rating organization" means every person; other than an admitted insurer, whether located within or outside this state, who has as his object or purpose the making of rates, rating plans or rating systems; two or more admitted insurers which act in concert for the purpose of making rates; rating plans or rating systems, and which do not operate within the specific authorized terms contained in Sections 1852.5, 1856.7, 1859.8, and Article 5 shall be deemed to be a rating organization. No single insurer shall be deemed to be a rating organization.

1850.2. In this chapter "advisory organization" means every person; other than an admitted insurer, whether located within or outside this state, who prepares policy forms or makes underwriting rules incident to but not including the making of rates; rating plans or rating systems; or which collects and furnishes to admitted insurers or rating organizations loss or expense statistics or other statistical information and data and acts in an advisory, as distinguished from a rate making, capacity. No duly authorized attorney at law acting in the usual course of his profession shall be deemed to be an advisory organization.

1850.3. Unless otherwise apparent from the context, in this chapter

(4) "Member" means an insurer who participates in or is entitled to participate in the management of a rating, advisory or other organization;

(4) "Subscriber" means an insurer which is furnished at its request (4) with rates and rating manuals by a rating organization of which it is not a member, or (4) with advisory services by an advisory organization of which it is not a member. The following standards shall apply to the making and use of rates pertaining to all classes of insurance to which the provisions of this chapter are applicable:

(4) Rates shall not be excessive or inadequate; as herein defined, nor shall they be unfairly discriminatory;

No rate shall be held to be excessive unless (4) such rate is unreasonably high for the insurance provided and (4) a reasonable degree of competition does not exist in the area with respect to the classification to which such rate is applicable;

No rate shall be held to be inadequate unless (4) such rate is unreasonably low for the insurance provided and (4) the continued use of such rate endangers the solvency of the insurer using the same; or unless (4) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same has, or if continued will have, the effect of destroying competition or creating a monopoly;

(4) Consideration shall be given; to the extent applicable, to past and prospective loss experience within and outside this state; to configuration and catastrophe hazards; to a reasonable margin for underwriting profit and contingencies; to past and prospective expenses both countrywide and those specially applicable to this state; and to all other factors, including judgment factors; deemed relevant within and outside this state; and in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during the most recent five-year period for which such experience is available;

Consideration may also be given in the making and use of rates to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers;

(4) The systems of expense provisions included in the rates for use by any insurer or group of insurers may differ from those of other insurers or groups of insurers to reflect the operating methods of any such insurer or group with respect to any kind of insurance; or with respect to any subdivision or combination thereof;

(4) Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions; or both. Such standards may measure any difference among risks that have a probable effect upon losses or expenses. Classifications or modifications of classifications of risks may be established based upon size, expense, management, individual experience, local conditions or dispersion of hazards; or any other reasonable considerations. Such classifications and modifications shall apply to all risks under the same or substantially the same circumstances or conditions;

1853. Subject to and in compliance with the provisions of this chapter authorizing insurers to be members or subscribers of rating or advisory organizations or to engage in joint underwriting or joint reinsurances; two or more insurers may act in concert with each other and with others with respect to any matters pertaining to the making of rates or rating systems, the preparation or making of insurance policy or bond for rates; underwriting rules; surveys; inspections and investigations; the furnishing of loss or expense statistics or other information and data; or carrying on of research;

1853.6. Members and subscribers of rating or advisory organizations may use the rates, rating systems, underwriting rules or policy or bond forms of such organizations, either consistently or intermittently; but, except as provided in Sections 1852.5, 1859.8, and Article 5, shall not agree with each other or rating organizations or others to adhere thereto. The fact that two or more admitted insurers, whether or not members or subscribers of a rating or advisory organization, use, either consistently or intermittently, the rates or rating systems made or adopted by a rating organization; or the underwriting rules or policy or bond forms prepared by a rating or advisory organization, shall not be sufficient in itself to support a finding that an agreement to so adhere exists; and may be used only for the purpose of supplementing or explaining direct evidence of the existence of any such agreement;

1853.7. Licensed rating organizations and admitted insurers are authorized to exchange information and experience data with rating organizations and insurers in this and other states and may consult with them with respect to rate-making and the application of rating systems;

1857.5. (4) The commissioner may promulgate reasonable rules and statistical plans; reasonably adapted to each of the rating systems in use within the state; which may be modified from time to time and which shall be used thereafter by each insurer in the recording and reporting of its loss and countrywide expense experience; in order that the experience of all insurers may be made available at least annually in such form and detail as may be necessary to aid him in determining whether rating systems comply with the standards set forth in this chapter. Such rules and plans may also provide for the recording and reporting of expense experience items which are specially applicable to this state and are not susceptible of determination by a proving of countrywide expense experience; in promulgating such rules and plans, the commissioner may give due consideration to the rating systems in use and, in order that such rules and plans may be as uniform as is practicable among the several states, to the rules and to the form of the plans used for such rating systems in other states. No insurer shall be required to record or report its loss experience on a classification basis that is inconsistent with the rating system in use by it. The commissioner may designate one or more rating organizations or advisory organizations to assist him in gathering such experience and making compilations thereof; and such compilations shall be made available, subject to reasonable rules promulgated by the commissioner, to insurers and rating organizations.

(4) Reasonable rules and plans may be promulgated by the commissioners for the interchange of data necessary for the application of rating plans.

(4) In order to further uniform administration or rate regulatory laws, the commissioners and every insurer and rating organization may exchange information and experience data with insurance supervisory officials, insurers and rating organizations in other states and may consult with them with respect to interchanging and the application of rating systems.

14800. The commissioner shall be appointed by the Governor, with the consent of the Senate and shall hold office for a term of four years, consecutive with the term of office of the Governor.

Article 2. Rating Organizations

1481. No rating organization shall conduct its operations in this state without first filing with the commissioner a written application for and securing a license to act as a rating organization. Any rating organization may make application for and obtain a license as a rating organization if it shall meet the requirements for license set forth in this chapter. Every such rating organization shall file with its application (a) a copy of its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules and regulations governing the conduct of its business; all duly certified by the custodian of the original thereof; (b) a list of its members and subscribers; (c) the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such rating organization may be served; and (d) a statement of its qualifications as a rating organization.

The fee for filing an application for license as a rating organization is one hundred seventy-five dollars (\$175) lawful money of the United States, payable in advance to the commissioner.

1482. To obtain and retain a license, a rating organization shall provide satisfactory evidence to the commissioner that it will:

(a) Permit any admitted insurer to become a member of or a subscriber to such rating organization at a reasonable cost and without discrimination; or withdraw therefrom.

(b) Neither have nor adopt any rule or exact any agreement, the effect of which would be to require any member or subscriber as a condition to membership or subscription, to adhere to its rules, rating plans, rating systems, underwriting rules, or policy or bond forms.

(c) Neither adopt any rule nor exact any agreement the effect of which would be to prohibit or regulate the payment of dividends, savings or unshared premium deposits allowed or returned by insurers to their policy holders, members or subscribers.

(d) Neither practice nor sanction any plan or act of boycott, coercion or intimidation.

(e) Neither enter into nor sanction any contract or act by which any person is restricted from lawfully engaging in the insurance business.

(f) Notify the commissioner promptly of every change in its constitution, its articles of incorporation, agreement or association, and of its bylaws, rules and regulations governing the conduct of its business; its list of members and subscribers; and the name and address of the resident of this state designated by it upon whom notices or orders of the commissioner or process affecting such organization may be served.

(g) Comply with the provisions of Section 1487.

1484. The commissioner shall examine each application for license to act as a rating organization and the documents filed therewith and may make such further investigation of the applicant, its affairs and its proposed plan of business, as he deems desirable.

The commissioner shall issue the license applied for within 60 days of its filing with him if from such examination and investigation he is satisfied that:

(a) The business reputation of the applicant and its officers is good.

(b) The facilities of the applicant are adequate to enable it to furnish the services it proposes to furnish.

(c) The applicant and its proposed plan of operation conform to the required merits of this chapter.

Otherwise, but only after hearing upon notice, the commissioner shall in writing deny the application and notify the applicant of his decision and his reasons therefor.

The commissioner may grant an application in part only and issue a license to act as a rating organization for one or more of the classes of insurance or subdivisions thereof or class of risk or a part or combination thereof as are specified in the application if the applicant qualifies for only a portion of the classes applied for.

Licenses issued pursuant to this section shall remain in effect until revoked as provided in this chapter.

1484.5. Notwithstanding the provision of Section 1482.5, each rating organization possessing a license of indefinite term pursuant to such section shall owe and pay to the commissioner an annual fee of one hundred seventy-five dollars (\$175) in lawful money of the United States in advance on account of such license until its final termination. Such fee shall be for periods commencing on July 1, 1964, and on each July 1st thereafter and ending on June 30, 1965, and each June 30th thereafter, and shall be due and payable on March 1, 1964, and on each March 1st thereafter and shall be delinquent on April 1, 1964, and each April 1st thereafter. 1484.5. Subject to the approval of the commissioner, licensed rating organizations may make reasonable rules governing eligibility for membership.

1484.5. If two or more insurers having a common ownership or operating in this state under common management, are admitted for the classes or types of insurance for which a rating organization is licensed to make ratings, the rating organization may require as a condition to membership or subscription of one or more that all such insurers shall become members or subscribers.

1484.5. A workers' compensation insurance rating organization licensed pursuant to the provisions of Article 2 (commencing with Section 11750) of Chapter

2 of Part 3 of Division 2 which does not make rating, rating plans or rating systems for insurance covering the liability of employers for compensation or damages under the United States Longshoremen's and Harbor Workers' Compensation Act (20 U.S.C. 901, et seq.) shall not be required to be licensed as a rating organization or registered as an advisory organization pursuant to the provisions of this chapter and shall have authority under its license as a workers' compensation insurance rating organization to:

(a) Collect and tabulate loss and expense experience statistics and other information and data relating to insurance covering employers against their liability for compensation under the United States Longshoremen's and Harbor Workers' Compensation Act.

(b) Furnish or exchange such information and experience data to or with rating organizations, advisory organizations and insurers in this and other states.

(c) Adopt and enforce compliance by its insurer members with reasonable rules and statistical plans to be used in the recording and reporting by insurer members of their California longshoremen's and harbor workers' insurance loss and expense experience in order that such experience of all of its insurer members shall be available in such form and detail as will be of aid to the commissioner in the enforcement of and to its insurer members in complying with the provisions of this chapter.

(d) Engage in the same activities and carry out the same functions with respect to insurance covering the liability of employers for compensation or damages under the United States Longshoremen's and Harbor Workers' Compensation Act that it is authorized to engage in or carry out with respect to California workers' compensation insurance generally under the provisions of Article 2 (commencing with Section 11750) of Chapter 2 of Part 3 of Division 2 other than the making of ratings, rating plans and rating systems.

Article 3. Unlawful Rebates, Profits, and Commissions

320. An insurer, insurance agent, broker, or solicitor, personally or by any other party, shall not offer or pay, directly or indirectly, as an inducement to insurance on any subject-matter in this state, any rebate of the whole or part of the premium payable on an insurance contract, or of the agent's or broker's commission thereon, and such rebate is an unlawful rebate.

320.5. The Legislature hereby finds and declares that the continued regulation of the business practices of insurers and their producers is in the interest of the citizens of the state and that the control and limitation of unlawful rebates, profits, and commissions is an essential component of that regulation which is necessary to effectuate an adequate and complete system and regulation of insurer and producer business practices.

The Legislature finds that the statutes controlling unlawful rebates, profits, and commissions continue to provide critical protection to insureds in this state from the numerous consequences that would occur in the absence of such regulation including company insolvency, unfair discrimination between insureds with identical risks creating subsidies from small purchasers of insurance in favor of large purchasers of insurance, decreased quality of services to insurance consumers, increased concentration of insurance distribution and sales mechanisms, and misrepresentation and unethical sales practices such as improper replacement or twisting to the detriment of the public.

It is the intent of the Legislature in enacting this section to clearly set forth the legislative intent supporting the enactment, continuing vitality, and importance of the unlawful rebates, profits, and commissions sections of this code.

321. An insurer, or an insurer's agent, broker, or solicitor, personally or otherwise, shall not offer or pay, directly or indirectly, as an inducement to enter into an insurance contract, any valuable consideration which is not clearly specified, promised or provided for in the policy, or application for the insurance, and any such consideration not appearing in the policy is an unlawful rebate.

322. Any person named as the insured in any policy or named as the principal, or obligee, in any surety policy or the agent or representative of any such person who, directly or indirectly, knowingly accepts or receives any unlawful rebate is guilty of a misdemeanor.

323. (a) It is unlawful for any insurance agent or broker, or any insurance solicitor employed thereby, to receive any financial benefit from an automobile repair facility or any other form of direct or indirect consideration from any person for referring insureds to that person or that person's designee for vehicle repairs covered under automobile comprehensive coverage, property damage coverage, or automobile collision coverage of an insurance policy issued through the insurance agent or broker or by an insurer represented by the insurance agent. (b) Subdivision (a) applies with respect to commercial and noncommercial policies of automobile insurance.

(c) For purposes of this section, "financial benefit" means the receiving of any commission or gratuity, discount on repair costs, free repairs, or employment by a repair facility.

324. Payments of commissions or fees by insurers or their agents to insurance brokers, when otherwise lawful under this code, are expressly authorized.

325. The paying or allowing of any commission or other valuable consideration on insurance business in this state to other than an admitted insurer or a licensed insurance agent, broker or solicitor is an unlawful rebate.

325.5. If at the time of the solicitation and issuance of a policy of life or disability insurance, or of a surety bond which by its terms continues until canceled, a person may lawfully receive commissions thereon, such person, or in the event of his death, his estate or heirs may continue to receive commissions thereon during the continuance in force or renewal of such policy or bond without being licensed under the provisions of Chapter 5, Part 3, Division 1 of this code, provided:

(a) Such recipient does not transact insurance in connection with such policy or bond while not so licensed; and

(b) The payment is made pursuant to a contract entered into, before such

solicitation and insurance; between the insurer paying or allowing the commission and such person.

324.5. It is unlawful for an insurance agent who is not also licensed as an insurance broker to receive commissions derived from insurance placed with an insurer which has not expected him to act as its agent in the transaction of such insurance.

It is unlawful for an insurance solicitor to receive commissions on insurance from any source other than the employer for whom he is licensed excepting on life or disability insurance transacted by him under individual licenses as life or disability agent issued to him pursuant to this code.

It is unlawful for any person to pay to an insurance agent or solicitor any commissions which he can not lawfully receive.

Except as provided in Section 325.2 it is unlawful for an insurer to receive for its own use commissions on insurance placed with another insurer.

324.6. Notwithstanding the provisions of Section 324.5, an insurer participating in any Assigned Risk Plan, as provided for in Article 4, commencing with Section 4480b, Chapter 1, Part 2, Division 8 of the Insurance Code, may pay to a licensed insurance agent and such agent may receive, a commission or consideration on any automobile or liability coverage written in addition to any commission or consideration required under such plan if such agent has been designated by the applicant for insurance as producer or record for the coverages required under such plan.

324.7. Any person, including but not limited to any person licensed, certified under this code or exempted under this code from regulation, who for consideration, addition, or agreed to advise, any person concerning insurance, insurance policies, insurance needs or insurance programs of any sort and who agrees to or does, allow credit against such consideration for such services for any portion of any insurance commission which may accrue directly or indirectly, to such person who so advises or agrees to advise, is guilty of making an unlawful rebate and guilty of a misdemeanor.

324.8. When the premium on a policy insuring an employer is based upon the amount or segregation of the employer's pay roll, and the employer, personally or knowingly through his employees, procures a lower premium by willfully misrepresenting the amount or segregation, such misrepresentation is an unlawful rebate as to the employees.

In addition to any penalty provided by law for unlawful rebates, the employer in such case is liable to the State in an amount ten times the difference between the lower premium paid and the premium properly payable. The commissioner shall collect the amount so payable and may bring a civil action in his name as commissioner to enforce collection unless the misrepresentation is made to and lower premium procured from the State Compensation Insurance Fund. In the latter case the liability to the State under this section shall be enforced in a civil action in the name of the State Compensation Insurance Fund and any amount so collected shall become a part of that fund.

324.9. When a statement of the amount or segregation of a pay roll is materially false, and an insurer, through a person employed by it in a managerial capacity, accepts the statement as the basis for the premium on a policy, the acceptance is an unlawful rebate if the accepting employee knows of the falsity.

324. Every insurer shall exercise reasonable diligence in securing the observance of this article by its agents:

324.1. It is unlawful for any insurer to appoint an agent for the purpose of enabling such agent, or the employer or person requesting the appointment of the agent, to obtain insurance at a cost less than that specified in the policy, or at a cost less than that specified in the application therefor.

324.2. As used in this section "personal or controlled insurance" means insurance covering an insurance agent, broker, or solicitor, or

(a) His spouse, his employer or his employer's spouse;

(b) Any person related to him or the persons mentioned in subdivision (a) within the second degree by blood or marriage;

(c) If the employer is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in such corporation.

