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them, will indeed become benefactors of humankind. And it is through the teaching and the study of the humanities that we may come most surely and rapidly to any successful prospect for achieving those goals for our system of education, and for leaving to a more remote posterity a legacy as rich and as brilliant as Jefferson, in his own time, left and passed down to us in our time.

Thank you very much.

The American Tort System

A TIME TO REBALANCE THE SCALES OF JUSTICE

By WILLIAM M. McCORMICK, *Chairman and Chief Executive Officer, Fireman's Fund Insurance Companies*

Delivered to Commonwealth North, Anchorage, Alaska, January 7, 1986

GEORGE BERNARD SHAW once wrote, "The road to hell is paved with good intentions." Probably no statement better describes the start of our tort system in this country. With the best of intentions, the scales of a system designed to render justice have been tipped. The balance has moved so far toward the desire to compensate all injuries and all losses that the overall cost to society has become too high. We have reached a point where exposure to liability is becoming almost limitless and incalculable, making everyone — governments, businesses and individuals — a victim.

Now, even people whom common sense would judge innocent are found liable by our courts.

In making these observations, I want to make it clear that I am doing it as a citizen, not as an insurance expert or as a lawyer. As chief executive of a major insurance company, I find myself in the middle of the current debate on our tort system. I have had the opportunity to examine the issues firsthand, and I don't mind telling you that I have become very concerned about the societal cost and fairness of litigation in this country.

To put the tort problem into perspective, let's look at a few recent suits and their outcomes:

—A little league player was injured when a fly ball hit him on the head. His parents sued the coaches on the theory that they were negligent in putting their son in the outfield. The parents recovered a settlement. As a result, the athletic league may have to disband because it cannot afford liability insurance. And coaches everywhere are beginning to worry about whether their contribution of time is worth the new risk.

—A man was hurt when a drunk driver crashed into th phone booth he was using. The California Supreme Court held that the manufacturer of the phone booth could be held liable for the man's injuries.

—A burglar accidentally fell through a painted-over skylight while he was stealing lights from the roof of a public school. He sued the school district and covered $260,000 in damages plus a continuing income.

—In New York City, a man attempted suicide by jumping in front of a subway train. The man was injured but did not die; he sued, claiming the driver should have put the brakes on faster. The New York Transit Authority paid $650,000.

—A man sued for emotional damages after seeing a leopard kill a neighbor's child at the circus. He was awarded more than $1 million. The child's parents, who had not witnessed the accident firsthand, received $120,000.

These few cases — and believe me, there are many more — do make you wonder where we are heading. Something is wrong when parents get paid damages because their child can't catch. Something is wrong when a manufacturer is liable because its telephone booths don't withstand sidewalk attacks from speeding autos. Something is wrong when a burglar can recover from the taxpayers because a public school wasn't safe to break into. Something is wrong when a person can sue because he was injured while trying to kill himself. Something is wrong when someone is paid $1 million for observing an accident, however tragic.

Decisions such as these are beginning to outrage our common sense notions of justice. Why is this happening? The fact is, the justice system as we long knew it no longer exists. The system no longer provides a clear definition of the law. It encourages plaintiffs to sue, hampers defense, makes incredible awards, and has stretched the line that defines responsibility from "true negligence" to what almost amounts to "innocent bystander." And as a result, the system is overloaded and fails to provide prompt, just and full compensation to injured victims at a reasonable cost.

1800s–1960s: Historical Stability

A little historical perspective is needed to understand how we got to where we are.

There are two broad areas of the law: criminal and civil. Tort law falls under the civil category and includes everything from slip and fall cases to automobile accidents to libel suits.

The rules in tort law center on what kinds of injuries can be compensated and what has to be proved to win the lawsuit. We inherited these rules from English common law. In the past, changes in these rules evolved slowly, largely from court decisions, not from statutes.

In America, we have 50 different state court systems and hundreds of federal courts that must interpret and apply these laws. There is often a difference between the rule in one place and the rule applied in another. Overall, however, most court decisions on tort law have followed the same general trend.

Surprisingly enough, even with all the minor adjustments and additions made through nearly 200 years of American court decisions, the balance struck by English common law remained essentially the same from the early 1800s until the 1960s.

With limited exception, a person suing could recover only if he proved that the defendant was at fault — that the defendant's negligence caused the injury. If the plaintiff — the person bringing the lawsuit — was the primary cause of his own injury through negligence or deliberate conduct, he could not recover.

Plaintiffs could usually get damages for intangible pain and suffering only if there was an accompanying physical injury. And punitive damages — punishment awards over and above compensation for injury — were available only for truly outrageous conduct. In other words, tort laws were defined in such a

manner that one only obtained redress for cases of true negligence, not for the personal risks of everyday life.

1960s–Today: The Erosion of Justice

The tort system we have today — only 25 years later — is vastly different. Our generation has overturned 200 years of legal tradition.

To illustrate recent changes, let's look at just a few of the important decisions of the last 25 years in California. I have chosen California because its lead has often been followed by other states.

In 1961, California rejected the common law doctrine of sovereign immunity, which for centuries had protected cities and states from lawsuits. In fiscal 1984, California cities — that's California taxpayers — paid out more than $19 million in claims, up from $5 million just three years ago.

In 1962, the concept of fault was tossed aside in the area of product liability. Now, an injured person doesn't have to prove any negligence — just that the injury might have been prevented by a different product design. That's how you get lawsuits against telephone booth manufacturers for not making their product crashproof.

In 1968, the California Supreme Court changed the standard of care owed by landowners, extending the duty of "utmost care" to even criminal trespassers. You can now see why a burglar robbing a school can successfully sue for injuries.

In 1975, California replaced the doctrine of "contributory negligence" with "comparative negligence." Comparative negligence allows an injured party to recover if he is partly — or even primarily — at fault for an accident.

Not only has legal doctrine been substantially altered, the dollar value of awards has ballooned. The tort system today has more million dollar winners than a state lottery. You may think that the high awards you read about are aberrations, but in 1984 the average product liability verdict was over a million dollars. The average medical malpractice award was $950,000.

Courts today also have become more liberal in awarding punitive damages. Recently, an insurance company disputed the proper settlement amount with a couple whose car was rear-ended. The insurance company offered $4,500; the couple believed they were entitled to $17,000. They sued, claiming the insurance company had failed to settle their claim in good faith, and recovered $7.4 million in punitive damages. Regardless of who was right or wrong, the punitive damages awarded were totally out of proportion to the claim at hand.

And courts in many states are handing out extraordinary awards even where there is no physical injury, just the mental trauma caused by watching an injury happen to someone else, or the worry brought on by fear that an injury might occur in the future. That is why the man who saw the boy killed at the circus sued and why people are now suing for fear of contracting AIDS.

Huge damage awards are a recent phenomenon. The first million-dollar tort verdict was awarded in 1961. In 1983 alone, this country settled 360 cases for $1 million or more. By comparison, in the entire judicial history of Canada, there have been only six $1 million tort cases — and three of those cases, applying Canadian law, were decided by U.S. courts. No other country pays these huge amounts.

The financial cost of our tort reparations system is staggering: In 1984, the tort system was estimated to cost 37 times as much as it did in 1950. Commercial liability insurers alone spent $2.9 billion defending suits in 1983; and legal defense costs had risen to 25 cents per premium dollar, compared with 5 cents per dollar in the 1950s.

The System Today: Expensive and Unpredictable

But while these statistics point out some of the dimensions of what has happened to our legal system in the past 25 years, there is another aspect that is harder to quantify and that is the cost of uncertainty as to what the law is. Just over a hundred years ago, U.S. Supreme Court Justice Oliver Wendell Holmes wrote: "The tendency of the law must always be to narrow the field of uncertainty."

That tendency hasn't been very apparent lately. Certainty and predictability have been two casualties of the developments of the last 25 years. Without certainty and predictability, plaintiffs sue, defendants don't know how to protect themselves and we in the insurance industry can't price, and in some cases can't accept, risks.

And do not forget, there is enormous leverage on these recent court cases. Decided cases are only the tip of the iceberg; they directly affect the thousands of other cases that get settled before going to court, not to mention acting as a stimulant for ever more lawsuits.

Defendants often pay huge settlements just to avoid the uncertainty of court judgments. One particularly successful plaintiff attorney in Los Angeles recently bragged to a journalist that defendants "are so afraid of going before the jury . . . that they are ready to settle a $10,000 claim for $100,000."

The impulse to find someone else to blame, and thus get compensated — and compensated highly — for every injury, has serious economic and behavioral repercussions. America has the most litigious and expensive legal system in the world, with the number of lawsuits and amount of damages growing at an unprecedented rate.

We now have three times as many lawyers per capita as England, and more than 20 times as many per capita as Japan. Can you believe that one out of every 12 adult Americans will be involved in a lawsuit this year?

Runaway tort litigation means we all pay higher prices for everything, whether it's in product prices, insurance rates or in municipal, state and federal taxes.

For example, the City of New York, which is large enough to be self-insured, pays claims itself. In 1983, New York City paid claims totaling $78 million. That was $78 million the city could have spent on police protection, subway improvements or road repair. By the year 2000, New York City expects to pay more to settle lawsuits than it pays to provide fire protection.

Even the federal government faces high liability costs: There are now 40,000 civil cases pending against the United States, with damage claims of over $138 billion.

But the biggest dollar cost imposed by our tort reparations system is the invisible tax we pay on almost every product and service we buy. When your purchase a stepladder, for example, one-fifth of the price tag goes to cover the manufacturer's liability protection. The product liability component of a GM car now costs more than the steel that goes into it.

The Societal Cost of Litigation

But money is just money. If everything gets more expensive because we decide to maintain our current tort liability system, somehow we will all muddle through. Our standard of living will go down a bit, we'll be a little less competitive in international markets, and a number of small companies will go out of business. What is more frightening, however, is that soon there

may be some necessary products and services that are no longer available at any price.

Day care centers all across the country are closing their doors. We have all read about instances of misconduct. But in addition, there is an attitude that if Susie hits Johnny with a building block, it's grounds for a suit claiming inadequate supervision and demanding punitive damages. The result is that many day care centers simply can't afford — or get — insurance.

Non-profit organizations and local government boards are now having trouble finding anyone willing to serve because they cannot afford insurance to protect their board members from lawsuits. Community service is rewarding, but for most of us it's not so rewarding that we would risk our homes and savings in a lawsuit — just for the privilege of volunteering personal time.

And some manufacturers of life-saving products have quit because the threat of product liability suits is so overwhelming. In the last few years, seven companies have withdrawn from the business of making anesthesia machines; only two are left. Johnson & Johnson recently withdrew a drug designed to prevent sudden infant death syndrome — crib death. The reason wasn't that the drug didn't work: It does. But because it is given to high-risk infants, some of whom would die of crib death regardless of whether or not they took the drug, the company did not feel it could expose itself to the inevitable product liability suits.

And American vaccine makers are being driven out of the business as well. There is only one maker of whooping cough vaccine in the United States, and they are talking about getting out of the business. Why? Because the vaccine, which saves thousands of lives every year, is not perfectly safe: It causes unavoidable injury in three out of every one million children. As a result, the manufacturer has attracted more than 100 lawsuits over the last three years, amounting to almost $2 billion in claims. The entire U.S. market for all vaccines amounts to $250 million.

Where is the next vaccine or wonder drug going to come from if the companies can't even distribute the life-saving products that they have already developed?

What we are facing is an issue that is very important and that affects all of society. The pendulum of the American tort system has swung too far. The desire to hugely reward every claimant is creating too great a price. The belief that the world owes us a living has come full circle — back to us. Each of us now lives in almost mortal fear of being sued, particularly if we have — or through insurance have access to — money. We can no longer count on being protected by the law: we can now be attacked by it.

What Is the Problem?

Part of the problem is the inherent difficulty of balancing the competing objectives in any tort law system. As society has become more complex over the centuries, the task of delicately balancing competing social goals — each of which has a place, and none of which can be totally neglected — is more difficult. How does one balance the tradeoffs among:

—Full compensation for injured parties;

—Deterrence of negligence or punishment of outrageous behavior;

—Deterrence of self-injuring behavior;

—Maintenance of an efficient court system for dispute resolution; and

—Avoidance of limitless or incalculable liability in order to encourage the productive elements of society and avoid disincentives for economic development and innovation?

Part of the problem is the fact that the enormous changes in legal doctrine made over the past 25 years have been, for the most part, invisible. Courts have expanded the law on a case-by-case basis without much public debate or even notice.

Each change has been a well-intentioned attempt to compensate someone for some injury. But the revolution in legal philosophy that occurred with the best of intentions affects all of society. Yet it was done by courts based on what they perceived to be changes in prevailing values without the benefit, or crucible, of public debate and legislative mandate.

Part of the problem is that most business people, most consumers and even some legislators think that tort reform is an area for the experts. They hear trial lawyers argue with insurance executives over the impact of the collateral source rule or the doctrine of joint and several liability, and their eyes glaze over. They figure the experts deserve each other.

There are no doubt even more parts to the problem. The result, however, is clear: We in America have the most unpredictable, expensive and litigious tort system in the world. This is no longer a problem just for lawyers, for the insurance industry or for the courts. The time for leaving decisions to narrow categories of experts is over. The costs — both economic and societal — are too great.

What Is the Solution?

We can't look to the lawyers to solve the problem. Abraham Lincoln, a lawyer himself, once said that the highest duty of an attorney was to discourage litigation. While I certainly support his view, it is a tough standard. It's like asking doctors to discourage medicine or ad agencies to discourage advertising. In fact, just the opposite is happening as lawyers increasingly advertise for tort clients.

We can't look to insurance companies to solve the problem. As middlemen, insurers are in the business of spreading risks in a society, not picking up the tab for them. Insurance is unusual in that it must price its product to cover the cost of lawsuits today and many years into the future. As long as the courts define the rules, the policies will be competitively priced to reflect those rules. If the liabilities are undefined, the insurance cannot, or should not, be written.

Finally, we can't look to the courts alone to solve the problem. Courts are focused institutions which decide narrow cases involving the parties before them. Only occasionally do they see repercussions beyond the immediate case. If they did, they would probably not have set many of these recent precedents.

It took 25 years of case-made changes in doctrine to create our most litigious society in the world; but we do not have 25 years to correct it. The stakes are simply too high. So, if we can't look to the lawyers, and we can't look to the insurance companies, and we can't look to the courts to solve the problem, who can we look to? Well, look around.

Citizens Must Act

The answer lies with us as citizens and with the legislature. But the legislature will not act until the voters make their voices known. Everyone must get involved because everyone is paying the price — municipalities, businesses, citizens and even the trial lawyers, who are themselves having trouble getting liability insurance.

It is time for all of us to step back and readdress some basic questions:

—Is fault still important?

—Where do we draw the line on defining and assigning liability?

—Should there be limits on financial damages?

—When does ease of suit cripple the productive elements of society?

These questions — and others — are big, important and complex. They must be thoroughly analyzed and debated at the local, state and national levels by everybody, not just the experts. We must understand the issues. We must talk to one another. We must involve our legislators. Only then will the system begin to change.

The key is to become involved. When citizens are involved, legislative change happens. Last fall in California, Lee Phelps, a retired Marine, founded a lobbying group to protect property owners from being sued by criminal trespassers who injure themselves on their property. To overrule the California Supreme Court case that held otherwise, Lee Phelps raised and spent $5,000. He faced opposition from the California Trial Lawyers Association, which had contributed over half a million dollars to candidates last year. But he got the measure passed. So something can be done.

The following are some solutions we might consider:

Put some *limits on liability*, whether that's limits on types of claims or on the size of damages awarded. For example:

—Product liability when there is no negligence on the part of the manufacturer and where the injured parties' own negligence contributed to the problem;

—Pain and suffering awards, particularly when there's no physical injury or when the injury occurred to someone else;

—Size of awards where the impact of taxes, expenses and collateral sources are significant.

A second area in need of reform is *punitive damages*. The original justification for punitive damages was to deter outrageous behavior, willful and wanton misconduct. In recent years, this good standard has been diluted to the point of capriciousness.

Third, we must reexamine the concept of *comparative negligence*. This doctrine allows plaintiffs to recover large damages even if they are more responsible for the injury than the defendant. That's what allows people who throw themselves in front of subway trains to recover hundreds of thousands of dollars from the taxpayers. It should be possible for judges to dismiss lawsuits at an early stage if the plaintiffs are clearly responsible.

Fourth, we must eliminate *joint and several liability*. The defendant should be financially responsible only for his own fault in the incident, and not for someone else's fault if that person can't pay.

Fifth, we should limit the *contingency fee system*, which encourages frivolous lawsuits and provides an irresistible incentive to extend the line on defining liability.

Sixth, we should seriously consider establishing a mechanism for manda ory, *non-binding arbitration* of smaller claims, which make up the bulk of tort cases. If a plaintiff then carries his case on to the courts, he should pay defense costs if he does not prevail.

But the specific details of one tort reform proposal or another aren't important yet. What matters is that we as a society make some comprehensive and fundamental changes to put our tort system back in balance. Tort law is an integrated system and piecemeal solutions will not do.

Someone once said that people get the kind of government they deserve. In a democracy, it's also true that we get the kind of civil justice system we deserve.

I think we deserve a system that is predictable. A system that provides prompt, just and full compensation to injured victims at a reasonable cost. A system that does not make each of us a potential target for lawsuits arising from someone else's accidents. A system, in other words, that does not outrage our common sense notions of justice.

But if that's the kind of system we want, then we must work to get it. We do not have it now.

Agriculture's Crossroads

WHICH WAY FROM HERE?

By KEN NIELSEN, *President of Farmland Industries, Inc.*

Delivered at the ASAE Winter Meeting, Chicago, Illinois, December 19, 1985

THANK YOU, Bill (Johnson), and good morning, ladies and gentlemen. I am both pleased and honored to participate in this forward-looking conference. *Pleased* by the challenge of sharing some of my thoughts about the forces of change that are reshaping American agriculture. *Honored* by this opportunity to address a group whose contributions in science and technology I recognize as having been important factors in the progress that has given America the world's greatest food production and distribution system.

But I am also a little bit *bothered* by the assignment you've given me.

Your conference theme: "The World Food Situation — Now and the Year 2007," flies in the face of some advice offered by two noted men of our time. One is the historian, Sir Kenneth Clarke, who said: "Predicting the future is, intellectually, the most disreputable form of public utterance."

The other sage is the legendary movie-maker Sam Goldwyn, who's supposed to have said, "Never make predictions — especially about the future."

Certainly, I lay no claim to more acute future vision than anyone else. Indeed, I often find myself puzzling more about what will happen next week — or what the weather will be for spring planting — than about the condition of agriculture in the 21st Century, as important as this subject is to us all.

And yet the year 2007 is much closer than it seems. It's 22 years off. Just 22 years ago John F. Kennedy was shot and that seems like yesterday to some of us.

Still, I believe I'll be more comfortable discussing some of the changes affecting present world food conditions as they relate to America's farmers and ranchers. My projections of

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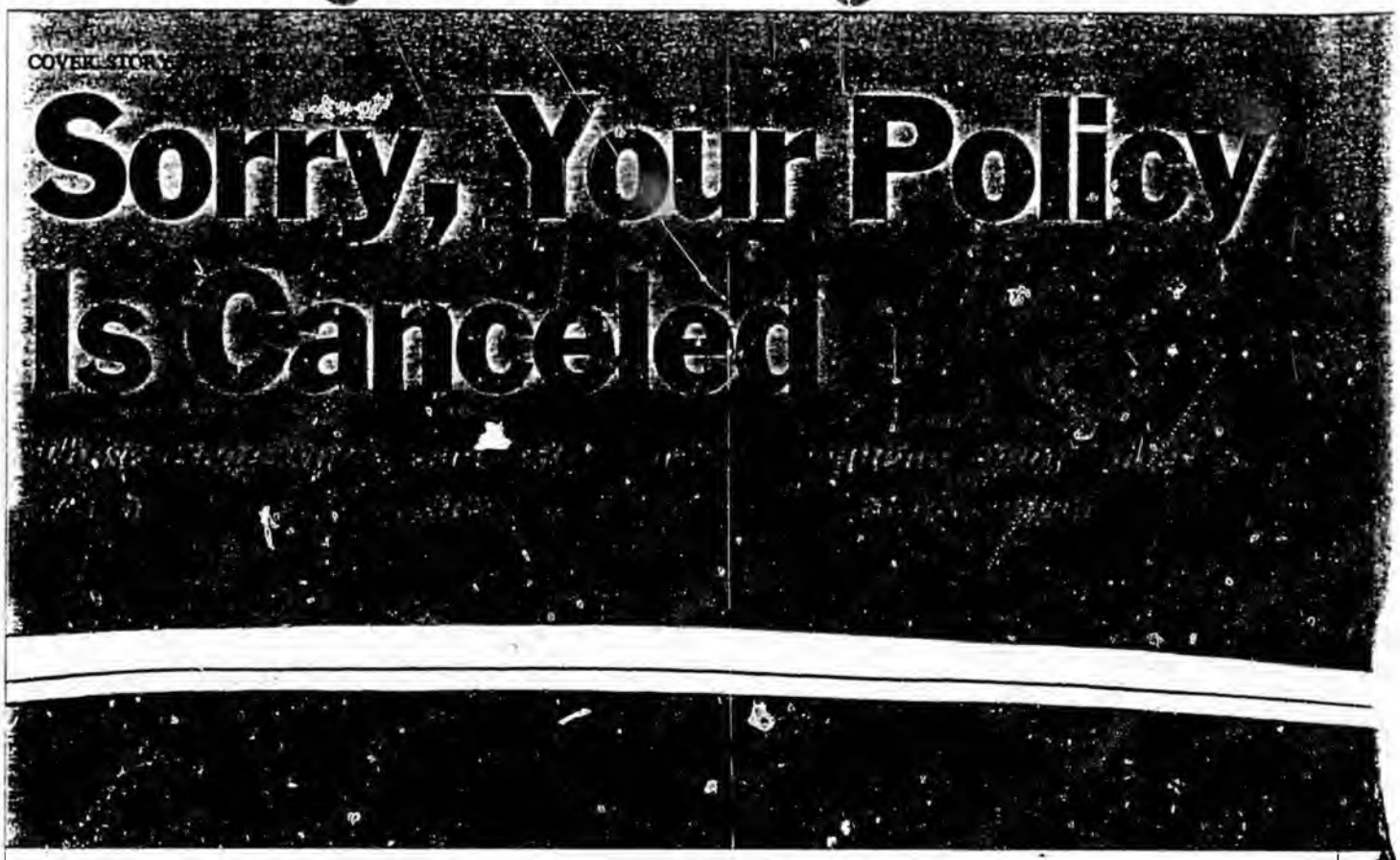


Nation

TIME/MARCH 24, 1986

On the Hawaiian island of Molokai, pregnant women who want a doctor in attendance when they give birth fly to neighboring Oahu or Maui. The five Molokai doctors who once delivered babies have stopped doing so because malpractice insurance would cost them more than the total of any obstetrical fees they could hope to collect.

Will County, Ill., last week closed its forest preserves until it can get a new liability policy on them—if that can be done at all—and Blue Lake, Calif. (pop. 1,200), has shut its skating rink, parks and tennis court. Hundreds of other towns in California and in New York State are "going bare." That is, they simply cannot get liability insurance.

The Texas sesquicentennial cattle drive, part of the state's celebration of 150 years of independence from Mexico, bogged down this month after one day on the road because liability insurance covering the 49 longhorn steers that were involved was doubled and the organizers could not afford it. The drive resumed last Friday with only 28 steers, whose owners agreed to pay for the insurance themselves.

Century Cartage Co., a small truck line out of Atlanta, is still in business only because the Georgia Public Service Commission approved an "emergency" 5% rate increase for its customers. But that boost came nowhere near meeting the cost of liability-insurance premiums that doubled to $48,000 last year and then leaped to $114,000 at the start of 1986.

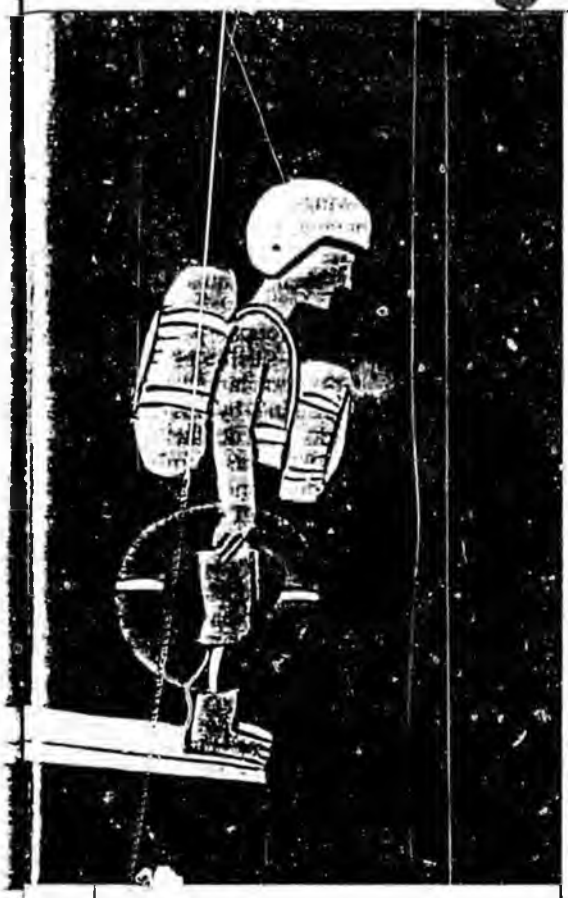
Outrageous? Yes. Ridiculous? In many cases. Unreasonable? Certainly. And yet the examples represent just a small sampling from a rising flood of problems growing out of what has become a new national crisis. Given the litigious nature of American society these days, just about any kind of business, profession or government agency is likely to become the target of a suit alleging malpractice or negligence resulting in personal injury. That makes liability insurance, the kind that pays off on such claims, just about as vital as oil in keeping the economy functioning. But in the past two years, liability insurance has become the kind of resource that oil was in the 1970s: prohibitively expensive, when it can be bought at all. The result is a pinch from which few can escape—not even liability specialists like J.B. Spence or Robert Rearden.

Spence, a Miami lawyer, is the kind of attorney insurers often blame for their troubles. He has won and earned a healthy slice of several multimillion-dollar awards for clients who suffered personal injuries. But if Spence should be sued for malpractice or negligence, as is happening to lawyers more and more, he would have to pay any court-ordered damages out of his own pocket. "There is no market that will sell me liability insurance," says Spence. "I am going bare, and it is a frightening prospect."

Rearden, president of Duncan Peek Inc., an Atlanta insurance brokerage, earns commissions selling policies at soaring premium rates. But when the time came to renew his own professional liability policy, his carrier wanted to jack up his $13,000 premium by 861%, to $125,000; Rearden had to scramble to find another company that would only triple his premium cost. "And that's me, and I'm in the insurance business!" wails Rearden. "That's what I mean when I say this crisis is affecting everybody."

And how. After years of eye-popping damage awards and shortsighted insurance-company practices, the U.S. is in danger of having its insurance canceled. The cost of this crisis, once generally hidden, is now hitting home. The $9.1 billion Americans paid last year in liability-insurance premiums was almost 60% higher than the figure as recently as 1983 and roughly equal to the combined 1985 budgets of the National Aeronautics

Illustrations for TIME by Guy Billout



and Space Administration and the Central Intelligence Agency. This year's total is sure to show another giant leap.

Every American pays: doctors and their patients, ski-slope operators and their patrons, municipal governments and their taxpayers, those who process cheese and those who eat pizza, those who take the bus and those who lease private jets, those who drill for oil and those who heat their homes.

Even more insidiously, the problem threatens the very character of American life, from the Great Peace March across the U.S. (which came apart last week in the Mojave Desert, partly because of a lack of liability coverage) to police patrols in New York's suburban Rockland County (suspended last week in the towns of Piermont and Sloatsburg; 13 officers have been told to sit at headquarters' desks while the towns look for a liability insurer to replace one that has gone into receivership). Factory owners seeking to expand, entrepreneurs seeking to launch new enterprises, young businessmen seeking to set up shop: all are running into an obstacle far harder to surmount than high taxes and interest rates in their pursuit of the American dream. Liability insurance has become their most crippling cost.

As a result, doctors have been marching on state capitols, some threatening to shut down their practices. Industry groups and insurance companies have launched loud lobbying and advertising campaigns. Bills have been introduced or passed in all 50 state legislatures to limit liability awards or regulate insurance practices or both. Congress has held public hearings. But federal and state lawmakers, who have been faced with cutting through a jungle of conflicting statistics, arcane accounting practices and tangled legal theory, have mostly come out baffled. Says South Dakota Republican Senator Larry Pressler: "We have not been able to get past the finger-pointing stage."