(d) If his employer is a partnership or association, any person owning any interest in such partnership or association.

(e) If the agent or broker is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in the agent or broker and any corporation which is also similarly directly or indirectly controlled by the person who directly or indirectly controls the agent or broker.

(f) If the agent or broker is a corporation, any corporation making consolidated returns for United States income tax purposes with any corporation described in subdivision (e).

If premiums on personal or controlled insurance transacted by an insurance agent, broker, or solicitor payable in one year exceed the premiums on other insurance transacted by such licensee payable in the same year, the receipt of commissions upon the excess is an unlawful rebate.

Provided that during and after the sixth calendar year following the initial licensing of such agent, broker, or solicitor, in any manner as an agent, broker or solicitor, whether continuously licensed or not, if premiums on personal or controlled insurance transacted by him payable in any one such calendar year exceed 20% percent of the other premiums transacted by him payable in the same calendar year, the receipt of commissions upon the excess over such 20% percent is an unlawful rebate. For the purpose of this paragraph, if the agent or broker be an organization the sixth calendar year shall be the first calendar year beginning five years or more after the initial licensing of the organization, or any predecessor thereof, as an agent or broker.

Provided further, that this section does not apply to an individual licensee who (1) is licensed during all of such calendar year as a solicitor, or individually as an agent or broker, (2) during such calendar year conducts an individual business, not

being named to transact on any organization license nor owning any interest in any corporation or partnership transacting an insurance agency or brokerage business, (3) has been continuously licensed in some manner as an active agent, broker or solicitor for at least 55 years, and (4) is at least 55 years of age at the beginning of the calendar year.

Whenever an officer or director of a corporation acts as agent, broker, or solicitor in the transaction of insurance covering the corporation, he shall be conclusively presumed to have received the full commission on such contract while an employee of the corporation. Whenever the remuneration for services of an employee is decreased by the employer or is made unreasonably small in amount but the employee is permitted, as an insurance agent, broker, or solicitor, to transact personal or controlled insurance, it shall be conclusively presumed that such employee received the full amount of commission on such personal or controlled insurance.

"Year" as used in this section means the calendar year. Suspension, revocation or denial of license for violation of this section may be ordered at any time within five years after the close of the year in which the violation occurred.

324.5. As used in this section "personal or controlled insurance" means insurance covering a life agent, or

(a) His spouse, his employer, his employer's spouse, or any group of employees under a group policy issued to his employer;

(b) Any person related to him, his spouse, his employer or his employer's spouse within the second degree by blood or marriage;

(c) If his employer is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in such corporation.

(d) If his employer is a partnership or association, any person owning any interest in such partnership or association.

(e) If the agent is a corporation, any person directly or indirectly owning or controlling a majority of the voting stock or controlling interest in the agent.

If commissions on personal or controlled insurance transacted by a life agent under his license as a life agent received in one year exceed the commissions received in that year on other insurance transacted by such licensee under his license as life agent, the receipt of commissions upon personal or controlled insurance in excess of those on such other insurance is an unlawful rebate.

Provided that during and after the sixth calendar year following the initial licensing of such life agent in any manner as a life agent, disability agent or life and disability agent, whether continuously licensed or not, if commissions on personal or controlled insurance transacted by him under any or all such licenses received in any such calendar year exceed 20% percent of the commissions received in the same calendar year on other insurance transacted by him under any or all such licenses, the receipt of commissions upon personal or controlled insurance in excess of 20% percent of those on such other insurance is an unlawful rebate. For the purposes of this paragraph, if the licensee be a joint firm licensee. The sixth calendar year as respects the firm shall be the first calendar year beginning five years or more after the initial licensing of the firm or any predecessor thereof as a joint firm licensee with any individual; the firm may be changed with a violation of this section separately based upon all joint firm licenses it may have held during the calendar year and an individual named on one or more joint firm licenses may be changed with a violation of this section separately, based upon all the licenses, individual and joint firm, he may have held during the calendar year.

Provided further, that this section does not apply to an individual licensee who (1) is licensed during all of such calendar year under one or more kinds of individual life licenses; (2) during all of such calendar year conducts an individual business, not being named in any joint firm license nor owning any interest in a corporation or partnership transacting business under any kind of life license; (3) has been continuously licensed in some manner as an active agent under some kind of life license for at least 55 years, and (4) is at least 55 years of age at the beginning of the calendar year.

"Year" as used in this section means the calendar year. Suspension, revocation or denial of license for violation of this section may be ordered at any time within five years after the close of the year in which the violation occurred.

324. Any insurer, insurance agent, broker, solicitor, or life agent and any officer or employee of an insurer, insurance agent, broker, or life agent that makes or receives an unlawful rebate is guilty of a misdemeanor.

324. The following acts are not unlawful rebates:

(a) The return by an insurer issuing policies on a participating plan, or any portion of the premium as a dividend after the expiration of the term covered by such policy;

(b) The payment of commission by any insurer or insurance agent, broker or solicitor, to another insurer, or insurance agent, broker or solicitor, upon insurance lawfully transacted in that capacity;

(c) The allowance by any marine insurer or marine insurance agent, broker or solicitor to any insured, of such usual discount as is sanctioned by custom among marine insurers as being additional to the agent's or broker's commission;

(d) The paying by an insurer to another insurer, or to an insurance agent, broker, or solicitor, of a commission in respect to a policy under which the payee is insured, or the receiving by such payee of such commission;

(e) The paying by an insurer of bonuses to policyholders on nonparticipating life insurance or otherwise about their premiums, in whole or in part, out of surplus accumulated from nonparticipating insurance;

(f) The return as a dividend by a life insurer of any portion of the premium on policies based on a participating plan at any time;

(g) The return by an insurer transacting individual insurance on a weekly payment plan, to policyholders who have made premium payments for a period of at least one year directly to the insurer at its home or district office, of a percentage of the premium which the insurer would have paid for the weekly collection of such premiums.

(h) The paying by any life insurer, or the receiving by life insurance policyholders of special compensations, or the allowing and receiving of credits already agreed upon in life insurance contracts now in force.

(i) The payment by an insurer of any portion of life insurance premiums payable by its employees pursuant to a life insurance program under which 75 percent or more of its employees are required to carry life insurance on their lives so long as they remain in the employment of insurer.

(j) The payment or allowance of a fee or commission by one surety insurer to another surety insurer in respect to a risk on which both are co-sureties.

763.5. The sale of the good will, business, list of policyholders or similar assets of an agent or broker in consideration of commissions or portions thereof to be thereafter earned by the use of such assets and payments of such consideration are not unlawful rebates if the purchaser is duly licensed to transact insurance and the receipt of the commissions would not constitute a violation of Section 760 if the person receiving them were licensed as an insurance agent.

764. Any person may be compelled to testify or produce evidence at the trial or hearing on a charge of violating a provision of this article, even though such testimony or evidence may incriminate him. A prosecution shall not be brought or maintained against such person for any act concerning which he thus testifies or produces evidence, except for perjury committed in so testifying.

765. If an insurer knowingly violates any provisions of this article, or knowingly permits any officer, agent, or employee so to do, the commissioner, after a hearing in accordance with the procedure provided in Section 704, may suspend the

insurer's certificate of authority to do the class of insurance in which the violation of this article occurred.

766. If an insurance agent, broker, or solicitor knowingly and wilfully violates any of the provisions of this article, the commissioner, after a hearing in accordance with the procedure provided in Article 13 of Chapter 5 of this part may suspend or revoke the violator's license.

767. Notwithstanding any provision in this article to the contrary, it shall not be unlawful for any licensed insurance broker to pay a commission to an agent or broker licensed under the laws of Mexico when such agent or broker in Mexico refers to the insurance broker licensed in this state a resident of Mexico who wishes to obtain a policy of automobile liability insurance to be effective in this state from an insurer licensed in this state, and such broker negotiates and effects such a policy of insurance for such resident of Mexico.

SECTION 8. Technical Matters

(a) This act shall be liberally construed and applied in order to fully promote its underlying purposes.

(b) The provisions of this act shall not be amended by the Legislature except to further its purposes by a statute passed in each house by roll call vote entered in the journal, two-thirds of the membership concurring, or by a statute that becomes effective only when approved by the electorate.

(c) If any provision of this act or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Proposition 104: Analysis

Continued from page 102

- Permits, but does not require, insurance companies to offer an unspecified "good driver" discount.
- Enacts other insurance-related provisions, and reenacts many provisions related to various lines of insurance which are currently in law.
- Provides that if this measure receives a higher number of votes than other measures on this ballot, then those provisions in other measures that relate to the business of insurance shall have no effect.

No-Fault System

Starting July 1, 1989, this measure establishes a no-fault motor vehicle insurance system that (1) applies only to bodily injury and (2) permits individuals to sue for losses which exceed specified limits.

This measure applies to private and commercial motor vehicles including automobiles, trucks, buses and trailers. It does not apply to motorcycles and "off-road-type" vehicles which are not registered with the Department of Motor Vehicles.

This measure contains the following features.

1. "Basic" Benefits. Requires the following minimum basic benefits to be paid by insurance companies to injured persons regardless of who is at fault:

- Up to \$10,000 for medical expenses;
- Up to \$15,000 for lost wages; and
- \$5,000 for funeral benefits, in case the injuries result in death.

In general, the basic benefits would not be provided to an uninsured motorist, a person driving a stolen car, or a person engaged in the commission of a felony.

This measure provides that the basic benefits shall be available only to pay medical expenses and lost wages to the extent that these expenses are not covered by workers' compensation and disability benefits.

Any dispute concerning payment of basic benefits would be decided by arbitration, and not by court trial. The arbitration would be conducted in accordance with procedures established by the Insurance Commissioner.

2. Recovery of Workers' Compensation Costs. Restricts the ability of employers to be reimbursed for medical expenses and wage losses paid under workers' compensation and other similar programs when employees are injured in motor vehicle accidents. Currently, an

employer may recover the cost of benefits—such as workers' compensation—it provides to an employee who was injured in an accident by another person who was at fault.

3. Additional Recovery. Permits an injured person to recover costs in excess of the no-fault basic benefits by suing the party at fault for the accident.

4. Noneconomic Losses. Prohibits recovery for noneconomic losses (such as pain and suffering), except in cases involving (a) death or (b) serious and permanent disfigurement or injury. It would not limit the right to sue for damages in cases involving (a) the operation of an uninsured vehicle, (b) harm caused intentionally, or (c) specified crimes.

5. Attorney Fees. Limits plaintiffs' attorney contingency fees in motor vehicle accident cases involving bodily injury to the following: (a) 15 percent of the basic no-fault benefits recovered; (b) 33.3 percent of the first \$50,000 recovered over the basic benefits; (c) 25 percent of the second \$50,000 recovered over the basic benefits, and (d) 15 percent of the recovery over \$100,000.

6. Premium Reduction. Requires insurance companies to reduce—by 20 percent for a two-year period (July 1989 through June 1991)—their average statewide premium rates for specified types of motor vehicle insurance. This would include rates for basic bodily injury liability, uninsured motorist and basic no-fault benefits provided under this measure. This reduction does not apply to the personal property liability damage, collision and comprehensive portions of a motor vehicle insurance policy.

Other Insurance-Related Provisions

The measure enacts other motor vehicle insurance-related provisions including the following.

1. Claims Settlement Practices. Requires that disputes between an insurance company and persons other than policyholders be settled by arbitration rather than by court action.

2. Penalty. Increases the penalty from an "infraction" to a "misdemeanor" for second and subsequent convictions for violation of the current financial responsibility laws.

3. Insurance Fraud. Increases the authority of the Insurance Commissioner to investigate and prosecute insurance fraud.

4. Premium Discounts. Permits, but does not require,

MEMORANDUM

TO: Ginger Baim

FROM: David Rogers

RE: HB 166-Pros

DATE: April 27, 1989

1) Section 1: Overview

"Tort Reform" is a national issue born of widespread frustration with the civil justice system. Periodically, judicial and other public institutions must be reexamined and modified to help resolve problems and reflect contemporary thinking and experience. HB 166 represents one such attempt following the first incomplete effort at tort reform in 1986. When viewed objectively, the bill proposes reasonable measures which attempt to a) clarify and refine existing law; b) reduce the costs of litigation and other costs of doing business; c) reduce and restructure awards by matching losses with compensation and eliminating windfalls that are not needed to adequately compensate the victim; d) promote stability; and, in general, create a more equitable distribution of the costs and risks of injury. In so doing, the sponsors hope to improve our tort system and help bring about much needed relief for many professionals, businesses, non-profits and municipalities, urban and rural alike, who cannot afford and/or obtain adequate liability insurance as a result of the present situation. Not to forget the public who suffers when services are unavailable and/or more difficult to obtain because of insurance problems; who suffers because legitimate claims cannot be satisfied because there is no insurance, or not enough. The bill follows the example of at least one state which appears to have accomplished these goals following passage of similar legislation (and related court challenges). It was introduced out of a sincere desire to make the system effective, fair and predictable.

Critics of HB 166 (and similar measures) repeatedly argue that it will take away rights without even reducing rates. First, this bill is not just about insurance premiums. Each provision can be

justified on the merits regardless of rate effects. Second, the sponsors agree there are no guarantees that rates will be reduced; but there is credible evidence that rates will, at a minimum, stabilize and possibly fall if the right mix of provisions is adopted and given time to work (See, for example, Milliman and Robertson, Inc. letter dated August 5, 1988; and information relating to California experience). As important, with the exception of the statute of repose which involves a delicate balancing of competing interests, no provision in this bill "takes away" the right to receive adequate and appropriate compensation; although it will reduce many awards. And while some tradeoffs are inevitable when you are trying to fix a problem of this magnitude and complexity, the sponsors feel a carefully crafted committee substitute can accommodate most of the significant concerns raised by victim rights advocates.

2) Sections 2-4: Statutes of Limitation/Repose

Statutes of limitation and repose are based on the premise that society as a whole cannot afford the price of lawsuits after a certain period of time. They are not designed to absolve defendants from any liability, but only to prevent them from having to defend an action brought many years after the acts in question have occurred; the so-called stale claim which often creates excessive problems of proof for defendants where documents are lost, witnesses have died or memories have faded, control has shifted to another party, standards have evolved and/or other circumstances have intervened. Given these considerations, it is simply not fair to subject possible defendants to the unreasonable risk of indefinite exposure to claims (including costly record keeping requirements), particularly when most actions can easily be brought within the proposed "window" periods, including those relating to minors and incompetents. Moreover, extended exposure to claims appears to result in significantly higher costs for "tail coverage" which force many of those affected to "go bare" and/or to withhold services. The public interest is not served in either case. Reasonable statutes of limitation/repose, which include appropriate exceptions, attempt to strike a difficult balance between competing interests - the interest of society in promoting a legal system which is fair to all parties, holds down costs and increases the possibility that services will be provided and victims will have a readily available source of money for compensation and the interests of society in protecting the relatively few victims who inevitably will be denied access to the courts under any repose system. An alternative solution, a reasonably priced "occurrence" policy, is not a realistic option at this

time. Please note that many states have adopted statutes of repose in various forms; many constitutional challenges to those laws have been unsuccessful (and the Alaska case is distinguishable). Finally, the sponsors doubt these provisions will encourage unprofessional conduct, as implied by critics.

3) Section 5 :

1986 legislation raised the standard of proof for punitive damages from a "preponderance of the evidence" to "clear and convincing evidence" but stopped short of defining what must be proved. The language proposed in HB 166 clarifies this ambiguity by restating the common law rule cited recently by the Alaska Supreme Court. (See *Tommy's Elbow Room, Inc. v. Kavorkian*, 727 P2d 1038 (Alaska 1986) at 1049)

4) Sections 6 and 7:

The law now specifies the crime committed by the would-be claimant must be a felony to preclude him or her from recovering damages. HB 166 logically expands this limitation to include misdemeanors which substantially contribute to the injury or death (but was not intended to cover minor prohibited conduct like jaywalking, joyriding or trespassing) and adds, in the interests of fairness, an exception which would prevent potential defendants from taking advantage of this shield if they too were engaged in committing a crime when the death or damages occurred. Any technical problems with this provision can be worked out.

5) Section 8:

Current law allows only the plaintiff to request periodic rather than lump-sum payments in connection with awards for future damages and makes no provision for determining attorney's fees in this instance. Since future damage awards compensate for loss of money which would have been received in the future, plaintiffs should not have an automatic "right" to receive that money now in one lump sum, if the award is otherwise adequate. In fact, society, which might otherwise get stuck with the tab, has an overriding interest in making sure that an award which is supposed to protect a person for a lifetime does just that. HB 166 therefore proposes to give either party the option to request periodic payments, but only with respect to that portion of a judgment relating to future damages. Since the court already has this authority, the so-called "mini-trial" concern expressed by critics is not a new issue. It should be noted that structured settlements are

not uncommon in Alaska, can have significant tax advantages for plaintiffs and are especially advantageous to "self-insured" municipalities and others with budget limitations. They do not "cheat" plaintiffs if properly established with strong companies by competent attorneys and/or judges on the basis of reasonable guidelines. Finally, in the interests of fairness and to prevent the possibility of attorney windfalls at the expense of plaintiff recoveries, this section clarifies that contingency fees be based on the present value of a settlement.