Consumer groups point to the insurance companies. When interest rates were high, they say, insurers wrote policies with little concern about how they would make good if claims went up and returns on their investments went down. Insurers point to the legal system. Juries, they say, have been handing out punitive damage awards that resemble lottery jackpots. Lawyers point to the negligence of Big Business. It can be redressed, they say, only if individuals have a right to present their cases to a jury. Businessmen point to changing attitudes. The individualistic notion of taking risks and accepting responsibility, they say, has been replaced by a sue-everyone-in-sight reaction to any accident. What makes the problem such a nightmare is that, to some extent, all of the finger pointers have a point.

What it finally boils down to is a matter of statistical logic and insurer psychology. If a few giant jury awards, actual or merely possible, can offset the premiums on an entire line of insurance, the companies feel they must raise premiums for everybody until there is some hope of making a profit. This means that premiums may bear no relationship to an individual policyholder's record, and buyers of many kinds of insurance are suddenly paying three or four times as much as they did a year or so earlier. Of all places, Hartford, Conn., known as the insurance capital of the world because so many carriers have their headquarters there, saw its own municipal liability coverage slashed to only $4 million, vs. $31 million in the 1984-85 fiscal year, despite a 20% rise in total premiums, to $1.8 million.

Some insurers are shying away from covering certain types of risks at any price. If there is no way of figuring what kind of damages a jury might award to the parents of a child molested at a day-care center, for example, then the companies will find it best to stop writing that kind of insurance at all. Says James Wood, a member of a firm of actuaries whose headquarters are in Atlanta: "If you are an insurer and have $100,000 in assets, do you want to risk those assets to keep day-

Lacrossed Up

As one of only two U.S. makers of lacrosse equipment, William H. Brine of Milford, Mass., lets customers know how to place reorders by printing his company's phone number on the back of each helmet. Now the helmets carry another message: a warning that lacrosse is a dangerous game. In 1984, Brine *(photo)* paid $8,000 annually for $25 million worth of product-liability insurance. In December, he received notice that his premium was going up to $200,000 for just $1 million of protection. Brine is taking his chances uninsured. "If we have a large judgment against us," he says, "it could be the end of lacrosse."

Other sporting-goods manufacturers face similar dilemmas: many U.S. firms have decided to abandon the manufacture of amateur hockey gear.

care centers open? The answer is probably no, because you do not know what you have to charge when you do not know what the ultimate costs of providing coverage might be." Most insurers flatly refuse to write policies to protect companies against suits arising from injuries caused by environmental pollution. They say they have no way of gauging the risk. That complicates further the question of who will pay for cleaning up toxic-waste dumps.

The dubious distinction of paying the highest increase on record may belong to Specialty Systems Inc., a Richmond, Ind., company that specializes in removing asbestos from buildings. Insurers are so terrified of anything having to do with asbestos that they canceled Specialty's policies three times between November 1984 and last April, though the nine-year-old company has never been sued. Because customers demand proof of insurance before they will give Specialty any business, the company wound up buying a $500,000 policy from the Great American Insurance Co. of Cincinnati, on which it will pay at least $460,000 in premiums, an increase of more than 4,900% over the $9,361 premium on its last full-year policy. Says Specialty President Frederick Treadway: "About half a million dollars paid to the insurance company for virtually nothing."

The situation is studded with an endless variety of similar horror stories *(see boxes)*. Among the most prominent are those that involve municipal services. The city council of Blue Island, Ill. (pop. 22,000), last October voted down a 30% increase in property taxes thought necessary to pay rocketing liability-insurance premiums, and the town expects to self-insure for the 1986-87 fiscal year, taking a chance that a large judgment might force taxes up anyway. Five counties in Missouri closed their jails for several weeks last fall, sending some prisoners elsewhere for incarceration and releasing minor offenders outright. The jails reopened after the counties' sheriffs set up a self-insurance pool, which was financed by tax money.

Among professionals, malpractice insurance problems have plagued lawyers, engineers, members of corporate boards and even clergymen. A growing number of clerics are buying, or having their churches buy, policies to protect them against suits like the one brought by a California couple who attributed the suicide of their 24-year-old son largely to inept counseling by his pastors. (That particular suit, filed in 1980, was dismissed for a second time last year; the case is still being appealed.) Suits against doctors, particularly specialists such as obstetricians and neurosurgeons, have been more successful and have led to some of the highest insurance premiums. A typical annual premium for an obstetrician in Los Angeles is about $45,000, and for a neurosurgeon in Long Island, N.Y., about $83,000.

Product-liability insurance presents a major problem for the makers of everything from toys to antitoxins. Pertussis vaccine for children ran short a year ago because Connaught Laboratories suspended production for a nine-month period during which it could not find insurance at an acceptable price. Now Lederle Laboratories, the only other maker of the vaccine, is talking of halting output in July if a threatened cutoff of its liability insurance materializes. Beech Aircraft figures the cost of liability premiums at a stunning $80,000 on each plane it sells. Says William Mellon, director of corpo-

Manufacturers massing to urge product-liability reform on Capitol Hill

"There are going to be people who are dumb and stupid."

Strung Out

When New York City's Roosevelt Island was opened for residential development nearly eleven years ago, part of its allure was a tramway that would soon connect the community to midtown Manhattan in six scenic minutes. That lifeline was cut last month when the tram's liability premium soared from $800,000 to nearly $9 million a year. Operators shut down the system, forcing some 5,250 islanders to spend up to an hour commuting on buses and subways.

After two weeks, New York State assumed responsibility for the tramway under a "self-insurance" plan that is increasingly becoming the solution of last resort for municipal services. Many legislators, however, are dubious about forcing governments to enter the insurance business. Meanwhile, the little tram that couldn't, now can—at least until somebody sues.

Bad Trip

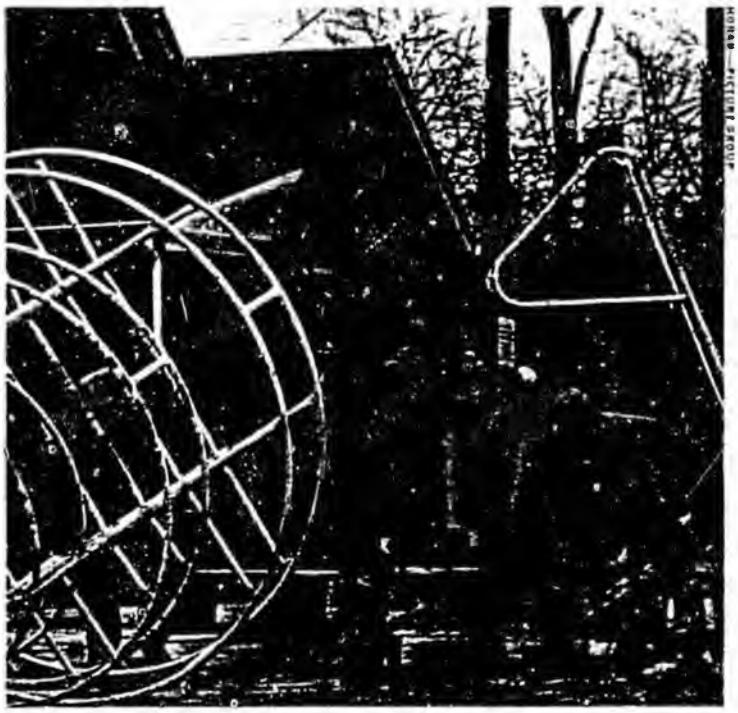
For sponsor PROpeace, the antinuclear Great Peace March between Los Angeles and Washington turned out to be a movable flop, beset by celebrity no-shows, cold weather and a lack of funds that last week caused the project's collapse. One major headache was the inability to obtain a $5 million liability policy required by some municipalities along the marchers' route. Because they lacked such coverage, 900 or so PROpeaceniks were denied the use of a schoolyard in Claremont, Calif., where they had planned to camp their third night on the road.

Sponsors of public events ranging from San Francisco's Chinese New Year festival to Maine's Fryeburg country fair have also run into trouble securing liability coverage. The main reason: the unpredictable nature of claims made by audience members, onlookers and participants.

rate communications: "The owner-pilot market has all but dried up, and one cause is the cost of product liability. It has driven the price of a new airplane out of the reach of the average person who wants to buy one." Some commercial fishing boats that once sailed out of Pacific Northwestern ports have been put into dry dock because owners could not afford liability-insurance premiums that commonly have doubled in the past year or so.

Rising premiums are forcing up prices on a variety of services too. Ski-lift tickets are jumping by $2 or $3 at many resorts. Through last year Kennestone Hospital in Marietta, Ga., insured itself for the first $1 million of any claims that might be made and paid a premium of $70,000 for additional coverage up to a maximum of $10 million. Now the premium has quintupled to $350,000, and on top of that the hospital has had to come up with another $1 million for its self-insurance trust fund, because the deductible was raised to $2 million. Says Executive Director Bernard Brown: "If you come to our hospital, you pay the price. It is being passed through."

Day-care centers, which have become an essential part of American life in an era of two-career families, are a striking example of how the insurance crunch may soon affect the lives of many unwary citizens. Operators fume that allegations of child abuse at a handful of centers have spooked insurers into indiscriminately canceling liability policies or demanding giant premiums. Mission Insurance Group, the chief provider of coverage for day-care centers, abruptly pulled out of the business last year. The handful of insurers that will still write day-care policies insist either on specifically excluding claims for damages arising from sexual abuse or setting up rules for strict supervision, such as unannounced visits by special investigators. Says Suzanne Grace, associate director of the Georgia Day Care Association: "The insurers are telling us, 'We don't care what your record is.' This business has the perceived risk of killing an insurance company."



Workers dismantling playground equipment on Chicago's Northwest Side

Says the insurer: "Park districts are a terrible risk for any carrier."

There is one area of general agreement about what has caused the insurance crisis: plain old-fashioned greed. Ah, but *whose* greed?

Insurers and some of their customers blame aggressive lawyers, inventive judges and soft-hearted juries for twisting legal concepts of negligence into novel shapes to justify excessive damage awards to people who claim personal injury (a tort in legal parlance). Avaricious lawyers, they argue, seek outrageously high damages for clients who have flimsy cases, so that the lawyers can reap huge contingency fees (if the case fails the plaintiff's attorney earns nothing, but if it succeeds he commonly takes one-third and, on occasion, as much as 50% of the award). Says Edward Levy, general manager of the Association of California Insurance Companies: "Lawyers are out to make a buck, and they seem to have little concern for the overall societal effects of what they are doing."

Plaintiffs' attorneys are every bit as willing to point the finger. Insurance companies, they charge, are using deceptive tales of excessive damage awards to justify the exorbitant premiums that they charge the public. Says Browne Greene, president-elect of the California Trial Lawyers Association: "Their greed takes us back to the robber barons of the 19th century." Many consumer organizations add that insurers are seeking unjustified premium hikes to cover up their own bad management and poor judgment of risks.

City Halt

Insurance woes have made for a sorry spectacle in the Northern California seaside village of Point Arena (pop. 450). When its $2 million liability policy expired in July, village officials decided to take the chance of going without coverage. A new policy was eventually offered, but at 50% more than the old rate of $6,700. Point Arena declined. Says Tracy Du Pont *(photo)*: "We would be broke."

Fearing personal vulnerability in litigation against the town, Du Pont's predecessor Kay Spack resigned in August. The town council voted to install wry signs at town limits warning visitors to "enter at your own risk," but abandoned the plan when a motel owner threatened to sue. Less wry is the prediction of some experts that two-thirds of California's 440 towns and cities will be forced to operate without liability insurance by next July.

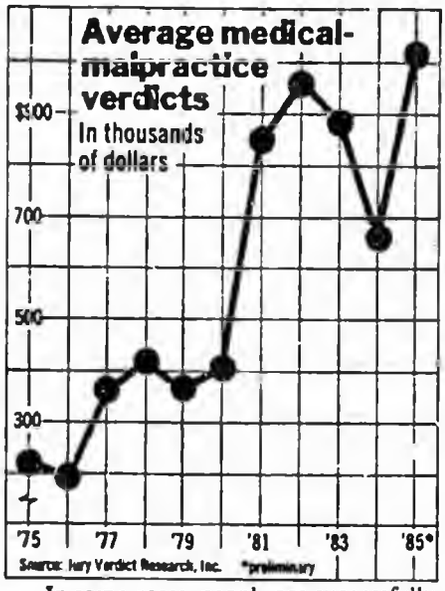
Overboard

When the board of Detroit's Armada Corp. meets these days, the directors could easily fit into a subcompact car—never mind a limo. The company, which produces automotive exhaust systems, had carried $10 million in liability coverage for its ten-member board and 28 corporate officers. Last November it was notified that the rate would increase from $45,000 a year to $720,000. Armada refused to pay. Fearing exposure to litigation, eight board members, including Chairman Jerry D. Luptak *(photo)*, resigned last month. (Luptak remained as president.)

Vice President Lowell Robinson could not recruit more than two new directors. Says he: "It's getting very difficult to find qualified people." The number of lawsuits filed against directors of U.S. corporations, by some estimates, has climbed by more than 150% since 1974.

Americans have always been a litigious people. But there does seem to be a rise in the number and size of liability suits facing every type of company, from soccer-ball makers to cigarette manufacturers. From 1977 to 1981, the number of civil lawsuits in state courts grew four times as fast as the population of the U.S. And in the decade between 1974 and 1984, the number of product-liability suits in federal courts expanded 680%. The first million-dollar verdict did not occur until 1962, but there were 401 in 1984, according to Jury Verdict Research Inc., a private group. The average verdict in product-liability cases now tops $1 million; preliminary figures for 1985 indicate that the average verdict in medical malpractice cases also exceeded $1 million for the first time. These giant awards, insurers say, exert an influence out of proportion to their numbers. They set a target for plaintiffs and their attorneys to shoot for, and move defendants to offer high out-of-court settlements rather than take a chance on what a jury might do.

The Association of Trial Lawyers of America counters by arguing that the Jury Verdict Research figures on averages are distorted by a relatively small number of huge verdicts. In addition, they say, the figures count only the initial outcomes of trials that the plaintiffs won. If defendant victories, out-of-court settlements and verdicts reduced on appeal were factored in, say the lawyers, even the average level of awards would be much lower. ATLA asserts that more than two-thirds of the million-dollar awards compensate victims or relatives for genuinely serious injuries, such as death or permanent paralysis, reflecting a laudable determination by juries to see that companies pay the price for misdeeds that once went unpunished.



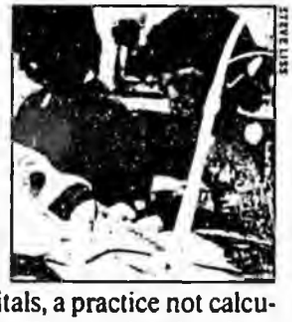
In some cases, people are successfully pressing claims that seem patently silly. One example: a man who attempted suicide by jumping in front of a subway train sued the New York City Transit Authority, contending that the motorman of the subway that hit him had been negligently slow in bringing the train to a halt. He won $650,000 in an out-of-court settlement.

Yet much of the lore surrounding the subject has been exaggerated. ATLA analyzed several cases that insurers regularly trot out to prove that the system has got out of hand and found that the facts did not quite support the versions that have passed into insurance folklore and public print, although one or two, even after correction, still sound odd. Some examples:

▶ According to one frequently cited tale, a body builder competing in a footrace with a refrigerator strapped to his back was injured when one of the straps came loose; he sued several defendants, including the strapmaker, and won $1 million. The facts, according to the lawyers' group: ten athletes competed in a televised stunt race, each with a 400-lb. refrigerator strapped to his back; each received a written contract guaranteeing that the equipment had been tested for safety. Franco Columbo, a world-champion body builder, did fall and suffered total knee displacement that required extensive surgery. At the trial, testimony showed that the equipment had never been tested on anyone of Columbo's size while running (he is 5 ft. 7 in., much smaller than anyone else in the race). In fact, the engineer for the fitness center that developed the contest said that he had warned the organizer, Trans World International, that the whole race was unsafe. Columbo did win slightly less than $1 million from Trans World, but the strapmaker was not sued because the strap never broke.

▶ Another tale allegedly involves a fat man with a history of coronary disease who suffered a heart attack while trying to start a Sears lawn mower, sued Sears and the manufacturer, contending that too much force was required to pull the rope, and won $1,750,000. The real story, the trial lawyers point out, is that a 32-year-old doctor, who had no history of heart trouble, fell victim to a heart attack after futilely yanking the lawn mower's starter cord 15 times. A Philadelphia jury found that the mower's exhaust valve failed to meet the manufacturer's own specifications, hindering start-up to the extent that the rope indeed had to be pulled with excessive force. The jury did award $1,750,000, but the case was subsequently settled for an undisclosed amount.

Birth Pangs



Six out of every ten babies born in Rhode Island draw their first breath in the Women & Infants' Hospital of Providence, a 102-year-old institution that handles only obstetrical and gynecological cases. The facility also takes high-risk cases from nearby hospitals, a practice not calculated to attract insurance salesmen. Women & Infants' has managed to hold on to a $3 million primary malpractice policy, but it has been trying vainly since last October to renew its $10 million supplemental coverage.

No field in medicine has been harder hit by the insurance crisis than obstetrics. According to the American College of Obstetricians and Gynecologists, 73% of its 24,500 members have been sued for malpractice at least once. To escape the soaring cost of malpractice protection, some 3,000 ob-gyns have abandoned the specialty.

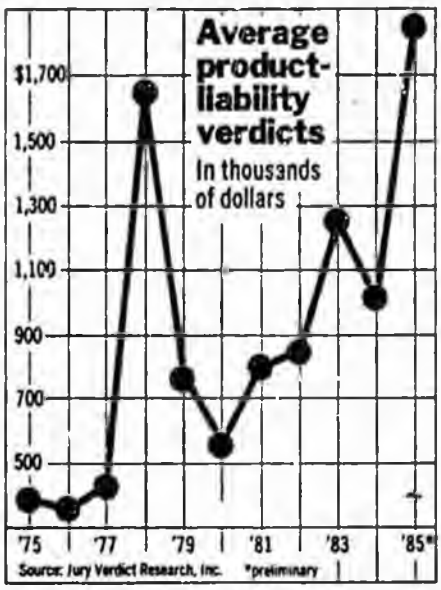
Crying Shame

The Edith B. Jackson child-care program operates seven day-care homes, a nursery school and toddler center for some 45 children in New Haven, Conn. Affiliated with Yale University, the widely recognized project has not incurred a single insurance claim in 13 years in business. Yet last year the program's liability coverage was canceled, and the only substitute policy available, for $2,400, is six times the 1984 premium and specifically excludes coverage for child abuse.

Co-Director Judy Silverman *(left in photo)* charges that underwriters are unduly skittish about day care because of a few widely publicized child-abuse cases. But even she is worried: "We try to be very careful," she says, "but I am uneasy. If a case of abuse came up and we were sued, my co-director and I could be held responsible."

▸ Another oft-used example is of two Maryland men who supposedly put a hot-air balloon into a commercial laundry dryer. The machine exploded, injuring both men, who won $885,000 from the maker of the dryer. What actually happened is that the men took the balloon to a hospital that had laundry equipment designed for industrial purposes. The dryer vibrated violently and then exploded. Both men were injured; one required microsurgery to reattach his hand, which was almost severed. The dryer's maker had a patent on a device that would have stopped the dryer automatically if it began to vibrate excessively, but had declined to install the device on the dryer because of the cost. Oddly, in this case the actual award, $1,260,000, exceeded the figure usually quoted, but the lawyers point out that the common account of the case ignores the dryer manufacturer's failure to install the protective device.

▸ In yet another celebrated case, a burglar supposedly fell through the skylight of a school, sued and was awarded $260,000, plus $1,500 a month. The full story, it seems, is that a 19-year-old man and three friends tried to take a floodlight off the roof of a California high school as a lark; he fell through the skylight and suffered loss of the use of all four limbs, plus severe brain damage. The skylight had been painted the same color as the roof and was indistinguishable at night; the school district knew that it was dangerous because someone else had been killed falling through a similar skylight at another school six months earlier, and had scheduled the skylight for repainting. It settled out of court for $260,000, plus $1,200 a month initially, to be increased by 3% each year. Still, it seems debatable whether someone should be so generously compensated for injuries, even that severe, sustained while committing a theft.



Yet whatever the merits of these and other specific cases, the insurance companies are correct in their basic contention: an evolution in liability law has led to higher jury awards and is at least partly responsible for the rise in insurance rates. One important change: the amounts assessed by juries to compensate for lost wages, medical payments and the like now make up a small part of many liability awards. Juries are increasingly likely to add on far larger amounts for noneconomic damages, that is, for such unquantifiable things as pain and suffering.

Equally significant is the growing size of punitive damages, which supposedly serve the same purpose as a don't-ever-do-anything-like-that-again fine of the defendant. Juries sometimes find that a person's actual damages amounted to only a few thousand dollars, yet decide that the corporation at fault should also pay punitive damages in the millions. In one startling case, now awaiting decision by the U.S. Supreme Court, an Alabama couple sued Aetna Life & Casualty Co., claiming that it had wrongfully refused to pay $1,650 of the wife's hospital bill. A jury awarded them punitive damages of $3.5 million, or 2,121 times the size of the disputed bill.

Courts and legislatures have steadily expanded definitions of who can be sued, and on what grounds. These days you usually can sue city hall, despite the doctrine of sovereign immunity, which holds that governments cannot be sued without their consent. State laws, and court interpretations of them, have granted that consent more and more.

Another legal concept being used ever more widely is that of strict liability, which makes possible an award of damages without any proof of negligence. Initially it was applied, for example, to businesses conducting abnormally dangerous activities. Now it has been expanded to product-liability cases: a plaintiff need not prove that the manufacturer of a product was negligent, only that the plaintiff was injured while using the product in the manner intended.

More states have also adopted looser standards of comparative negligence. Even if an accident was partly due to the plaintiff's own negligence, he can successfully sue someone else who also bears some of the blame. In California, for example, a woman who stumbled in a church parking lot on the way to a meeting sued the church, the group holding the meeting and the city, contending that the lot was not lit well enough. Although the defendants felt she was largely responsi-

Truck Stop

Tom Leonard's Miami-based trucking firm, founded by his grandfather in 1919, was besieged in recent years by a fleet of problems, including sharp tax increases and price competition. The company (1984 sales: $21 million) managed to work around all of them but one: finding the $5 million in liability insurance it was required to carry. Because many Leonard trucks hauled parts of the space shuttle, rockets and other explosives, underwriters kept hiking rates, limiting coverage and finally refusing to provide sufficient insurance at any price. When his coverage expired last July, Leonard simply shut down.

Insurance is scarce for carriers of any hazardous materials, especially if flammable or toxic. "Companies used to write us up with no problem," says Leonard. "But when rates changed, we may as well have been child molesters."

Sawed Off

The saws, lathes and other woodworking equipment manufactured by the Oliver Machinery Co. of Grand Rapids are designed to last for years. That sign of good workmanship is anathema to insurers, who shun hazardous products that can lead to lawsuits over long periods. "A machine may be 50 or 60 years old, been through a number of owners," says Company President Dana Baldwin. "But if someone gets hurt on it, we will get sued." Largely because of that exposure, Oliver's product-liability premium quadrupled this year, from $72,000 to $282,000.

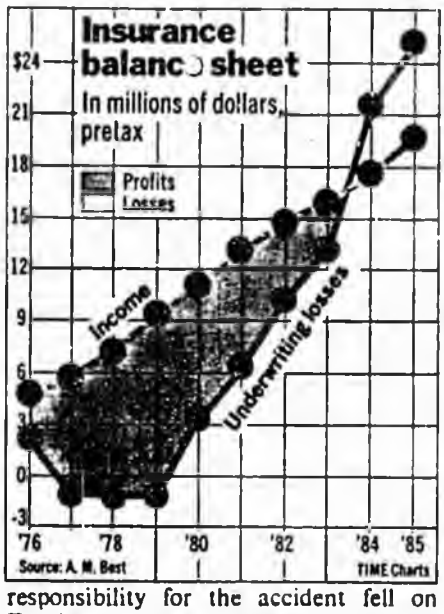
Oliver swallowed its rate hike, but others cannot; 34 of the 113 members of the Wood Machinery Manufacturers of America have left the business. In their place are small, single-product companies that do not have the same long insurance "tail" that often gets caught in lawsuits.

ble, all three agreed to a settlement paying her $60,000.

Perhaps the thorniest concept, one that has become a growing factor in many cases, is called "joint and several liability." It allows a plaintiff to sue everyone who might share in the responsibility for an accident, and if any one of the defendants is found to be partially at fault, that defendant may be forced to pay the entire judgment. Originally, it was applied to wrongdoers who had acted in concert, but now is more often invoked against defendants who acted independently. In practice, it increasingly means that awards fall most heavily on the defendant with "deep pockets," often the one carrying the most insurance. The doctrine is now in force in nearly all states.

One way to show how these concepts work—and the effects they can have on insurance coverage—is through a classic case settled last year that began with a child's fall and ended with most of Chicago's parks being stripped of certain kinds of playground equipment. It began in 1978 when two-year-old Frank Nelson fell through a wide space at the top of a slide in a city playground and struck his head on the pavement 11 ft. below. He suffered severe brain damage; the left side of his body is still paralyzed, and his speech and vision are impaired. Nelson's family sued the manufacturer of the slide, the contractor who installed it and the Chicago Park District. Lawyers contended that the district had been negligent in failing to warn against use of the slide by small children, in not providing proper supervision of the playground and not putting a softer surface under the slide.

Officials of the park district and its insurer, U.S. Fidelity and Guaranty Co. of Baltimore, still contend that the primary



responsibility for the accident fell on Frank's mother; she allowed the boy to go on a slide he was too young to use, and should have been watching him more closely. But they never formally accused the mother of negligence in pretrial proceedings; such an argument would not have succeeded unless they also could have convinced a jury that the park district bore no blame whatever. In this case the park district was the defendant with the deep pockets—$50 million in liability insurance—and Fidelity was afraid that it would be hit with the largest share of any judgment. Paul Jacob, the insurer's Chicago branch manager, notes that in Illinois a defendant who is found to bear any part of the responsibility for an accident can be liable for all of a damage award. Says he: "Showing that any defendant is not 1% negligent is virtually impossible."

Unwilling to risk paying the damages a jury might award to a child who had been so severely injured, Fidelity offered a settlement. It proposed to put up $1.5 million to buy an annuity that will make payments each year to Frank Nelson for the rest of his life. The family accepted, and the case was closed without trial.

But that is not quite the end of the story. Fidelity at first canceled the park district's insurance, but eventually renewed for much less coverage at a greatly increased premium. "Park districts are a terrible risk for any carrier to have to assume," explains Jacob. Finally, the park district, gun-shy because several suits are still pending against it, began tearing down all jungle gyms and slides over 6½ ft. high and carting them out of the city's 513 playgrounds. "Accidents happen no matter what you do," says Park District Treasurer Jack Matthews. "In the past, when Johnny fell off the swings, the park superintendent took him to the hospital, and that was the end of it. Now the parks are inundated with suits."

Such cases show how complex and changing legal doctrines can increase the risks faced by insurance companies and make those risks more unpredictable. But, as consumer advocates point out, they do not explain the full story. The legal doctrines in question have been evolving for many years. The rise in the number of personal-injury lawsuits and the size of jury awards has also been gradual. But apart from medical malpractice insurance, which has been a headache for both doctors and insurers for at least a decade, it is only in the past two years that liability premiums have exploded and policies have been canceled wholesale.

What happened? Lawyers and consumer activists charge that insurers are paying the price—or rather, trying to

Stiff Drinks


STEVE LISS

From 5 to 6 p.m., the price of a Heineken beer at the Red Blazer restaurant in Concord, N.H., was $14.75 instead of the usual $2.25, and a Beefeater's martini cost $40. Inflation? Sort of. The Red Blazer and some 400 other New Hampshire bars sponsored an Unhappy Hour last month to dramatize the rising cost of liability insurance for liquor retailers. The restaurant's premium had been hiked from $1,000 to $12,000 annually, and its owner hoisted bar tabs in protest. As courts have held tavern owners at least partly responsible for damage caused by intoxicated customers, retail liquor outlets have felt the squeeze from insurance companies. But Unhappy Hour prices are not likely to become permanent: New Hampshire Insurance Commissioner Louis Bergeron argues that higher premiums have actually raised bar costs no more than 18¢ a drink.

Hung Up


BROWN—PICTURE GROUP

When a late-winter storm dumped nearly 100 in. of snow on California's Sierra Nevada range near Lake Tahoe in March 1982, operators of the Alpine Meadows ski area closed down their 13 lifts and warned guests not to venture onto the slopes. When an avalanche struck, however, it did not bury the ski trails but the parking lot and a ski-patrol building, killing seven people. The families of three victims sued Alpine Meadows for $10 million in damages.

Last December a jury decided that the resort was not responsible for the tragedy. Nevertheless, Alpine Meadows did not emerge unscathed: legal fees for the trial totaled some $700,000, and the resort's 1986 liability premium doubled, to nearly $800,000. Like other businesses hit with major cost increases, Alpine Meadows passed on the added expense. It raised the price of a one-day lift ticket from $24 to $26.

make the public pay the price—for their own mismanagement and bad judgment. Liability insurance has always been a notoriously cyclical industry. Says Robert Hunter, head of the National Insurance Consumer Organization: "At the top of the cycle you write [policies for] everybody, no matter how bad, and at the bottom you cancel everybody, no matter how good. It's a manic-depressive cycle."

Harsh words, but again containing some truth. In the best of times, property and casualty insurers, the kind that issue liability policies, rarely make much money on underwriting: the premiums collected have exceeded claims paid in only two of the past ten years. Most of their profits come from investing the premiums they collect. Five years ago, when the prime rate, keystone of the U.S. interest-rate structure, hit an incredible high of 21½%, such investments paid off very, very well.

Insurers grudgingly concede that they went all out to attract premium income that could be invested at those towering interest rates. They wrote liability policies that posed a high risk at premiums low enough to almost guarantee an underwriting loss; competitive rate-cutting slashed some premiums by 20% or more. But the insurers never got the bonanza they expected. Underwriting losses rose faster than investment income grew even when interest rates were at their peak.

Then the bottom fell out. Interest rates began tumbling in 1981; the prime is now at an eight-year low of 9%. Underwriting losses ballooned. Foreign reinsurers—Lloyd's of London is the biggest—that indemnify most American casualty companies against extraordinary losses, cut back sharply or ran away from the business entirely, leaving the American firms to shoulder the losses alone. Finally, in 1984 underwriting losses swallowed up investment income entirely and, according to industry statistics, property casualty insurers suffered an overall pretax loss of $3.8 billion. It was the first red-ink figure in nine years. In 1985 the pretax loss increased to $5.5 billion. Some 40 liability insurers have become insolvent in the past two years.

Like the figures on jury verdicts, the insurers' profit-and-loss statistics are in sharp dispute. Consumer advocates insist that if adjustments are made for some quirks in insurance accounting (primarily involving the treatment of taxes, dividends and the rising paper value of investments), the industry made a net profit every year. The Insurance Information Institute, indeed, has acknowledged an industry profit after taxes of $1.7 billion last year, which it contends still amounts to a poor return.

The National Insurance Consumer Organization maintains that the true figure was $5 billion. Given that, the industry's critics argue, the premium increases now being posted go far beyond what is justified. Sneers Gerry Spence, a famed Wyoming trial lawyer (no relation to Miami's J.B. Spence): "What the insurance companies have done is to reverse the business so that the public at large insures the insurance companies." Consumerists often point to the judgment of Wall Street, hardly a Naderite stronghold. Stock traders bid up the price of property-casualty insurance shares an average of about 50% last year, in the apparent belief that the industry at minimum is on its way back to solid profitability.

Well, maybe. But that road to recovery threatens, at least for the moment, to cripple large segments of the U.S. economy and be extremely costly for every policyholder, taxpayer and consumer. Every day brings word of new repercussions: doctors raising their fees, playgrounds closing, swimming meets being called off, transit systems facing financial jolts, fraternities having their coverage canceled, old-field service companies closing down. Amid all of the attendant finger pointing, a serious search is under way for some solutions.

Self-insurance is a strategy that many businesses, professional people and governments are exploring (or, more often, being forced into). But the experience of doctors indicates it is not much of a solution. In the mid-1970s, doctors organized a number of companies, promptly dubbed "bedpan mutuals," to write malpractice insurance at lower premiums. But several of the bedpan mutuals are said to be in financial trouble, and as a group they too are raising premiums rapidly. Going bare is an act of desperation: business executives and professionals who are operating without insurance almost unanimously voice deep worry that a single big lawsuit could wipe them out.

As might be expected, many are seeking new legislation as a solution. But what line should it take? One approach is called tort reform, which involves putting limits on damage awards in malpractice, negligence and personal-injury cases. Advocates insist that this will allow insurers to get enough of a handle on their potential risks to make writing liability policies a predictable exercise rather than a crapshoot. The leading ideas:

▶ Put limits on pain-and-suffering awards and punitive damages. Republican Senator Mitch McConnell of Kentucky has introduced a congressional bill encouraging states to cap pain-and-suffering awards at $100,000 and to require that punitive damages be paid to a court, as outright fines are, rather than to a plaintiff and his or her attorney.

▶ Establish stricter standards for proving who really bears how much of the blame for an accident or injury. Senator John Danforth, a Missouri Republican, is sponsoring a bill that would set uniform federal standards in product-liability cases to replace the present morass of 50 often conflicting state laws; it would require a plaintiff to prove negligence or fault by the manufacturer.

▶ Either abolish the doctrine of joint and

several liability or revise it along the lines of a proposition that Californians will put to a vote on June 3. The proposition would make a defendant's share of any pain-and-suffering award proportionate to the defendant's degree of blame; a defendant found to bear 25%, say, of the responsibility for an accident or injury could be forced to pay no more than 25% of the damages. That would be more equitable, but requiring juries to assess proportionate shares of fault among several defendants would add to the complexity of lawsuits and the time needed to settle them.

▸ Limit contingency fees, so that lawyers would have less incentive to seek outsize damages for their clients. Several states are pondering variations on a California law that sets up a sliding scale in medical malpractice cases: an attorney can take up to 40% of the first $50,000 of a judgment, but that share dwindles by stages to only 10% of any amount over $200,000.

▸ Institute some sort of punishment, perhaps a fine, for attorneys who file frivolous suits. At minimum, reformers often urge adoption of the European system, under which the loser of a lawsuit usually pays the winner's court costs.

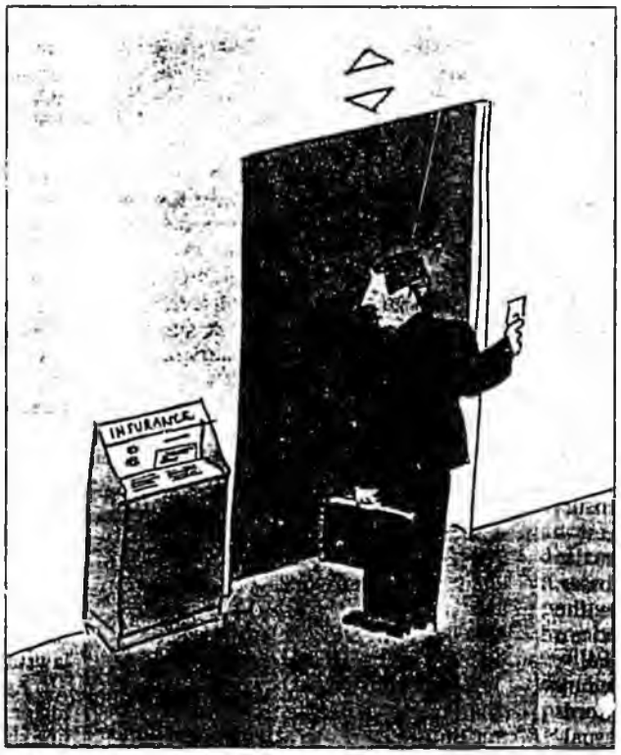
This last idea has yet to gain much ground, but different combinations of the others are being advanced in several states. The National Conference of State Legislatures estimates that around 1,200 bills have been introduced since last December dealing with the insurance crisis in one way or another, and most contain some sort of tort reform. On the federal level, besides the McConnell and Danforth proposals, a Reagan Administration study group headed by Assistant Attorney General Richard Willard is expected to recommend a bill limiting pain-and-suffering awards and punitive damages; it would also establish tighter standards for gauging fault to govern suits in federal courts. (Uncle Sam has more than a bystander's interest: the U.S. was a defendant in more than 10,000 damage suits in fiscal 1985, and wound up paying $200 million to plaintiffs.)

Some 600 members of the National Association of Manufacturers descended on Washington last week to lobby for the Danforth bill, which besides setting national standards for product-liability suits would establish a new procedure for speedy out-of-court settlement of claims for economic damages. They first gathered at the Marriott Hotel to swap horror stories and pep talks. Under present legal rules, "you're afraid to try anything, put any new product on the market," cried Gust Headbloom, president of Michigan's Apex Broach & Machinery Co. Peter J. Nord, president of Schauer Manufacturing Corp. in Cincinnati, which makes battery-charging machines, drew loud applause by declaring, "There are going to be people who are dumb and stupid and screw up no matter what we do." Ohio Democratic Congressman Thomas Luken showed up to cheer on the manufacturers. Said he: "Probably no recent issue has snowballed so quickly."

After eating paper-bag lunches, the manufacturers boarded buses to Capitol Hill to buttonhole legislators from their home states. So many Michiganders packed into the office of Democratic Senator Carl Levin that several of the businessmen had to perch on upended attaché cases. Levin warned them that "the whole spirit of Congress is to get away from regulation," but promised to take a careful look at the Danforth bill. Plaintiffs' attorneys, needless to say, oppose all tort-reform plans. They commonly accuse insurers of creating a sense of crisis to enact laws that would deny just compensation to victims of malpractice or injury. More troubling, they insist that all the tort-reform ideas would undermine a fundamental principle of democracy: the idea that any citizen should have unrestricted access to the courts for redress of any grievances he might suffer. Robert Habush, president of the Association of Trial Lawyers, says of the tort-reform movement, "In my 25 years in law, this is as serious a threat to the civil justice system as I have ever seen. People have decided there is going to be a hanging, and it is just a question of what tree and what rope."

In all probability, that seriously overstates the case. Present and former trial lawyers populate state legislatures and Congress in numbers large enough to wield formidable blocking power. There is a question, too, of whether the courts would uphold any serious tort reforms that might be enacted. One omen: the Cook County, Ill., circuit court last year ruled that major parts of a newly enacted law stretching out damage awards in medical malpractice cases violated the Illinois constitution.

The alternative legislative approach to the insurance crisis is tighter regulation of insurance companies. At the federal level, trial lawyers and consumer advocates are pressing for repeal of the insurance industry's exemption from antitrust laws. That exemption allows insurers to share information and, according to their opponents, engage in collusive premium-setting policies that would be illegal in any other industry. In state legislatures, many proposed bills would enlarge the authority of insurance commissioners to block arbitrary policy cancellations and gargantuan premium increases. The Florida department of insurance has written a proposed bill that would require insurers to disclose what discounts and surcharges they apply to premium rates. Without that information, says Insurance Commissioner Bill Gunter, "the rate itself is meaningless." He adds, "We think insurers need someone to look over their shoulder and keep them honest."



One mildly encouraging sign is that a growing number of legislators seem to recognize that, just as the crisis has no single cause, it cannot have any single solution. They are proposing various combinations of tighter insurance regulation and tort reform. A bill on the verge of enactment by the Minnesota legislature would set up "joint underwriting associations" to issue liability policies, written by the state, to customers who could not get commercial insurance; any losses would be picked up jointly by the state's insurers. But to limit those losses, the bill also would restrict punitive damages, among other tort reforms.

Some combination of measures seems needed, and fast. Anything that affects matters ranging from the pace of oil exploration to the availability of slides in Chicago playgrounds must be taken very seriously. The nation, once proud of its frontier individualism, has gradually adopted a no-risk mentality based on the belief that if anything bad happens, someone should be made to pay. But as damage awards lose any connection to actual damages and insurance companies flail around anxiously, that someone is turning out to be everyone. ■ *By George J. Church. Reported by Anne Constable/Washington, B. Russell Leavitt/Atlanta and Michael Riley/Los Angeles*

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TORT REFORM

(REPORTS & CASE LAW)

not received 5/29/86

THE
INSTITUTE FOR
CIVIL JUSTICE
THE RAND CORPORATION

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Gustave H. Shubert
Director

22 April 1986

MEMORANDUM TO INSTITUTE FRIENDS AND SPONSORS

Re: Senate Testimony on Medical Malpractice

On March 26, 1986, ICJ consultant Patricia Danzon* appeared before the U.S. Senate Judiciary Committee to deliver testimony on *The Effects of Tort Reforms on the Frequency and Severity of Medical Malpractice Claims: A Summary of Research Results*. We have reprinted her remarks and are sending them to you under separate cover.

In her previous work for the Institute, the author analyzed medical malpractice claims data for the years 1974-1978. This early analysis, while contributing valuable information to a growing debate, could not purport to measure the long-term impact of tort reforms enacted since 1975. For her most recent research, Patricia has used claims data for the full decade 1975-1984. Her testimony summarizes this new research and compares the results to her earlier work.

The Institute will publish the full version of Dr. Danzon's updated research results in early summer. Her testimony is a preview of her full report.

Sincerely,

GHS:tp

* Dr. Danzon is now Associate Professor of Health Care Systems and Insurance at The Wharton School, The University of Pennsylvania.

not needed
5/27/86

THE
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1700 Main Street, P.O. Box 2138, Santa Monica, CA 90406-2138 • (213) 393-0411

Gustave H. Shubert
Director

30 April 1986

MEMORANDUM TO INSTITUTE FRIENDS AND SPONSORS

Re: Senate Testimony on Tort Liability

On February 27, 1986, ICJ senior researcher Dr. Deborah R. Hensler delivered testimony on the tort liability system before the U.S. Senate Commerce Committee. We have reprinted her remarks as an ICJ Paper, *Summary of Research Results on the Tort Liability System,* P-7010-ICJ, and are sending a copy to you under separate cover.

Institute research reports have addressed many of the key questions now facing policymakers in their debate on the liability "crisis." In her summary for the Commerce Committee, Dr. Hensler highlighted five topics on which the ICJ has conducted research: trends in civil jury verdicts, corporate responses to product liability lawsuits, public expenditures for personal injury litigation, mass toxic torts, and the use of alternative dispute resolution procedures.

I'm sure you will find Debby's remarks interesting and germane to the continuing debate on the liability system in this country.

Sincerely,

Gustave H. Shubert

GHS:tp

rata contribution is that it terminate the litigation. Criterion Ins. Co. v. Laitala, Sup. Ct. Op. No. 2599 (File No. 6014), 658 P.2d 112 (1983).

Sec. 09.16.040. Release or covenant not to sue. When a release or covenant not to sue or not to enforce judgment is given in good faith to one of two or more persons liable in tort for the same injury or the same wrongful death

(1) it does not discharge any of the other tortfeasors from liability for the injury or wrongful death unless its terms so provide, but it reduces the claim against the others to the extent of any amount stipulated by the release or the covenant, or in the amount of the consideration paid for it, whichever is the greater; and

(2) it discharges the tortfeasor to whom it is given from all liability for contribution to any other tortfeasor. (§ 1 ch 80 SLA 1970)

NOTES TO DECISIONS

Section applies where settlement was made after effective date of chapter. — Although causes of action arose at the time of the accident before the effective date of this chapter, this section is applicable where the settlement was made after this chapter became effective. Layne v. United States, 460 F.2d 409 (9th Cir. 1972).

This section is intended to include those vicariously liable. Alaska Airlines v. Sweat, Sup. Ct. Op. No. 1464 (File Nos. 2912, 3105), 568 P.2d 916 (1977).

The language "one of two or more persons liable in tort for the same injury . . ." seems to include a party who is vicariously liable. Alaska Airlines v. Sweat, Sup. Ct. Op. No. 1464 (File Nos. 2912, 3103), 568 P.2d 916 (1977)

Implied indemnity between concurrently negligent tortfeasors. — Public policy dictates that Alaska should not adopt implied indemnity between concurrently negligent tortfeasors. Vertecs Corp. v. Reichhold Chems., Inc., Sup. Ct. Op. No. 2647 (File No. 6566), P.2d (1983); State Mechanical, Inc. v. Liquid Air, Inc., Sup. Ct. Op. No. 2684 (File Nos. 6145, 6172), P.2d (1983).

Plaintiff permitted to receive only amount of adjudged damages. — While this section changed the common law in one respect (i.e., by providing that release of one joint tortfeasor does not automatically release the other joint tortfeasors), it retained that part of the common law rule embodying the sound public policy of permitting a plaintiff to receive only the amount of his adjudged damages and no more, regardless of the source of the recovery. Layne v. United States, 460 F.2d 409 (9th Cir. 1972).

Amount paid for release reduces pro tanto judgment against another. — Whether or not the release party is in fact jointly liable with the defendant against whom a judgment is rendered, to prevent recovery by plaintiff of more than his legitimate damages, the amount paid for the release or covenant not to sue must reduce pro tanto the injured person's judgment against another. Layne v. United States, 460 F.2d 409 (9th Cir. 1972).

Whether released party is joint tortfeasor is not relevant. — Since the principle is that there can be but one satisfaction for the same injury, whether or not the released party is in fact jointly liable with the defendant against whom a judgment is rendered is not relevant. Layne v. United States, 460 F.2d 409 (9th Cir. 1972).

To require proof at trial that the released party was in fact a joint tortfeasor before this section can operate to cause a pro tanto reduction in the award equal to the amount recovered in the settlement would effectively thwart the major policy justifications for encouraging extra-judicial settlements — the disposition of claims without litigation, and the reduction and simplification of the issues requiring judicial determination. The language or intent of this chapter does not require such a result. Layne v. United States, 460 F.2d 409 (9th Cir. 1972).

Settlement for less than entire liability. — A joint tortfeasor may remove

Sec. 09.17.055. COLLATERAL BENEFITS. (a) After the fact finder has rendered an award to a claimant, and after the court has awarded costs, including attorneys fees, and interest, a defendant may introduce evidence of amounts received or to be received by the claimant as compensation for the same injury from collateral sources that do not have a right of subrogation against the claimant by law or contract.

(b) If the defendant elects to introduce evidence under (a) of this section, the claimant may introduce evidence of

(1) the amount that the actual attorney fees incurred by the claimant in bringing the claim exceed the amount of attorney fees awarded to the claimant under Rule 82; and

(2) the amount that the claimant has paid or contributed to secure the right to an insurance benefit introduced by the defendant as evidence.

(c) If the total amount of collateral benefits introduced as evidence under (a) of this section exceeds the total amount that the claimant introduced as evidence under (b) of this section, the court shall deduct from the total award the amount by which the value of the nonsubrogated sums under (a) of this section exceed the amount of payments under (b) of this section.

Sec. 09.55.546. Advance payments. In an action to recover damages under AS 09.55.530 — 09.55.560, no advance payment made by the defendant health care provider or the professional liability insurer of the defendant to or on behalf of the plaintiff is admissible as evidence or may be construed as an admission of liability for injuries or damages suffered by the plaintiff; however, a final award in favor of the plaintiff shall be reduced to the extent of any advance payment. The advance payment shall inure to the exclusive benefit of the defendant or the insurer making the payment. (§ 35 ch 102 SLA 1976)

Sec. 09.55.547. Pleading of damages. In a cause of action against a health care provider for malpractice, the complaint or any other pleadings may not contain an ad damnum clause or monetary amount claimed against the defendant health care provider, except as necessary for jurisdictional purposes. (§ 35 ch 102 SLA 1976)

Sec. 09.55.548. Awards, collateral source. (a) Damages shall be awarded in accordance with principles of the common law. The fact finder in a malpractice action shall render any award for damages by category of loss. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump-sum payment; the judgment shall include, if necessary, other provisions to assure that funds are available as periodic payments become due. Insurance from an authorized insurer as defined in AS 21.90.080 or from the Medical Indemnity Corporation of Alaska is sufficient assurance that funds will be available. Any part of the award which is paid on a periodic basis shall be adjusted annually according to changes in the consumer price index in the community where the claimant resides. In this subsection, future damages includes damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(b) Except when the collateral source is a federal program which by law must seek subrogation and except death benefits paid under life insurance, a claimant may only recover damages from the defendant which exceed amounts received by the claimant as compensation for the injuries from collateral sources, whether private, group or governmental, and whether contributory or noncontributory. Evidence of collateral sources, other than a federal program which must by law seek subrogation and the death benefit paid under life insurance, is admissible after the fact finder has rendered an award. The court may take into account the value of claimant's rights to coverage exhausted or depleted by payment of these collateral benefits by adding back a reasonable estimate of their probable value, or by earmarking and holding for possible periodic payment under (a) of this section that amount of the award that would otherwise have been deducted, to see if the impairment of claimant's rights actually takes place in the future. (§ 35 ch 102 SLA 1976)

Rule 68. Offer of Judgment.

At any time more than 10 days before the trial begins, a party defending against a claim may serve upon the adverse party an offer to allow judgment to be taken against him for the money or property or to the effect specified in his offer, with costs then accrued. If within 10 days after the service of the offer the adverse party serves written notice that the offer is accepted, either party may then file the offer and notice of acceptance together with proof of service thereof and thereupon the clerk shall enter judgment. An offer not accepted shall be deemed withdrawn and evidence thereof is not admissible except in a proceeding to determine costs. If the judgment finally obtained by the offeree is not more favorable than the offer, the offeree must pay the costs incurred after the making of the offer. The fact that an offer is made but not accepted does not preclude a subsequent offer. When the liability of one party to another has been determined by verdict or order or judgment, but the amount or extent of the liability remains to be determined by further proceedings, the party adjudged liable may make an offer of judgment, which shall have the same effect as an offer made before trial if it is served within a reasonable time not less than 10 days prior to the commencement of hearings to determine the amount or extent of liability.

CROSS REFERENCES: Civ. Forms 128, 129, 130

Rule 82. Attorney's Fees.

(a) Allowance to Prevailing Party.

(1) Unless the court, in its discretion, otherwise directs, the following schedule of attorney's fees will be adhered to in fixing such fees for the party recovering any money judgment therein:

ATTORNEY'S FEES IN AVERAGE CASES

	Contested	*Without Trial*	*Non-Contested*
First $2,000	25%	20%	15%
Next $3,000	20%	15%	12.5%
Next $5,000	15%	12.5%	10%
Over $10,000	10%	7.5%	5%

Should no recovery be had, attorney's fees for the prevailing party may be fixed by the court in its discretion in a reasonable amount.

(2) In actions where the money judgment is not an accurate criteria for determining the fee to be allowed to the prevailing side, the court shall award a fee commensurate with the amount and value of legal services rendered.

(3) The allowance of attorney's fees by the court in conformance with the foregoing schedule is not to be construed as fixing the fees between attorney and client.

(4) Attorney's fees upon entry of judgment by default shall be determined by the clerk. In all other matters the court shall determine attorney's fees. Awards not pursuant to the schedule set forth in subparagraph (1) of this Rule shall be made only upon motion.

(b) Allowance in Mental Cases. In proceedings under the Mental Health Act, the attorney appointed to represent the patient shall be allowed and paid a fee of $25.00, unless the judge, in his discretion, orders otherwise. A lay advisor appointed in such proceedings shall be allowed and paid a fee of $10.00, unless the judge, in his discretion, orders otherwise. (Amended by Supreme Court Order 497 effective January 18, 1982)

Plaintiff's view:

In his article, Mr. Kleinfeld concludes that Rule 82, under which the prevailing party is compensated partially for attorneys' fees, should be abolished. I presume this expresses disagreement with Chief Justice Burger's proposal to expand the approach to the federal courts. I respectfully, but sincerely, disagree with Mr. Kleinfeld's conclusion. In my view, Rule 82 does encourage settlement, in a fair and meaningful manner, and would be especially appropriate in the federal system.

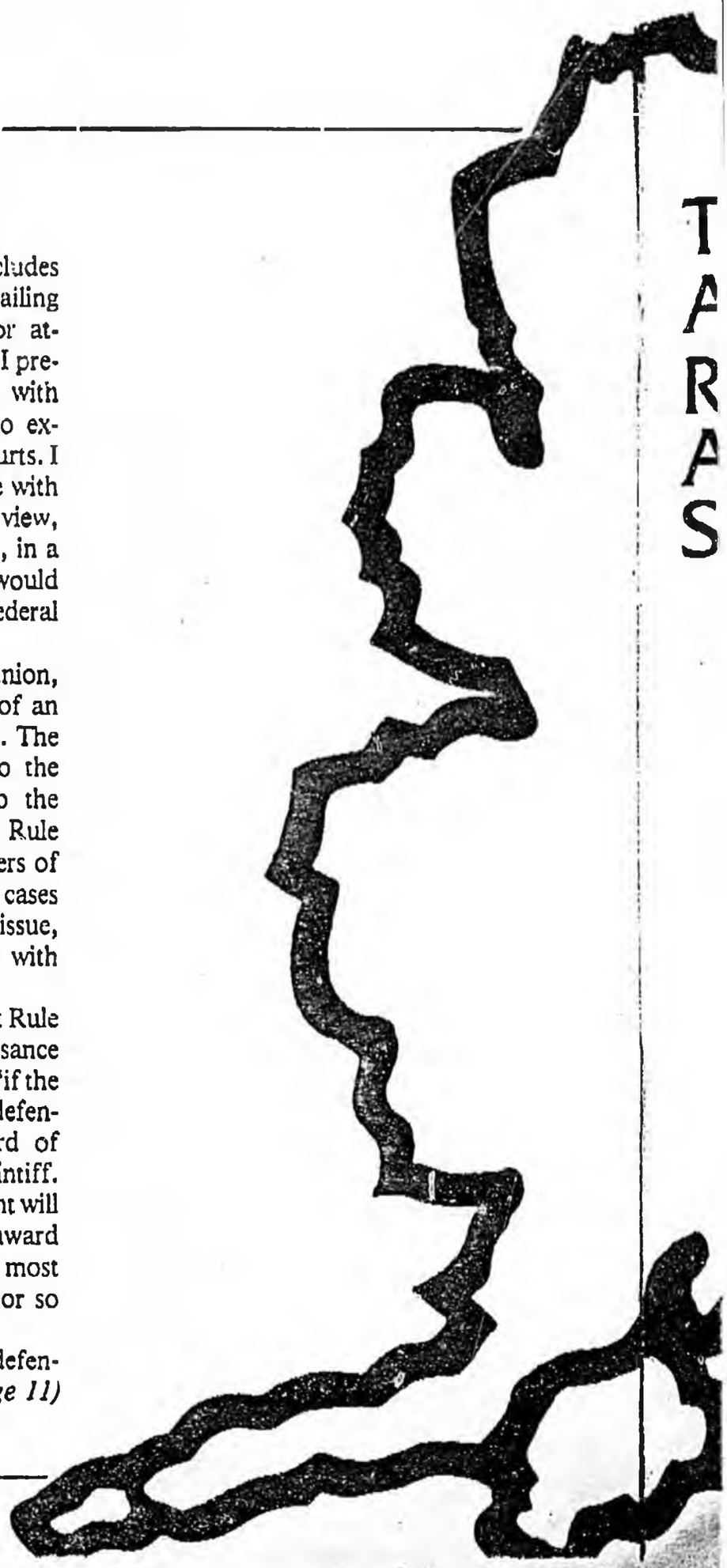
Contrary to Mr. Kleinfeld's opinion, plaintiffs do consider the impact of an adverse Rule 82 award upon them. The Rule 82 award directly applies to the determination of liability and to the amount of the judgment through Rule 68. In my experience, Rule 68 offers of judgment less often control. In cases where damages are the primary issue, parties are usually able to settle, with some help from Rules 82 and 68.

Mr. Kleinfeld also concludes that Rule 82 is ineffective in discouraging nuisance cases. He does so on the basis that "if the case is litigated through trial, the defendant will probably win an award of $5,000 to $10,000 against the plaintiff. But because the cost to the defendant will exceed the award, and because the award will probably be uncollectible, most defendants will pay up to $5,000 or so even on frivolous claims."

My experience has been that defen-

(Please turn to page 11)

By James A. Parrish



The Alaska Rules Are a Success

Defense view:

Civil Rule 68, which has been in operation in Alaska for many years, permits only the defendant to make an offer of judgment. However, with the passage of Alaska Statute § 09.30.055 in 1980, either party may make an offer of judgment. The difference is that Rule 68 provides for awards of costs and attorneys' fees, while the statute increases or decreases the prejudgment interest by 2 percent, making a 4 percent difference when applied to both sides' costs. That could be substantial if the case were large and several years old at the time of judgment.