6) Section 9:

In the interests of fairness to plaintiffs, this provision was intended to amend existing law to require increases for anticipated inflation where periodic payments of future damages are ordered by the judge.

7) Section 10:

It is good public policy to protect volunteers from personal liability when acting within the scope of their official duties; although additional exceptions to this provision (e.g. auto accident situations) may be warranted. These organizations serve important public purposes and their vitality and effectiveness depends on the willingness of people from all walks of life to participate. Eliminating personal liability for acts or omissions which do not constitute gross negligence should help to encourage this kind of participation. It is important to keep in mind that a right of action against the entity itself is retained. Appropriate screening of applicants for these positions should take care of most concerns that immunity will foster sloppy decisionmaking.

8) Section 11:

Current law requires a deduction of certain collateral benefits from the judgement at defendants request. This determination is made after the trier of fact has established the amount of the award. To help minimize the impacts of prejudicial inferences concerning the plaintiffs financial circumstances, the jury should have all relevant information at its disposal before making a decision about the amount of a judgement including information regarding certain collateral benefits and any tax implications(or lack thereof)of an award of damages. The sponsors feel the jury can be trusted to be fair, particularly if this kind of information is evaluated in the context of appropriate jury instructions. Issues relating to offsets for plaintiff's out of pocket costs (e.g. insurance

premiums paid) and similar matters may warrant further consideration.

9) Section 12:

In the interests of fairness, this provision prevents plaintiffs from receiving a windfall since current rates for non-institutional investors (e.g. "T-Bills") are well below 10.5%. What a particular defendant can make on investments is irrelevant to the question of what is fair compensation to plaintiffs. "Offers of judgement" should be used to encourage settlements, not artificially high interest rate provisions.

10) Section 13:

Other than the fact that it is current practice, there is no good reason why plaintiffs should receive another windfall in the form of pre-judgment interest on damages relating to money not yet earned. Moreover, prejudgment interest requirements should not be evaluated on the basis of their settlement incentive value. Other provisions of the law are designed to serve that purpose.

11) Sections 14 and 15:

The bill's sponsors intended to limit this provision to pecuniary losses in situations where the decedent has no statutory dependents (spouse, children, other dependents). Current law already prevents recovery for non-pecuniary loss where there are no such dependents. HB 166 simply proposes to extend this principle to pecuniary loss since there is no compelling reason to award damages relating to economic loss to a successor in interest who did not rely on decedent for economic support. This amounts to economic waste which increases a defendant's financial obligations with no commensurate benefits to the public. Exceptions for medical or other expenses which must be paid by a relative or guardian may be warranted.

12) Section 16:

Primarily designed to protect potential defendants from nuisance suits, Rule 82 allows the court to award the cost of "reasonable" attorney's fees from the losing party to the winning one. The court decides what fee amount is appropriate on a case by case basis; if the plaintiff prevails, it's usually 10% of the award (ordinarily based on a fee schedule that is incorporated into the rule) and most often the fees are paid by the defendant or its insurer. If the defendant prevails there is no relative standard and,

typically, no insurance policy or "deep pocket" from which to collect. As a result, Rule 82 does little to deter frivolous suits and amounts to a "one sided" tax since victorious defendants rarely see this money. Alaska alone has such a rule; and speaking of mini-trials, Rule 82 is often the subject of litigation as to its applicability in a variety of situations.

13) Section 17:

A hospital's duty to provide certain services should not, by itself, be enough to find the hospital vicariously liable for the negligence of its non-employees; particularly since there is no reasonable way for a hospital to prevent an otherwise competent physician from committing malpractice. Please note that nothing in this provision removes the incentive to exercise care in the credentialing process or to maintain rigorous review procedures to insure standards. Any failure to exercise this care will still result in liability for the hospital. This section also is intended to create a "safe harbor" provision enabling hospitals that comply with appropriate notice requirements to avoid liability on a theory of ostensible, apparent or implied agency. It attempts to deal with two problems. First, some feel that hospitals should be vicariously liable for the negligence of independent contractor health providers because the public reasonably looks to the hospital (not the individual physicians) as the health care provider, and the hospitals do nothing to dispel this belief. Second, although hospitals may be held liable for the acts of independent contractor health providers on an implied agency theory upon a showing that the hospital "held itself out" as the employer of the provider, there are no guidelines to assist hospitals in determining what steps they might take to avoid this result. Section 17 attempts to solve both problems by permitting hospitals that wish to avoid vicarious liability on a "holding out" theory to give appropriate public notice, or fair warning, that the public must look to the provider, not the hospital, in the event of injury. And by spelling out the exact terms of this requirement, the hospital will know exactly what it takes to avoid liability on this theory.

While hospital's could require all doctors to carry insurance, this approach could lead to a loss of doctors at particular institutions and an increase of uninsured health facilities who can't afford to insure contractors who can't or won't insure themselves. In addition, the spectre of cross claims between the hospital and its doctors is an administrator's nightmare. Finally, since there is only one for-profit hospital in Alaska, the monopoly argument advanced

by critics is unpersuasive and does not take into account the fact that under Medicaid rules, hospital's cannot assume the liability for doctors and pass it through in the form of increased rates.

14) Sections 18 and 21:

These provisions are designed to increase our understanding of the current insurance crisis in Alaska by providing additional information and analysis regarding liability insurance issues including a review of the impact of "tort reform" measures on the availability and affordability of insurance. In response to comments that these studies should precede tort reform legislation, it is important to keep in mind that this is not a new issue. Alaska, like many other states, has been considering tort reform matters for a number of years. In fact, HB 166 is a response to our experience following passage of the 1986 package.

15) Section 19: This issue has already been addressed by the Committee.

16) Section 20:

a. Repeal of 9.17.010(c): The disfigurement and severe physical impairment exception has been characterized as an exception so large it swallows the rule. In practice, there are few cases to which the cap would apply unless these exceptions are deleted. Damages for non-economic loss (eg. pain and suffering, physical impairment, loss of consortium, disfigurement, and loss of enjoyment of life) are designed to give the victim some solace for her/his pain, emotional loss and inconvenience, and to make the negligent party acknowledge these effects through an additional monetary payment. It has always been recognized that the payment of money was both inadequate and imprecise; a measure of rough justice. While there is good reason to award such damages, according to a 1987 U.S. Attorney General's Tort Policy Working Group report, a primary cause of the current liability crisis is the increasing and unpredictable size of damage awards, especially those relating to non-economic damages, which in turn can be attributed to a relatively small percentage of all tort cases. This situation appears to encourage higher premiums to protect against the uncertainty. Further, according to the Working Group, disagreement over the value of pain and suffering awards coupled with the potential for an extremely high recovery for plaintiff is a major obstacle to out of court settlements. As the Working Group put it: "A limitation on damages is the single most important legislative reform of the tort law. Not only does it

significantly reduce costs of the tort system, but it also serves to expedite settlements....and mitigates the unfairness of the tort system for many plaintiffs and defendants arising from the fact that widely different damages often are awarded for nearly identical injuries...Ultimately, the question of whether non-economic damages should be limited or allowed to continue their rapid growth involves a balancing of conflicting societal interests, including society's interest in maintaining a stable and affordable tort system. This is a balance which State legislatures seem to be far more capable of striking than courts engaged in case-by-case adjudications." Note that a reasonable cap will have little or no effect on a majority of all tort cases. While it will reduce of size of some awards, the sponsors feel that such recoveries will still be appropriate by any reasonable standard.

b. This is an unnecessary provision. It is our understanding that competent defense attorneys are unlikely to agree to calculate damages under Beaulieu.

c. Bill's sponsors intended only to repeal the provision regarding periodic payments; not the subsection concerning collateral benefits in medical malpractice cases.

C.11

ALASKA STATE LEGISLATURE

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SAM COTTEN SPEAKER OF THE HOUSE

MEMORANDUM

TO: Liability Insurance Task Force

FROM: Speaker Sam Cotten, Chair

RE: Overview

DATE: September 15, 1989

I. INTRODUCTION AND OVERVIEW.

The Liability Insurance Task Force was established by the Alaska House of Representatives last session through House Resolution 10 (HR 10) in an effort to sort out the many controversies concerning "Tort Reform" and to "determine how the State may more effectively regulate insurance and provide civil justice"(see attached copy of HR 10). The task force consists of the chairs of the House Judiciary, Labor and Commerce and Health, Education and Social Services Committees and other members appointed by the Speaker of the House including public members "who are involved in tort reform issues or who are involved in insurance or civil justice".

The resolution notes in particular the problems faced in the public and private sectors as a result of rising insurance costs. It concludes that a comprehensive review of "statutes, case law, practices of the insurance and legal fields and the relationship between insurance costs and civil justice" is warranted under the circumstances and instructs the task force to "recommend to the legislature any changes to the statutes appropriate and necessary for reducing insurance costs and improving civil justice". A report of our findings and proposed legislation must be submitted to the legislature by January 31, 1990. The Task Force also terminates on that date.

As most of you already know, many of the issues we are obligated to address are highly controversial and have been on the table in one form or another for many years. The primary driving force behind creation of the task force was to obtain a "second opinion" from a balanced, independent source in a sincere effort to resolve, once and for all, these difficult questions to the greatest extent possible. Accordingly, I intend to be thorough, fair and objective; and hereby pledge that all interested parties will have their "day in court". I hope you share this view.

II. PRIOR LEGISLATIVE EFFORTS

The issue of skyrocketing insurance rates first surfaced in Alaska in the early 1970's. By 1975, the medical community concluded that legislative relief was required. A bill creating a Joint Underwriting Association passed the legislature during the 1975 session, but was vetoed by Governor Hammond who instead created the Governor's Medical Malpractice Commission to study the problem and make recommendations to the Legislature. (See attached). On the basis of this report and following extensive hearings on the matter, the Legislature enacted a comprehensive program which set up the basic medical malpractice claims system in operation today and which created the Medical Indemnity Corporation of Alaska, a primary medical malpractice insurer and required all Alaska doctors to participate as a condition of licensure. This latter provision was repealed in 1978 where participation was made voluntary.

There were no significant additional developments until 1986 when the Legislature passed "Tort Reform" legislation largely in response to the concerns of doctors and others who had organized into a broad based coalition. Conference CS for Senate Bill 377 (see attached) made a series of changes to our civil justice system including: Modified joint and several liability; Caps on non-economic damages (\$500,000 except damages relating to disfigurement or severe physical impairment); increased burden of proof for establishing punitive damages; limits on a persons's ability to recover damages for personal injury incurred while that person was committing a felony; detailed provisions on requirements for damage awards; limited liability for certain directors and officers of non-profit corporations, non-profit hospitals (including hospital citizen advisory boards) and members of school boards and school districts and members of governing bodies, commissions and citizen's advisory committees of a municipality; and provisions on contributory fault, collateral benefits, apportionment of damages, offers of judgment, costs and attorney's fees, including pre-judgment interest, and the effects of a release. This legislation has been characterized as a "patch-work quilt" of necessary compromises, and, in the

view of many tort reform advocates, did not go far enough toward making Alaska's civil justice system fair and predictable.

During the 1988 session, tort reform legislation intended to complete the 1986 effort was considered by the Legislature but significant differences between the House and Senate could not be resolved. The final Senate version of this bill (SCS HB 85) was substantially similar to HB 166 which will be discussed in detail below and is attached for your information.

And finally, the voters approved in November 1988 an initiative which eliminated joint liability for tort and other actions involving fault. A related provision limiting attorney contingency fees was disallowed by the Lieutenant Governor and is now the subject of litigation.

III. CURRENT SITUATION; SUMMARY OF PENDING LEGISLATION

Many Tort and Insurance reform proposals were discussed in great detail last legislative session, although most of the work was done in the House Labor and Commerce Committee chaired by Rep. Dave Donley, a member of this panel. Here is a brief summary of these measures in numerical order:

HB 166, by Cotten, Larson, Hoffman, Pettyjohn, Grussendorf, Foster, Collins and Boucher: An Act relating to civil actions; amending Alaska Rules of Civil Procedure 68 and 82; and providing for an effective date. CS for HB 166, by the House Labor and Commerce Committee: An Act relating to civil actions; amending Alaska Rule of Civil Procedure 68; and providing for an effective date.

HB 166 attempts to follow in the footsteps of its 1986 predecessor. In original form, it proposes significant changes to our civil justice system in an effort to a) clarify and refine existing law; b) reduce the costs of litigation and other costs of doing business in Alaska; c) reduce and restructure damage awards by matching losses with compensation and eliminating windfalls that the sponsor's feel are not needed to adequately compensate the victim d) promote stability; and in general, create a more equitable distribution of the costs and risks of injury. This controversial bill, similar to legislation passed in other states, is criticized primarily because it appears to limit the rights of victims without good cause. The bill: includes a six year statute of repose (i.e. absolute time limit starting from the date of injury) for bringing actions relating to personal injury, death or property damage; adds language which attempts to clarify the standard for punitive damages; limits a person's ability to recover for personal injuries or death occurring while that person was committing a crime; allows a defendant to request the court to order

periodic payments of damage awards(now only the plaintiff can make such a request); adds a requirement that periodic payment orders include increases for anticipated inflation; adds partial immunity for officers and directors of public corporations and electric or telephone cooperatives; rewrites the collateral benefits rule by allowing the jury to take into consideration certain other sources of compensation before making its damage determination; proposes a reduction of the interest rate on judgments and decrees from 10.5% to 8%; prohibits the current practice of allowing pre-judgment interest on future economic and noneconomic damages; requires attorney's to discount their fees to present value; establishes dollar limitations (caps) on certain awards; amends Alaska Rule of Civil Procedure 82 by prohibiting the application of Rule 82 attorney's fees in a civil action for personal injury, death or property damage unless allowed by statute or agreement of the parties; eliminates certain provisions regarding the computation of damages; limits civil liability of hospitals for nonemployees; and requires the state to provide to the legislature on a regular basis certain information and analysis regarding liability insurance issues including a review of the impact of "tort reform" on the availability and affordability of insurance.

CS for HB 166 is the result of several months of hearings in the House Labor and Commerce Committee. It makes several significant changes to the original bill including: revised "Findings and Purpose"; substantially revised statute of repose provisions; deletion of provisions in original bill concerning: limited liability for directors and officers of public corporations, Rule 82 attorney's fees, pre-judgment interest rates, damage caps, hospital immunity for the actions of non-employees, periodic payments, reductions of interest rates, discount of attorney fees to present value and punitive damages. The committee substitute also adds several reporting requirements, repeals AS 9.55.548 dealing with Medical Malpractice periodic payment and collateral sources rules, keeps provisions in the original bill which prohibit prejudgment interest on future damages not yet due at the time of trial, eliminates certain references regarding the computation of damages and completely rewrites the collateral benefits law but retains the opportunity to present evidence of collateral benefits to the jury prior to the award determination.

HB 333, by the House Labor and Commerce Committee: An Act relating to civil actions against insurers for unfair or deceptive acts.

This bill makes an insurer, who commits an unfair or deceptive act against an insured, liable for the actual damages resulting from the unfair or deceptive act.

HB 334, by the House Labor and Commerce Committee: An Act requiring certain persons who are in a regulated occupation or profession to obtain malpractice insurance.

Any regulated professional with a malpractice judgement entered against them would be required to obtain a malpractice insurance policy from a qualified insurer with coverage in an amount which is not less than \$100,000. This requirement would not apply to a person who is no longer employed in the occupation or profession that resulted in an award of civil damages, or to a regulated occupation or profession that is unrelated to the occupation or profession that resulted in an award of damages.

HB 335, by the House Labor and Commerce Committee: An Act amending Rule 68 of the Alaska Rules of Civil Procedure relating to the award of costs and attorney fees and to the payment of prejudgment interest.

This bill rewrites Rule 68 of the Alaska Rules of Civil Procedure by enhancing "offer of judgment" sanctions which are intended to provide incentives to settle litigation.

HB 336, by the House Labor and Commerce Committee: An Act relating to Medical malpractice advisory panels.

HB 336 would increase the size of Medical Malpractice Advisory panels from 3 to 5; limit the number of health care providers who serve on the panel to three members; and change the way the panel considers evidence.

HB 337, by the House Labor and Commerce Committee: An Act relating to malpractice insurance for health care providers.

Under this proposal, a malpractice insurance policy issued in Alaska to a health care provider would have to include coverage, as an insured under the policy, for any hospital at which the health care provider practices. The definition of "health care provider" includes: audiologists, chiropractors, dental hygienists, dentists, nurses, dispensing opticians, optometrists, physical and occupational therapists, physicians, podiatrists, psychologists and psychological associates.