I strongly support both the rule and the statute. The benefit of Rule 68 is to the defendant. Even Mr. Kleinfeld does not suggest abolishing Rule 68. The purpose of Rule 68 is to provide protection to the defendant against Alaska Rules 82 and 79, which allow for awards of costs and attorneys' fees to the prevailing party. If Rule 68 did not exist, a plaintiff might claim $1 million and demand in settlement $100,000, but only recover $10,000 and still be the prevailing party. If, under those circumstances the defendant recognizes the claim as a $10,000 claim and makes an offer of judgment for $10,000, he can protect himself against a subsequent award of costs and attorneys' fees; thus, in effect, making himself the prevailing party. Without Rule 68 he would be helpless to protect himself against costs and attorneys' fees short of paying an unreasonable demand.

(Please turn to page 10)

By H. Bixler Whiting

Robert Woolley

(Continued from page 9)

The benefit to the court system is that offers of judgment create some stark realities to clients. I have not found anything more difficult to explain to a client, or more helpful in making an otherwise unreasonable client recognize the true value of his case, than having to explain the effect of a Rule 68 offer of judgment. When such an offer is made, one must have a very serious conversation with his client along the lines described in Mr. Kleinfeld's article. The client needs to have the effect of Rule 68 explained to him and some appraisal of costs and attorneys' fees which might be assessed against him if he does not prevail. Of course, it also makes the plaintiff's lawyer very realistic, requiring him to examine the merits of his case prior to going forward.

I do not think defense attorneys in general use Rule 68 effectively, although there are some who are adept at using it. Those generally tend to be the defense attorneys who are professionally interested in protecting their clients as opposed to some defense attorneys who put their personal financial gain ahead.

As far as the plaintiff is concerned, Rule 68 is useless. Under the statute, a plaintiff could make an offer to settle a case at the high end of the settlement range and hope to beat it before the jury, but the risk is a 4 percent difference on the interest if he does not beat the offer. A plaintiff cannot very well make an offer at the low end of his settlement range because of the impact that might have on future settlement negotiations. We all know that it is very difficult to negotiate a settlement if the plaintiff begins demanding more money.

In conclusion, I think Rule 68 is extremely effective if used properly. I know for a fact that it deters litigation. I have used it myself to do so, as have many other lawyers.

Rule 68 clearly provides incentives to settle, even improving on prejudgment interest provisions, which do not come into effect until the eve of trial. Rule 68, however, is not a substitute for prejudgment interest, because at the eve of trial, the defendant is facing the prospect of an adverse judgment plus prejudgment interest, which might have accumulated over a 3-to-5 year period. The two elements can work together to enhance settlements with prejudgment interest providing a return on investment if the case is not settled.

CIVIL RULE 82

Civil Rule 82 has the same effect as the laws providing for prejudgment interest, except that Rule 82 can work to the benefit of either party and the prejudgment interest provision really only benefits the plaintiff. Rule 82 is the biggest factor which comes into play when one has to consider a Rule 68 offer of judgment, as Mr. Kleinfeld has pointed out.

Rule 82 is a rule which recognizes the reality of attorneys' fees. I do not think there is any provision in Alaska law regarding civil litigation that has been clarified so extensively by the Alaska Supreme Court. In my opinion, the rule is well-balanced. It certainly does not fully compensate a party for attorneys' fees. If it did, I fear that it would have a chilling effect upon potential litigation, including meritorious litigation. It, thus, offers a proper balance between creating a chilling effect and providing some compensation to the prevailing party in litigation in which he was wrongfully involved.

Rule 82 compensates the prevailing party with an additional 10 percent of the judgment for attorneys' fees. The normal attorney's fee in a contingent fee case is one-third of the recovery. In most plaintiffs' recoveries, Rule 82 compensates the plaintiff for approximately one-third of the attorneys' fees he has paid. For defendants who prevail, the court is required to make an equitable award based on the work done.

Like Rule 68, Rule 82 definitely forces sobering reality on both parties when evaluating settlement. The plaintiff must explain to his client the prospect of the defendant recovering attorneys' fees if the case is lost. Rule 82 discourages people from filing and prosecuting lawsuits that they know they are likely to lose but are willing to try as long as they stand to lose nothing.

Another beneficial effect of Rule 82 is to give a sued party some incentive to defend against meritless claims. If it were not for Rule 82, insurance companies—as well as other defendants—would be more prone to pay a nuisance value on a meritless claim rather than spend the money to defend. Rules 68 and 82 give those unjustly sued defendants some substantial protection by allowing the wrongfully sued person to recover costs and fees.

I do believe that Rule 82 does have an effect on settlements by increasing the amount, but I do not think that

The late **H. Bixler Whiting** was an attorney in Fairbanks, Alaska. **James A. Parrish** is a partner in the Parrish Law Office, Fairbanks, Alaska.

is unjust considering the fact that the recipient has been obligated to incur attorneys' fees to recover the money to which he is entitled.

Attorneys spend very little time preparing a cost bill and motion regarding same. The cost bill is decided by the clerk, not the court. A party may ask the court to review the clerk's rulings, but that does not even require a hearing in most cases, and the costs to the awarded are pretty well-established. Attorneys' fees can be awarded without any hearing at all by the trial judge, although sometimes hearings are held. The time spent on this aspect of the case is normally very small and should probably not have any effect on considering the merits of Rule 82.

I strongly support the provisions for prejudgment interest and Rule 82 attorneys' fees, primarily because they recognize economic and legal reality and are equitable. I support them secondarily because they tend to promote settlement of cases.

Ultimately, the bench and bar are responsible for resolving disputes, whether by settlement or litigation, and I believe these provisions advance that.

Parrish

(Continued from page 8)

dants, especially insurers, do not pay unfounded nuisance claims. Any win is a win for the company involved. The less merit there is to a case, the less likely it is to settle.

Whether an average award of $5,000 to $10,000 upon a successful defense is full compensation says nothing about the impact upon prospective plaintiffs considering such suits. Even impecunious plaintiffs are usually morally responsible and are especially sensitive about incurring attorneys' fees against them. It is the rare plaintiff, well-heeled or not, who is willing to press an obviously unfounded claim at the risk of incurring $5,000 to $10,000 liability. The mere filing of such a judgment creates a lien on any real property he might acquire.

To the extent there are those plaintiffs or attorneys who would file nuisance cases at the risk of a substantial attorney fee award, abolishing Rule 82 would not help. Those claimants base their claim on what they think the defendant will pay to avoid defending a lawsuit. There is no prospect of obtaining an affirmative attorney fee award in such cases. As to this class of litigant, imposing Rule 82 is, at worst, neutral. At best, it discourages the filing of some of what would otherwise be nuisance cases.

The other side of the problem is the nuisance defense. Rule 82 is flexible enough to allow full or nearly full attorneys' fees to a plaintiff who has been forced to try a case over a nuisance defense. Absent such a rule, institutional or well-heeled private defendants can literally drive plaintiffs' attorneys out of the market in small-to medium-size cases. It is simply impossible, even with a clear liability and clear damage case, in the $10,000 to $20,000 range, to make a profit against an obstructive defense in the absence of an attorneys' fees rule. Even simple contract cases can be forced to take 10 days actual trial time without regard to the amount at issue. If the claim is in the $20,000 range, counsel must charge by the hour. Without an award of attorneys' fees, the justly deserving claimant can actually lose money.

Although such cases can happen, even with attorneys' fee awards, they are much more likely to happen without them. When they do occur, it is mandatory that the plaintiff receive an award for attorneys' fees, hopefully near actual expenses.

On a practicing level, a plaintiff's attorney faced with Rule 82 is required to advise his client, up front, of the possibility of an adverse Rule 82 award. This advice usually prompts the client to more completely disclose the weak points of his case to the attorney and to express a more realistic attitude toward evaluating it.

In other words, once the client has a *personal* stake in a lawsuit—over and above the mere possibility of recovering money in his favor—he takes much more interest in it. This enables the attorney, early on, to evaluate the case more fairly by shifting the emphasis away from sympathy, revenge, or so-called "principle." Cases, which are evaluated fairly and early, tend to settle early. Where this does not happen, interim resources are wasted, making settlement difficult to achieve, if at all. Thus, when the plaintiff is financially realistic, Rule 82 serves a very beneficial purpose to all.

ECONOMIC DURESS ON PLAINTIFFS

I think Mr. Kleinfeld protests too much concerning the economic duress on plaintiffs. He fails to consider several factors:

(1) the impact of Rule 82 on settlement before the hiring of counsel or filing of litigation;

(2) the real need to at least partially compensate plaintiffs with bona fide claims for the attorneys' fees they incur;

(3) the resolve of average plaintiffs to pursue a bona fide claim even at some risk of paying attorneys' fees; and

(4) the very real economic impact which Rule 82 has upon defendants.

Rule 82 applies in uncontested as well as contested litigation. It applies to nearly all civil claims, contractual or tort in nature. In the presence of Rule 82, a potential defendant cannot, without incurring expenses to himself, force the plaintiff to hire an attorney and file a lawsuit just to see if he is serious.

In undisputable claims, which would not be contested in court, the mere filing of a complaint provides for an award of attorneys' fees based upon the uncontested schedule. Thus, in contract and debt cases, there is considerable incentive to avoid delaying payment to creditors to the point of forcing litigation.

In tort cases, Rule 82 provides an added incentive for insurance companies to affirmatively seek settlement prior to selection of legal counsel. Aside from the obvi-

(Please turn to page 53)

donment of his appeal. This promotes settlements, but not necessarily in a just manner.

SUPREME COURT INCONSISTENCY

An oddity of Alaska Supreme Court practice suggests an inference that the court does not really believe in the justice of the doctrines it has imposed.

Although the supreme court awards attorneys' fees to prevailing parties, it does not follow anything like Rule 82. Instead, it routinely awards $250 to $750. The prevailing party is ordinarily not allowed to submit evidence of his actual fees, and the court does not consider them. Actual attorney's fees on appeals in substantial civil cases are typically in the $5,000 to $15,000 range. If a trial court followed this practice, it would be reversed.

The Alaska Supreme Court has ..ever explained its anomalous practice on attorney's fees awards to prevailing parties. Does the court wish to avoid discouraging appeals? Then why not similarly avoid discouraging trials? Delay is a more serious problem in Alaska at the appellate than at the trial level, so administrative considerations do not favor keeping the door open wider at the appellate level.

Supreme court results are unpredictable, but so are trial results. Trial results in similar cases may approximate a bell shaped curve, with most in a predictable range, but substantial tails on the low and high ends. In certain kinds of cases, such as the weak liability, high damages personal injury case, the results may be an even more unpredictable dumbbell curve, with clusters around zero, and at very high levels, and few in between. In some cases, a plaintiff or his lawyer may be unreasonable in going to trial, but in many, trial is as good a means as settlement to decide how much money, if any, ought to be taken from one party and given to the other.

ABOLISH RULE 82

I suppose the above criticism implies that the rules are too effective, rather than not effective enough, in promoting settlement. The plaintiff is forced to settle his case for less than it is worth because of his lesser ability than the defendant to try the case on a double or nothing basis.

Some may feel that encouraging settlement is of such great value as to justify this result. Where the stakes are so high, my own values place a greater weight on justice than administrative convenience, so I cannot accept this outcome as desirable.

The Alaska Bar Association passed a resolution more than a decade ago calling upon the supreme court to repeal Rule 82. The court has never acted, nor explained its inaction, regarding this resolution. I think the bar was correct. We have gone too far in the direction of threatening litigants with catastrophe to compel them to settle. We ought to use our luxuriously expensive system of courts to try cases, not frighten people of moderate means out of trying them.

Parrish

(Continued from page 11)

ous fairness of forcing an insurance company to share plaintiff's costs of counsel in bona fide litigated cases, Rule 82 provides an economic incentive to insurers to avoid involving counsel altogether. The rule promotes settlement of litigation before it starts, as much as after. Wise insurers should, and I believe do, take this cost into account in deciding upon prelitigation settlement policies.

RULE 82 PROVIDES PARTIAL COMPENSATION

Although the prospect of an adverse award does promote a more meaningful evaluation, I doubt that it discourages the filing of many bona fide claims. Clients as a class are self-righteous, especially when they have a good case.

I also question whether the system suffers that much when a plaintiff who lacks confidence in his position, even though it may be well-founded, elects not to pursue his claim. At least his decision is predominantly free, coerced only by fair risks which are beneficial to the integrity of the system. What detriment there is in this situation is small in comparison to the alternative. The greater injustice by far is the bona fide case which cannot, as a matter of economics, be brought at all. Without fee awards, the freedom to bring bona fide claims in the $20,000 range can be lost altogether. We should not attempt to avoid one injustice by imposing a larger one.

Of course, there is the occasional case where a plaintiff without a serious injury and a reasonably good liability position loses to a jury and suffers a fee award. This can be harsh, but the trial courts have sufficient discretion to temper the awards in light of the plaintiff's circumstances and the quality of the case.

Also, as Mr. Kleinfeld noted, marginal appellate grounds can be bargained against the fee award in most instances. But by this mechanism, the rule again prompts realistic consideration of the merits of the case before proceeding into the appellate court. The plaintiff, who could otherwise not have anything to lose on appeal, suddenly does.

Average contingent fees in contested cases are one-third. As a result, plaintiffs, even with clearly bona fide claims, are rarely fairly compensated for their losses. Aside from the occasional run-away verdict, which is so often publicized, plaintiffs rarely come out ahead. To the extent Rule 82 covers approximately one-third (10 percent divided by 33⅓ percent) of fees actually paid, it reduces the under-compensation.

The successful defendant also is partially compensated. Thus, Rule 82 effects a redistribution of resources. Because both sides usually come out behind, it is better that the prevailing party suffers less.

Whether a rule providing for full attorney fees in normal cases should be adopted is an interesting question. Theoretically, it would benefit plaintiffs overall. From a practical standpoint, I doubt that it would work or be beneficial.

Without a personal stake in the amount of attorneys' fees charged to a successful plaintiff, there would be no market force to sustain competition as to the contingent fee contract percentage. A plaintiff under a contingent fee pays only if he wins. If a plaintiff will be repaid full attorneys fees, he could care less what percentage the attorney charges. With unlimited attorneys fees, contingent fee contracts would edge, if not leap, upward.

On the defense side, it would be impossible to police hours and rates charged by counsel for a successful defendant. When a successful defendant must still pay a large proportion, usually about two-thirds, of his attorney's billings, those billings are adequately policed. But where a successful defendant might pay nothing, he could encourage the largest billing from his attorney so as to punish his adversary.

In my view, full fee awards as a matter of course would be difficult to enforce fairly. The primary goals can be achieved without them. The loss of market control would cause more unfairness than it would resolve.

NO INTERFERENCE WITH THE FEE AGREEMENT

Mr. Kleinfeld's reference to "tinkering" with the fee agreement between the attorney and client does not in my opinion merit serious consideration. Rule 82 does not and should not govern the private fee agreement.

The right to counsel is fundamental. To protect this right, clients must be free to negotiate fees in the manner they wish. Otherwise, clients with money will always be able to afford attorneys. A limitation on contingency fees would mean that some people without money will be denied attorneys that they might otherwise have retained.

I believe any system that would limit contractual attorneys fees to given scheduled amounts or that would require court-awarded attorneys' fees to be paid exclusively to the attorney would be abhorrent. These are matters between attorney and client which must be left to the competitive forces of the market.

Although interference with attorneys' fee agreements in workmen's compensation cases and federal tort claims has successfully limited attorneys' fees, it has done so at the expense of access. My own office turns away many cases that should otherwise be brought because fair compensation to the attorney for prosecuting those cases is not possible. Countless people, especially those without funds, have been denied representation, and therefore relief, which they could have received but for such "tinkering."

SUPREME COURT INCONSISTENCY

In Alaska, Rule 82 applies at the trial level but not at the appellate level. I do not believe this is an inconsistency, much less one that merits discarding the rule altogether.

Rule 82 applies after trial but is not effective unless the case is affirmed. If the case is reversed, a new award, under the same rule, would eventually be required.

Applying Rule 82 at the appellate level would be difficult. When an appellant wins a retrial, the ultimate outcome of the litigation is rarely known. It also would not be beneficial to compensate for purely technical victories, because an appellate court with a limited record before it would have difficulty assessing who the prevailing party is, and, especially, whether the prevailing party's action has actually advanced the litigation. The Alaska Supreme Court, more so than trial courts, has better things to do than evaluate attorneys' fee claims.

More importantly, the Alaska Supreme Court does not wish to discourage the raising of bona fide legal claims on appeal. Likewise, it does not wish to encourage attorneys to bring appeals unless the clients are serious enough about the issue to bear the cost. This allows free access to the court and maintains strict adversity. Also, the absence of significant fee awards tends to keep the court's focus on legal issues, thereby maintaining a "detached" image and attitude essential to an appellate body.

As a practicing plaintiff's lawyer, with extensive appellate experience in the Alaska Supreme Court, I would like to see larger attorneys' fee awards to the successful party on appeal. Fees usually run $250 to $750 even for three weeks' work on an appellate brief. I have found no consistency in the fees awarded in my cases and, by the nature of the system, have not had the opportunity to set fee awards in others. I assume with clearly frivolous appeals that fee awards are more substantial, but I do not know. I accept our court's trivial and unexplained awards knowing they have not diverted the court from important matters.

Finally, whether there is any merit to the Alaska Supreme Court's method of awarding fees on appeal seems entirely beside the point. The issue is whether Rule 82 should be enforced in trial courts. To the extent Rule 82 is beneficial there, it should be used.

The Alaska Supreme Court's appellate fee practice may be "an oddity," but I do not believe that it "suggests an inference that the court does not really believe in the justice of the doctrines it has imposed." The supreme court has been firm, consistent, and predictable regarding awards of attorneys' fees pursuant to Rule 82. There is nothing in its cases applying Rule 82 that suggests that it does not believe in the justice of the rule.

ADOPT RULE 82 IN THE FEDERAL SYSTEM

Rule 82 is effective. From one who represents plaintiffs, let it be said they are better off with it. Fewer cases would have to go to lawyers or to trial if Rule 82 were adopted in the federal system. (The rule is followed by the U.S. District Court of Alaska, where civil trials are rare. [Local Rule 21.1.]) If this rule were followed by other federal courts, plaintiffs with bona fide claims would receive a greater proportion of their fair recovery, and many nuisance claims would be discouraged.

Although the Alaska Bar Association passed a resolution more than a decade ago calling upon the Alaska Supreme Court to appeal Rule 82, my office was not aware of it. I am not aware that it is a current issue today. To the extent it is, I doubt that those who represent individuals, and not large companies, would support abolishing Rule 82.

In my view, Rule 82 does not compel litigants to settle by threatening them with catastrophe. On the contrary, it should be strengthened some to further settlement. Every potential litigant, whether plaintiff or defendant, ought to consider the extreme cost of entering the courts and trying cases. Except in unusual circumstances, each litigant should be faced with the prospect of bearing part of his opponent's costs if he loses. We all tend to be considerably more introspective, less arrogant, and more willing to hear our opponent's view of the case when we must stand ready to pay a reasonable part of his costs.

Overall, the rule enhances the image and effectiveness of the judiciary. No institution that regularly allows its costs to devour its benefits can merit respect. Provision for partial fees in most cases, and full fees in appropriate ones, goes a long way to advance the primary goal of the judicial system: the fair and efficient resolution of private disputes. ⊞

Taylor/Buchanan

(Continued from page 35)

*K. Phillip Taylor and Raymond W. Buchanan are authors, with David U. Strawn of the book, *Communication Strategies for Trial Lawyers*, published by Scott, Foresman and Co., and priced at $7.95 for the paperback edition.

1. M. Ludden, *In death penalty was, a short letup*, SENTINEL STAR, *December 8, 1981*, pp. 1, 6A.

2. *See* D. Phillip, *The Deterrent Effect of Capital Punishment: New Evidence on an Old Controversy*, AMERICAN JOURNAL OF SOCIOLOGY (July 1980) 139-148; G. Kleck, *Capital Punishment, Gun Ownership and Homicide*, AMERICAN JOURNAL OF SOCIOLOGY (January, 1979), 882-910; D. Lester, *Effect of Gary Gilmore's execution on homicide behavior*, PSYCHOLOGICAL REPORTS (December, 1980), 1262.

3. M. McLaughlin, T. Cheatham, K. Erickson, and B. Waggenspack, *Juror Perceptions of Participants in Criminal Proceedings*, J. OF APPLIED COMMNICATIONS RESEARCH 2 (November, 1979), 91-102.

4. *See* C. KIESLER, THE PSYCHOLOGY OF COMMITMENT, Academic Press, New York, New York 1971; B. Pryor, K.P. Taylor, R.W. Buchanan, D.U. Strawn, An Affective-Cognitive Consistency Explanation of Comprehension of Standard Jury Instructions, COMMUNICATION MONOGRAPHS (March, 1980), 68-76.

5. J. Cooper and S. Worchel, *Role of Undesired Consequences in Arousing Cognitive Dissonance*, 16 J. OF PERSONALITY AND SOCIAL PSYCHOLOGY 2 (1970), 199-206; J. Cooper, *Personal Responsibility and Dissonance: The Role of Foreseen Consequences*, J. OF PERSONALITY AND SOCIAL PSYCHOLOGY 3 (1971), 354-363

6. V. BUGLIOSI and K. KURWITZ, TILL DEATH US DO PART, W.W. Norton & Co., New York, New York, 1978, pp. 364-365.

7. C. Millin, *The Jury System in Death Penalty Cases: A Symbolic Gesture*, LAW AND CONTEMPORARY PROBLEMS (Autumn 1980), 137-153.

8. *See* D. Myers and H. Lamm, *The Polarizing Effect of Group Discussion* PSYCHOLOGICAL BULLETIN, (1976), 602-627; K. P. Taylor, R.W. Buchanan, B. Pryor, D.U. Strawn, *How Do Jurors Reach a Verdict?* J. OF COMMUNICATION, (1981), 37-42; K. P. TAYLOR, R.W. BUCHANAN, D.U. STRAWN, COMMUNICATION STRATEGIES FOR TRIAL ATTORNEYS, Scott Foresman & Co., Glenview, Illinois 1984.

Special

(Continued from page 28)

statistics concerning volume," jurors, witnesses in law suits and, finally, other judges."

A major concern of the Report is "confidentiality"[19] as to the source of information, in order to protect the "informant" from "reprisal,"[20] presumably from the judge! The Report expressly rejects any concern that such a shield will be misused, encouraging vindictiveness or other meanly-based motives for attack upon the judge.

No corresponding concern appears for the reputation of a judge wrongly accused. The Report would keep the evaluations confidential "except to the extent required by the particular program."[21]

ANALYSIS AND RECOMMENDATIONS

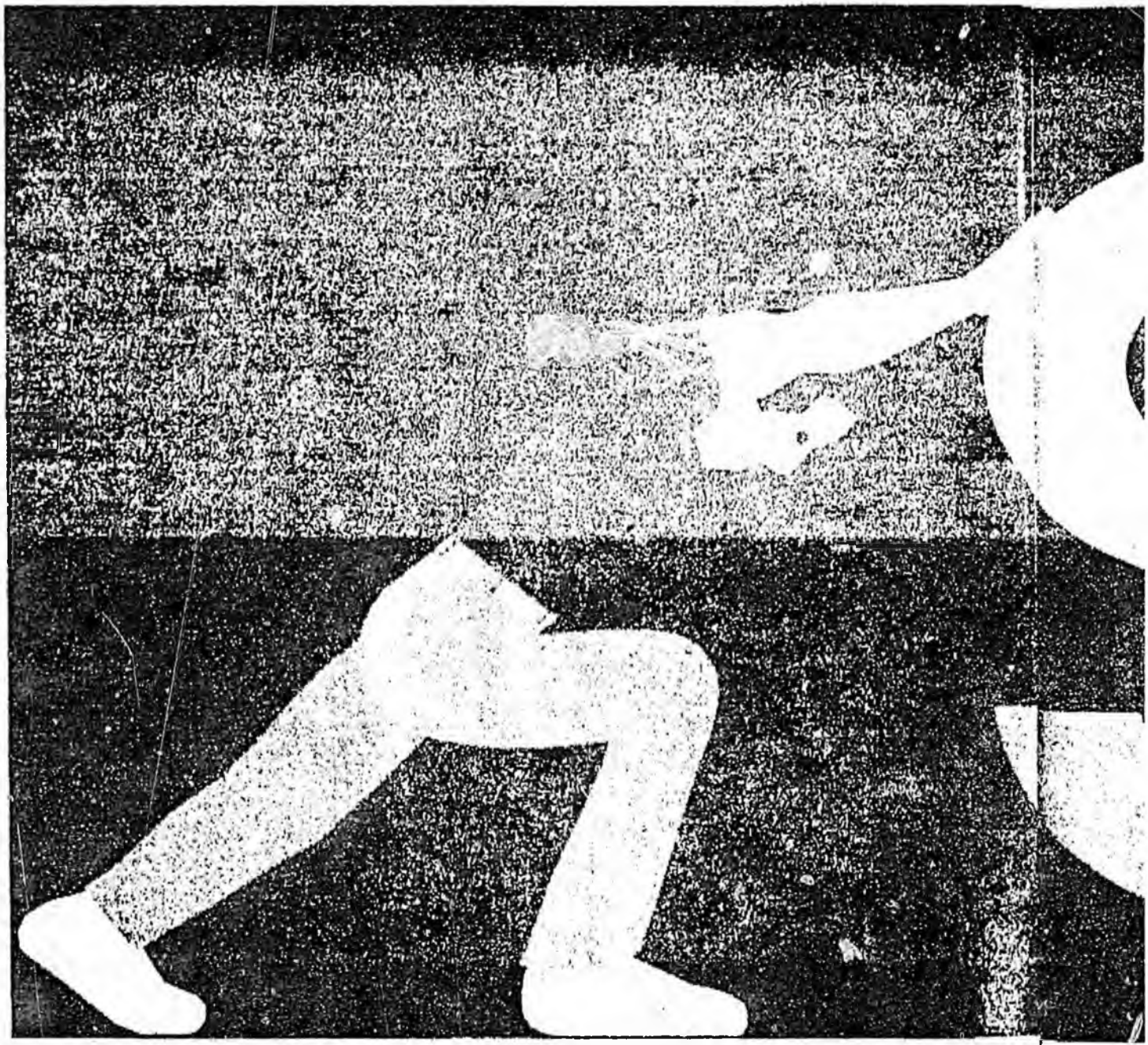
In the judgment of this committee, this Report proposes a dangerous intrusion upon judicial independence for reasons hereafter stated. The individual criticisms are such as to lead us to believe that our concerns for judicial independence cannot be overcome by mere modifications of the proposal.

(1) Judicial evaluation committees are superfluous. Judges are continually undergoing "judicial performance evaluations." The appellate process is precisely such an evaluation, on a case-by-case basis, of judicial performance. As a judge continues in the judicial system, the accumulation of appellate reviews constitutes a far more knowing description of judicial performance than any which could be provided by the proposed evaluation committees.

True, the appellate process does not deal with judicial temperament, mannerisms, punctuality, and matters of that sort except in the most egregious cases meriting comment or even reversal. On the other hand, such conduct is the very reason for the existence of our judicial discipline commissions.