HB 345, by the Rules Committee by request of the Governor: An Act Relating to medical malpractice and claims against health care providers and creating the Alaska Health Care Claims Board.

This bill, introduced by the Governor during the last days of the session, proposes a new way of handling medical malpractice claims. This is a significant piece of legislation which has not yet received much attention. The bill has three main components. It creates an Alaskan Health

Care Claims Board; specifies the procedures that the Board must use in deciding claims; and creates a no-fault system similar to Worker's Compensation. According to the Governor in his transmittal letter: "This bill simplifies the procedures that those injured by health care providers must go through to recover damages. The bill sets up a "no-fault" recovery system in an effort to reduce costs to both injured parties and health care providers. This proposed legislation is not perfect. It will need alot of analysis, public scrutiny, and careful drafting. Essentially it is a new concept which addresses a problem which affects all of us." For a more detailed review of this bill please see attached transmittal letter from the Governor dated May 5, 1989.

HB 449, by Donley and Gruenberg: An Act making a special appropriation to the Alaska medical malpractice matching fund for medical malpractice insurance premiums; and providing for an effective date. HB 450, by Donley and Gruenberg: An Act creating the Alaska medical malpractice matching fund; and providing for an effective date.

These bills propose a direct means of reducing certain medical malpractice insurance premiums by establishing a state assistance program for qualified applicants based on a statutory formula. The proposed initial appropriation to this fund is \$500,000 from unexpended and unobligated money that has been repaid to the medical malpractice liability revolving loan fund; the unexpended and unobligated balance of this appropriation would lapse and return to the general fund on July 1, 1995.

HB 355, by the House Labor and Commerce Committee: An Act relating to imposition of a uniform insurance premium tax; and providing for an effective date.

This bill proposes several changes to the laws concerning insurance premium taxes including the establishment of a uniform tax rate for all lines of insurance.

HCR 37, by the House Labor and Commerce Committee: Relating to the Alaska Bar Association.

This resolution urges the Alaska Bar Association: to develop an impaired Attorney program which will establish sanctions to encourage attorneys to practice competently; to hire an investigator to look into allegations of improper or incompetent practices; to require licensed attorneys to post the Association's disciplinary procedures in a prominent place in their law offices; to publish a list of disciplinary actions at least once per year and to stop the practice of keeping these matters private; and to review attorney fees and their relationship to the cost of liability insurance, to review the relationship between Rule 82 and contingency fees, to adopt standards for reasonable

contingency fees and to require disciplinary actions be taken against attorneys who exceed those standards.

IV. TASK FORCE STRATEGY/ORGANIZATIONAL PROPOSAL.

Immediately following our first organizational meeting, we will conduct an informal two-day workshop which will begin to focus on one or more of the following critical threshold questions: 1) Who is having insurance problems; and what are those problems?; 2) Litigation statistics and experience in Alaska; 3) How certain malpractice insurance rates are set by the insurance industry, including our own medical malpractice carrier, MICA; 4) The relationship between "tort reform" legislation (similar to that proposed in HB 166) and insurance rate setting including the experience in one or two other states; 5) The role of the State of Alaska in setting and monitoring insurance costs; 6) the extent to which professional competency is regulated in Alaska, with particular emphasis on doctors, lawyers, engineers and architects; 7) the pros and cons of adopting classic "tort reform" measures, regardless of their impact on insurance premiums; and 8) alternate systems for resolving tort claims. It is my hope that our ultimate efforts will be enhanced if we can develop, at the outset, a clearer understanding of these fundamental issues. A formal agenda for this first meeting will be sent to you as soon as possible.

If you have comments or questions please give me or Special Counsel David Rogers a call.

STEVE COWPER
GOVERNOR



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

May 5, 1989

The Honorable Sam Cotten
Speaker of the House
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Mr. Speaker:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to medical malpractice and claims against health care providers. This bill simplifies the procedures that those injured by health care providers must go through to recover damages. The bill sets up a "no-fault" recovery system in an effort to reduce costs to both injured parties and health care providers.

This proposed legislation is not perfect. It will need a lot of analysis, public scrutiny, and careful drafting. Essentially it is a brand new concept which addresses a problem that affects all of us. I propose that the Legislature hold hearings and do the requisite research on this bill during the interim, so that we can make the necessary amendments and act expeditiously in the 1990 session.

The bill has three main components. First, the bill creates an Alaskan Health Care Claims Board. Next, the bill specifies the procedures that the board shall use in deciding claims. Finally, the bill changes the system of recovery to be one of no fault, paralleling the theory behind workers' compensation.

The Alaska Health Care Claims Board is made up of five members, three of whom are not, and have not been, connected with the legal or medical professions. The members are appointed by the governor. Board members serve staggered four-year terms and are compensated \$400 a day plus transportation and per diem. This amount will be necessary given the time commitment that is envisioned. The board has the power to adopt regulations, subpoena witnesses and information, and hold hearings concerning disputed claims. (The board may decide to hear nondisputed claims in certain circumstances). The Department of Commerce and Economic Development will employ the board's staff and provide general support for the board.

The board's rules are required to be as simple as possible, to encourage people to do their own claims rather than use outside counsel.

The bill sets out the procedure necessary to bring a claim to the Alaska Health Care Claims Board if the claim is denied by a health care provider. If the claim is accepted, the board reviews the claim to make certain that it is fair and complies with the provisions of the Act but, unless the agreement somehow violates the Act or is unfair, all agreements between parties must be accepted by the board. Since this is a no-fault system, it should be easier for parties to come to agreements, thus alleviating the great stress and cost of our current system.

If a claim is denied, the board may investigate the claim on its own. The board in its own discretion may order a hearing. If the board does so, the hearing must take place within 90 days after the order. If a party (the claimant, the health care provider, or some other third party whom the board finds to be "interested") requests a hearing, the board must hold a hearing within 90 days of the receipt of the request.

All interested parties are to receive 10 days' notice of a hearing, and, 30 days after the record closes, the board shall render its decision rejecting the claim or awarding compensation. Board orders must be easy to understand and must be supported by reasoned conclusions.

If the board orders compensation, it must comport with the compensation outlined in the bill. As previously mentioned, fault is not at issue in this decision. Because of this, there may not be compensation for pain and suffering or loss of enjoyment of life. In essence the bill establishes a "quid pro quo" not unlike that of the workers' compensation system. Although an injured person may not recover for pain and suffering or loss of enjoyment of life the person will recover for his other losses, and in a much speedier manner. Compensation may be had for medical expenses, treatment, and lost wages for existing employment at the time of injury.

To deal with cases of permanent impairment, the board must adopt a rating schedule for injuries (defining percentages of impairment) that is consistent with the American Medical Association Guides to the Evaluation of Permanent Impairment, supplemented from other recognized guides where the injury cannot be rated by the use of the American Medical Association Guide. The board shall make its awards to permanently impaired persons by using this rating system and multiplying the appropriate percentage of impairment by \$1,000,000.

In cases of nonpermanent injury, medical expenses are to be covered for a two-year period, or longer if the board determines it is necessary; and 100 percent of a person's wages are recoverable for the period the person cannot return to work.

Medical expenses are to be paid within 30 days after the date the expense is incurred. In cases of permanent impairment, compensation is to be paid in a lump sum, within 30 days after the date the board files the impairment rating. Lost wages are paid out on a weekly basis, as the loss is incurred. Lost wages are reduced by any temporary disability compensation payable under the Alaska's Workers' Compensation Act, the Federal Employees' Compensation Act, the Longshore and Harbor Workers' Compensation Act, or similar workers' compensation laws.

In cases where death results in an award, the award will not only include medical expenses and lost wages but also \$1,000,000 in compensation to the decedent's dependents. The statute sets out a schedule of how the award is to be distributed. All awards are subject to insurance subrogation and must be reduced by damages recovered through collateral sources.

In cases where there has been an "aggravated injury" caused by a health care provider's use of drugs or alcohol, or caused by a health care provider's deliberate and malicious act or conscious disregard and reckless indifference, penalties up to \$1,000,000 may be assessed against the health care provider.

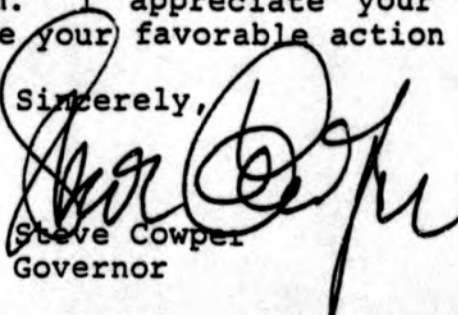
In all cases covered by the Act, compensation does not include pain and suffering or loss of enjoyment of life. This will reduce arguments over these subjects and clarify the liability to which health care providers are subject.

Final orders of the board may be appealed to the superior court. The superior court may review the final order as provided by the Alaska Administrative Procedure Act and the Alaska Appellate Rules.

This is a unique system and will provide the exclusive remedy that injured parties have against health care providers. However, in this era of rising insurance costs, when doctors have been forced out of business, something must be done to control the system of recovery. This bill is an attempt to come to a solution that will lessen the burden on both sides of a claim.

This bill is being introduced late in the legislative session, rather than waiting until next year, so that it may be studied over the interim. I appreciate your efforts concerning this topic and urge your favorable action on it.

Sincerely,



Steve Cowper
Governor

**Report of the Tort Policy Working Group
on the Causes, Extent and Policy
Implications of the Current Crisis in
Insurance Availability and Affordability**



February 1986

**The Citizens Coalition
For Tort Reform**

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INTRODUCTION
AND
EXECUTIVE SUMMARY

In October of last year the Attorney General established the Tort Policy Working Group, an inter-agency working group consisting of representatives of ten agencies and the White House. One of the tasks the Working Group was asked to undertake was to examine the rapidly expanding crisis in liability insurance availability and affordability.

The following is the report of the Tort Policy Working Group on the causes, extent and policy implications of this crisis. The primary contributing agencies included the Department of Justice, the Department of Commerce and the Small Business Administration.

Chapter 1 of the report (The Crisis in Insurance Availability and Affordability) describes in detail the significant problems many businesses, professionals and municipalities are having obtaining liability insurance. The Chapter documents a dramatic change in the last two years in the availability, affordability and adequacy of liability insurance. Where insurance is available (and in some areas it simply is not), premium increases of several hundred percent over the last year or two have become commonplace. Few if any private or public entities that rely on liability insurance have escaped the problems generated by this crisis.

Part A of Chapter 2 (The Causes of the Crisis in Insurance Availability and Affordability) reviews the current financial condition of the insurance industry, and the economic factors leading to that condition. The property-casualty industry in the past two years has suffered significant underwriting losses (\$21 billion in 1984; \$25 billion in 1985) which have limited its ability to offer as much insurance as its customers desire, and have made it reluctant to insure high risk activities which may expose it to further substantial underwriting losses. These underwriting losses appear to be largely a result of coverage written in the late 1970's and early 1980's which may have been underpriced due to the industry's desire to obtain premium income to invest at the then prevailing high interest rates.

Nonetheless, there is little to suggest that the recent massive increases in premiums is related solely to these losses, or that the cost of liability insurance will decline significantly as the industry limits its underwriting losses and restores its desired level of overall profitability. To the contrary,

indications are that developments in tort law are a major cause for the sharp premium increases. 1/

Part B of Chapter 2 reviews the contribution of tort law to the insurance availability/affordability crisis. The Working Group found that in the past decade there has been a veritable explosion of tort liability in the United States. Four specific problem areas are identified and discussed:

- ° The movement toward no-fault liability, which increasingly results in companies and individuals being found liable even in the absence of any wrongdoing on their part.
- ° The undermining of causation through a variety of questionable practices and doctrines which shift liability to "deep pocket" defendants even though they did not cause the underlying injury or had only a limited or tangential involvement.
- ° The explosive growth in the damages awarded in tort lawsuits, particularly with regard to non-economic awards such as pain and suffering or punitive damages. And,
- ° The excessive transaction costs of the tort system, in which virtually two-thirds of every dollar paid out through the system is lost to attorneys' fees and litigation expenses.

The Working Group was particularly struck by the extraordinary growth over the last decade of the number of tort lawsuits and the average award per lawsuit. A few examples amply illustrate this point:

- ° Between 1974 and 1985 there has been a 758% increase in the number of product liability lawsuits filed in federal district court.
- ° The number of medical malpractice lawsuits per 100 physicians doubled between 1979 and 1983, and tripled during that period for obstetricians/gynecologists.
- ° According to a jury verdict reporting service, between 1975 and 1985 the average medical malpractice jury

1/ The Working Group also considered whether state regulation of the insurance industry may be a cause of the crisis, and found little compelling evidence that state regulation is a major cause of these problems.

verdict increased from \$220,018 to \$1,017,716, and the average product liability jury verdict increased from \$393,580 to \$1,850,452. 2/

- ° A survey of punitive damage awards in Cook County, Illinois indicates that the average personal injury punitive damage award (measured in constant 1984 dollars) increased from \$40,000 in 1970-74 to \$1,152,174 in 1980-84.

The above data demonstrates that the insurance industry was selling coverage at constant or even reduced cost over a period of years during which tort liability was undergoing a dramatic expansion. This suggests that a major factor underlying the availability/affordability crisis is the industry's attempt to bring premiums quickly back into line with rapidly growing liability risks. 3/ The high -- and in some areas unaffordable -- insurance premiums reflect the fact that tort law is now placing a massive compensation burden on the private sector.

A second important contribution of tort liability to the availability/affordability crisis is the tremendous uncertainty that has been generated by rapidly changing standards of liability and causation. The "rules of the game" have become so unpredictable that the insurance industry often cannot assess liability risks with any degree of confidence. This appears to have severely exacerbated the problem.

Chapter 3 of the report (Recent Insurance Industry Developments) summarizes a number of responses of the insurance industry, its customers and state regulators to the crisis. These developments include the use of claims-made policies, the inclusion within policy limits of all or part of defense costs, the increasing use of self-insurance and captives, and more exacting state regulation.

In Chapter 4 of the report (Tort Law Reform) the Working Group concludes that while some of the above recent developments in the insurance industry, along with a likely improvement in the industry's financial condition, should relieve some of the current availability/affordability problems, it is unlikely that these changes will provide long-term, systemic relief without

2/ For purposes of comparison, the dollar lost approximately half of its purchasing power during this period.

3/ While some have suggested that the dramatic premium increases are an attempt by the industry to recoup its past underwriting losses, for the reasons discussed in the report such a theory makes little economic sense.

some fundamental reforms of tort law. Indeed, there are good reasons to believe that absent such reforms, particularly the insurance affordability problem will remain a long-term fixture of the American economy.

The Working Group recommends eight reforms of tort law that should significantly alleviate the crisis in insurance availability and affordability. The Working Group does not at this time recommend how these reforms should be implemented (whether at the federal or state level, or through legislative or judicial modification of the law); nor are these reforms meant to be an exhaustive list of potential reforms. The recommended reforms are:

- ° Return to a fault-based standard for liability.
- ° Base causation findings on credible scientific and medical evidence and opinions.
- ° Eliminate joint and several liability in cases where defendants have not acted in concert.
- ° Limit non-economic damages (such as pain and suffering, mental anguish, or punitive damages) to a fair and reasonable maximum dollar amount.
- ° Provide for periodic (instead of lump-sum) payments of damages for future medical care or lost income.
- ° Reduce awards in cases where a plaintiff can be compensated by certain collateral sources to prevent a windfall double recovery.
- ° Limit attorneys' contingency fees to reasonable amounts on a "sliding scale."
- ° Encourage use of alternative dispute resolution mechanisms to resolve cases out of court.

Chapter 5 of the report (Government Insurance: A Non-Solution) details the reasons why government insurance or indemnification would be highly undesirable and would do nothing to remedy the problems underlying the availability/affordability crisis. Such a federal insurance or indemnification program would not only be extremely expensive, but also could exacerbate the problems of tort law by making the "deep pocket" of the taxpayer available in many cases. In addition, such a program could undermine public health and safety, require more extensive government regulation of private sector activities, involve the government in substantial litigation, lead to increased federal involvement in state insurance regulation, and inhibit the ability of the private sector to adapt insurance services to changing economic and social conditions.

The Conclusion to the report lists five conclusions as to the appropriate response of the federal government to the current crisis in insurance availability and affordability. In sum, the Working Group concludes that while there are a number of factors underlying the insurance availability/affordability crisis, tort law is a major cause which the federal government can address in various sensible and appropriate ways. As for some of the other factors underlying the crisis, such as the insurance industry's recent large underwriting losses, there is little the federal government can or should do to remedy these problems.

In that both the tort liability and insurance developments in this report are highly dynamic, and because more detailed data and other studies undoubtedly will become available, the Working Group will continue to follow developments in this area, and, where appropriate, supplement its conclusions and recommendations.

Richard K. Willard
Chairman
Tort Policy Working Group

Robert L. Willmore
Chairman
Task Force on Liability
Insurance Availability

February, 1986

CHAPTER 1

THE CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY

Liability insurance is a linchpin in the operation of the United States economy, yet many American businesses, professionals and municipalities, both large and small, are encountering serious insurance problems arising from premium increases, policy cancellations and refusals to underwrite certain activities.

The liability insurance crisis has three separate but related faces that individually or in various combinations make it difficult for many entities to obtain the desired liability insurance. These problems are availability of insurance, affordability of insurance coverage and adequacy of coverage.

This Chapter describes the current nature and extent of these problems. The Chapter focuses, first, on the problems encountered within the various lines of insurance, and, second, on the effect of those problems on different sectors of the economy.

I. INSURANCE COVERAGE SUMMARIES

The following are insurance summaries taken predominantly from insurance industry reports prepared by the Alliance of American Insurers or published in Business Insurance.

Environmental Impairment Liability Insurance ("EIL")

EIL covers pollution incidents stemming from gradual pollution exposures (as opposed to "sudden and accidental" pollution, which traditionally has been covered under general liability coverage). Two major companies dropped out of the market in 1985, and by the end of the year only two companies were offering EIL coverage. Forty-seven companies were forced to close hazardous-waste management facilities for lack of EIL coverage. Most hazardous waste businesses currently are looking toward captives and self-insurance. Brokers expect significant price increases on the limited insurance still available.

Sudden and Accidental Pollution Coverage

Coverage for sudden and accidental pollution traditionally has been provided as part of general liability coverage. New general liability forms, however, specifically exclude all pollution liability. This is due to court decisions interpreting "sudden and accidental" coverage as also covering gradual and intentional pollution. (See Chapter 3 for a discussion of the new policy forms.) The London market currently is excluding pollution coverage from the large risks it insures.

Directors and Officers Liability ("D & O")

Premiums in 1985 rose 50% to 500%, and include larger deductibles, lower limits, more restrictive endorsements and shorter policy durations. Industries particularly affected include financial institutions, electric (nuclear) utilities, new high technology business, wildcat oil and gas companies, research and development enterprises, real estate developers, highly leveraged businesses, petrochemical companies and the steel industry. Capacity constrictions have hurt larger risks more than smaller risks. Traditional primary and reinsurance capacity has been reduced, but Lloyd's of London, which has in the past not been active in this line, is offering primary coverage up to \$20 million. Not surprisingly, business with Lloyd's of London is up to 100% to 200%. Much of the reinsurance market for such coverage has virtually dried up.

Bank Fidelity Bond Coverage

Premiums are up about 300%. A group of fifty banks are creating a mutual insurer to provide D & O and bankers blanket bond coverage.

Motor Carrier Liability Coverage

Bus and trucking companies are having severe difficulties obtaining the insurance coverage required by federal law. The Motor Carrier Act of 1980 requires insurance minimums of from \$750,000 for carriers of non-hazardous cargo to \$5 million for carriers of hazardous waste and most hazardous materials carried in bulk. The Bus Regulatory Reform Act of 1982 set insurance minimums from \$1.5 million to \$5 million, depending on the passenger capacity of the bus. Capacity is limited both in the primary and reinsurance markets. Small trucking firms and independent owner-operators have the most difficulty getting insurance.

Liquor Liability Coverage

Liquor liability coverage may be available as part of a commercial lines package, but is severely constrained and virtually nonexistent in some parts of the country as monoline coverage. This line has been affected by the bankruptcy of one of the largest dram shop insurers, Ideal Mutual Insurance Company.

Medical Malpractice Insurance

Availability problems are being encountered by nurse/midwives, obstetricians/gynecologists, pediatricians and dentists. Premiums are being raised and coverage limits are being reduced, sometimes by as much as 50%. Reinsurers are also restricting coverage in this line. St. Paul's Insurance Company, the largest medical malpractice insurer, has placed a moratorium on new policies. St. Paul's writes coverage for approximately 20%

of the Nation's doctors, and wrote an estimated \$600 million in malpractice business in 1985. It had a pure loss ratio (excluding loss adjustment expenses and operating expenses) of 81.3% in 1984. Doctor-owned mutual insurance companies account for more than half of the medical liability coverage in the country.

Commercial General Liability ("CGL")

Commercial general liability insurance has undergone significant premium increases. The Insurance Services Office ("ISO"), the property-casualty insurers' statistical and ratemaking organization, has filed a new CGL form which will limit coverage and which contains certain exclusions and policy limitations (see Chapter 3).

Excess Coverage

Excess coverage capacity has been sharply reduced. This coverage currently is offered primarily on a claims-made basis, which may or may not mesh with the primary, reinsurance and other excess layers.

Reinsurance

Reinsurance capacity for the United States market has been severely limited, particularly with regard to Lloyd's of London, which has faced both its own problems and a disillusionment with the American market. This capacity problem is expected to ease somewhat in 1986, but is likely to remain a problem for some time longer.

II. SECTORAL SUMMARIES

The following are summaries of the effect of the insurance availability/affordability crisis on various sectors of the United States economy. This information was obtained from surveys conducted by business groups, articles in the trade press and materials prepared by trade associations or provided by industry representatives. While the following does not include all of the available information, it summarizes the major findings.

Municipalities

Municipalities are among the hardest hit groups by both affordability and availability problems. Local officials preparing their budgets for the next fiscal year report that the market for public entities is "extremely limited" and "diminishing to nothing." Those cities able to secure bids are finding insurance companies' offers prohibitively expensive. Renewal rates have climbed by as much as 400% -- and often for lower coverages with higher deductibles. Some cities are facing premium increases of up to 1,000%.

The United States Conference of Mayors conducted a survey of 39 cities in the summer of 1985. Over half the cities were quoted premium increases of over 100%, and 16 were quoted increases greater than 200%. In addition, a recent report by the Wyatt Company, Public Officials Liability Insurance: Understanding the Market (1986), notes that local governments have reported premium increases of 200% to 300% in the insurance purchased for their officials.

Rather than renew, many cities have decided to "go bare." All cities have been forced to reevaluate and sometimes limit the services they provide their communities. Finally, in the wake of policy cancellations, a number of city and county officials have resigned, fearing personal exposure to lawsuits stemming from their official duties.

Transportation

The American Public Transit Association, the nation's largest organization of transit operators, reports that premiums for those companies able to obtain insurance this year have gone up 500% to 1,000%, and sometimes more. In Los Angeles, the Southern California Rapid Transit District's annual premium jumped from \$67,000 to \$1.7 million, while coverage was reduced. Transit problems were compounded by the bankruptcy of one of the largest companies involved in insuring mass transit systems. Some local transit systems have had to suspend operations.

Publishing

Newspaper and magazine publishers are finding it more difficult to obtain libel insurance.

Nurse-Midwives

The American College of Nurse-Midwives represents 2,500 members, 1,400 of whom were covered under a blanket policy through the association. The policy was cancelled on July 1, 1985. The association has been unable to obtain other coverage and has been attempting to create a captive insurer. The captive was to have started operation by April 1, 1986, but that deadline will not be met.

Grocers

A survey by the National Grocers Association found that its members' liability insurance premium rates had recently increased from 25% to 500%. The survey covered 161 retailers and 20 wholesalers.

Architects and Engineers

Most architectural and engineering firms, and particularly smaller firms, are experiencing severe availability and affordability problems. Insurance premium rate increases of

200% to 300% have become the norm. Roughly 30% to 40% of smaller firms are going bare. Engineering firms involved in asbestos or other toxic substances abatement activities face extreme difficulties in obtaining insurance, with rate increases, where insurance is available, of 5,000% not uncommon.

Day Care Centers

The National Association for Education of Young Children conducted a survey of day care providers. They covered family day care providers who care for children in a home setting, day care centers and headstart programs. The survey found that 40% of the respondents had had their insurance cancelled or not renewed and the majority of those with coverage had premium increases, most of which rose 200% to 300%.

Toy Manufacturers

The Toy Manufacturers of America recently surveyed its 243 members on insurance cost and availability problems. Final results will not be available until April, but initial responses are:

<u>Members</u>	<u>%Increase in premiums</u>
21	50
9	50-100
12	100-150
2	150-200
11	300-500
7	500-1000
1	over-1000
2	cannot obtain insurance

Companies that normally had three to four months to negotiate a policy renewal have been given only 72 hours to do so this year. This permits insufficient time for policy shopping. The association reports that it had recommended a captive to its members a few years ago. Commercial insurers reduced prices upon learning of the proposal, eliminating industry interest in a captive.

Household Appliance Manufacturers

The household appliance industry has seen sharp reductions in available coverage, and the Association of Home Appliance Manufacturers has lost group coverage it had arranged in 1983. Many companies have been able to obtain only about one-third of the coverage sought for product liability, and the cost of that coverage is increasing. Member companies are having similar problems obtaining D & O insurance.

Automobile Repair

The Automotive Services Councils, an association representing automobile repair shops and garages, conducted a survey with 104 responses. Average premium increases were 70% to 80%. Some 13% of the membership reported purchasing an average of 30% less coverage. Approximately 41% had experienced policy cancellations and 26% were unable to find new carriers.

Medical Equipment

The medical equipment industry has had a captive, MedMarc, an affiliate of the Health Industry Manufacturers Association, since 1979. The captive started with 35 companies and has recently reached 100 member companies. The rate of growth increased in 1985 as the result of cancellations by commercial insurers of about 20% of the Association's members and premium increases of five to ten-fold.

Biotechnology

Biotechnology companies are having a particularly difficult time in the tight market because they are generally new, small companies dealing mostly in research and development in a field largely unknown to insurers. Their inability to obtain coverage causes them difficulty in obtaining bank financing, which, in turn, causes some of these companies to sell out or forego promising research. The industry is exploring the creation of a captive.

Oil and Gas Drilling

The International Association of Drilling Contractors represents 1,500 contractors operating drilling rigs. It estimates maritime liability premium increases of 300% to 700% and inland liability premium increases of 100% to 150%.

Construction Contractors

Constructor magazine (October 1985) estimates average increases in general liability coverage of 40% to 75%. For contractors who were able to negotiate significant discounts in past years increases currently are running up to 300%. In 1985 premium increases for umbrella coverage were approximately 300% for less coverage.

Natural Gas Transportation

The National L-P Gas Association represents 4,100 firms that prepare and transport liquefied petroleum gases for residential and industrial users. According to a spokesman, as many as 25% of the transporters are operating with less than the \$5 million in insurance coverage that is required of motor carriers by federal law. Difficulties are attributed to unavailability and prohibitive costs of umbrella insurance.

General Manufacturing

The Machinery & Allied Products Institute ("MAPI") recently conducted a survey of 81 companies producing a broad range of products in the manufacturing industries and obtained an 80% response rate. The typical respondent experienced increases for every type of insurance covered in the survey. The survey covered general liability, D & O, environmental impairment liability, products and other property and casualty coverages. The size of the increases varied with the date of the renewal; consequently, the survey results understate the problem since many of the respondents are not up for renewal until early this year. Significant survey results are shown in the table below.

MAPI Survey Results on Liability Coverages

<u>Premiums</u>	<u>% Higher</u>	<u>% Change (Median)</u>
CGL-Primary	73	40
CGL-Excess	100	250
D & O	72	300
EIL	94	60
Products	95	116
Other	87	40
<u>Lower Limits</u>	<u>% Lower</u>	<u>% Change (Median)</u>
CGL-Primary	13	-36
CGL-Excess	66	-50
D & O	27	-25
EIL	59	-50
Products	33	-50
Other	18	-25
<u>Deductibles & Exclusions</u>	<u>% Higher Deductible</u>	<u>% More Exclusions</u>
GCL-Primary	34	97
GCL-Excess	25	96
D & O	49	95
EIL	50	89
Products	50	100
Other	28	100

In addition to the foregoing, 35% of the MAPI respondents indicated that their general liability coverage excluded "sudden and accidental" pollution coverage, while 49% indicated that it was excluded in some layers and included in others. Some 65% of the respondents indicated that they had some coverages cancelled since January 1, 1985.

Machine Tool Manufacturers

The National Machine Tool Association represents 300 to 400 businesses that manufacture heavy machinery which cuts, shapes and forms metal. Preliminary results of a survey indicated product liability premiums have doubled since 1984, and that about half of the respondents have been or expect to be put on claims-made policy forms.

Battery Recycling & Smelting Companies

Battery recycling companies are typical of many industries where processes create toxic wastes. Recycling 50 million scrap batteries accounts for up to 50% of the annual lead smelter production. If the batteries are not recycled, they will be disposed of in landfills, leading to more serious toxic exposure. One major smelting company was offered a \$10 million policy with a \$2.5 million deductible at a cost of \$650,000. While it deems the policy uneconomic, it has not found an alternative. The problem is widespread with smelters of various metals. The uncertainty of the risk and size of pollution liabilities has lead to substantial reductions in coverage with sharp increases in deductibles and premiums.

Power Equipment Manufacturers

Outdoor power equipment manufacturers had been reporting premium increases of from 50% to 70% during the past year. At the end of the year, with many renewals coming due, some have experienced increases of 400% to 600%. The Association once again is considering establishment of a captive.

General Aviation Manufacturers

The General Aviation Manufacturers Association reports that the cost of liability insurance per aircraft was \$51 for the 6,778 business, commuter and private aircraft delivered in 1962, and increased to \$211 for the 9,774 delivered in 1972. Currently, for the 2,000 planes delivered in 1985, the liability insurance cost has increased to \$70,000 per plane. The cost of liability insurance to air frame manufacturers in 1985 was about \$135 million, with a total cost of \$175 to \$200 million for the entire industry that includes manufacturers of engines, electronics and parts.

Ski Operators

Liability insurance premium increases of up to 400% have been reported by the National Ski Areas Association. Some small ski areas have closed, and the average price of lift tickets has increased substantially.

Aerospace Equipment Manufacturers

Aerospace equipment manufacturers are increasingly concerned that the escalating cost of product liability insurance and other associated costs are causing them to lose their ability to compete with overseas manufacturers of similar equipment.

III. THE NATURE AND EXTENT OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above examples of insurance availability, affordability and adequacy problems demonstrate the broad scope of the liability insurance crisis in the mid-1980's. In a similar crisis in the mid-1970's, the problem areas were largely confined to medical malpractice and product liability. Medical malpractice coverage has been a continuing problem, with almost half that coverage currently underwritten by doctors' and hospitals' mutuals and other alternative markets. Product liability coverage, however, was readily available at declining cost during the late 1970's and early 1980's.

A growing capacity shortage over the last year or more has caused commercial insurers to review carefully their underwriting standards and pricing policies in order to determine where insurance capacity can be utilized most profitably. The inevitable result of this reevaluation has been a severe disruption for insurance buyers.

Insurance Availability

Availability problems are occurring in certain specialty commercial insurance markets. These include pollution, day care, municipal, liquor, motor carrier and D & O liability coverages. The bankruptcies of some specialty insurers, particularly in the lines of motor carrier and liquor liability, have affected the capacity in these coverages.

In each of these lines, insurers have perceived the possibility of significant losses based on highly publicized verdicts and settlements. General line insurers who ordinarily would fill the gap left by specialty carriers are unwilling to do so because they can use their scarcer dollars in less volatile and more profitable lines.

Insurance Affordability

Premiums are increasing in virtually all commercial coverages. Examples of affordability problems include nurse-midwives and general aviation manufacturers, both of which face premium costs which may be warranted by the experience, but are too expensive for the buyers. Solutions to problems like these appear to lie outside of the insurance system.

Insurance Adequacy

Problems of insurance adequacy are being experienced across all commercial lines of coverage. The main problem seems to lie with the fact that many buyers are unable to buy as much

insurance as they desire. This is particularly true for large firms which seek large amounts of excess and higher limits coverage. These problems appear related in part to a capacity crunch created both by the insurance cycle and the withdrawal of capacity by the overseas reinsurers. The lack of capacity related to the insurance cycle shows signs of abating as the corner of the cycle has turned and surplus is increasing. But many firms may have to use alternative market mechanisms for at least a couple of years until this capacity fully returns. It may take much longer to get reentry by overseas reinsurers who have grave concerns about the American tort liability system. A second area of inadequacy lies in the growth of exclusions, deductibles and other policy limitations that are just now being introduced into the market. These are discussed in Chapter 3.

The Insurance Availability/Affordability Crisis

Finally, it should be noted that the crisis in insurance availability and affordability does not appear to be a crisis for the insurance industry. While the industry (as discussed in Chapter 2) is suffering substantial underwriting losses, the Working Group does not perceive this crisis to be a major threat to the financial viability of the industry. Rather, it is a crisis for the insureds who cannot obtain or afford the insurance they believe necessary for their on-going activities. And, to the extent that entities are forced to operate without insurance or with inadequate insurance, it is a crisis for victims of tortious conduct who may find that liable defendants cannot pay them their damages.