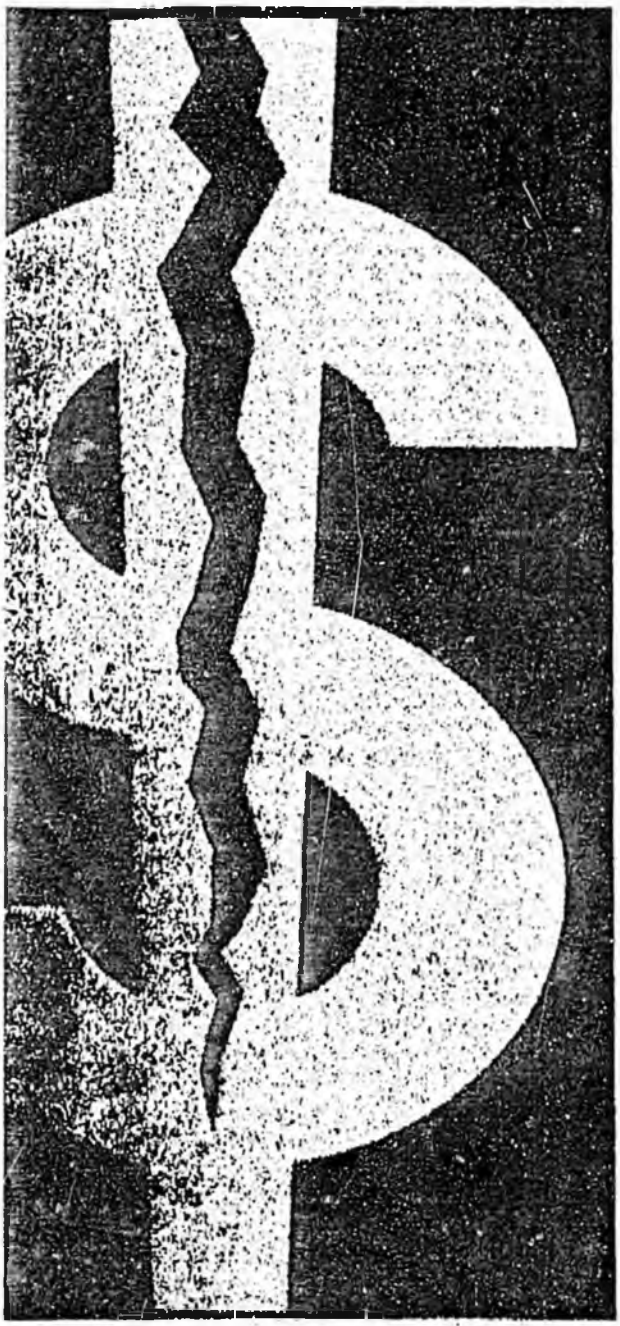
(2) *Reliability.* The information to be collected by the proposed judicial evaluation committee is almost guaranteed to be unreliable. The sources are most likely to be losers, the uninformed, and the merely venal. The design of record collecting and protection is such as to invite the comment of such people without any means whatever for evaluating its accuracy. Thus, the disgruntled clerk who is not permitted to catch a four o'clock train to his out-of-county home becomes a source of information; the lawyer, unfamiliar with the rules of evidence whose objection or tender of evi-

Alaska: Where the Loser Pays the Winner's Fees



Only one state has this provision (with an offer of judgment rule). How is it working?

By Andrew J. Kleinfeld



Alaska combines a federal-style Rule 68 offer of judgment rule with the English rule awarding attorneys' fees to the prevailing party in civil litigation. This article summarizes the Alaska system and discusses its effect on litigation and settlement.

Under Alaska Civil Rule 68, as under the federal rule, a party, ordinarily the defendant, may at any time prior to judgment make a formal offer to allow judgment to be taken against himself for a specified amount plus costs. If the plaintiff rejects the offer and subsequently wins a verdict lower than the amount of the offer plus interest, the defendant is deemed the prevailing party from the time of the offer and is entitled to costs from the time of the offer.

Costs (other than attorneys' fees) allowed under the rule are much less than actual out-of-pocket costs. For example, a party is likely to have to pay a physician who testifies in court $500 to $1,500 for routine, brief testimony, but will usually receive only the subpoena rate for expert witnesses—less than $50 in most cases—under Rule 68.

The Rule 68 offer would have little force were it not for Alaska's use of the English rule on attorneys' fees. The risk that a few hundred, or at most, a few thousand dollars in a costs award may be shifted will ordinarily not affect the settlement evaluation of a plaintiff anticipating an award ten or a thousand times as large.

The power of Rule 68 offers of judgment in Alaska derives from Civil Rule 82, requiring that the prevailing party should ordinarily recover partial com-

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pensation for attorneys' fees. The rule works slightly differently for plaintiffs and defendants. Rule 68 offers of judgment work mainly with defense awards, but both sides of the rule should be understood.

For successful plaintiffs, the courts ordinarily follow a schedule provided in the text of the rule. Cases are broken down into three categories: noncontested (defaulted); contested without trial (resolved after an answer or motion by defense but before trial); and contested through trial.

Awards on contested without trial cases are 20 percent of the first $2,000, 15 percent of the next $3,000, 12.5 percent of the next $5,000, and 7.5 percent of everything over $10,000. Thus, the substantial case entails an award of $1,475 plus 7.5 percent of everything over $10,000, if resolved before trial, as by acceptance of a Rule 68 offer of judgment—attorneys' fee awards being in addition to offer of judgment. If a case is tried, the Rule 82 award to a prevailing plaintiff is $1,850 plus 10 percent of the excess over $10,000.

Rule 82 computations are performed on the sum of the verdict and prejudgment interest. For example, a verdict of $100,000 three years after the accident yields a judgment of $131,500 with prejudgment interest at 10.5 percent and $145,500, including Rule 82 attorneys' fees at the contested rate of $1,850 plus 10 percent of the excess over $10,000. Thus, with costs, a $100,000 jury verdict yields about a $150,000 judgment after a typical lag.

On the defense side, the operative language of the rule is that the award should be "in a reasonable amount" which is "commensurate with the amount and value of legal services rendered." The Alaska Supreme Court has provided little guidance for trial judges on what this language means.

The Alaska Supreme Court has made it reversible error to award full or substantially full compensation for his attorney's fees to the prevailing party, if the unsuccessful party litigated in good faith. Awards are to "partially" compensate the prevailing party, not fully compensate him. *Malvo v. J.C. Penney Co., Inc.*, 512 P.2d 575 (Alaska 1973).

The Supreme Court will also reverse denial of attorneys' fees to the prevailing party without some good reason articulated by the trial judge. *Stordahl v. Government Employees Insurance Co.*, 564 P.2d 63 (Alaska 1977). The trial judge has broad discretion, but must award some partially compensatory amount based upon the actual work done and fees charged by the prevailing party's attorney.

Awards between 20 percent and 80 percent of actual defense fees are, as a practical matter, not reversible. These awards can amount to substantial four- or even five-figure judgments against unsuccessful plaintiffs.

Here is how Rule 68 and Rule 82 fit together.

The defendant offers to allow the plaintiff to take judgment against him for x dollars plus costs and attorney's fees.

If the plaintiff accepts the offer, he may file a Rule 79 costs bill and move for a Rule 82 attorney's fee award, which will ordinarily be the scheduled "contested without trial" amount. For example, a $45,000 Rule 68 offer is worth $49,100 plus allowable Rule 79 costs, for a total in the neighborhood of $50,000. Prejudgment interest is already accounted for in the amount of the offer. Usually plaintiff's and defendant's attorneys agree on these amounts over the telephone and avoid the extra filings.

If the plaintiff rejects the Rule 68 offer and the case is tried to a verdict, a little arithmetic must be performed to determine which party obtains a Rule 82 attorney's fees award. The court must compute prejudgment interest to the date of the offer of judgment, using the amount of the verdict as the principal amount.

If the sum of the verdict plus interest is less than the offer of judgment, then the defendant is entitled to a Rule 82 award from the date of the offer to the date of judgment. This may be a great deal of money, since trial of a substantial case is likely to entail defense attorneys' fees of $10,000 to $50,000, or more, for protracted and complex litigation. The wise defendant will have made an offer of judgment early in the discovery process, so that most of the attorneys' fees will have been incurred after the Rule 68 offer and will be subject to Rule 82.

Thus, the plaintiff who wins an award lower than the Rule 68 offer plus interest faces an often catastrophic result. For example, in a personal injury case with a projected value in the $10,000 to $30,000 range, if the defendant makes a Rule 68 offer of $10,000, and the jury award with interest is less, the plaintiff will lose money on the litigation. The plaintiff will have to pay the defendant's attorney fees award—probably in the $5,000 to $10,000 range—and the plaintiff's own nonreimbursable costs for medical experts and so forth in the $1,000 to $5,000 range.

The knife also gets a little twist from a new Alaska statute on prejudgment interest. Under the statute, either side may make an offer of judgment within the first 60 days of the litigation, or five days after discovery ends. If the party does better than its offer

The rules do not substantially reduce the burden of attorneys' fees for successfu' plaintiffs

(lower for a defendant's offer, higher for a plaintiff's), then the prejudgment interest rate will be raised or lowered 2 percent for its benefit. Thus a plaintiff who wins a verdict higher than its offer is entitled to 12.5 percent prejudgment interest, and a successful defendant lowers the interest rate to 8.5 percent.

DO THESE RULES SERVE THEIR INTENDED PURPOSES?

This combination of rules is intended to serve two purposes—achieving more perfect justice between the litigants and encouraging settlement. They serve the latter objective better than the former.

The model villain, against whom the entire complex of rules is aimed, is the "bad man" who acknowledges the justice of the plaintiff's demand, but refuses to pay the obligation in order to profit from delay or use the plaintiff's anticipated litigation expenses as leverage to obtain an unjustly low settlement. The honest claimant, whom the rules are intended to benefit, is the person who demands what he is entitled to—and prevails. He is supposed to obtain sufficient interest and compensation for his attorneys' fees so that his victory is not Pyrrhic.

First, the rules do not substantially reduce the burden of attorneys' fees for successful plaintiffs. Here are the mechanics for typical contingent fee arrangements.

The scheduled percentages are much less than the percentages conventionally charged by plaintiffs' attorneys. Contingent fees in Alaska, as elsewhere, range from 25 percent to 50 percent. Most Alaska plaintiff attorneys' fee contracts, in my experience, provide that the Rule 82 award is rolled into the total recovery against which the contractual percentage is applied. Thus, if a case is settled, without trial, for the defendant's $100,000 liability insurance policy limit and Rule 82 attorneys' fees of $8,225, the usual one-third contingent fee will be applied to $108,225, yielding an actual fee of $36,075, and compensation to the plaintiff of only $72,150, a far cry from the $100,000 he should supposedly receive.

The obvious tinkering would be to limit attorneys' fees actually charged to the amount awarded, as in workers' compensation. But unless the scheduled percentages were raised to market levels, this might dry up the supply of attorneys willing to handle plaintiffs' personal injury claims, particularly the smaller ones.

Analogously, it has become extremely difficult during the last year or so for injured workers to hire attorneys in Alaska to prosecute moderately sized workers' compensation claims, because fees awarded by the workers' compensation board are below the amounts needed to make handling of the claims as profitable as alternative work.

If the Rule 82 schedule were raised to market rates, liability insurance premiums would have to be increased substantially in order to spread the much higher cost. This might well increase the amount of evasion of Alaska's very loose new mandatory insurance law.

If the rules designated the Rule 82 award as the amount actually to be paid to the plaintiff's attorney, an additional problem would develop around personal injury cases, resulting in judgments higher than the defendant's liability insurance policy limits A line of Alaska cases holds that the Rule 82 award should be calculated on the total verdict plus interest, not merely the policy limit. And unless the insurance policy clearly provides otherwise, the total verdict plus interest must be paid by the insurer as costs on top of its policy limit. If a defendant has a $100,000 policy limit, and the verdict plus prejudgment interest is $2 million, then the Rule 82 award is $200,850 (again, $1,850 + 10 percent of the excess over $10,000). Under current practice, the attorney would get his contingent fee percentage computed on the amount actually recovered from the insurance company—the $100,000 policy limit plus the $200,850 Rule 82 award and the Rule 79 costs would be rolled together, and the client would receive the rest. If the rules were changed so that the attorney received the Rule 82 award and nothing else, he would wind up with about twice as much as his client in this not extraordinary situation.

Second, the rules do not effectively discourage nuisance claims. These are claims for which the plaintiff knows that in all likelihood, a jury will find no liability or no damages, but suit is filed in hope of a settlement. If the case is litigated through trial, the defendant will probably win an award of $5,000 to $10,000 against the plaintiff, but the cost to the defendant will exceed the award, and the award will probably be uncollectible, so most defendants will pay up to $5,000 or so, even on frivolous claims.

Third, the rules do not really promote settlement in the manner contemplated. Alaska Supreme Court opinions have suggested that defendants would be more eager to settle because the stakes at trial are raised to include prejudgment interest and attorneys' fees. But the plaintiffs' attorneys are equally aware of the "add-ons" and factor them into their settle-

(Please turn to page 52)

matters to the disciplinary counsel, is that the ABA Standing Committee on Professional Discipline is advocating referring every minor infringement of the ethical rules.

Obviously, that is not the case; nor is it the problem. If I have overemphasized the need to refer misconduct in this article, it is because judges as a group are not referring the misconduct they observe or become aware of. I have attempted to show why referral is appropriate and also ethically mandated by Canon 3B(3). I believe that for the judge referral is usually the most advantageous response to lawyer misconduct.

Judges and judicial organizations interested in further information on disciplinary agencies or other information in this article may contact the author, Timothy McPike, ABA Center for Professional Responsibility, 11th Floor, 750 N. Lake Shore Drive, Chicago, Illinois 60611.

Kleinfeld

(Continued from page 7)

ment demands. The arithmetic consequence is that if the plaintiff's and defendant's attorneys evaluate the case differently, the difference is magnified, not shrunk, by the "add-ons." Interest and attorney's fees are proportional, so if the parties are far apart, their mutual awareness of the rules pushes them further apart.

ECONOMIC DURESS ON PLAINTIFFS

A positive feature of the rules is that by making a small case larger, they make it easier for plaintiffs with small cases to induce attorneys to accept them. But this increasing of the stakes works both ways—and has a serious negative side effect.

The combination of Rule 68 offers, statutory adjustment of prejudgment interest rates, Rule 79 costs, and Rule 82 attorney's fees, greatly raises the stakes in litigation. As was shown above, if the defendant loses a $100,000 case, he pays about $150,000. If the plaintiff wins a $10,000 verdict after rejecting a higher offer of judgment, he winds up owing money to the defendant as well as to his own lawyer.

The economic effect is like doubling the stakes in a poker game. It drives out the players whose resources do not allow them to stay at the table for a long enough time for the probabilities to work themselves out beyond a few bad hands.

Plaintiffs suffer more from the increased stakes than defendants. To understand why, one must consider the varying abilities of persons and institutions to bear risk. An institutional defendant, such as a large business or an insurance company, can afford the risk of a single adverse judgment much more easily than the person or firm of moderate resources who rarely litigates.

Consider the plaintiffs in a clear liability but unpredictable damages case. Most typical are the preexisting condition plaintiffs. These individuals present themselves to the jury with substantial disabilities, but the defendant has a good opportunity to show that their disabilities should be attributed to conditions which preexisted the accident. It is not at all unusual in these cases to have an offer of judgment around $50,000, a demand around $100,000, and jury verdict substantially lower than the offer or higher than the demand.

Now consider the risks to each side. In order to try the case, the defendant must risk a judgment which, with interest and attorneys' fees, may be twice the demand. But a professional litigant, such as a liability insurer, would be wise to take this risk rather than pay the demanded amount, because the occasional high verdict will be more than offset by the general run of moderate verdicts and the occasional low one.

The real pressure on insurers to settle these cases arises not from the interest and attorneys' fees rules, but instead from the risk of a judgment in excess of insurance policy limits, leading to a bad faith claim. Many cases worth $40,000 have settled for $50,000 policy limits plus Rule 82 attorneys' fees because of the bad faith risk. But sophisticated insurers are now learning to take the cap off their policy limit rather than be forced by the risk of a bad faith claim to pay more than a claim is worth.

The plaintiff faces a much more brutal choice. This is probably the only lawsuit he will ever have, so he cannot balance the occasional low verdict against the occasional high one. His resources are probably limited, so the difference between collecting the offered settlement and perhaps collecting nothing—because of a verdict lower than the offer of judgment—matters more to him than the same dollar difference matters to the institutional defendant. A four-or five-figure judgment against him for attorneys' fees and costs, because he did not beat the defendant's offer of judgment or lost on liability, may be catastrophic.

As a practical matter, if the defendant makes an offer of judgment early in the litigation at the low end of the likely value of the case, or even 10 percent to 20 percent less, the plaintiff takes an imprudent and unaffordable risk if he rejects it. The risk is made unaffordable by the impact of Rule 68, Rule 82, Rule 79 costs, and the new interest statute. In effect, the defendant is empowered to turn the plaintiff's reasonable bet on the outcome into a double or nothing bet which the plaintiff cannot prudently risk. The chance of recovering his loss plus all the add-ons is not worth the risk of having defendant's add-ons set off against his recovery.

When a plaintiff runs the risk of trial against a moderate offer of judgment and loses, the defendant often has enough leverage to prevent appeal. Typically the defendant offers to drop his costs and attorneys' fee awards in exchange for the plaintiff's aban-

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MEMORANDUM

TO: House Judiciary members

FROM: Rep. John Sund

DATE: April 24, 1986

RE: The state of our insurance companies

I have distributed a copy of an internal memo from the Division of Insurance which indicates that Alaska's insurance companies are far from hurting during our nationwide "insurance crisis."

Note especially the summary — first paragraph on page 4.

MEMORANDUM State of Alaska

TO: John L. George, Director

DATE: March 17, 1986

FILE NO.:

THRU:

TELEPHONE NO.:

SUBJECT: 1985 Underwriting Results
Other Liability

FROM: Donald DeMuth
Chief Financial Examiner

You have asked me to review the underwriting results of approximately the 10 leading writers of the line "Other Liability" "(17)" in the State of Alaska. The results of my study follow.

You will note that I have actually supplied statistics on 13 companies. The reason for the three additional companies are: You stated that you did not want companies like "State Farm" - companies that are not traditionally considered to be writers of Other Liability included. For this reason, I did not know if you wanted ARECA Insurance Exchange included or not. I added one company and you may exclude "ARECA" if you wish. I also question the accuracy of the Continental Insurance Company's Alaska direct losses incurred figure, and both noted a probable aberration in schedule "P" figures and am aware that CIGNA made some big reserve adjustments which may well be without basis at year-end, and which may have skewed Alaska Pacific Assurance Company's figures. You may, hence, eliminate the figures for these two companies if you wish and still be left with the statistics on 10 companies. I also eliminated the figures for the Insurance Company of North America as their page 14 figures for this line are probably erroneous and meaningless.

The first area of experience that I looked at was the company's direct underwriting results in Alaska. The results are summarized as follows:

Rank by Premium Written In Alaska		Alaska Direct Premium Written	Alaska Direct Premium Earned	Alaska Direct Losses Paid	Alaska Direct Losses Incurred	Alaska Loss Ratio
12	Federal Insurance Company	$ 759,348	$ 556,132	$ 4,380	$ 32,347	5.8%
13	The Continental Ins. Co.	552,533	558,869	299,050	(387,290)	*
	Pacific Marine Insurance Co. of Alaska	792,416	808,528	150,530	245,804	30.4%
2	Alaska National Ins. Co.	3,938,343	2,703,705	1,581,666	2,173,774	80.4%
1	AK Pacific Assurance Co.	4,148,556	4,329,380	1,845,266	2,960,272	68.4%
7	Fremont Indemnity Co.	1,581,809	1,600,374	283,530	856,617	53.5%
9	ARECA Insurance Exchange	975,398	975,398	50,849	175,312	18.0%
6	Providence Washington Insurance Co. of Alaska	1,827,910	2,424,073	4,275,334	2,817,529	116.2%

5	Industrial Indemnity Company of Alaska	1,838,269	1,842,175	1,226,617	1,423,207	77.3%
4	Alaska Insurance Company	1,870,196	1,539,729	576,349	896,926	58.3%
3	Nat'l Union Fire Ins. Co.	3,732,736	2,636,895	170,668	677,159	21.9%
11	Employers Insurance of Wausau, A Mutual Company	759,889	675,147	124,435	992,116	147.0%
8	General Accident Ins. Company of America	1,004,405	996,593	22,857	733,765	75.7%
		$23,781,808	$21,649,998	$10,621,731	$13,497,538	62.3%

* Meaningless

The column above entitled "Alaska Direct Losses Paid" is not of much significance. I included it only to illustrate the great disparity between losses paid and losses incurred in certain cases. There are a number of possible reasons for this disparity, but I cannot identify which reason is responsible for the cases reflected in the above exhibit.

For comparative purposes, I attempted to develop the same information for the same companies on a national basis. The companies are not required to provide this information on a national basis, but a few companies volunteer and, hence, complete page 14 of the annual statement on a national basis. The results of this comparative study does not reveal very much information, but the results are as follows:

Rank by Premium Written In Alaska		National Direct Premium Written	National Direct Premium Earned	National Direct Losses Paid	National Direct Losses Incurred	National Loss Ratio
12	Federal Insurance Company	Information not available.				
13	The Continental Ins. Co.	Information not available.				
10	Pacific Marine Insurance Co. of Alaska	Information not available.				
2	Alaska National Ins. Co.	Information not available.				
1	AK Pacific Assurance Co.	Information not available.				
7	Freemont Indemnity Co.	$31,645,042	$34,211,163	$25,679,707	$53,934,431	157.0%
9	ARECA Insurance Exchange	National experience same as Alaskan experience.				
6	Providence Washington Insurance Co. of Alaska	Information not available.				
5	Industrial Indemnity Company of Alaska	Information not available.				
4	Alaska Insurance Company	National experience same as Alaskan experience.				
3	Nat'l Union Fire Ins. Co.	Information not available.				
11	Employers Insurance of Wausau, A Mutual Company	Information not available.				
8	General Accident Ins. Company of America	Information not available.				

In an attempt to get some kind of comparative information - Alaska vs. National - I then decided to take a look at the same companies' net national business. This is not a direct comparison due to the fact that net business is net of assumed and ceded reinsurance, but the annual statement does not reflect direct national premium earned, only written, so I had no choice.

The result of this study is as follows:

Rank By Premium Written In Alaska		National Net Premium Written	National Net Premium Earned	National Net Losses Paid	National Net Losses Incurred	National Net Loss Ratio
12	Federal Insurance Company	$223,854,784	$166,392,450	$ 42,483,524	$ 85,539,084	51.4%
13	The Continental Ins. Co.	38,763,790	32,026,227	19,576,743	30,650,173	95.7%
10	Pacific Marine Insurance Co. of Alaska	Not Applicable				
2	Alaska National Ins. Co.	2,077,776	1,547,010	222,217	1,051,834	68.0%
1	AK Pacific Assurance Co.	3,884,456	3,271,879	3,995,018	5,151,751	157.5%
7	Freemont Indemnity Co.	33,624,745	26,542,239	11,277,702	36,844,816	138.8%
9	ARECA Insurance Exchange	823,895	823,895	50,949	175,312	21.3%
6	Providence Washington Insurance Co. of Alaska	Not Applicable				
5	Industrial Indemnity Company of Alaska	Not Applicable				
4	Alaska Insurance Company	Not Applicable				
3	Nat'l Union Fire Ins. Co.	357,841,310	283,621,245	80,724,018	222,277,500	78.4%
11	Employers Insurance of Wausau, A Mutual Company	112,716,611	104,759,066	73,570,268	73,177,983	69.9%
8	General Accident Ins. Company of America	31,868,701	29,249,804	10,955,921	20,886,903	71.4%
		$805,656,070	$648,233,815	$242,856,260	$475,756,156	73.4%

I also felt that it might be interesting to make a similar review on an accident year basis rather than on a calendar year basis. The reason for this comparative review is that reserve changes made during 1985 applicable to prior year business is reflected in the calendar year 1985 experience, but not in the 1985 accident year experience. The accident year business only reflects the company's experience on accidents that actually happened during 1985. The result of this review is as follows:

Rank By Premium Written In Alaska		Nat'l Net 1985 Accident Year Premium Earned	Nat'l Net 1985 Accident Year Loss Payments	Nat'l Net 1985 Accident Year Losses Incurred	Nat'l Net 1985 Accident Year Loss Ratio
12	Federal Insurance Company	$166,392,450	$ 8,109,100	$ 77,210,574	46.4%
13	The Continental Ins. Co.	32,026,247	1,618,902	24,550,326	76.7%

10	Pacific Marine Insurance Co. of Alaska	Not Applicable			
2	Alaska National Ins. Co.	1,547,010	34,420	1,012,476	65.5%
1	AK Pacific Assurance Co.	3,271,879	414,259	2,790,689	85.3%
7	Fremont Indemnity Co.	26,542,239	1,605,638	26,435,512	100.0%
9	ARECA Insurance Exchange	823,895	30,435	362,961	44.1%
6	Providence Washington Insurance Co. of Alaska	Not Applicable			
5	Industrial Indemnity Company of Alaska	Not Applicable			
4	Alaska Insurance Company	Not Applicable			
3	Nat'l Union Fire Ins. Co.	283,621,245	7,168,480	211,149,406	74.5%
11	Employers Insurance of Wausau, A Mutual Company	104,759,072	6,085,504	50,311,511	48.0%
8	General Accident Ins. Company of America	29,249,801	1,126,201	16,247,129	55.6%
		$548,233,838	$ 26,192,939	$410,070,584	63.3%

Overall, in spite of all the tears that the insurance industry is shedding, it appears to me that the insurance industry is doing quite well for this line. Unfortunately, accident year direct statistics are not available for Alaska, but I would guesstimate that if they were, they would reflect a loss ratio down around 50%. I also note that the paid loss ratio for accident year 1985, on a national basis, is down around 4%. Fat city on investment income coming up in 1986, particularly in those states that do not allow pre- and postjudgment interest.

I would suggest that you have your market conduct "rate section" follow-up on this memo - perhaps doing some research work in some of the companies offices. I hope to take a look at Providence Washington Insurance Company of Alaska and Industrial Indemnity Insurance Company of Alaska shortly, as both are overdue for an examination.

I would also suggest that you have your rate people perhaps take a look at 1984 experience for comparative purposes. It might also be interesting to do a policy year review of the same companies for 1984. This information should now be available but it is not reported in the annual statement. It would entail a special statistical call.

All figures reflected in this memo were taken from filed annual statements, but I have no idea how accurate the information is.

DD/mst3523m
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IN THE LEGISLATURE
of the
STATE OF WASHINGTON

CERTIFICATION OF ENROLLED ENACTMENT

SUBSTITUTE SENATE BILL NO. 4630

Chapter 305, Laws of 1986

49th Legislature
Regular Session

EFFECTIVE DATE: June 11, 1986
Except: Section 904 which becomes effective on April 4, 1986.

Passed the Senate February 15, 19 86
Yeas 32 *Nays* 13

Passed the House March 6, 19 86
As Amended
Yeas 66 *Nays* 31

3/10/86 - The Senate concurred in the House amendments and passed the bill as amended by the House.

YEAS 31 NAYS 16

CERTIFICATE

I, Sidney R. Snyder, Secretary of the Senate of the State of Washington do hereby certify that the attached is enrolled Substitute Senate Bill No. 4630 *as passed by the Senate and the House of Representatives on the dates hereon set forth.*

Secretary of the Senate

ENGROSSED SUBSTITUTE SENATE BILL NO. 4630
AS AMENDED BY THE HOUSE

State of Washington 49th Legislature 1986 Regular Session
by Committee on Judiciary (originally sponsored by Senator Talmadge)

Read first time 2/5/86.

AN ACT Relating to civil actions; amending RCW 5.60.060, 4.22.030, 51.24.060, 4.16.350, 4.24.115, 4.16.160, 4.16.310, and 4.16.300; adding a new section to chapter 4.22 RCW; adding new sections to chapter 4.24 RCW; adding new sections to chapter 4.56 RCW; adding new sections to chapter 5.40 RCW; adding a new section to chapter 7.70 RCW; adding a new section to chapter 48.19 RCW; adding a new section to chapter 48.22 RCW; creating new sections; repealing RCW 4.56.240; and declaring an emergency.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. Sec. 100. PREAMBLE. Tort law in this state has generally been developed by the courts on a case-by-case basis. While this process has resulted in some significant changes in the law, including amelioration of the harshness of many common law doctrines, the legislature has periodically intervened in order to bring about needed reforms. The purpose of this chapter is to enact further reforms in order to create a more equitable distribution of the cost and risk of injury and increase the availability and affordability of insurance.

The legislature finds that counties, cities, and other governmental entities are faced with increased exposure to lawsuits and awards and dramatic increases in the cost of insurance coverage. These escalating costs ultimately affect the public through higher taxes, loss of essential services, and loss of the protection provided by adequate insurance. In order to improve the availability and affordability of quality governmental services, comprehensive reform is necessary.

The legislature also finds comparable cost increases in professional liability insurance. Escalating malpractice insurance premiums discourage physicians and other health care providers from

initiating or continuing their practice or offering needed services to the public and contribute to the rising costs of consumer health care. Other professionals, such as architects and engineers, face similar difficult choices, financial instability, and unlimited risk in providing services to the public.

The legislature also finds that general liability insurance is becoming unavailable or unaffordable to many businesses, individuals, and nonprofit organizations in amounts sufficient to cover potential losses. High premiums have discouraged socially and economically desirable activities and encourage many to go without adequate insurance coverage.