CHAPTER 2

THE CAUSES OF THE CRISIS IN INSURANCE AVAILABILITY AND AFFORDABILITY

A number of reasons have been proffered for the crisis in the availability, affordability and adequacy of liability insurance. Many of these reasons relate to the economic decisions and performance of the insurance industry over the past decade. Other reasons focus on recent developments in tort law. While the two in fact are closely related, this Chapter discusses each of these areas separately. Part A deals with the general economic reasons for the current crisis; Part B reviews the contribution of tort law. 1/

1/ There have been suggestions that the availability/affordability crisis may be caused by certain aspects of state regulation. While some regulatory measures may have aggravated the problem, the Working Group has found little compelling evidence that the crisis is the result of a regulatory failure, either in the sense of insufficient or inadequate regulation, or in the sense of ill-conceived regulation. In this regard, it is worthwhile noting the 1977 report of the Department of Justice to the Task Group on Antitrust Immunities on The Pricing and Marketing of Insurance, which concluded that "in the commercial lines . . . state regulatory schemes are largely illusory and that insurers are generally free to set their own prices." Id., at vii. The report further indicated that rigid state rate regulation, such as is found in automobile insurance, may in fact aggravate an availability problem. Id., at vi.

In this regard, it is worth noting the conclusion of the Medical Malpractice Policy Guidebook (1985), prepared by Henry Manne (general editor) and Barry Anderson, Patricia Danzon, Clark Havighurst, Charles Phelps and Frank Sloan (principal authors) for the Florida Medical Association. The Guidebook concluded that it was difficult to fault the state insurance regulatory system for the high medical malpractice insurance premiums in Florida. Id., at 11. The report concluded that premium increases lag claims costs, and that "malpractice premiums are almost certainly not 'too high' compared to the increases in claims costs emerging over recent years." Id., at 149-50.

Some have pointed to state insurance reserve requirements as a cause of the insurance availability/affordability crisis, to the extent that they believe these requirements to have exacerbated capacity constraints. While the Working Group did not analyze whether state reserve requirements are too high or too low, it should be noted that these requirements exist to ensure the solvency of insurance carriers, and thereby to protect insureds. It also should be noted that the only way that state insurance reserve requirements conceivably could be modified to

(CONTINUED)

A.

I. INSURANCE INDUSTRY PERFORMANCE

Recent news accounts have presented a seemingly conflicting view of the economic performance of the property-casualty insurance industry. In order to understand the financial condition of the industry itself and of some of its specific lines of business, it is useful to compare the condition of the industry as a whole to what has been happening to premiums in the lines which present significant availability/affordability problems.

The table below presents premium and loss data for the property-casualty insurance industry for the period 1981 through 1985.

Year	Net Premiums Written (000)	Loss and LAE (000)	Expenses (000)	Statutory Under- writing Loss after Policyholder Dividends (000)
1981	\$ 98,805,725	\$75,764,229	\$27,132,052	\$- 6,323,534
1982	103,115,653	82,152,241	28,996,122	-10,415,751
1983	107,802,698	87,719,055	30,799,231	-13,285,049
1984	117,743,957	103,720,652	32,980,082	-21,455,300
1985*	142,300,000	126,840,220	37,353,750	-25,200,000

*Estimated

Source:

Best's Insurance
Management Reports

The most striking number in the table, of course, is the \$25 billion underwriting loss estimated for 1985. This number represents the difference between premiums written and expenses, policyholder

1/ (FOOTNOTE CONTINUED)

produce lower premiums would be if the reserve requirements were relaxed. It would be difficult to justify relaxing reserve requirements, however, in light of the fact that both insurance company insolvencies and the number of insurance companies reported to be in financial difficulty have increased substantially in the last two years.

The Working Group is continuing to review the contribution, if any, of state regulation to the insurance availability/affordability crisis.

dividends, 2/ estimated losses and loss adjustment expenses ("LAE").

The underwriting loss, however, while significant, represents only part of the industry's overall financial picture. Since premiums are collected well in advance of any anticipated payout, they are invested and earn income. In addition, other income is generated which also must be considered in reviewing the industry's financial condition. Overall income in 1985 resulted in the industry showing a \$7.6 billion gain in policyholders' surplus (the equivalent of net worth), 3/ on an underwriting loss of \$25.2 billion and net investment and other income of \$32.8 billion. Thus, the industry appears to have made an overall profit in 1985, though at a lower rate than historical levels or other sectors of the economy.

In discussing the overall financial review of the property/casualty industry, Best's reported that:

Investor interest in the property-casualty industry cannot be denied. While the Dow Industrial Average had made headlines by surpassing the 1500 mark (a 25% gain for the year), Best's Index of property/casualty companies has jumped 50% at this writing, and security analysts specializing in insurance--and cognizant of 1985's underwriting losses--nevertheless continue to be optimistic about the industry's prospects. 4/

Two factors must be taken into account in assessing the role of the insurance industry's financial performance in the insurance availability/affordability crisis. First, even though the industry currently is making a profit, that profit is well below the profitability of most other major industries, as well as the insurance industry's historical average. For example, in 1984 the property-casualty insurance industry produced an annual rate

2/ Questions have been raised as to whether or not the \$2.1 billion paid out in policyholder dividends should be included in the underwriting loss. Policyholder dividends are offered to some policyholders in some lines, and reduce the net cost of their insurance coverage. Consequently, any reduction in such premiums simply increases the net cost to policyholders.

3/ Policyholders' surplus is the difference between insurers' assets and liabilities. It is considered "the financial security that stands behind every insurance policy and is that which provides the cushion to support the shock of major catastrophe, stock market declines and loss of reserve inadequacies." ISO, Financial Condition of the Insurance Industry -- An Update (1985).

4/ Best's Insurance Management Reports (December 30, 1985).

of return on net income after taxes as a percent of net worth of 1.8%, whereas the median for Fortune 500 companies was 13.6%. 5/ The comparable rate of return for the property-casualty insurance industry from 1975 to 1984 was 10.9%. 6/

Second, the insurance availability/affordability crisis has not manifested itself across the entire spectrum of insurance services, but only in specific lines. These lines account for a relatively small portion of the industry. For example, the entire property-casualty insurance market accounts for only approximately one-third of the overall insurance market in terms of written premiums. 7/ The two property-casualty lines that have been the primary source of availability/affordability problems -- general commercial liability and medical malpractice -- amounted to only 7% of all the property-casualty lines in terms of 1984 written premiums. 8/ (These two lines thus represent approximately 2.5% of the entire industry's written premiums in 1984.) But, as can be seen in Subsection II, about one-fifth of the property-casualty industry's \$21.5 billion 1984 underwriting loss came from these two lines. And in 1985, the two lines accounted for almost one-quarter of the property-casualty industry's estimated \$25.2 billion underwriting loss. These two lines, as well as the Commercial Multiple Peril line, 9/ are discussed in greater detail in Subsection II.

II. UNDERWRITING RESULTS BY MAJOR LINES

While the industry overall has been profitable, certain lines have made major contributions to the underwriting losses. This section examines the major commercial lines in which availability and affordability problems have been most prominent.

Commercial Multiple Peril

Commercial Multiple Peril ("CMP") is related to the general liability line of insurance in that it is a packaged line of business which includes some commercial general liability coverage and its long-tail losses; that is, losses which may be

5/ Insurance Information Institute, 1985-86 Property/Casualty Factbook, page 22.

6/ Id. The comparable statutory accounting rate of return was 11.9%. Id.

7/ Congressional Quarterly Weekly Report, page 150 (January 25, 1986).

8/ Insurance Information Institute, 1985-86 Property/Casualty Factbook, page 16.

9/ If the Commercial Multiple Peril line is taken into account, approximately 14% of the property-casualty industry (in terms of 1984 written premiums) accounted for about one-third of its underwriting losses in both 1984 and 1985. Id.

reported many years after the policy year. CMP experience over the past five years is reflected in the chart below.

Commercial Multiple Peril

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Under- writing Expenses (Billions)	Statutory Under- Writing Loss After Policyholder Dividends (Billions)
1981	\$6.8	\$4.6	\$2.5	\$-0.5
1982	6.9	5.3	2.7	-1.2
1983	7.2	5.9	2.9	-1.7
1984	8.2	7.9	3.2	-2.9
1985*	11.7	10.4	4.1	-3.0

*Estimated

Source: Best's Insurance Management
Reports 12/30/85

While the underwriting losses for CMP rose to \$3 billion in 1985, it is readily apparent that until recently there had been little premium growth in the line. Best's predicts that the short-tail, non-liability portion of CMP should provide the ability for a fast turnaround for this line. It also notes that ISO's new CGL claims-made form will be added to the standard CMP form, but that market pressures should assure the availability and affordability of the smaller businessowner's package. 10/

Commercial General Liability

Commercial General Liability ("CGL") coverage includes most of the commercial sectors which are experiencing serious availability/affordability problems. It covers product liability, municipalities, day care centers and other commercial coverages. It is the line for which ISO has introduced its new claims-made form. The experience of this line over the past five years is summarized below.

General Liability

Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Under- writing Expenses (Billions)	Statutory Under- Writing Loss After Policyholder Dividends (Billions)
1981	\$6.0	\$5.1	\$1.8	\$-1.0
1982	5.6	5.4	1.8	-1.7
1983	5.7	6.0	1.8	-2.1
1984	6.5	7.8	1.9	-3.2
1985*	11.1	13.2	2.7	-4.6

*Estimated

Source: Best's Insurance
Management Report

10 Best's Insurance Management Reports (December 30, 1985).

As is apparent, written premiums dropped in 1982 and 1983 and rose slightly in 1984. The figures for 1985, however, show a dramatic increase of 72% over the 1984 premium. Increases are continuing to occur in the line as policies come up for renewal. Losses increased throughout the period, but did so at a relatively even pace until 1984, when losses increased by over \$1 billion dollars over the previous year's losses.

Medical Malpractice

Medical malpractice represents only about 1.8% of property/casualty insurance written, but has been the source of major availability/affordability problems. The following chart summarizes the experience of the line over the past five years.

Medical Malpractice				
Year	Net Premiums Written (Billions)	Loss and LAE (Billions)	Under- writing Expenses (Billions)	Statutory Under- writing Loss After Policyholder Dividends (Billions)
1981	\$1.3	\$1.6	\$0.2	\$-0.5
1982	1.5	2.0	0.2	-0.7
1983	1.6	2.1	0.2	-0.8
1984	1.8	2.8	0.3	-1.1
1985*	2.6	3.6	0.3	-1.4

*Estimated

Source: Best's Insurance
Management Report

Medical malpractice experience is receiving considerable attention at the state level. Unlike many lines of coverage such as product liability, rates are based on state claims rather than national data.

III. PREMIUM TRENDS

The recent rapid growth in premiums has been a major element in the current availability/affordability crisis. This section examines this trend. The following data was provided by the ISO.

Cash-flow underwriting is generally acknowledged to have played a role in causing the large underwriting losses presently being experienced in the commercial lines. According to ISO, the industry's current underwriting losses are a result of "a

prolonged period of underpricing and rapidly expanding tort liabilities." 11/ In this regard, the ISO report states:

For the better part of seven years, the insurance industry has been engaged in a brutal price war. During the early 1980's, the price for commercial insurance was decreasing, sometimes sharply, as insurers vied for premium dollars to invest at the high interest rates then in effect. At the time, commercial customers did not complain. Indeed, many realized that commercial insurance in the United States was being sold below cost, even when investment income was considered. 12/

Chart A, based on ISO data, tracks commercial line premiums in constant 1967 dollars. As can be noted from the chart, 1984 marked the first real increase in premiums (in constant dollars) after five consecutive years of declining written premiums. But 1984 written premiums were almost 20% less than premiums collected in 1978, the year preceding the dramatic decline in premiums. At the same time, losses and expenses in 1984 were at an all-time high. 13/

A similar comparison of the general liability premiums written, premiums earned and line outgo over the past ten years (not in constant dollars) is shown in Chart B.

Analyzing this data, the Best's report notes that during the relevant period (1975 - 1985):

. . . the inflation of liability awards could have been no secret to any underwriter. Had the ascending line of premiums written that was established in 1975 through 1978 continued to rise, the general liability losses of \$13 billion incurred in the last six years largely would have been avoided. 14/

11/ ISO, Financial Condition of the Insurance Industry -- An Update (1985).

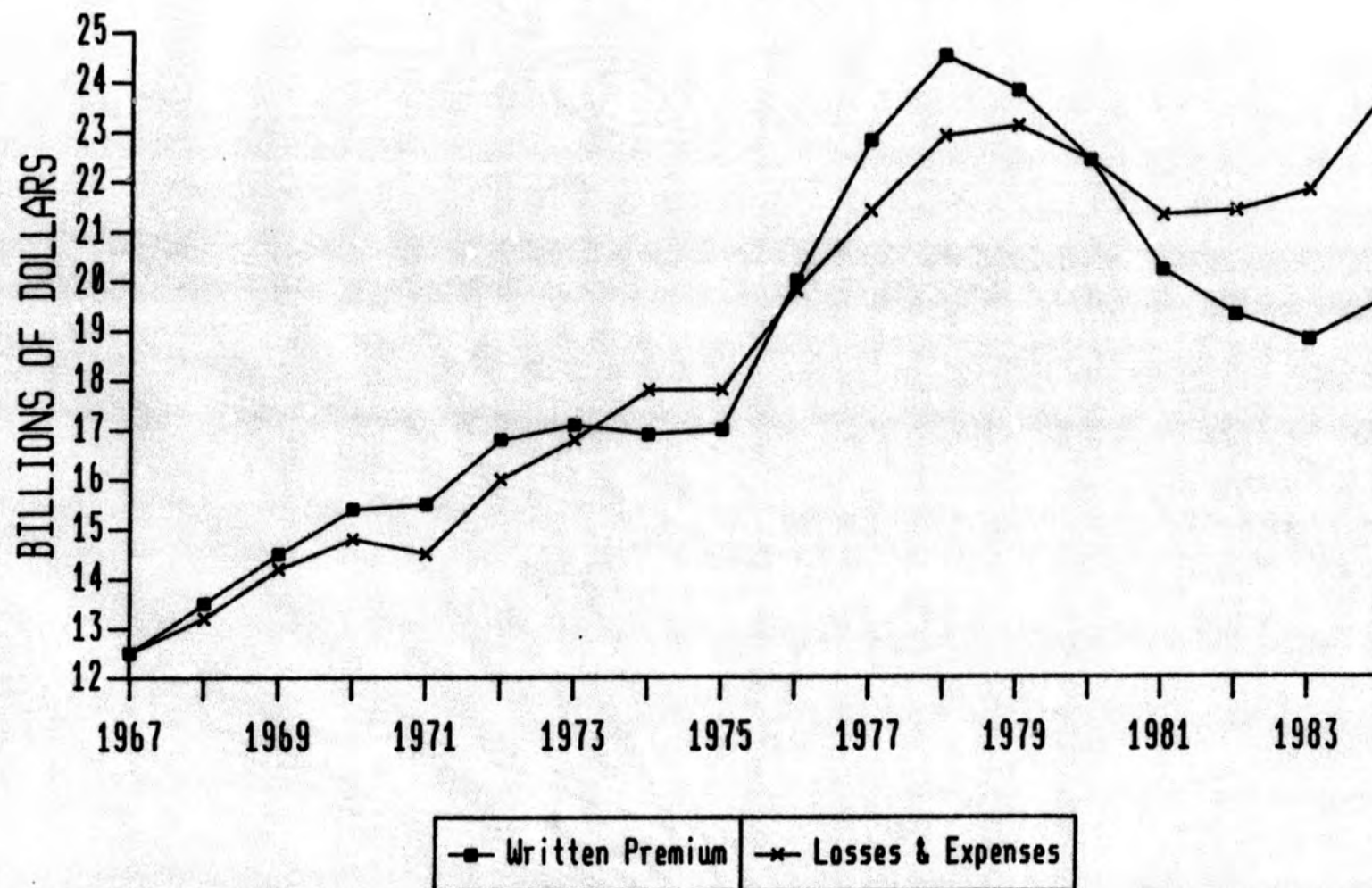
12/ Id.

13/ Id.

14/ Best's Insurance Management Reports (December 30, 1985).