Therefore, it is the intent of the legislature to reduce costs associated with the tort system, while assuring that adequate and appropriate compensation for persons injured through the fault of others is available.

PART I

ACCELERATED PHYSICIAN-PATIENT PRIVILEGE

Sec. 101. Section 294, page 187, Laws of 1854 as last amended by section 1, chapter 56, Laws of 1982 and RCW 5.60.060 are each amended to read as follows:

(1) A husband shall not be examined for or against his wife without the consent of the wife, nor a wife for or against her husband without the consent of the husband; nor can either during marriage or afterward, be without the consent of the other, examined as to any communication made by one to the other during marriage. But this exception shall not apply to a civil action or proceeding by one against the other, nor to a criminal action or proceeding for a crime committed by one against the other, nor to a criminal action or proceeding against a spouse if the marriage occurred subsequent to the filing of formal charges against the defendant, nor to a criminal action or proceeding for a crime committed by said husband or wife against any child of whom said husband or wife is the parent or guardian, nor to a proceeding under chapter 71.05 RCW: PROVIDED That the spouse of a person sought to be detained under chapter 71.05 RCW may not be compelled to testify and shall be so informed by the

court prior to being called as a witness.

(2) An attorney or counselor shall not, without the consent of his client, be examined as to any communication made by the client to him, or his advice given thereon in the course of professional employment.

(3) A clergyman or priest shall not, without the consent of a person making the confession, be examined as to any confession made to him in his professional character, in the course of discipline enjoined by the church to which he belongs.

(4) A ((regular)) physician or surgeon or osteopathic physician or surgeon shall not, without the consent of his patient, be examined in a civil action as to any information acquired in attending such patient, which was necessary to enable him to prescribe or act for the patient, ((but--this--exception-shall-not-apply-in-any-judicial proceeding-regarding-a-child's-injuries,-neglect-or-sexual-abuse,--or the-cause-thereof)) except as follows:

(a) In any judicial proceedings regarding a child's injury, neglect, or sexual abuse or the cause thereof; and

(b) Within ninety days of filing an action for personal injuries or wrongful death, the claimant shall elect whether or not to waive the physician-patient privilege. If the claimant does not waive the physician-patient privilege, the claimant may not put his or her mental or physical condition or that of his or her decedent or beneficiaries in issue and may not waive the privilege later in the proceedings. Waiver of the physician-patient privilege for any one physician or condition constitutes a waiver of the privilege as to all physicians or conditions, subject to such limitations as a court may impose pursuant to court rules.

(5) A public officer shall not be examined as a witness as to communications made to him in official confidence, when the public interest would suffer by the disclosure.

PART II

ATTORNEYS' FEES

NEW SECTION. Sec. 201. A new section is added to chapter 4.24 RCW to read as follows:

The court shall, upon petition by a named party in any tort action, except those provided for in RCW 7.70.070, determine the reasonableness of that party's attorneys' fees. The court shall take into consideration the following:

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal service properly;

(2) The likelihood, if apparent to the client, that the acceptance of the particular employment will preclude other employment by the lawyer;

(3) The fee customarily charged in the locality for similar legal services;

(4) The amount involved and the results obtained;

(5) The time limitations imposed by the client or by the circumstances;

(6) The nature and length of the professional relationship with the client;

(7) The experience, reputation, and ability of the lawyer or lawyers performing the services;

(8) Whether the fee is fixed or contingent;

(9) Whether the fixed or contingent fee agreement was in writing and whether the client was aware of his or her right to petition the court under this section.

NEW SECTION. Sec. 202. Section 201 of this act applies to agreements for attorney's fees entered into after the effective date of this section.

PART III

LIMITATION ON NONECONOMIC DAMAGES

NEW SECTION. Sec. 301. A new section is added to chapter 4.56 RCW to read as follows:

(1) As used in this section, the following terms have the meanings indicated unless the context clearly requires otherwise.

(a) "Economic damages" means objectively verifiable monetary losses, including medical expenses, loss of earnings, burial costs, loss of use of property, cost of replacement or repair, cost of

obtaining substitute domestic services, loss of employment, and loss of business or employment opportunities.

(b) "Noneconomic damages" means subjective, nonconetary losses, including, but not limited to pain, suffering, inconvenience, mental anguish, disability or disfigurement incurred by the injured party, emotional distress, loss of society and companionship, loss of consortium, injury to reputation and humiliation, and destruction of the parent-child relationship.

(c) "Bodily injury" means physical injury, sickness, or disease, including death.

"Average annual wage" means the average annual wage in the state of Washington as determined under RCW 50.04.355.

(2) In no action seeking damages for personal injury or death may a claimant recover a judgment for noneconomic damages exceeding an amount determined by multiplying 0.43 by the average annual wage and by the life expectancy of the person incurring noneconomic damages, as the life expectancy is determined by the life expectancy tables adopted by the insurance commissioner. For purposes of determining the maximum amount allowable for noneconomic damages, a claimant's life expectancy shall not be less than fifteen years. The limitation contained in this subsection applies to all claims for noneconomic damages made by a claimant who incurred bodily injury. Claims for loss of consortium, loss of society and companionship, destruction of the parent-child relationship, and all other derivative claims asserted by persons who did not sustain bodily injury are to be included within the limitation on claims for noneconomic damages arising from the same bodily injury.

(3) If a case is tried to a jury, the jury shall not be informed of the limitation contained in subsection (2) of this section.

PART IV

APPORTIONMENT OF DAMAGES

NEW SECTION. Sec. 401. A new section is added to chapter 4.22 RCW to read as follows:

(1) In all actions involving fault of more than one entity, the trier of fact shall determine the percentage of the total fault which

is attributable to every entity which caused the claimant's damages, including the claimant or person suffering personal injury or incurring property damage, defendants, third-party defendants, entities released by the claimant, entities immune from liability to the claimant and entities with any other individual defense against the claimant. Judgment shall be entered against each defendant except those who have been released by the claimant or are immune from liability to the claimant or have prevailed on any other individual defense against the claimant in an amount which represents that party's proportionate share of the claimant's total damages. The liability of each defendant shall be several only and shall not be joint except:

(a) A party shall be responsible for the fault of another person or for payment of the proportionate share of another party where both were acting in concert or when a person was acting as an agent or servant of the party.

(b) If the trier of fact determines that the claimant or party suffering bodily injury or incurring property damages was not at fault, the defendants against whom judgment is entered shall be jointly and severally liable for the sum of their proportionate shares of the claimants total damages.

(2) If a defendant is jointly and severally liable under one of the exceptions listed in subsections (1)(a) or (1)(b) of this section, such defendant's rights to contribution against another jointly and severally liable defendant, and the effect of settlement by either such defendant, shall be determined under RCW 4.22.040, 4.22.050, and 4.22.060.

(3)(a) Nothing in this section affects any cause of action relating to hazardous wastes or substances or solid waste disposal sites.

(b) Nothing in this section shall affect a cause of action arising from the tortious interference with contracts or business relations.

(c) Nothing in this section shall affect any cause of action arising from the manufacture or marketing of a fungible product in a generic form which contains no clearly identifiable shape, color, or

marking.

Sec. 402. Section 11, chapter 27, Laws of 1961 and RCW 4.22.030 are each amended to read as follows:

Except as otherwise provided in section 401 of this 1986 act, if more than one person is liable to a claimant on an indivisible claim for the same injury, death or harm, the liability of such persons shall be joint and several.

Sec. 403. Section 4, chapter 85, Laws of 1977 ex. sess. as last amended by section 5, chapter 218, Laws of 1984 and RCW 51.24.060 are each amended to read as follows:

(1) If the injured worker or beneficiary elects to seek damages from the third person, any recovery made shall be distributed as follows:

(a) The costs and reasonable attorneys' fees shall be paid proportionately by the injured worker or beneficiary and the department and/or self-insurer;

(b) The injured worker or beneficiary shall be paid twenty-five percent of the balance of the award: PROVIDED, That in the event of a compromise and settlement by the parties, the injured worker or beneficiary may agree to a sum less than twenty-five percent;

(c) The department and/or self-insurer shall be paid the balance of the recovery made, but only to the extent necessary to reimburse the department and/or self-insurer for compensation and benefits paid;

(i) The department and/or self-insurer shall bear its proportionate share of the costs and reasonable attorneys' fees incurred by the worker or beneficiary to the extent of the benefits paid or payable under this title: PROVIDED, That the department or self-insurer may require court approval of costs and attorneys' fees or may petition a court for determination of the reasonableness of costs and attorneys' fees.

(ii) The sum representing the department's and/or self-insurer's proportionate share shall not be subject to subsection (1) (d) and (e) of this section.

(d) Any remaining balance shall be paid to the injured worker or

beneficiary;

(e) Thereafter no payment shall be made to or on behalf of a worker or beneficiary by the department and/or self-insurer for such injury until the amount of any further compensation and benefits shall equal any such remaining balance. Thereafter, such benefits shall be paid by the department and/or self-insurer to or on behalf of the worker or beneficiary as though no recovery had been made from a third person;

(f) If the employer or a co-employee are determined under section 401 of this 1986 act to be at fault, (c) and (e) of this subsection do not apply and benefits shall be paid by the department and/or self-insurer to or on behalf of the worker or beneficiary as though no recovery had been made from a third person.

(2) The recovery made shall be subject to a lien by the department and/or self-insurer for its share under this section.

(3) The department or self-insurer has sole discretion to compromise the amount of its lien. In deciding whether or to what extent to compromise its lien, the department or self-insurer shall consider at least the following:

(a) The likelihood of collection of the award or settlement as may be affected by insurance coverage, solvency, or other factors relating to the third person;

(b) Factual and legal issues of liability as between the injured worker or beneficiary and the third person. Such issues include but are not limited to possible contributory negligence and novel theories of liability; and

(c) Problems of proof faced in obtaining the award or settlement.

(4) In the case of an employer not qualifying as a self-insurer, the department shall make a retroactive adjustment to such employer's experience rating in which the third party claim has been included to reflect that portion of the award or settlement which is reimbursed for compensation and benefits paid and, if the claim is open at the time of recovery, applied against further compensation and benefits to which the injured worker or beneficiary may be entitled.

(5) In an action under this section, the self-insurer may act on behalf and for the benefit of the department to the extent of any

compensation and benefits paid or payable from state funds.

(6) It shall be the duty of the person to whom any recovery is paid before distribution under this section to advise the department or self-insurer of the fact and amount of such recovery, the costs and reasonable attorneys' fees associated with the recovery, and to distribute the recovery in compliance with this section.

(7) The distribution of any recovery made by award or settlement of the third party action shall be confirmed by department order, served by registered or certified mail, and shall be subject to chapter 51.52 RCW. In the event the order of distribution becomes final under chapter 51.52 RCW, the director or the director's designee may file with the clerk of any county within the state a warrant in the amount of the sum representing the unpaid lien plus interest accruing from the date the order became final. The clerk of the county in which the warrant is filed shall immediately designate a superior court cause number for such warrant and the clerk shall cause to be entered in the judgment docket under the superior court cause number assigned to the warrant, the name of such worker or beneficiary mentioned in the warrant, the amount of the unpaid lien plus interest accrued and the date when the warrant was filed. The amount of such warrant as docketed shall become a lien upon the title to and interest in all real and personal property of the injured worker or beneficiary against whom the warrant is issued, the same as a judgment in a civil case docketed in the office of such clerk. The sheriff shall then proceed in the same manner and with like effect as prescribed by law with respect to execution or other process issued against rights or property upon judgment in the superior court. Such warrant so docketed shall be sufficient to support the issuance of writs of garnishment in favor of the department in the manner provided by law in the case of judgment, wholly or partially unsatisfied. The clerk of the court shall be entitled to a filing fee of five dollars, which shall be added to the amount of the warrant. A copy of such warrant shall be mailed to the injured worker or beneficiary within three days of filing with the clerk.

(8) The director, or the director's designee, may issue to any person, firm, corporation, municipal corporation, political

subdivision of the state, public corporation, or agency of the state, a notice and order to withhold and deliver property of any kind if he or she has reason to believe that there is in the possession of such person, firm, corporation, municipal corporation, political subdivision of the state, public corporation, or agency of the state, property which is due, owing, or belonging to any worker or beneficiary upon whom a warrant has been served by the department for payments due to the state fund. The notice and order to withhold and deliver shall be served by the sheriff of the county or by the sheriff's deputy, or by any authorized representatives of the director. Any person, firm, corporation, municipal corporation, political subdivision of the state, public corporation, or agency of the state upon whom service has been made shall answer the notice within twenty days exclusive of the day of service, under oath and in writing, and shall make true answers to the matters inquired of in the notice and order to withhold and deliver. In the event there is in the possession of the party named and served with such no order, any property which may be subject to the c department, such property shall be delivered forthwi director or the director's authorized representative upon d the party served and named in the notice and order fails to answe the notice and order within the time prescribed in this section, the court may, after the time to answer such order has expired, render judgment by default against the party named in the notice for the full amount claimed by the director in the notice together with costs. In the event that a notice to withhold and deliver is served upon an employer and the property found to be subject thereto is wages, the employer may assert in the answer to all exemptions provided for by chapter 7.33 RCW to which the wage earner may be entitled.

PART V

LIMITATION OF ACTIONS

NEW SECTION. Sec. 501. A new section is added to chapter 4.24 RCW to read as follows:

It is a complete defense to any action for damages for personal

injury or wrongful death that the person injured or killed was engaged in the commission of a felony, if the felony was causally related to the injury or death in time, place, or activity. However, nothing in this section shall affect a right of action under 42 U.S.C. Sec. 1983.

Sec. 502. Section 1, chapter 80, Laws of 1971 as amended by section 1, chapter 56, Laws of 1975-'76 2nd ex. sess. and RCW 4.16.350 are each amended to read as follows:

Any civil action for damages for injury occurring as a result of health care which is provided after June 25, 1976 against:

(1) A person licensed by this state to provide health care or related services, including, but not limited to, a physician, osteopathic physician, dentist, nurse, optometrist, podiatrist, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his estate or personal representative;

(2) An employee or agent of a person described in subsection (1) of this section, acting in the course and scope of his employment, including, in the event such employee or agent is deceased, his estate or personal representative; or

(3) An entity, whether or not incorporated, facility, or institution employing one or more persons described in subsection (1) of this section, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his employment, including, in the event such officer, director, employee, or agent is deceased, his estate or personal representative;

based upon alleged professional negligence shall be commenced within three years of the act or omission alleged to have caused the injury or condition, or one year of the time the patient or his representative discovered or reasonably should have discovered that the injury or condition was caused by said act or omission, whichever period expires later, except that in no event shall an action be

commenced more than eight years after said act or omission: PROVIDED, That the time for commencement of an action is tolled upon proof of fraud, intentional concealment, or the presence of a foreign body not intended to have a therapeutic diagnostic purpose or effect.

For purposes of this section, notwithstanding RCW 4.16.190, the knowledge of a custodial parent or guardian shall be imputed to a person under the age of eighteen years. Any action not commenced in accordance with this section shall be barred((:--PROVIDED,--That--the limitations--in-this-section-shall-not-apply-to-persons-under-a-legal disability-as-defined-in-RCW-4:16:190)).

PART VI

INDEMNIFICATION AGREEMENTS

Sec. 601. Section 2, chapter 46, Laws of 1967 ex. sess. and RCW 4.24.115 are each amended to read as follows:

A covenant, promise, agreement or understanding in, or in connection with or collateral to, a contract or agreement relative to the construction, alteration, repair, addition to, subtraction from, improvement to, or maintenance of, any building, highway, road, railroad, excavation, or other structure, project, development, or improvement attached to real estate, including moving and demolition in connection therewith, purporting to indemnify against liability for damages arising out of bodily injury to persons or damage to property:

(1) Caused by or resulting from the sole negligence of the indemnitee, his agents or employees is against public policy and is void and unenforceable;

(2) Caused by or resulting from the concurrent negligence of (a) the indemnitee or the indemnitee's agents or employees, and (b) the indemnitor or the indemnitor's agents or employees, is valid and enforceable only to the extent of the indemnitor's negligence and only if the agreement specifically and expressly provides therefor, and may waive the indemnitor's immunity under industrial insurance, Title 51 RCW, only if the agreement specifically and expressly provides therefor and the waiver was mutually negotiated by the parties. This subsection applies to agreements entered into after

the effective date of this 1986 section.

PART VII

BUILDER LIMITATION

Sec. 701. Section 2, chapter 43, Laws of 1955 and RCW 4.16.160 are each amended to read as follows:

The limitations prescribed in this chapter shall apply to actions brought in the name or for the benefit of any county or other municipality or quasimunicipality of the state, in the same manner as to actions brought by private parties: PROVIDED, That, except as provided in RCW 4.16.310, there shall be no limitation to actions brought in the name or for the benefit of the state, and no claim of right predicated upon the lapse of time shall ever be asserted against the state: AND FURTHER PROVIDED, That no previously existing statute of limitations shall be interposed as a defense to any action brought in the name or for the benefit of the state, although such statute may have run and become fully operative as a defense prior to February 27, 1903, nor shall any cause of action against the state be predicated upon such a statute.

Sec. 702. Section 2, chapter 75, Laws of 1967 and RCW 4.16.310 are each amended to read as follows:

All claims or causes of action as set forth in RCW 4.16.300 shall accrue, and the applicable statute of limitation shall begin to run only during the period within six years after substantial completion of construction, or during the period within six years after the termination of the services enumerated in RCW 4.16.300, whichever is later. The phrase "substantial completion of construction" shall mean the state of completion reached when an improvement upon real property may be used or occupied for its intended use. Any cause of action which has not accrued within six years after such substantial completion of construction, or within six years after such termination of services, whichever is later, shall be barred: PROVIDED, That this limitation shall not be asserted as a defense by any owner, tenant or other person in possession and control of the improvement at the time such cause of action accrues. The limitations prescribed in this section apply to all claims or causes

of action as set forth in RCW 4.16.300 brought in the name or for the benefit of the state which are made or commenced after the effective date of this 1986 section.

Sec. 703. Section 1, chapter 75, Laws of 1967 and RCW 4.16.300 are each amended to read as follows:

RCW 4.16.300 through 4.16.320 shall apply to all claims or causes of action of any kind against any person, arising from such person having constructed, altered or repaired any improvement upon real property, or having performed or furnished any design, planning, surveying, architectural or construction or engineering services, or supervision or observation of construction, or administration of construction contracts for any construction, alteration or repair of any improvement upon real property. This section is intended to benefit only those persons referenced herein and shall not apply to claims or causes of action against manufacturers.

PART VIII

PERIODIC PAYMENTS

NEW SECTION. Sec. 801. A new section is added to chapter 4.56 RCW to read as follows:

(1) In an action based on fault seeking damages for personal injury or property damage in which a verdict or award for future economic damages of at least one hundred thousand dollars is made, the court or arbitrator shall, at the request of a party, enter a judgment which provides for the periodic payment in whole or in part of the future economic damages. With respect to the judgment, the court or arbitrator shall make a specific finding as to the dollar amount of periodic payments intended to compensate the judgment creditor for the future economic damages.

(2) Prior to entry of judgment, the court shall request each party to submit a proposal for periodic payment of future economic damages to compensate the claimant. Proposals shall include provisions for: The name of the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, the number of payments or the period of time over which the payments shall be made, modification for hardship or unforeseen

circumstances, posting of adequate security, and any other factor the court deems relevant under the circumstances. After each party has submitted a proposal, the court shall select the proposal, with any changes the court deems proper, which in the discretion of the court and the interests of justice best provides for the future needs of the claimant and enter judgment accordingly.

(3) If the court enters a judgment for periodic payments and any security required by the judgment is not posted within thirty days, the court shall enter a judgment for the payment of future damages in a lump sum.

(4) If at any time following entry of judgment for periodic payments, a judgment debtor fails for any reason to make a payment in a timely fashion according to the terms of the judgment, the judgment creditor may petition the court for an order requiring payment by the judgment debtor of the outstanding payments in a lump sum. In calculating the amount of the lump sum judgment, the court shall total the remaining periodic payments due and owing to the judgment creditor converted to present value. The court may also require payment of interest on the outstanding judgment.

(5) Upon the death of the judgment creditor, the court which rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages. Money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor.

(6) Upon satisfaction of a periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security posted pursuant to this section shall revert to the judgment debtor.

NEW SECTION. Sec. 802. Section 5, chapter 56, Laws of 1975-'76 2nd ex. sess. and RCW 4.56.240 are each repealed.

PART IX

MISCELLANEOUS

NEW SECTION. Sec. 901. A new section is added to chapter 5.40 RCW to read as follows:

Sec. 901

A breach of a duty imposed by statute, ordinance, or administrative rule shall not be considered negligence per se, but may be considered by the trier of fact as evidence of negligence; however, any breach of duty as provided by statute, ordinance, or administrative rule relating to electrical fire safety, the use of smoke alarms, or driving while under the influence of intoxicating liquor or any drug, shall be considered negligence per se.

NEW SECTION. Sec. 902. A new section is added to chapter 5.40 RCW to read as follows:

It is a complete defense to an action for damages for personal injury or wrongful death that the person injured or killed was under the influence of intoxicating liquor or any drug and that such condition contributed more than fifty percent to his or her injuries or death. If the amount of alcohol in a person's blood is shown by chemical analysis of his or her blood, breath, or other bodily substance to have been 0.10 percent or more by weight of alcohol in the blood, it is conclusive proof that the person was under the influence of intoxicating liquor.

NEW SECTION. Sec. 903. A new section is added to chapter 4.24 RCW to read as follows:

(1) Except as provided in subsection (2) of this section, a member of the board of directors or an officer of any nonprofit corporation is not civilly liable for any act or omission in the course and scope of his or her official capacity unless the act or omission constitutes gross negligence.

(2) Nothing in this section shall limit or modify in any manner the duties or liabilities of a director or officer of a corporation to the corporation or the corporation's shareholders.

NEW SECTION. Sec. 904. A new section is added to chapter 4.24 RCW to read as follows:

A member of the board of directors or a superintendent of any school district is not civilly liable for any act or omission in the course and scope of his or her official capacity unless the act or omission constitutes gross negligence.

NEW SECTION. Sec. 905. A new section is added to chapter 7.70 RCW to read as follows:

Members of the board of directors or other governing body of a public or private hospital are not individually liable for injuries resulting from health care administered by a health care provider granted privileges to provide health care at the hospital unless the decision to grant the privilege to provide health care at the hospital constitutes gross negligence.

NEW SECTION. Sec. 906. A new section is added to chapter 48.22 RCW to read as follows:

The commissioner shall by regulation require insurers authorized to write casualty insurance in this state to form a market assistance plan to assist persons and other entities unable to purchase casualty insurance in an adequate amount from either the admitted market or nonadmitted market.

For the purpose of this section, a market assistance plan means a voluntary mechanism by insurers writing casualty insurance in this state in either the admitted or nonadmitted market to provide casualty insurance for a class of insurance designated in writing to the plan by the commissioner.

The bylaws and method of operation of any market assistance plan shall be approved by the commissioner prior to its operation.

A market assistance plan shall have a minimum of twenty-five insurers willing to insure risks within the class designated by the commissioner. If twenty-five insurers do not voluntarily agree to participate, the commissioner may require casualty insurers to participate in a market assistance plan as a condition of continuing to do business in this state. The commissioner shall make such a requirement to fulfill the quota of at least twenty-five insurers. The commissioner shall make his or her designation on the basis of the insurer's premium volume of casualty insurance in this state.

NEW SECTION. Sec. 907. A new section is added to chapter 48.19 RCW to read as follows:

The commissioner shall, in reviewing a casualty rate filing, determine in accordance with sound and reliable actuarial principles

whether this act requires an insurer to grant its policyholders a credit in such casualty rate filing. Upon determining that data in support of such a credit is actuarially credible, the commissioner shall approve or disapprove such casualty rate filing in accordance therewith. The commissioner shall not approve any casualty rate that is inadequate, excessive, or unfairly discriminatory.

NEW SECTION. Sec. 908. The commissioner shall, as chairman of the tort reform study commission, require the task force to study the effectiveness of joint underwriting authorities throughout the United States to specifically determine:

(1) The price as it relates to a filed Insurance Services Organization rate;

(2) The solvency of such mechanisms;

3) The effect it has on the admitted market;

(4) The effect it has on the nonadmitted market;

(5) The effect or availability on the voluntary market; and

(6) What effect it has on lines or classes of insurance not designated.

NEW SECTION. Sec. 909. The insurance commissioner shall submit a report to the legislature by January 1, 1991, on the effects of this act on insurance rates and the availability of insurance coverage and the impact on the civil justice system.

NEW SECTION. Sec. 910. Except as provided in sections 202 and 601 of this act and except for section 904 of this act, this act applies to all actions filed on or after August 1, 1986.

NEW SECTION. Sec. 911. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. Sec. 912. Section 904 of this act is necessary for the immediate preservation of the public peace, health, and safety, the support of the state government and its existing public institutions, and shall take effect immediately.

Passed the Senate March 10, 1986.

John A. Cherberg
President of the Senate.

Passed the House March 6, 1986.

Speaker of the House.

Approved April 4, 1986

Governor of the State of Washington

FILED

APR 4 1986

SECRETARY OF STATE
STATE OF WASHINGTON

7:37 pm.

"(2) First time homebuyer requirement.—The amendments made by subsection (c) [amending subsec. (e)] shall also apply to obligations issued after April 24, 1979, and before the date of the enactment of this Act [Sept. 3, 1982] but only to the extent that the proceeds of such obligations are not committed as of the date of the enactment of this Act [Sept. 3, 1982]."

For effective dates of further amendments to this section by Pub.L. 97-248 with respect to applicability to obligations issued after December 31, 1982, see section 310(d) of Pub.L. 97-248.

Effective Date of 1980 Amendment. Pub.L. 96-595, § 5(c), provided that the amendment by Pub.L. 96-595 shall take effect as if included in the amendments made by section 1102 of Pub.L. 96-499.

Effective Date. Pub.L. 96-499, § 1104, as amended by Pub.L. 97-248, § 221(c)(2), provided that, except as otherwise provided in section 1104(a)(2) through (*o*)(2) of Pub.L. 96-499, this section shall apply to obligations issued after Apr. 24, 1979.

§ 104. Compensation for injuries or sickness

(a) In general.—Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include—

(1) amounts received under workmen's compensation acts as compensation for personal injuries or sickness;

(2) the amount of any damages received (whether by suit or agreement and whether as lump sums or as periodic payments) on account of personal injuries or sickness;

(3) amounts received through accident or health insurance for personal injuries or sickness (other than amounts received by an employee, to the extent such amounts (A) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (B) are paid by the employer);

(4) amounts received as a pension, annuity, or similar allowance for personal injuries or sickness resulting from active service in the armed forces of any country or in the Coast and Geodetic Survey or the Public Health Service, or as a disability annuity payable under the provisions of section 808 of the Foreign Service Act of 1980; and

(5) amounts received by an individual as disability income attributable to injuries incurred as a direct result of a violent attack which the Secretary of State determines to be a terrorist attack and which occurred while such individual was an employee of the United States engaged in the performance of his official duties outside the United States.

For purposes of paragraph (3), in the case of an individual who is, or has been, an employee within the meaning of section 401(c)(1) (relating to self-employed individuals), contributions made on behalf of such individual while he was such an employee to a trust described in section 401(a) which is exempt from tax under section 501(a), or under a plan described in section 403(a), shall, to the extent allowed as deductions under section 404, be treated as contributions by the employer which were not includible in the gross income of the employee.

(b) Termination of application of subsection (a)(4) in certain cases.—

(1) In general.—Subsection (a)(4) shall not apply in the case of any individual who is not described in paragraph (2).

(2) Individuals to whom subsection (a)(4) continues to apply.—An individual is described in this paragraph if—

(A) on or before September 24, 1975, he was entitled to receive any amount described in subsection (a)(4),

(B) on September 24, 1975, he was a member of any organization (or reserve component thereof) referred to in subsection (a)(4) or under a binding written commitment to become such a member,

(C) he receives an amount described in subsection (a)(4) by reason of a combat-related injury, or

(D) on application therefor, he would be entitled to receive disability compensation from the Veterans' Administration.

(3) Special rules for combat-related injuries.—For purposes of this subsection, the term "combat-related injury" means personal injury or sickness—

(A) which is incurred—

(i) as a direct result of armed conflict,

(ii) while engaged in extrahazardous service, or

(iii) under conditions simulating war; or

(B) which is caused by an instrumentality of war.

In the case of an individual who is not described in subparagraph (A) or (B) of paragraph (2), except as provided in paragraph (4), the only amounts taken into account under subsection (a)(4) shall be the amounts which he receives by reason of a combat-related injury.

(4) Amount excluded to be not less than veterans' disability compensation.—In the case of

any individual described in paragraph (2), the amounts excludable under subsection (a)(4) for any period with respect to any individual shall not be less than the maximum amount which such individual, on application therefor, would be entitled to receive as disability compensation from the Veterans' Administration.

(c) Cross references.—

(1) For exclusion from employee's gross income of employer contributions to accident and health plans, see section 106.

(2) For exclusion of part of disability retirement pay from the application of subsection (a)(4) of this section, see section 1403 of title 10, United States Code (relating to career compensation laws).

(Aug. 16, 1954, c. 736, 68A Stat. 30; Sept. 8, 1960, Pub.L. 86-723, § 51, 74 Stat. 847; Oct. 10, 1962, Pub.L. 87-792, § 7(d), 76 Stat. 829; Oct. 4, 1976, Pub.L. 94-455, Title V, § 505(b), (e), Title XIX, § 1901(a)(18), 90 Stat. 1567, 1568, 1766; Oct. 17, 1980, Pub.L. 96-465, Title II, § 2206(e)(1), 94 Stat. 2162; Jan. 14, 1983, Pub.L. 97-473, Title I, § 101(a), 96 Stat. 2605.)

Editorial Notes

Effective Date of 1983 Amendment. Pub.L. 97-473 amended subsec. (a)(2) to exclude from gross income damages received as lump sums or as periodic payments, applicable to taxable years ending after Dec. 31, 1982.

References in Text. Section 831 of the Foreign Service Act of 1946, referred to in subsec. (a) (4), is classified to 22 U.S.C.A. § 1081, Foreign Relations and Intercourse.

§ 105. Amounts received under accident and health plans

(a) Amounts attributable to employer contributions.—Except as otherwise provided in this section, amounts received by an employee through accident or health insurance for personal injuries or sickness shall be included in gross income to the extent such amounts (1) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (2) are paid by the employer.

(b) Amounts expended for medical care.—Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include amounts referred to in subsection (a) if such amounts are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for the medical care (as defined in section 213(d)) of the taxpayer, his spouse, and his dependents (as defined in section 152). Any child to whom section 152(e) applies shall be treated as a dependent of both parents for purposes of this subsection.

(c) Payments unrelated to absence from work.—Gross income does not include amounts referred to in subsection (a) to the extent such amounts—

(1) constitute payment for the permanent loss or loss of use of a member or function of the body, or the permanent disfigurement, of the taxpayer, his spouse, or a dependent (as defined in section 152), and

(2) are computed with reference to the nature of the injury without regard to the period the employee is absent from work.

[(d) Repealed. Pub.L. 98-21, Title I, § 122(b), Apr. 20, 1983, 97 Stat. 87.]

(e) Accident and health plans.—For purposes of this section and section 104—

(1) amounts received under an accident or health plan for employees, and

(2) amounts received from a sickness and disability fund for employees maintained under the law of a State or the District of Columbia,

shall be treated as amounts received through accident or health insurance.

(f) Rules for application of section 213.—For purposes of section 213(a) (relating to medical, dental, etc., expenses) amounts excluded from gross income under subsection (c) or (d) shall not be considered as compensation (by insurance or otherwise) for expenses paid for medical care.

(g) Self-employed individual not considered an employee.—For purposes of this section, the term "employee" does not include an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

(h) Amount paid to highly compensated individuals under a discriminatory self-insured medical expense reimbursement plan.—

(1) In general.—In the case of amounts paid to a highly compensated individual under a self-insured medical reimbursement plan which does not satisfy the requirements of paragraph (2) for a plan year, subsection (b) shall not apply to such amounts to the extent they constitute an excess reimbursement of such highly compensated individual.

insurance contracts did not qualify as insurance under the estate tax law.

In the instant case the taxpayer is considered to have purchased two contracts, one a life annuity contract and the other a contract which, while designated a life insurance contract, has no element of "insurance" and is, therefore, not a contract of the type contemplated in section 101(a) of the Code.

Accordingly, it is held that the annual payments received under the annuity contract will be subject to the provisions of section 72(b) of the Code. The proceeds of the other contract, even though received by reason of the insured's death, will not be excludable from gross income under section 101(a) of the Code and will be subject to income tax to the extent they exceed the net premiums paid for that contract.

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26 CFR 1.101–2: Employees' death benefits.

Treatment of payments under annuity contracts purchased by certain exempt organizations. See T.D. 6783, page 180.

SECTION 104.—COMPENSATION FOR INJURIES OR SICKNESS

26 CFR 1.104–1: Compensation for injuries or sickness. (Also Section 61; 1.61–1.)

Rev. Rul. 65–29

Income realized from the investment of a lump-sum payment representing the discounted present value of a damage award for personal injuries is not excludable from gross income under section 104 of the Internal Revenue Code of 1954.

Advice has been requested whether income realized from the investment of a damage award computed as stated below may be excluded from the taxpayer's gross income under section 104(a) of the Internal Revenue Code of 1954 for any period of time.

A sued *B* for tortious injury to his spouse. The Court found that due to *B*'s negligence *A*'s spouse was rendered 100 percent and permanently disabled, and that her life expectancy was thereby shortened to 10 years. The reasonable cost of care, medicine, and medical attention was found to be 1 x dollars per week, totaling 520 x dollars (1 x dollars times 52 weeks times 10 years).

The Court awarded *A* 416 x dollars, which amount represents the present value of 520 x dollars payable over a 10-year period.

Section 61(a) of the Code provides that except as otherwise provided in subtitle A, gross income means all income from whatever source derived, expressly including various types of investment income.

Section 104(a)(2) of the Code provides, in relevant part, that gross income does not include the amount of any damages received by suit or agreement on account of personal injuries or sickness.

As *A* has unfettered control over the lump-sum payment and over the income from the investment of such payment, it is concluded that

only the lump-sum payment, 416 x dollars, is received as damages within the meaning of section 104(a)(2) of the Code.

Accordingly, it is held that none of the investment income may be excluded from the gross income of A, under section 104 of the Code.

SECTION 107.—RENTAL VALUE OF PARSONAGES

26 CFR 1.107–1: Rental value of parsonages. Rev. Rul. 65–124
(Also Sections 1402, 3121, 3401; 1.1402(a)–11, 31.3121(b)(8)–1, 31.3401(a)(9)–1.)

Unordained members of a religious denomination which provides for ordination of ministers, who are commissioned by a church or a related religious organization without investing them with the authority of ordained ministers, do not qualify as ministers of the gospel for purposes of section 107 of the Internal Revenue Code of 1954.

Further, such individuals may not be regarded as "duly ordained, commissioned, or licensed ministers of a church" for purposes of section 3121(b)(8)(A) of the Federal Insurance Contributions Act, section 1402(e) of the Self-Employment Contributions Act, as amended, or section 3401(a)(9) of the Code relating to the Collection of Income Tax at Source on Wages.

Advice has been requested whether unordained religious workers, members of a religious denomination which provides for ordination of ministers, who have been commissioned by a church, denominational convention, religious organization, or integral agencies thereof under the circumstances described below, qualify as ministers of the gospel for purposes of section 107 of the Internal Revenue Code of 1954.

An administrative denominational convention adopted a resolution which provided that, in order to clarify the status of those serving as ministers of education, ministers of music, and those serving in the administration and maintenance of religious organizations and their integral agencies who have been ordained, commissioned, or licensed by a church as such, or who have been commissioned by a denominational convention or its integral agencies to serve in an administrative capacity in that convention and who are deemed to be serving in the capacities as stated above, shall be recognized as commissioned ministers of the gospel.

Pursuant to this resolution, the individuals involved were commissioned by their respective churches, the denominational convention, religious organizations, and integral agencies thereof.

In one instance, the resolution of a State convention stated that for many years the convention had employed lay workers to do full-time religious work, operating under the same regulations and with the same benefits as clergy employees. This resolution further stated that it was the opinion of the convention that these lay employees, even though not ordained, were definitely commissioned as religious workers and were giving their life to that work. Pursuant to this resolution several lay workers were commissioned by a committee of the State convention to serve in a promotional and administrative capacity.

In another instance, an individual was licensed to preach by a local church, but such license did not clothe him with the authority to perform sacerdotal functions of the church usually performed by a pastor or assistant pastor. If called to a pastoral position he then would be ordained accordi
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rived from investing the original proceeds of the series B issue in 4.345-percent Treasury obligations. (However, the yield on the acquired obligations, taking into account $15,000 of administrative costs paid on January 1, 1983, would be only 4.252 percent. The yield on the series B issue would also be 4.252 percent.)

(9) Column E of Table II shows when the original proceeds of the series B issue would be spent. The original proceeds would be $4,915,000 (*i.e.*, $4,950,000 less issuing expenses of $35,000). All these original proceeds would be used to pay interest on the prior issue except for $15,000 that would be used to pay administrative costs of investing the original proceeds of the series B issue.

(10) Column F of Table II shows administrative costs of carrying and repaying the series B issue and investing the proceeds of the series B issue. These administrative costs would be paid with investment proceeds of the series B issue.

(11) Column G of Table II shows the amount of original proceeds of the series B issue that would be invested in Treasury obligations as of the end of the corresponding day in column A.

(12) Column H of Table II shows small amounts of original and investment proceeds of the series B issue that would be kept in a checking account. These amounts would be temporary investments (see § 1.103-14(e)(3)(ix)).

(d) Based on items (a), (b), and (c) of this example, the following conclusions may be drawn:

(1) All of the excess proceeds of the series B issue and substantially all (*i.e.*, all but $6,106) of the excess proceeds of the series A issue would be used to pay principal and interest on the series B issue.

(2) All of the excess proceeds of the series B and series A issues would be investment proceeds.

(3) All of the principal and interest on the series B issue would be paid with proceeds of the series B and series A issues.

(4) The series B issue would be discharged on January 1, 1990, the same day as the prior issue.

(5) The proceeds of the series B issue would not be spent faster than principal and interest on the series B issue and administrative costs of the series B issue would be paid. For example, on January 1, 1984, $956,500 of proceeds of the series B would have been spent (*i.e.*, $752,416 of original proceeds plus $204,084 of investment proceeds), which is the same as the $956,500 of principal, interest, and administrative costs of the series B issue that would be paid on or before January 1, 1984 (*i.e.*, $750,000 of principal plus $190,500 of interest plus $16,000 of administrative costs).

(e) Based on the conclusions in item (d) of this example, the series A and series B bonds are not treated as arbitrage bonds under this section (see paragraph (c) of this section).

This Treasury decision is issued under the authority contained in section 7805 of the Internal Revenue Code of 1954 (68A Stat. 917; 26 U.S.C. 7805).

JEROME KURTZ,
Commissioner of Internal Revenue.

Approved May 8, 1979.

DONALD C. LUBICK,
Assistant Secretary of the Treasury.

(Filed by the Office of the Federal Register on May 31, 1979, 8:45 a.m., and published in the issue of the Federal Register for June 7, 1979, 44 F.R. 32657)

Section 104.—Compensation for Injuries or Sickness

26 CFR 1.104-1: Compensation for injuries or sickness.
(Also Sections 61, 451; 1.61-1, 1.451-1.)

Damages; monthly payments; amount excludable. An insurance company purchased and retained exclusive ownership in a single premium annuity contract to fund monthly payments stipulated in settlement of a damage suit. The recipient may exclude the full amount of the payments from gross income under section 104(a)(2) of the Code rather than the discounted present value. Payments made to the estate after the recipient's death are also fully excludable.

Rev. Rul. 79-220

ISSUE

Does the exclusion from gross income provided by section 104(a)(2) of the Internal Revenue Code of 1954 apply to the full amount of monthly payments received in settlement of a damage suit or only to the discounted present value of such payments?

FACTS

A, an individual, sued *B* for damages for personal injuries. *B* is insured by *M*, an insurance company. Before trial, *A* accepted *M*'s offer to settle the suit for a lump-sum payment of $8,000 and *M*'s agreement to provide *A* with the discounted present value of the monthly payments of $250 for *A*'s lifetime or 20 years, whichever is longer, the payments to be made to *A*'s estate after *A*'s death if *A* should die before the end of 20 years. *A* had no right to which, at date of settlement, was less than the total monthly payments to be provided) or to control the investment of that amount.

To provide the monthly payments for *A*, *M* purchased a single premium annuity contract from *O*, another insurance company. *M* advised *O* to make payments directly to *A*. However, *M* is the owner of the annuity contract and has all rights of ownership, including the right to change the beneficiary. *A* can rely on only the general credit of *M* for collection of the monthly payments.

LAW AND ANALYSIS

Section 61(a) of the Code and the Income Tax Regulations thereunder provide that, except as otherwise provided by law, gross income means all income from whatever source derived.

Section 104(a)(2) of the Code provides that except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical and dental expenses) for any prior taxable year, gross income does not include the amount of any damages received (whether by suit or agreement) on account of personal injuries or sickness.

Section 1.104-1(c) of the regulations provides, in part, that the term "damages received (whether by suit or agreement)" means an amount received (other than workmen's compensation) through prosecution of a legal suit or action based upon tort or tort type rights, or through a settle-

ment agreement entered into in lieu of such prosecution.

However, if a lump-sum damage payment is invested for the benefit of a claimant who has actual or constructive receipt or the economic benefit of the lump-sum payment, only the lump-sum payment is received as damages within the meaning of section 104(a)(2) of the Code, and none of the income from the investment of such payment is excludable under section 104. See Rev. Rul. 65-29, 1965-1 C.B. 59, relating to damages awarded a claimant for tortious injuries in a lump-sum payment of 416*x* dollars over which claimant had unfettered control. The 416*x* dollars represented the discounted value of 520*x* dollars, which was found to be the reasonable cost of care, medicine, and medical attention for the injured person over a 10-year period. Rev. Rul. 65-29 holds that only the lump-sum payment, 416*x* dollars, is received as damages within the meaning of section 104(a)(2). See also Rev. Rul. 76-133, 1976-1 C.B. 34, which reaches a similar conclusion with regard to a court approved settlement awarded a minor and transmitted by the clerk of the court, in the name of the minor, to a savings and loan association for deposit in certificates of deposit.

In the instant case, there is a continuing obligation by *M* to pay $250 per month to *A* for the agreed period. *M*'s purchase of a single premium annuity contract from the other insurance company was merely an investment by *M* to provide a source of funds for *M* to satisfy its obligation to *A*. See Rev. Rul. 72-25, 1972-1 C.B. 127, which relates to a similar arrangement made by an employer to provide for payment of deferred compensation to an employee. In Rev. Rul. 72-25, as here, the arrangement was merely a matter of convenience to the obligor and did not give the recipient any right in the annuity itself.

HOLDINGS

The exclusion from gross income provided by section 104(a)(2) of the Code applies to the full amount of the monthly payments received by *A* in settlement of the damage suit because *A* had a right to receive only the monthly payments and did not have the actual or constructive receipt or the economic benefit of the lump-sum amount that was invested to yield that monthly payment. If *A* should die before the end of 20 years, the payments made to *A*'s estate under the settlement agreement are also excludable from income under section 104.

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26 CFR 1.104-1: Compensation for injuries or sickness.

✓ **Disability benefits; payments increased yearly.** A taxpayer received payments for personal injury in settlement with an insurance company as a result of an accident. The insurance company agreed to make fifty consecutive annual payments, each of which would be increased by five percent a year. The entire amount of the payments received is excludable from gross income under section 104(a)(2) of the Code.

Rev. Rul. 79-313 ✓

ISSUE

Are payments received by the taxpayer, under the circumstances described below, excludable from the gross income of the taxpayer under section 104(a)(2) of the Internal Revenue Code?

FACTS

In 1977, the taxpayer sustained severe and permanent personal injuries as the result of being struck by an automobile. Thereafter, the taxpayer brought an action against *X*, the owner-operator of the automobile. *X* carried automobile liability insurance with *M*, an insurance company.

In 1979, *M* proposed a settlement of taxpayer's suit against *X*, which the taxpayer accepted. Pursuant to the settlement agreement, *M* agreed to make fifty consecutive annual payments to the taxpayer, the first payment to be made one year after the date of settlement. These payments are for "personal injury, pain and suffering, disability, and loss of bodily function." The amount of each annual payment will be increased by five percent over the amount of the preceding annual payment.

The settlement also provides that the taxpayer does not have the right to accelerate any payment or increase or decrease the amount of the annual payments specified.

Under the agreement, *M* is not required to set aside specific assets to secure any part of its obligation to the taxpayer. The taxpayer's rights against *M* are no greater than those of *M*'s general creditors. *M*'s obligations to the taxpayer result solely from the settlement out of court of the legal action that the taxpayer instituted against *X* who was insured by *M*.

LAW AND ANALYSIS

Section 104(a)(2) of the Code provides that except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 for any prior taxable year, gross income does not include the amount of any damages received (whether by suit or agreement) on account of personal injuries or sickness.

Section 1.104-1(c) of the Income Tax Regulations provides that the term "damages received (whether by suit or agreement)" means an amount received (other than workmen's compensation) through prosecution of a legal suit or action based upon tort or tort type rights, or through a settlement agreement entered into in lieu of such prosecution.

The annual payments to be received by the taxpayer are amounts received through a settlement agreement entered into in lieu of the prosecution of a legal suit based upon tort or tort

expenses for household and dependent care services necessary for gainful employment).

(2) Earned income.—The term "earned income" shall have the meaning given such term in section 32(c)(2), but such term shall not include any amounts paid or incurred by an employer for dependent care assistance to an employee.

(3) Employee.—The term "employee" includes, for any year, an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

(4) Employer.—An individual who owns the entire interest in an unincorporated trade or business shall be treated as his own employer. A partnership shall be treated as the employer of each partner who is an employee within the meaning of paragraph (3).

(5) Attribution rules.—

(A) Ownership of stock.—Ownership of stock in a corporation shall be determined in accordance with the rules provided under subsections (d) and (e) of section 1563 (without regard to section 1563(e)(3)(C)).

(B) Interest in unincorporated trade or business.—The interest of an employee in a trade or business which is not incorporated shall be determined in accordance with regulations prescribed by the Secretary, which shall be based on principles similar to the principles which apply in the case of subparagraph (A).

(6) Utilization test not applicable.—A dependent care assistance program shall not be held or considered to fail to meet any requirements of subsection (d) merely because of utilization rates for the different types of assistance made available under the program.

(7) Disallowance of excluded amounts as credit or deduction.—No deduction or credit shall be allowed to the employee under any other section of this chapter for any amount excluded from the gross income of the employee by reason of this section.

(Added Pub.L. 97-34, Title I, § 124(e)(1), Aug. 13, 1981, 95 Stat. 198, and amended Pub.L. 97-448, Title I, § 101(e), Jan. 12, 1983, 96 Stat. 2366; Pub.L. 98-369, Title IV, § 474(r)(6), July 18, 1984, 98 Stat. 339.)

Editorial Notes

Effective Date of 1984 Amendment. Amendment by section 474(r)(6) of Pub.L. 98-369 applicable to taxable years beginning after Dec. 31, 1983, and to carrybacks from such years, pursuant to section 475(a) of Pub.L. 98-369.

Effective Date. Section 124(f) of Pub. L. 97-34 provided that this section is applicable to taxable years beginning after Dec. 31, 1981.

Prior Provisions. A prior section 129 was renumbered section 130 of this title.

§ 130. Certain personal injury liability assignments

(a) In general.—Any amount received for agreeing to a qualified assignment shall not be included in gross income to the extent that such amount does not exceed the aggregate cost of any qualified funding assets.

(b) Treatment of qualified funding asset.—In the case of any qualified funding asset—

(1) the basis of such asset shall be reduced by the amount excluded from gross income under subsection (a) by reason of the purchase of such asset, and

(2) any gain recognized on a disposition of such asset shall be treated as ordinary income.

(c) Qualified assignment.—For purposes of this section, the term "qualified assignment" means any assignment of a liability to make periodic payments as damages (whether by suit or agreement) on account of personal injury or sickness—

(1) if the assignee assumes such liability from a person who is a party to the suit or agreement, and

(2) if—

(A) such periodic payments are fixed and determinable as to amount and time of payment,

(B) such periodic payments cannot be accelerated, deferred, increased, or decreased by the recipient of such payments,

(C) the assignee does not provide to the recipient of such payments rights against the assignee which are greater than those of a general creditor,

(D) the assignee's obligation on account of the personal injuries or sickness is no greater than the obligation of the person who assigned the liability, and

(E) such periodic payments are excludable from the gross income of the recipient under section 104(a)(2).

(d) Qualified funding asset.—For purposes of this section, the term "qualified funding asset" means any annuity contract issued by a company licensed to do business as an insurance company under the laws of any State, or any obligation of the United States, if—

expenses for household and dependent care services necessary for gainful employment).

(2) Earned income.—The term "earned income" shall have the meaning given such term in section 32(c)(2), but such term shall not include any amounts paid or incurred by an employer for dependent care assistance to an employee.

(3) Employee.—The term "employee" includes, for any year, an individual who is an employee within the meaning of section 401(c)(1) (relating to self-employed individuals).

(4) Employer.—An individual who owns the entire interest in an unincorporated trade or business shall be treated as his own employer. A partnership shall be treated as the employer of each partner who is an employee within the meaning of paragraph (3).

(5) Attribution rules.—

(A) Ownership of stock.—Ownership of stock in a corporation shall be determined in accordance with the rules provided under subsections (d) and (e) of section 1563 (without regard to section 1563(e)(3)(C)).

(B) Interest in unincorporated trade or business.—The interest of an employee in a trade or business which is not incorporated shall be determined in accordance with regulations prescribed by the Secretary, which shall be based on principles similar to the principles which apply in the case of subparagraph (A).

(6) Utilization test not applicable.—A dependent care assistance program shall not be held or considered to fail to meet any requirements of subsection (d) merely because of utilization rates for the different types of assistance made available under the program.

(7) Disallowance of excluded amounts as credit or deduction.—No deduction or credit shall be allowed to the employee under any other section of this chapter for any amount excluded from the gross income of the employee by reason of this section.

(Added Pub.L. 97-34, Title I, § 124(e)(1), Aug. 13, 1981, 95 Stat. 198, and amended Pub.L. 97-448, Title I, § 101(e), Jan. 12, 1983, 96 Stat. 2366; Pub.L. 98-369, Title IV, § 474(r)(6), July 18, 1984, 98 Stat. 839.)

Editorial Notes

Effective Date of 1984 Amendment. Amendment by section 474(r)(6) of Pub.L. 98-369 applicable to taxable years beginning after Dec. 31, 1983, and to carrybacks from such years, pursuant to section 475(a) of Pub.L. 98-369.

Effective Date. Section 124(f) of Pub.L. 97-34 provided that this section is applicable to taxable years beginning after Dec. 31, 1981.

Prior Provisions. A prior section 129 was renumbered section 130 of this title.

§ 130. Certain personal injury liability assignments

(a) In general.—Any amount received for agreeing to a qualified assignment shall not be included in gross income to the extent that such amount does not exceed the aggregate cost of any qualified funding assets.

(b) Treatment of qualified funding asset.—In the case of any qualified funding asset—

(1) the basis of such asset shall be reduced by the amount excluded from gross income under subsection (a) by reason of the purchase of such asset, and

(2) any gain recognized on a disposition of such asset shall be treated as ordinary income.

(c) Qualified assignment.—For purposes of this section, the term "qualified assignment" means any assignment of a liability to make periodic payments as damages (whether by suit or agreement) on account of personal injury or sickness—

(1) if the assignee assumes such liability from a person who is a party to the suit or agreement, and

(2) if—

(A) such periodic payments are fixed and determinable as to amount and time of payment,

(B) such periodic payments cannot be accelerated, deferred, increased, or decreased by the recipient of such payments,

(C) the assignee does not provide to the recipient of such payments rights against the assignee which are greater than those of a general creditor,

(D) the assignee's obligation on account of the personal injuries or sickness is no greater than the obligation of the person who assigned the liability, and

(E) such periodic payments are excludable from the gross income of the recipient under section 104(a)(2).

(d) Qualified funding asset.—For purposes of this section, the term "qualified funding asset" means any annuity contract issued by a company licensed to do business as an insurance company under the laws of any State, or any obligation of the United States, if—

(1) such annuity contract or obligation is used by the assignee to fund periodic payments under any qualified assignment,

(2) the periods of the payments under the annuity contract or obligation are reasonably related to the periodic payments under the qualified assignment, and the amount of any such payment under the contract or obligation does not exceed the periodic payment to which it relates,

(3) such annuity contract or obligation is designated by the taxpayer (in such manner as the Secretary shall by regulations prescribe) as being taken into account under this section with respect to such qualified assignment, and

(4) such annuity contract or obligation is purchased by the taxpayer not more than 60 days before the date of the qualified assignment and not later than 60 days after the date of such assignment.

(Added Pub.L. 97–473, Title I, § 101(b)(1), Jan. 12, 1983, 96 Stat. 2605.)

Editorial Notes

Effective Date. Section 101(c) of Pub.L. 97–473 provided that this section shall apply to taxable years ending after December 31, 1982.

§ 131. Certain foster care payments

(a) General rule.—Gross income shall not include amounts received by a foster parent during the taxable year as qualified foster care payments.

(b) Qualified foster care payment defined.—For purposes of this section—

(1) In general.—The term "qualified foster care payment" means any amount—

(A) which is paid by a State or political subdivision thereof or by a child-placing agency which is described in section 501(c)(3) and exempt from tax under section 501(a), and

(B) which is—

(i) paid to reimburse the foster parent for the expenses of caring for a qualified foster child in the foster parent's home, or

(ii) a difficulty of care payment.

(2) Qualified foster child.—The term "qualified foster child" means any individual who—

(A) has not attained age 19, and

(B) is living in a foster family home in which such individual was placed by—

(i) an agency of a State or political subdivision thereof, or

(ii) an organization which is licensed by a State (or political subdivision thereof) as a child-placing agency and which is described in section 501(c)(3) and exempt from tax under section 501(a).

(c) Difficulty of care payments.—For purposes of this section—

(1) Difficulty of care payments.—The term "difficulty of care payments" means payments to individuals which are not described in subsection (b)(1)(B)(i), and which—

(A) are compensation for providing the additional care of a qualified foster child which is—

(i) required by reason of a physical, mental, or emotional handicap of such child with respect to which the State has determined that there is a need for additional compensation, and

(ii) provided in the home of the foster parent, and

(B) are designated by the payor as compensation described in subparagraph (A).

(2) Limitation based on number of children.—In the case of any foster home, difficulty of care payments for any period to which such payments relate shall not be excludable from gross income under subsection (a) to the extent such payments are made for more than 10 qualified foster children.

(Added Pub.L. 97–473, Title I, § 102(a), Jan. 14, 1983, 96 Stat. 2606.)

Editorial Notes

Effective Date. Section 102(c) of Pub.L. 97–473 provided that this section shall apply to taxable years beginning after December 31, 1978.

§ 132. Certain fringe benefits

(a) Exclusion from gross income.—Gross income shall not include any fringe benefit which qualifies as a—

(1) no-additional-cost service,

(2) qualified employee discount,

(3) working condition fringe, or

(4) de minimis fringe.

(b) No-additional-cost service defined.—For purposes of this section, the term "no-additional-cost service" means any service provided by an employer to an employee for use by such employee if—

(1) such service is offered for sale to customers in the ordinary course of the line of business

by the jury of the seriousness of the crime, and ultimately by the judge in setting sentence where the punishment may then fit the crime.

Accordingly, the court finds that it is not necessary for defendant to have prior knowledge that the stolen purse contained C.D.S. for him to be convicted of theft of C.D.S. pursuant to *N.J.S.A.* 2C:20–3 a. The jury will therefore be instructed as follows:

> In your deliberations you are further instructed that it is not necessary for the State to prove that the defendant had prior knowledge that the victim's purse contained C.D.S. in order for you to convict him of a theft of the C.D.S.

186 N.J.Super. 381

Johanna Marie LANDGRAF, an infant, by her guardian ad litem, John LANDGRAF, and John Landgraf and Mari-Jean Landgraf, individually, Plaintiffs,

v.

John William Henry GLASSER, M.D., Ellezer Ronen, M.D., William J. Muster, Jr., M.D., and Valley Hospital, individually, severally and/or jointly, Defendants.

Superior Court of New Jersey,
Law Division, Bergen County.