CHART A

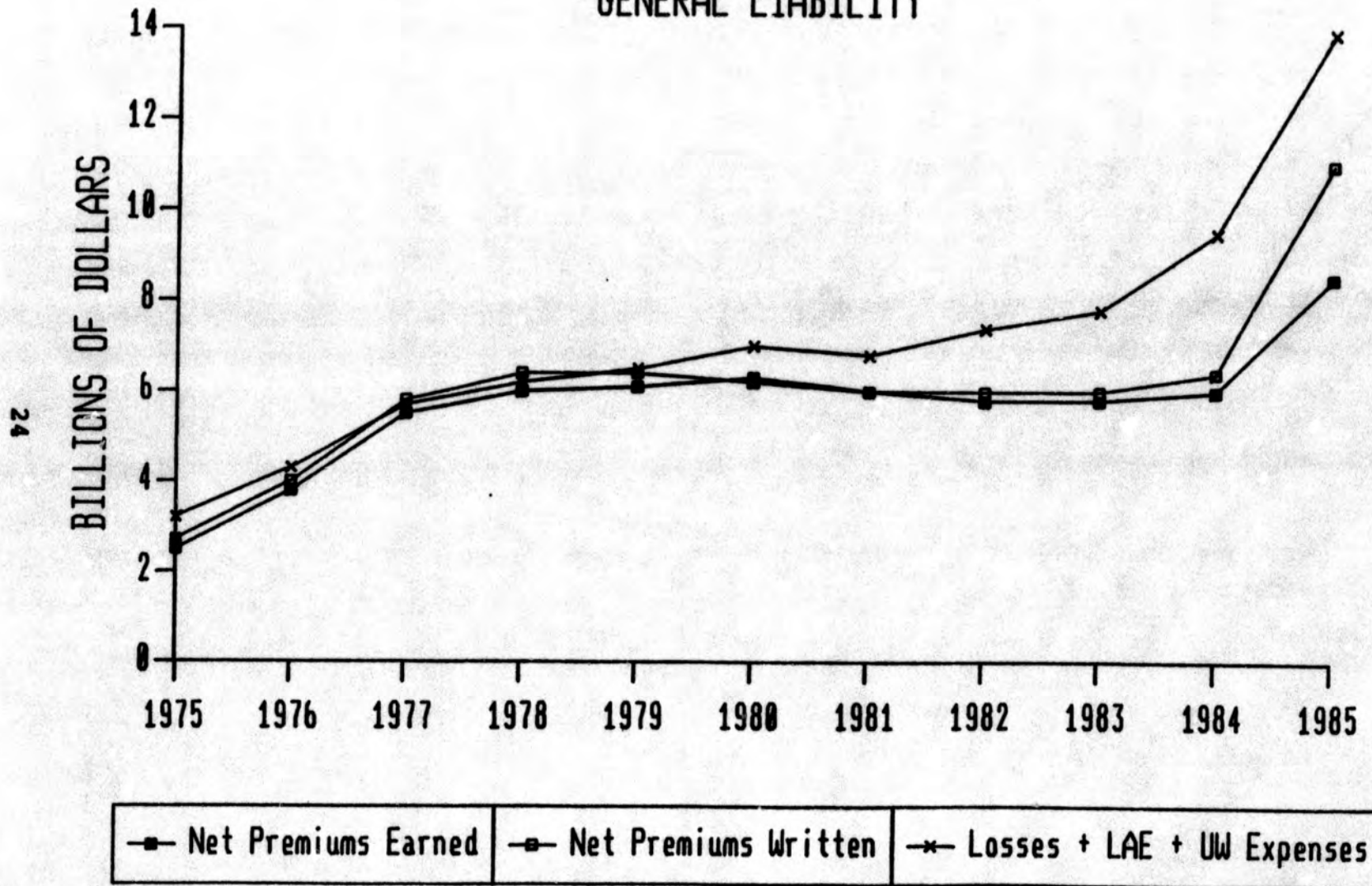
WRITTEN PREMIUM vs. LOSSES & EXPENSES COMMERCIAL LINES IN CONSTANT 1967 DOLLARS



Source: Insurance Services Office

CHART B

GENERAL LIABILITY



Source: Best's Insurance Management Report, 12/30/85

IV. THE ECONOMIC CAUSES OF THE INSURANCE AVAILABILITY/AFFORDABILITY CRISIS

The above discussion indicates that during the late 1970's and early 1980's the insurance industry engaged in significant premium reductions while claim losses increased steadily. The result, not surprisingly, has been massive underwriting losses in recent years.

It is useful in considering the contribution of such economic factors to the insurance availability/affordability crisis to distinguish two different effects which frequently are confused. The first is the inflationary effect on premiums of the recent decline in interest rates. The second is the premium cutting which took place in the late 1970's and early 1980's as a consequence of the industry's desire to take advantage of high interest rates available during that period.

As to the first effect, there is an obvious inverse relationship between premiums and the prevailing interest rate. A significant portion of an insurer's profits stem from the return on the premium income it invests between receipt of the premium and payout of the incurred liabilities. When interest rates are high, premiums tend to be lower since more of the insurer's income comes from such return on investment; and when interest rates are low, premiums will tend to be higher since the insurer is more dependent on the premium principal to cover the anticipated payout. Thus, as interest rates fall -- as they have in the mid-1980's -- insurance premiums inevitably increase.

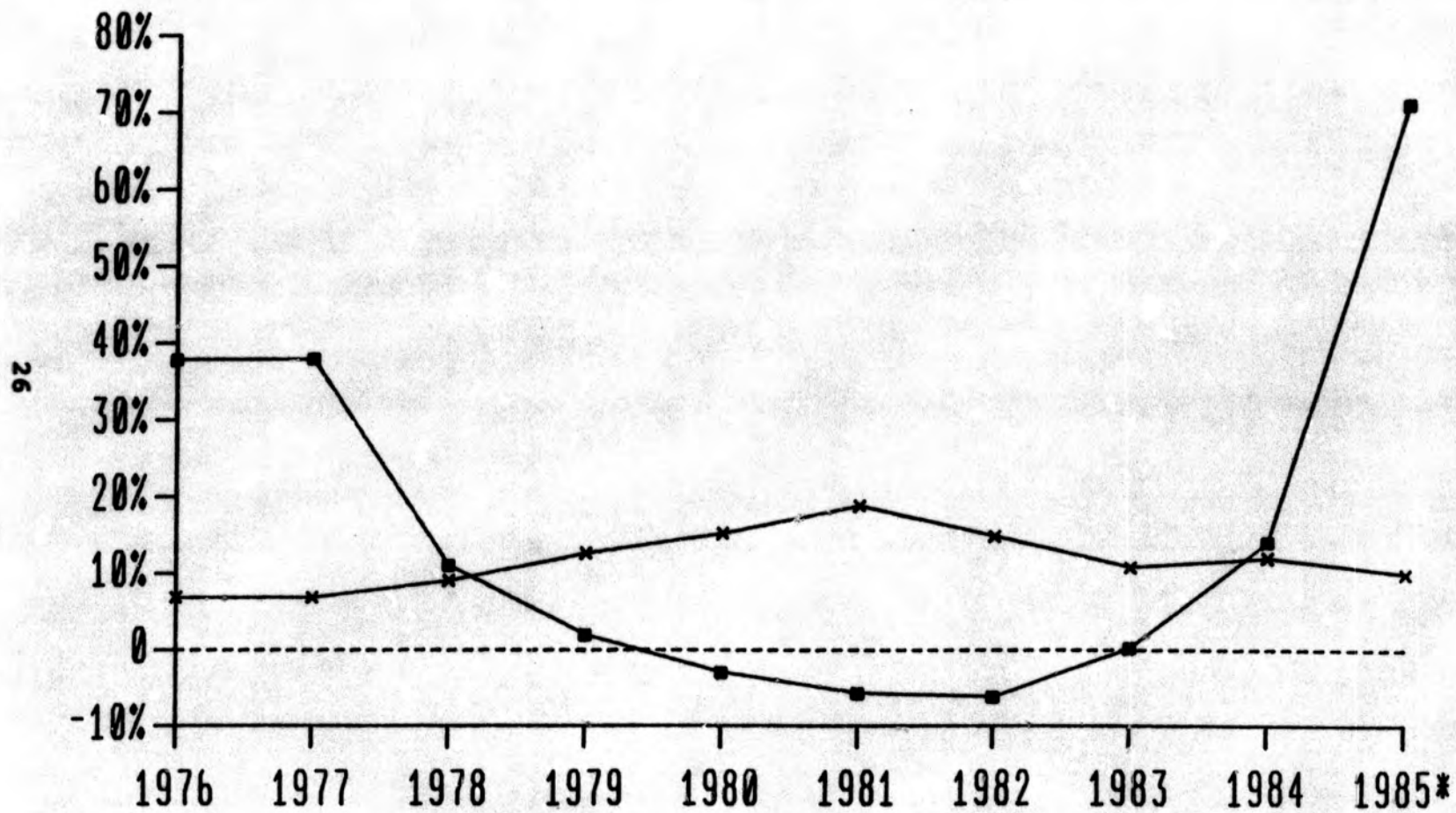
This inverse relationship is illustrated by Chart C, which compares the prime rate in 1976 through 1985 to the annual percentage change of the total Commercial General Liability (CGL) premiums written by the insurance industry in each of those years. ^{15/} Chart C graphically demonstrates that the rate of growth of the written premiums changes inversely with the movement of the prime interest rate.

To the extent that the recent sharp premium increases are related to the drop in interest rates, there is little the federal (or any) government can or should do to mitigate this market effect. Declining interest rates cause innumerable economic realignments which, on the whole, are quite beneficial to the economy. An increase in insurance premiums resulting from such a reduction in interest rates, while of itself undesirable, is a relatively minor side effect to the far more significant economic consequences of a drop in the interest rate.

^{15/} The percentage change in 1976 through 1984 is obtained from the Insurance Information Institute's most recent Property/Casualty Factbook. The estimate for 1985 is obtained from the ISO data discussed supra.

CHART C

PERCENTAGE CHANGE IN GCL PREMIUMS COMPARED TO INTEREST RATE



* PRIME INTEREST RATE	* ANNUAL % CHANGE IN WRITTEN GENERAL LIABILITY PREMIUMS
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*1985 Data Estimated

Moreover, there is little that can be done to address this source of premium volatility. It would be absurd to try to keep interest rates high simply to keep insurance premiums as low as possible. But as long as interest rates fluctuate, premiums necessarily will reflect such changes.

A second economic factor related to interest rates is the extent to which high interest rates may have triggered "excessive competition" in the insurance industry which led the industry to sell its product too cheaply. For one thing, even assuming one accepts the concept of "excessive competition," it is unclear how such losses in fact contribute to the insurance availability/affordability crisis. As discussed later in this Chapter, such losses are "sunk costs" which the industry cannot recoup simply by charging higher premiums. If premiums in fact are higher than the insured risks and the currently available investment return dictate, either other sources of capital (including insurers who have suffered no losses or lower losses) should offer the same insurance at a lower price, or insureds will retain these "excess profits" for themselves through self-insurance or the formation of captives. The fact that there appears to be little insurance coverage being made available by new or expanding underwriters, and that many insureds are highly reluctant to self insure or form captives (even though many with serious availability problems may have no alternative), strongly indicates that recoupment of losses is not a particularly compelling explanation for the current insurance availability/affordability crisis.

It is particularly puzzling that the proponents of this theory advocate the abolition of the insurance industry's antitrust immunity contained in the McCarran-Ferguson Act (Public Law 79-15) as an appropriate response to the asserted problem of the industry's cash-flow "mismanagement." It is hard to reconcile the argument that the current problems of the insurance industry stem from "excessive competition" with the proffered solution of removing the industry's antitrust immunity. Since the goal of antitrust law is to enhance competition, if one truly believes that the problems of the insurance industry are a result of too much competition, the last thing one would advocate is a legal change which would increase the level of competition. While the Working Group did not review and takes no position on the continuing validity of the industry's antitrust immunity, 16/ it is readily obvious that the suggestion that allegedly "excessive competition" can be cured by even more competition is patently absurd.

16/ Despite the assertions of some, the Working Group found no evidence to suggest that the industry's antitrust immunity is a significant factor in the insurance availability/affordability crisis. It should be noted, however, that the immunity has been criticized for a variety of other reasons. See the 1977 report of the Task Force on Antitrust Immunities, footnote 1, supra.

The reasons why the loss recoupment (or excessive pricing) theories advocated by some make little economic sense can briefly be summarized as follows:

- ° Insurers, like all profit maximizing companies, charge the price which maximizes their profits. Past gains or past losses are irrelevant to setting the price today which will maximize profits tomorrow. The argument that insurers are charging higher premiums to recoup past losses suggests that absent such losses their premiums would be lower -- that is, that they would not be charging premiums that maximize their profits. That makes little sense.
- ° Even if excessive premiums were being charged by some insurers to recoup their past losses, for the reasons discussed, other insurers would offer the same coverage at lower prices reflecting the actual risk, or insureds would retain such excess profits for themselves through self-insurance or the formation of captives. 17/
- ° The commercial lines of insurance, which are at the center of the availability/affordability crisis, in fact are relatively competitive. For example, the 1977 report of the Task Force on Antitrust Immunities (see footnote 1, supra) found that the property-liability insurance industry "appears to possess an atomistic market structure," including over 900 companies. Id., at 7. 18/ The Task Force also found that the restrictions to entry do not appear significant in the property-liability insurance industry, id., at 9, and that there appears to be price competition in this line as a result of "an industry structure that favors competition." Id., at 27-28. 19/ It is, of course,

17/ Many insurance companies are mutuals, meaning that they are owned by their policyholders. The suggestion that they are charging their policyholder-owners unnecessarily high premiums makes even less sense, since any such excess profits must be rebated through policyholder dividends.

18/ The report states that 20 insurance groups account for 53% of written premiums, and that no single group accounts for a major share of the market. Id., at 8. This is consistent with the analysis of the Medical Malpractice Policy Guidebook (H. Manne, 1985), which found the medical malpractice insurance market in Florida to be "substantially and effectively competitive." Id., at 166.

19/ See also page 348 of the report summarizing the Task Force's

(CONTINUED)

difficult to conceive how premiums are being kept at artificially high levels for a line of insurance in which prices appear to be competitively determined.

- ° Finally, many of the strongest proponents of the loss recoupment theory also contend that these losses were the result of excessive price competition in the industry. Obviously, it is difficult to reconcile these arguments. 20/

In sum, to the extent that purely economic factors underlie the insurance availability/ affordability crisis, they do not appear to be the type of problems which can be cured by different or more intensive forms of government regulation -- either at the state or federal level -- of the insurance industry. There, however, is a cause of the availability/ affordability crisis at the very heart of that crisis which the government is well placed to address in a variety of constructive ways. That cause is tort law, and its role in the crisis is discussed in Part B of this Chapter.

B.

The above discussion has focused largely on the current financial condition of the insurance industry, and the economic factors leading to that condition. The following discussion examines the state of tort law, and its central role in the insurance availability/affordability crisis.

Unlike the above related economic data on the insurance industry, it is difficult to obtain good empirical data indicating precisely what has happened to tort liability in

19/ (FOOTNOTE CONTINUED)

conclusion that the "industry is structured in a manner conducive to competition." It should be noted that these conclusions did not appear to apply to some other lines of insurance such as life insurance.

20/ These same points apply equally well to arguments that premiums are set excessively high to recoup losses resulting from mismanaged investment portfolios. Just as past losses are irrelevant to determining the premiums which will maximize profits, investment portfolio losses should have no bearing on premiums. In this regard, however, it should be noted that the property-casualty industry made \$32.8 billion from net investment and other income in 1985. See supra.

recent years. 21/ It is plain even to the most uninitiated that tort law has changed dramatically in recent years -- from a relatively quiescent legal backwater into one of the most important and dynamic areas of the law today. 22/ Moreover, a growing body of case examples and empirical data suggest that the current tort system has serious problems and is operating quite poorly. The insurance availability/affordability crisis is one symptom -- albeit the most dramatic and acute symptom -- of the dislocations and problems generated by a malfunctioning tort system.

I. PROBLEM AREAS IN TORT LAW

In attempting to understand what has happened to tort liability in the United States, the Working Group has focused on four interrelated areas: fault, causation, damages and transaction costs. Each is discussed separately below.

The Movement Toward No-Fault Liability

One of the most disturbing aspects of the current tort system is the degree to which it has moved toward no-fault liability. While this movement began in earnest over twenty years ago, it appears to have accelerated dramatically in recent years.

Beginning in the early to mid-1960's it became fashionable to reject the twin pillars upon which tort law historically had been constructed -- deterrence and compensation -- in favor of seemingly more enlightened theories based largely on concepts of societal insurance and risk spreading. 23/ While many of these

21/ The Rand Corporation, through its Institute for Civil Justice, has produced the best empirical data and analyses available in the area. While the Institute has only been able to research discrete areas of civil justice, the conclusions drawn from those analyses are invaluable to understanding many broader problems. The recently published five-year overview of the Institute's program offers an excellent summary of the research, results and continuing work of the Institute's staff.

22/ For example, at the end of fiscal year 1975, what is now the Torts Branch of the United States Department of Justice contained 39 attorneys, who handled or supervised about 4,000 cases totalling approximately \$1 billion in claims. At the end of fiscal year 1985, the Torts Branch had grown to 124 attorneys handling or supervising about 11,000 cases totalling approximately \$200 billion in claims.

23/ One of the most explicit statements of such a theory can be found in the decision of the New Jersey Supreme Court in Beshada v. Johns-Manville Products Corp., 90 N.J. 191, 447 A.2d 539 (1982), in which the Court expressly denied defendants

(CONTINUED)

theories were couched in terms of economic efficiency, they represented the beginning of a devastating, and to this day, ongoing challenge to the role of fault as a predicate of tort liability. The long-term effect of this development has been less to promote a more efficient or sensible tort system, ^{24/} than to undermine the importance of fault (or wrongdoing) as a moral and doctrinal justification for and limitation on tort liability. As this limitation has been removed or undermined in certain areas of tort liability, tort law increasingly has come to rest only on the pillar of compensation, with compensation often awarded merely for the sake of compensation.

As the tort system moves away from fault it increasingly imposes liability upon persons and companies that have done nothing wrong. This has been accomplished in a variety of ways: by directly reducing or even eliminating the fault requirement; by

23/ (FOOTNOTE CONTINUED)

the opportunity to raise a "state of the art" defense. The Court held that even if the danger at issue was scientifically unknowable at the relevant time, defendants nonetheless were still liable for having failed to warn of an unknowable risk. As justification for its holding, the Court relied heavily on risk spreading. In the words of the Court, "manufacturers and distributors . . . can insure against liability and incorporate the cost of the insurance in the price of the product." ⁴⁴⁷ A.2d at 547. The Court went on to opine that the likely increase in premiums to compensate for unanticipated risks was "not a bad result." Id.

24/ The belief that tort liability should be no-fault so as to serve as a risk spreading mechanism for all injuries is in fact quite anti-consumer. Such a view of tort liability effectively would mean that the price of every product and service would include an insurance surcharge for the risk of any injury related to the product or service. It has long been understood, however, that because of the extraordinarily high transaction costs of the tort system, such compulsory insurance through the tort system would be among the most inefficient and costly ways for consumers to purchase insurance. Thus, for every \$1 of compensation, the tort system requires the consumer to pay approximately \$3 in premiums (assuming, as discussed infra, two-thirds transaction costs), while that same \$1 of compensation can be obtained through first-party health and disability insurance for only \$1.25. H. Manne, Medical Malpractice Policy Guidebook 143 (1985). It is highly ironic that many proponents of no-fault liability argue that such liability is in the best interest of consumers. In fact, since consumers ultimately pay the premiums of whatever compensation scheme is devised, quite the contrary is the case. See also Epstein, "Products Liability as an Insurance Market," 14 J. Legal Stud. 645 (1985).

defining new duties that effectively create fault where no fault existed previously; and, by engaging in after-the-fact analyses that "find" fault wherever there has been an injury. 25/ The ultimate effect of these developments has been the same -- to shift liability for compensation to "deep pocket" defendants that have the resources to compensate plaintiffs generously. 26/

Fault has not, however, been openly (or completely) rejected as part of our tort law. One reason is that fault remains the only vehicle in tort law capable of distinguishing wrongful (or undesirable) from beneficial (or desirable) conduct. If fault were rejected altogether, it would mean that desirable activities would be just as likely to incur liability as wrongful conduct. An open rejection of fault thus necessarily would result in a sweeping transformation in the public's attitude toward tort law, which continues to be bottomed on the concept of tort liability as a form of justified redress for wrongful conduct. A second reason why fault continues to be part of tort law (and why courts often will engage in amazing distortions of relevant facts or legal doctrines to find fault rather than simply reject the principle of fault) is that fault is the basis of much of the structure and process of tort law.

25/ The duty to warn has been a particularly fertile ground for such after-the-fact compensation oriented findings of fault. It is all too easy after the occurrence of an injury to postulate a warning that might have influenced the plaintiff to be more careful or to reconsider his action, no matter how fanciful or unreasonable such a warning might appear prior to the injury. Such analyses have been a major factor in the medical malpractice and product liability litigation explosion.

26/ A recent and almost classic example of such compensation oriented liability findings is the California Supreme Court's decision in Bigbee v. Pacific Tel. & Tel. Co., 34 Cal.3d 49, 665 P.2d 947 (1983). In that case, a man was injured when an allegedly intoxicated driver lost control of her car, veered off the street into a parking lot, and crashed into a telephone booth in which the man was standing. Suit was brought against the companies responsible for the design, location, installation, and maintenance of the booth. The Court, in an opinion authored by Chief Justice Rose Bird, found that the risk that someone might veer off the road and crash into the phone booth was not unforeseeable as a matter of law. The Court also determined that it was of no consequence that the harm to plaintiff came about through the negligent or reckless acts of an allegedly intoxicated driver. In a concluding footnote, Chief Justice Bird stated that "there are no policy considerations which weigh against imposition of liability" against the defendants even though their "conduct may have been without 'moral blame,'" and referred specifically to "the probable availability of insurance for these types of accidents" 665 P.2d at 953 n. 14.

If fault were no longer a central element in determining liability, the current tort system would in many ways be wasteful, inefficient and unfair in the extreme. 27/

Tort law thus has gradually (with a marked acceleration in recent years) been moving in the direction of no-fault liability without an adequate acknowledgement of either the existence or the implications of this development. The result is an increasingly common and perverse combination of fault-based levels of compensation based on no-fault liability.

The Undermining of Causation

Tort law traditionally has sought to place liability only upon those actors whose wrongful conduct actually caused an injury. This principle is found in the concept of "proximate cause," which requires a reasonable relationship between a given cause and effect. For some time, however, proximate cause has been under systematic attack. No single doctrinal change can be identified as the primary vehicle for this attack. Rather, the challenge has come through a variety of questionable practices and doctrinal innovations.

One such development has been the increasing use of joint and several liability to shift the cost of compensation to "deep pockets." Joint and several liability developed in the context of defendants acting in concert. 28/ Over the years, however, it increasingly has been used to make a defendant with only a limited role in causing an injury bear the full cost of compensating plaintiff, even in some cases where the plaintiff may have been largely responsible for his own injury. 29/ The result has been that joint and several liability in the absence of concerted action can and does lead to highly inequitable

27/ For example, the way in which damages are measured and awarded can only be justified, if at all, on the basis of redressing wrongful conduct. Once wrongdoing is removed as an element of liability, many of the principles involving damages become grossly unfair.

28/ See generally Prosser and Keeton on Torts (5th ed. 1984), Chapter 8. As may be obvious, as with so many other aspects of tort law, fault remains a central and essential justification for joint and several liability.

29/ The application of joint and several liability in cases where there in fact is no concerted action is discussed in some detail in Speiser, Krause & Gans, The American Law of Torts § 3:7 (1983). It is interesting to note that the English courts apparently have maintained the traditional common law basis for joint and several liability, and have refused to apply such liability in the absence of concerted action. Id.

treatment of defendants, particularly "deep pocket" defendants. 30/

A related development is the way in which joint and several liability has been applied by some courts to theories of "enterprise" or "market share" liability for injuries caused by generic products (e.g., DES). "Market share" liability, in its pure theoretical sense, allocates liability among manufacturers of a generic product on the basis of their share of the relevant market. While there can be some serious problems and inequities with this approach, as long as all relevant manufacturers (and their respective market shares) are accounted for, and the product is truly generic in nature, such an allocation of liability may be the only way plaintiffs in some cases can obtain compensation for injuries caused by wrongdoing on the part of the manufacturers of such a product. Serious problems with this approach arise, however, when not all relevant manufacturers are accounted for, or where the product is not truly generic in nature. Even more troublesome is the approach of several courts which use some industry liability allocation formula, but then apply joint and several liability to all defendants. See, e.g., Abel v. Eli Lilly & Co., 418 Mich. 311, 343 N.W.2d 164, cert. denied., 105 S.Ct. 123 (1984); Collins v. Eli Lilly Co., 116 Wis.2d 166, 342 N.W.2d 37 (1984). This, in fact, represents a clear abuse of joint and several liability, and cannot be justified on the basis of the unique difficulties plaintiffs sometimes face in identifying the manufacturer of an injury causing generic product.

A third means that has been used to undermine causation -- increasingly common in toxic torts cases -- is the use of presumptions or burden-shifting techniques to force the defendant to prove the lack of causation in order to avoid liability. 31/ Frequently, this amounts to asking the defendant

30/ The legal doctrine of contribution in theory could serve to mitigate some of those inequities. In certain areas of the law, such as antitrust law, where joint and several liability generally tends to be applied to established businesses, contribution appears to function quite well. (And, in any event, joint and several liability in antitrust cases is virtually always based on concerted action -- the traditional basis for such liability.) In personal injury cases, however, many multi-defendant cases involve a "deep pocket" and one or more defendants who are either judgment proof or have limited assets or insurance coverage. In such cases, the belief that contribution serves as a mitigating factor is largely illusory.

31/ A particularly dramatic example of such a practice can be found in Allen v. United States, 588 F.Supp. 247 (D. Utah 1984), a low-level radiation exposure case in which the court shifted to the government the burden of proving that particular cancers were not caused by radiation exposure.

to meet an impossible burden of proving the negative.

Another way in which causation often is undermined -- also an increasingly serious problem in toxic tort cases -- is the reliance by judges and juries on noncredible scientific or medical testimony, studies or opinions. It has become all too common for "experts" or "studies" on the fringes of or even well beyond the outer parameters of mainstream scientific or medical views to be presented to juries as valid evidence from which conclusions may be drawn. The use of such invalid scientific evidence (commonly referred to as "junk science") has resulted in findings of causation which simply cannot be justified or understood from the standpoint of the current state of credible scientific and medical knowledge. ^{32/} Most importantly, this development has led to a deep and growing cynicism about the ability of tort law to deal with difficult scientific and medical concepts in a principled and rational way.

These are but four developing areas that are causing defendants to be found liable for injuries they did not cause. The one common attribute of these developments is that the defendants to whom liability is shifted almost invariably happen to be those with the deepest pockets.

The Explosive Growth in Damage Awards

Another area of great concern is the explosive growth in tort damages awards over the last decade. A few statistics will illustrate this point.

Jury Verdict Research, Inc., publishes data on the average jury verdict in product liability and medical malpractice cases. The service's latest report ^{33/} shows that the average medical

^{32/} An instructive decision in this regard is the district court opinion in Johnston v. United States, 597 F.Supp. 374 (D. Kansas 1984). The court there exhaustively reviewed the theories and credentials of a number of plaintiffs' experts on the effects of low-level radiation, and rejected their testimony as biased, contradictory and totally without scientific merit. Of particular interest is the court's frustration that these same experts had played prominent roles in major radiation cases such as Silkwood and Allen, and that their testimony was being used in numerous cases throughout the country. The court noted its disappointment that such "so-called experts can take such license from the witness stand [to] say and conclude things which . . . they would not dare report in a peer-reviewed format." Id. at 415.

^{33/} Jury Verdict Research, Inc., Injury Valuation: Current Award Trends No. 304 (1986). The 1985 data provided by the service is incomplete, and is subject to refinement. The

(CONTINUED)

malpractice jury verdict increased from \$220,018 in 1975 to \$1,017,716 in 1985 (see Chart D), a 363% increase. 34/ Average product liability jury verdicts during this same period increased from \$393,580 to \$1,850,452, a 370% increase (see Chart E). 35/

Interestingly, much of this increase can be attributed to a remarkable growth in verdicts above \$1 million. In 1975 there were three million-dollar medical malpractice verdicts and nine million-dollar product liability verdicts reported by Jury Verdict Research, Inc. In 1984, the numbers had grown to 71

33/ (FOOTNOTE CONTINUED)

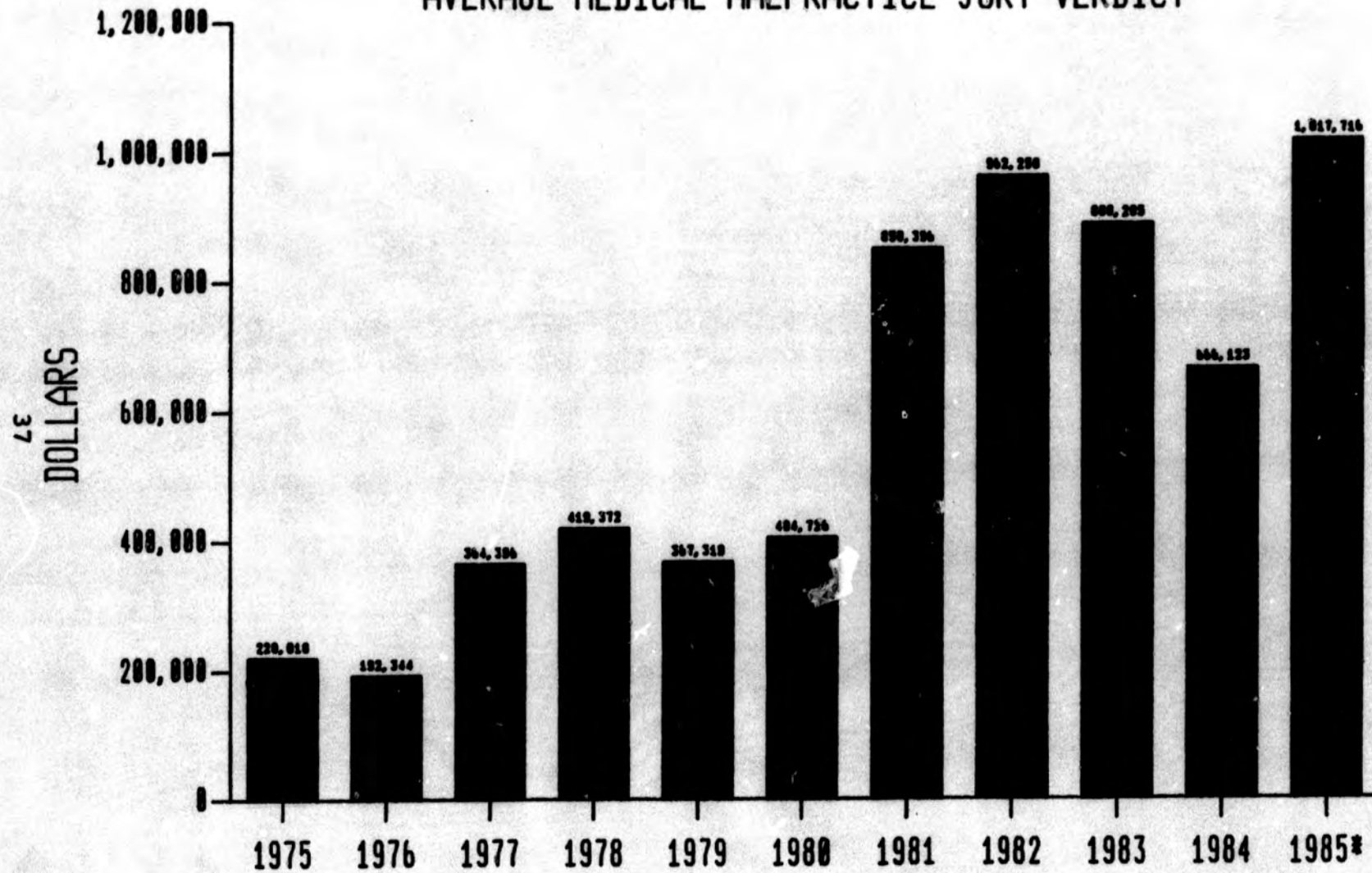
service indicates that it bases "its findings, values and probabilities upon collected verdicts using accepted statistical methods in their analysis and application." Nevertheless, the reported average annual verdicts are not used by the Working Group as an accurate statement (though they may very well be) of the average jury verdict in any particular year. Rather, the Working Group found the Jury Verdict Research data useful for purposes of showing the trend in jury verdicts over the last decade. In this regard, it should be noted that the service has used the same basic methodology since well before the relevant reported years. Moreover, while there are different estimates of average jury verdicts for particular areas and years, a number of other sources that have collected such data -- including the Institute for Civil Justice -- corroborate the overall trends reported by Jury Verdict Research, Inc.

34/ This percentage increase is consistent with a survey of California Superior Court medical malpractice verdicts. That survey shows the average medical malpractice award as increasing from \$152,970 in 1975 to \$649,210 in 1983, a 324% increase. American Medical Association Special Task Force on Professional Liability and Insurance, Professional Liability in the '80s (October 1984). Because the \$250,000 cap in California on awards for non-economic damages in medical malpractice cases was only recently affirmed as constitutional (see Chapter 4), it is unclear what effect, if any, the cap has had on malpractice verdicts in California. It is worth noting, however, that the recent insurance problems for medical malpractice have been far less serious in California than in many other states, and that in California the insurance crisis primarily has affected areas other than medical malpractice (e.g., municipal liability).

35/ This remarkable increase is also reflected in the Institute for Civil Justice study of civil jury verdicts in Cook County, Illinois. For example, the average wrongful death award in Cook County increased (in constant dollar terms) from \$166,000 in 1970-74 to \$336,000 in 1975-79, a doubling over roughly half a decade. M. Peterson, Compensation of Injuries: Civil Jury Verdicts in Cook County 54 (1984).

CHART D

AVERAGE MEDICAL MALPRACTICE JURY VERDICT



Sources: Jury Verdict Research, Inc.

* 1985 Information Not Complete