Decided Sept. 17, 1982.

Attorney applied for approval of attorney fee in excess of contingent fee provided for in retainer agreement and allowable under rule of court governing contingent fees. The Superior Court, Law Division, Bergen County, Simpson, A. J. S. C., held that inasmuch as medical malpractice panel split in determination as to malpractice, attorney was also physician, and written retainer contained standard provision reserving attorney's right to apply for additional fee, request for increase in fee from 10% to 20% of recovered amount was reasonable.

Order accordingly.

1. Attorney and Client ⇐148(3)

Secrecy provisions of in camera provision of statute governing professional medical liability in malpractice actions are not intended to preclude reference thereto by assignment judge in determining reasonable fee pursuant to rule of court governing contingent fees. R. 1:21–7(f); R. 4:21–7.

2. Attorney and Client ⇐148(3)

Skill and ability of such lawyer doctor were factors supporting reasonableness of increased fee in medical malpractice action, even though dual qualification might have permitted attorney to develop case in less time than lawyer without medical training. R. 1:21–7(f).

3. Attorney and Client ⇐148(3)

Although parents of infant plaintiff who brought medical malpractice action relied on fee schedule provided by rules of court that was incorporated in retainer agreement, where written retainer agreement also contained standard provision reserving attorney's right to apply for additional fees pursuant to rule governing contingent fees, fee was already discounted to present value by calculation on net recovery based upon present cost of deferred annuity and balloon payments, and attorney who brought action was also physician, request for increase in allowable attorney fees from 10% to 20% was reasonable. R. 1:21–7(c, d, f).

Kenneth A. Anderson, Englewood, for plaintiffs (Goldsmith & Tabak, Englewood, attorneys).

Jeffrey A. Lester, Hackensack, guardian ad litem, for Johanna Marie Landgraf (filed a report of guardian ad litem respecting proposed settlement).

No appearance was required on behalf of any of the remaining parties.

SIMPSON, A.J.S.C.

This is an application under *R.* 1:21–7(f) for approval of an attorney's fee in excess of the contingent fee provided for in the retainer agreement and allowable under *R.* 1:21–7(c). The request is for an increase of the 10% otherwise allowable under *R.* 1:21–7(c)(6) as to recovery over $250,000, to 20%, relying upon *Merendino v. F.M.C.*, 181 *N.J. Super.* 503, 438 *A.*2d 365 (Law Div.1981).

The trial judge approved a structured settlement for the benefit of an infant plaintiff, as well as reimbursement to the parents for $16,500 expenses, disbursements by counsel totalling $8,812.36, and a guardian *ad litem* fee of $772.50. The child, Johanna Marie Landgraf, was born December 30, 1976, is severely brain damaged, and is totally incapable of caring for herself. A medical malpractice action was commenced against an obstetrician, an anesthesiologist and a pediatrician. The anesthesiologist was uninsured, but ultimately contributed $100,000 of the settlement. The same insurance carrier covered the other two doctors, with the policy limits being $1,000,000 for the obstetrician and $500,000 for the pediatrician. The difficulties of the case are apparent from the findings of the *R.* 4:21 medical malpractice panel. A unanimous disposition would have been admissible at trial pursuant to *R.* 4:21–5(e). Two panelists determined that, as to one claim of malpractice, the obstetrician and anesthesiologist deviated from accepted standards of medical practice which was a proximate cause of the brain injury; but the third panelist disagreed. The panel unanimously rejected all other claims of malpractice, except that as to one claim against the pediatrician they unanimously found deviation from accepted standards but that such deviation was not a proximate cause of any injury to the infant.

The case was settled with the aid of the trial judge on the day of trial and after a full day's negotiations. The terms were $250,000 cash, $40,000 a year for the life of the child with a ten-year guarantee, and $100,000 lump sum at the end of ten years. For fee purposes the settlement may be summarized as follows:

Cash	$250,000.00
Cost [1] of $40,000 a year annuity	283,254.00
Cost [1] of $100,000 lump sum payable in ten years	35,242.00
Gross aggregate recovery	$568,500.00
Less: disbursements	8,812.36
Net sum recovered [R. 1:21-7(d)]	$559,687.64

The allowable and requested fee calculations are:

R. 1:21-7(c)	%	On	Allowable	Requested
(1) Limited by (7)	25	$ 1,000.00	$ 250.00	$ 250.00
(2) Limited by (7)	25	2,000.00	500.00	500.00
(3) Limited by (7)	25	47,000.00	11,750.00	11,750.00
(4)	25	50,000.00	12,500.00	12,500.00
(5)	20	150,000.00	30,000.00	30,000.00
(6)	10	309,687.64	30,968.76	61,937.53
		$559,687.64	$85,968.76	$116,937.53

[1] For attorney fee purposes, this case is similar to three other situations where increase of *R.* 1:21–7(c)(6) allowances from 10% to 20% were approved. *Merendino, supra; Pacillo v. Harris*, 182 *N.J.Super.* 322, 440 *A.*2d 1168 (Law Div.1982); *Tobias v. Autore*, 182 *N.J.Super.* 328, 440 *A.*2d 1171 (Law Div.1982). In addition, the split *R.* 4:21 panel determination as to malpractice is a factor supporting allowance of the requested increase in attorney's fee. *R.* 1:21–7(f); DR 2–106(A)(1). The secrecy provisions of *R.* 4:21–7 are not intended to preclude reference thereto by an assignment judge determining a reasonable fee pursuant to *R.* 1:21–7(f).

[2] Two other aspects of the present case require consideration. This was a difficult medical malpractice case that was fully prepared for trial by an attorney who is also a physician. Although it was suggested that this dual qualification might have permitted plaintiff's attorney to develop the case in less time than a lawyer without medical training, the skill and ability of such a lawyer-doctor are factors supporting the reasonableness of the increased

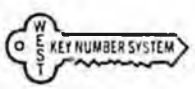
1. The present cost of future annuity and lump sum payments are the recovery figures to be utilized for contingent fee calculation purposes.

Merendino v. F.M.C., supra at 509, 438 *A.*2d 365.

fee. DR 2-106(A)(1) and (7). Additionally, the parents of the infant plaintiff object to the increased fee application despite their complete satisfaction with the settlement.

[3] The objections of the parents are understandable. Although the written retainer agreement contains the standard provision reserving the attorney's right to apply for an additional fee pursuant to *R.* 1:21-7(f), they relied upon the *R.* 1:21-7(c) schedule incorporated in the retainer. They also suggested that the fee should be "structured" since the settlement was—but this overlooks the fact that the fee has already been discounted to present value by calculation on the net recovery based upon the present cost of the deferred annuity and "balloon" payments. In virtually all cases, it is impossible for lay persons to make an informed judgment as to the reasonableness of an attorney's contingent fee. To safeguard against the possibility of such a fee improperly affecting the outcome of settlement negotiations, the New Jersey Supreme Court has limited *R.* 1:21-7(f) applications to the assignment judge. Under all the circumstances of this case, I am satisfied that the requested increase is reasonable and a total fee of $116,937.53 is approved.

An appropriate order should be submitted pursuant to *R.* 4:42-1.



186 N.J.Super. 386

STATE of New Jersey, Plaintiff.

v.

John GARCIA, Defendant.

Superior Court of New Jersey, Law Division, Hudson County.

Decided Oct. 4, 1982.

After defendant pled guilty to third-degree burglary but before sentencing, the Superior Court, Law Division, Hudson County, Stern, J.S.C., held that under statute presuming that first offender convicted of offense other than crime of first or second degree should not be imprisoned and explicitly excluding from benefit of the presumption any person who has previously been convicted of offense, prior uncounselled conviction for nonindictable offense did not constitute prior offense so as to make presumption inapplicable.

Order accordingly.

Criminal Law ⇐1202(1)

Under statute creating presumption that first offender convicted of offense other than crime of first or second degree should not be imprisoned and explicitly excluding from benefit of presumption any person who has previously been convicted of offense, prior uncounselled conviction for nonindictable offense did not constitute prior offense so as to make presumption inapplicable. N.J.S.A. 2C:44-1, subd. e.

Denise Teich, Asst. Prosecutor, for plaintiff (Harold J. Ruvoldt, Jr., Hudson County Prosecutor, attorney).

Thomas Kilcoyne, Asst. Deputy Public Defender, for defendant (Joseph H. Rodriguez, Public Defender, attorney).

STERN, J. S. C.

Defendant has pled guilty to third degree burglary, *N.J.S.A.* 2C:18-2, and is awaiting sentencing. He has been convicted of one or more nonindictable offenses[1] but has never been convicted of a crime. The question for consideration is whether the "presumption" against imprisonment applies when defendant's prior convictions are only for nonindictable offenses which may have followed disposition without the assistance of counsel.

N.J.S.A. 2C:44-1(c) provides:

1. The disposition of two complaints downgraded to charge "nonindictable" offenses is not indicated in the presentence report. Those matters will be the subject of a further report from the probation department before sentencing.

[12] During this period of time, which was between October 14, 1980 and December 15, 1980, Burroughs was a member of the statutorily protected class and entitled to a request for an extension if one was to be made. Any other conclusion would give Board the discretion to eliminate all bidders but its favorite, then give this bidder an extension which would work to the bidder's benefit in a number of ways.

In this case the benefit becomes obvious. Honeywell had a problem with the 90-day delivery schedule. On December 15, 1980 it did not have the equipment. However, it readily admits that it is *now* in possession of the necessary equipment and that it became available during the *unilaterally* extended period of time.

Nothing in the specifications remotely suggests that bidders should state how long their bids were effective and that Board may possibly utilize such criteria in awarding the bid. Certainly, a bidder may voluntarily set a time limitation on its bid; however, this voluntary limitation, which is in excess of the statutory 60-day period, cannot be utilized to the benefit of that bidder unless the contracting unit has given the same opportunity to all bidders at the time of the original advertisement for bids. Otherwise, Honeywell would be placed in the position of a legislator creating laws for its own benefit. A different interpretation would do violence to the legislative purposes and judicial policy of this State.

As Justice Francis stated and has often been quoted as stating in *Hillside Twp. v. Sternin*, 25 *N.J.* 317, 136 *A.*2d 265 (1957):

> In this field it is better to leave the door tightly closed than to permit it to be ajar, thus necessitating forevermore in such cases speculation as to whether or not it was purposely left that way. [at 326, 136 *A.*2d 265]

To open the door, as requested by Honeywell, by loosely construing and violently stretching the intentions of the Legislature as expressed by unambiguous words and phrases, would clearly give too much discretion to Board. It would also create the possibility of favoritism, improvidence, extravagance and corruption.

Both bidders for this reason, and for all of the reasons heretofore expressed, are declared ineligible and both motions for partial summary judgment are granted. Board is hereby permitted to readvertise for bids.

181 N.J.Super. 503

Rose Ann MERENDINO, Administratrix Ad Prosequendum of the Estate of Joseph Merendino, Jr., and General Administratrix of the Estate of Joseph Merendino, Jr., Plaintiff,

v.

FMC CORPORATION, Wayne Manufacturing Company, Inc. and North Jersey Equipment Company, Inc., Defendants.

Superior Court of New Jersey,
Law Division, Bergen County.

Decided Nov. 6, 1981.

Application was filed for approval of attorney fees in wrongful death action in excess of contingent fee provided for in retainer agreement or allowable pursuant to rule. The Superior Court, Law Division, Bergen County, Simpson, A. J. S. C., held that: (1) multiplier to be used in determining fee was the lower multiplier as between those set forth in retainer agreement and those provided in the rule itself; (2) proper base figure to which percentage multiplier should be applied was the "cost" of settlement which was part in cash and part by purchase of annuities; and (3) in light of excellent settlement achieved, ten percent attorney fee as to amounts recovered over $250,000 as provided in rule was inadequate, and award would be increased to allow 20% on all amounts recovered over $100,000.

So ordered.

1. Attorney and Client ⇐147

Since infant's share in wrongful death recovery was directly involved in application for approval of attorney fees in excess of contingent fee provided for in retainer agreement or allowable pursuant to rule, concurrences by guardian ad litem and by the widow were not controlling. R. 1:21–7(c, f).

2. Attorney and Client ⇐147

Twenty-five percent fee limitation on first $50,000 of recovery in the case of an infant, pursuant to rule governing contingent fees, was not applicable in case where the class of beneficiaries in wrongful death action included both adults and infants. R. 1:21–7(c)(7).

3. Attorney and Client ⇐147

In determining maximum fee allowable under contingent fee rule, the lower multipliers, as between those set forth in retainer agreement and those provided by rule itself, were applicable. R. 1:21–7(c, e).

4. Attorney and Client ⇐147

Proper base or "recovery" figure to which percentage multipliers should be applied in determining attorney fee under contingent fee rule was the cost of settlement, which was paid part in cash and part by purchase of annuities, representing the actual present value of the settlement, rather than a "value" of the settlement based on assumption of 8.5% rate or interest return. R. 1:21–7(c).

5. Attorney and Client ⇐147

In light of excellent settlement obtained, ten percent attorney fee as to amounts recovered over $250,000 as provided in rule concerning contingent fees was inadequate, and award would be increased to allow 20% on all amounts recovered over $100,000. R. 1:21–7(c)(6).

Alan Y. Medvin, Newark, for plaintiff (Horowitz, Bross, Sinins, Imperial & Medvin, Newark, attorneys).

Paul L. Potenza, New Milford, guardian ad litem for Justine Merendino, filed a report as guardian ad litem respecting proposed settlement.

No appearance was required on behalf of any of the remaining parties.

SIMPSON, A. J. S. C.

This is an application under *R.* 1:21–7(f) for approval of an attorney's fee in excess of the contingent fee provided for in the retainer agreement or allowable pursuant to *R.* 1:21–7(c). The retainer and rule schedule are identical, except the retainer only provides for 33⅓% of the first $3,000 recovered while the rule permits up to 50% on the first $1,000 and 40% on the next $2,000. Plaintiff's counsel seeks a fee of $103,691.25 and asserts that $81,293.55 is allowable under *R.* 1:21–7. I find that $73,495.80 is allowable under the cited rule, but determine pursuant to *R.* 1:21–7(f) that $87,824.93 is a reasonable fee in light of all the circumstances.

Plaintiff is the administratrix *ad prosequendum* and general administratrix of the estate of Joseph Merendino, Jr., her husband, who died March 21, 1979 while operating a street sweeper as an employee of the City of Garfield. The widow, Rose Ann Merendino, was born September 3, 1947 and the only child, Justine, was born February 27, 1969. Workers' compensation death benefits under *N.J.S.A.* 34:15–13, and based upon decedent's weekly wages of $167.69, are $92.20 for 419 weeks until Justine is 18 and then $84.10 for an additional 31 weeks. The 450 weeks total compensation would be $41,238.90, and since this is less than the settlement of the third-party wrongful death claim (the first $50,000 of which is subject to counsel fees of at least 33⅓% under the retainer or *R.* 1:21–7(c)), one-third thereof or $13,746.30 is the employer's obligation under *N.J.S.A.* 34:15–40 for its pro rata share of the attorney's fee. *Owens v. C. & R. Waste Material*, 76 *N.J.* 584, 388 *A.*2d 977 (1978). Worker's compensation paid to date totals $12,736.00, so that Rose Ann Merendino is now entitled to $1,010.30 plus $200 litigation costs. *N.J.S.A.* 34:15–40(e). Depending upon future contingencies, the widow may be entitled after the

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450 weeks to further weekly payments from the employer (or carrier) representing additional pro rata share of the attorney's fee not exceeding 33⅓% of additional weekly payments otherwise due pursuant to *N.J.S.A.* 34:15–40(e) and 34:15–13(j). The absolute maximum, of course, would be the $87,824.93 herein allowed as a counsel fee in the third-party action (including the $13,746.30 calculated as above for the first 450 weeks).

The trial judge handling the products liability-wrongful death action approved a proposed "structured" settlement, and allocation between the widow and child pursuant to *N.J.S.A.* 2A:31–4, as follows:

1. $210,000 cash "up front" to the widow, Rose Ann Merendino, from which attorney's fees and litigation expenses are to be paid.

2. Annual payments to the widow, beginning with $11,928.00 and increasing at 6% a year, compounded annually, for 25 years certain. Appendix A schedules these payments and the cumulative totals. The final payment is $48,295.76 and the cumulative total is $654,424.66.

3. Five annual payments to the daughter, Justine Merendino, beginning in six years when she will be just under 18 years of age, in the amounts of $11,000, $12,000, $13,000, $14,000 and $22,000. The grand total is $72,000.

The annual payments to the widow and child are guaranteed, with appropriate survivorship provisions, and the trial judge had the benefit of a guardian *ad litem* report essentially concurring in the settlement provisions. For purposes of trial, plaintiff's expert economist had prepared an "Appraisal of Economic Loss" due to the death of Mr. Merendino which, discounted to present value, was asserted to be $343,647. *Tenore v. Nu Car Carriers*, 67 *N.J.* 466, 474, 341 *A.2d* 613 (1975). For purposes of settlement, trial court approval thereof, and this application for counsel fees in excess of the amount allowable under *R.* 1:21–7(c), plaintiff's attorney retained a "mediator and negotiator," one Daniel Bellin, president of Litigation Support Corporation. Bellin's opinion was that the "value of the settlement could be conservatively stated as $472,722," calculated as follows:

Cash	$210,000
Value at 8.5% net rate of return for Justine Merendino payments	36,738
Value, at same rate, for Rose Ann Merendino payments	225,984
Total	$472,722

Litigation Support Corporation apparently was also instrumental in obtaining insurance company funding of the annuities on a basis that makes the proceeds payable to Rose Ann and Justine Merendino without any federal income taxation thereon.[1] The cost to defendant of the annuities, however, was less than Bellin's valuations, so that the actual present cost of the package is:

Cash	$210,000
Cost of Justine Merendino Annuity	29,622
Cost of Rose Ann Merendino Annuity	159,938
Total	$399,600

Although no trial or appeal was required, and no novel questions of law appear to have been involved, this case resulted in an excellent recovery for the widow and minor child of decedent. The imaginative blending of cash and annuities, on an after-tax basis and capitalizing on the power of compound interest, places the case, for attorney fee purposes, somewhere between the situations in *Murphy v. Mooresville Mills*, 132 *N.J.Super.* 197, 333 *A.2d* 273 (App.Div.1975), certif. den. 68 *N.J.* 156, 343 *A.2d* 444 (1975), and *Bolle v. Community Memorial Hospital*, 145 *N.J.Super.* 592, 368 *A.2d* 935 (App.Div. 1976), certif. den. 74 *N.J.* 275, 377 *A.2d* 679 (1977). When an attorney considers the fee permitted by *R.* 1:21–7(c) to be inadequate, he may seek approval by the assignment judge "of a reasonable fee in light of all the circumstances." *R.* 1:21–7(f). Pursuant to *R.* 1:21–7(e) all contingent fees must con-

1. One of the defendants is obligated to make all periodic payments to Rose Ann and Justine Merendino. Said defendant owns the annuity contracts. The periodic payments are therefore fully excludable, for federal income tax purposes, from gross income. I.R.C. § 104(a)(2); *Treas. Regs.* § 1.104 1(c); *Rev. Rulings* 79 220 and 79 313.

form to DR 2-106(A) that include, in pertinent part, as "guides in determining the reasonableness of a fee":

(1) The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal services properly.

. . . . . .

(4) The amount involved and the results obtained.

. . . . . .

(7) The experience, reputation, and ability of the lawyer or lawyers performing the services.

[1, 2] The trial judge approved the settlement on the basis of the above-described annuities and an indicated distribution of $100,000 of the $210,000 "up front" money to Rose Ann Merendino. Plaintiffs' counsel requests the balance of $110,000 for counsel fees and all disbursements, including the guardian *ad litem's* fee and costs. Disbursements were $4,459.45 and the trial judge allowed the guardian *ad litem* an $1,800 fee plus disbursements of $49.30. These items total $6,308.75; hence the requested counsel fee is $103,691.25. It was agreed, however, that any reduction of this requested counsel fee would inure to the benefit of Justine Merendino. At a hearing before me Mrs. Merendino testified that her attorneys did an outstanding job, she was very satisfied, and she and her brother (also a New Jersey attorney) believed the attorneys deserved the requested fee. The guardian *ad litem* did not oppose the fee application either. Since the infant's share is directly involved, these concurrences are not controlling. *Murphy v. Mooresville Mills, supra* at 200, 333 *A.*2d 273. The 25% fee limitation on the first $50,000 recovery in the case of an infant, pursuant to *R.* 1:21-7(c)(7), is not applicable in a case such as this, however, where the class of beneficiaries in a wrongful death action includes both adults and infants. *McMullen v. Maryland Cas. Co.*, 127 *N.J.Super.* 231, 239, 317 *A.*2d 75 (App.Div.1974), aff'd 67 *N.J.* 416, 341 *A.*2d 334 (1975).

[3, 4] In determining the maximum fee allowable under *R.* 1:21-7(c) the first question is the multipliers to be used—those set forth in the retainer agreement or those provided by the rule itself. In view of *R.* 1:21-7(c), the lower multipliers are applicable—but the differences are only as to the first $3,000 recovered and in this case the difference is *de minimis.*

The second and more important question is the proper base or "recovery" figure to which the percentage multipliers should be applied. Plaintiffs' counsel suggests "value" of $472,722 as set forth above, rather than "cost" of $399,600 as also analyzed above. I find that the lower figure is the correct one, which represents the actual present value of the settlement. Bellin's calculation assumes an 8.5% rate or interest return, whereas the cost of the annuities reflects the actual present value in the marketplace. The marketplace cost is the acid test in a case like this—with fixed, guaranteed, periodic payments not requiring actuarial assumptions as to life expectancy or survivorship—rather than calculations of "value" that involve interest rate estimates for the future. In addition, presumably defendants would be willing to alternatively pay the total cash cost of the package, or $399,600, to plaintiffs now—since they are presently expending such total to plaintiffs and the annuity underwriter. From this figure disbursements of $6,308.75, as set forth above, are deducted pursuant to *R.* 1:21-7(d), leaving an aggregate sum of recovery of $393,291.25 upon which to calculate the contingent fee.

Applying the retainer agreement percentage to the first $3,000 and the *R.* 1:21-7(c) percentages to the rest of the $393,291.25 results in the following initial calculation of allowable counsel fees:

R.1:21-7(c)	%	On	Fee
(1) – Retainer agreement	33 ⅓	$ 1,000.00	$ 333.33
(2) – Retainer agreement	33 ⅓	2,000.00	666.67
(3) – Rule	33 ⅓	47,000.00	15,666.67

R. 1:21-7(c)	%	On	Fee
(4) - Rule	25	$ 50,000.00	$12,500.00
(5) - Rule	20	150,000.00	30,000.00
(6) - Rule	10	143,291.25	14,329.13
	Totals	$393,291.25	$73,495.80

The difference between plaintiffs' attorney's calculation of $81,293.55 as allowable under *R.* 1:21–7(c) and the court's calculation of $73,495.80 is largely due to the different bases upon which the multiplications are made. In any event, the application is under *R.* 1:21–7(f) for an attorney fee of $103,691.25 plus disbursements of $6,308.75 (including guardian *ad litem* allowance and costs) for a total of $110,000.00.

This presents the third and most important question of additional allowance, if any, to rectify any inadequacy, as permitted under *R.* 1:21–7(f), in order to provide a total "reasonable fee in light of all the circumstances." In my view, it is preferable to provide such allowance by adjustment of one or more of the *R.* 1:21–7(c) percentages rather than an undetailed flat figure. This will facilitate future calculation of possible additional payments to Rose Ann Merendino by decedent's employer (or carrier) representing additional pro rata share of attorney's fee, as noted above in connection with worker's compensation benefits.

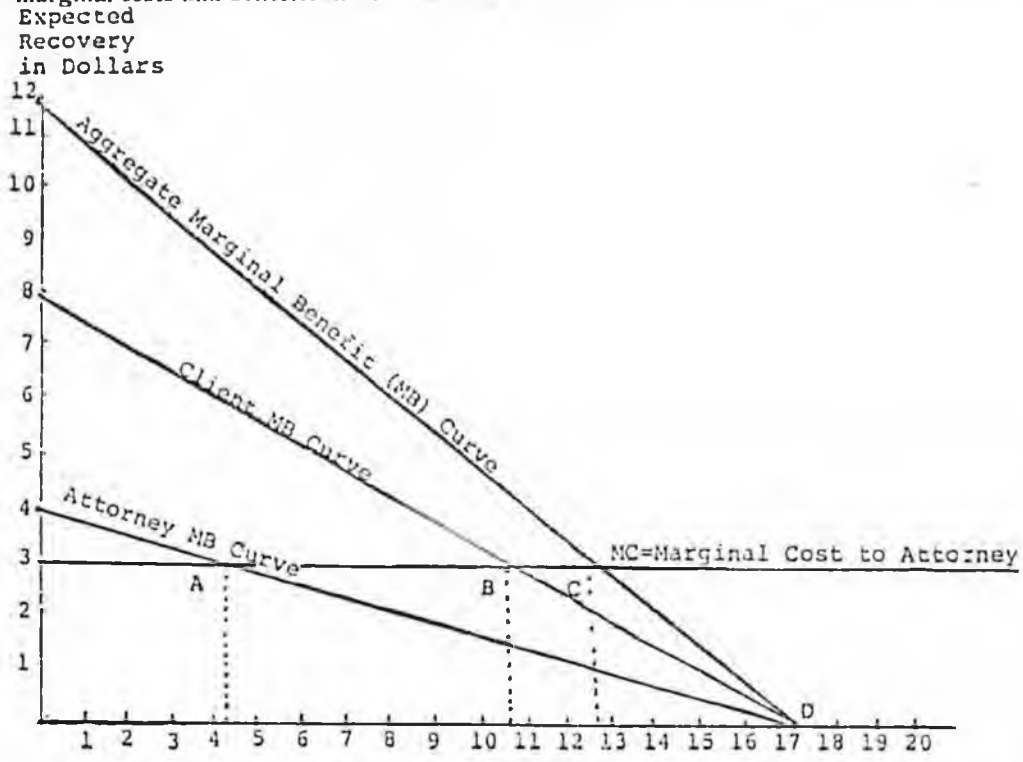
In this case, for the reasons already stated and those to be hereafter chronicled, I have concluded that the 10% attorney's fee allowance as to $143,291.25 under *R.* 1:21–7(c)(6) is inadequate and should be increased to 20%. This amounts to an additional allowance of $14,329.13 which, when added to the $73,495.80 calculated as above, results in a total attorneys' fee of $87,824.93. Disbursements of $6,308.75 are also allowable for a total of $94,133.68. The remaining balance of the $210,000 cash payments is distributable to the infant, Justine Merendino, so that the "up front" moneys will be distributed as follows:

Rose Ann Merendino	$100,000.00
Justine Merendino[2]	15,866.32
Counsel fees and disbursements (including guardian *ad litem* allowance and costs)	94,133.68
Total	$210,000.00

[5] In a case such as this, with the excellent "structured" settlement already described, the 10% attorney's fees as to amounts recovered over $250,000 provided by *R.* 1:21–7(c)(6) is inadequate. Contingent fees are an imaginative solution to the problem of the cost of legal services being an obstacle to vindication of a claim even when the plaintiff's stakes are very large. It is sometimes argued that contingent fees are often exorbitant, but the concept permits quality representation plaintiffs could otherwise not afford. By pooling a number of such claims, the lawyer specializing in such matters can reduce the risk of loss or inadequate return on invested legal services. Additionally, the contingent fee compensates the lawyer for the loan of his services until the case is won or settled—usually a matter of years. *R.* 1:21–7(b) always requires that the client have the opportunity to decline a contingent fee arrangement and retain an attorney on the basis of reasonable value for services rendered. The contingent fee is therefore consensual, with court rule protection against overreaching. The remaining problem is to structure permissible fees, both generally and in specific cases, to try to attain the maximum aggregate marginal benefit for the client and the attorney. From an eco-

2. To be placed in the Bergen County Surrogate's Intermingled Account, pursuant to *R.* 4:57-2(b), unless otherwise ordered by the court. This account currently earns interest at 15% compounded daily, for an effective annual yield of 16.122% to October 1, 1982.

nomics point of view, the relationship of marginal costs and benefits involved in contingent fee contracts may be modeled as follows:



Units of Legal Effort

The vertical axis reflects increasing expected recovery due to increasing units of legal effort as shown on the horizontal axis. The marginal benefit curves show the expected value in dollars of marginal increases in the number of units of legal effort. It is assumed all units of legal effort, borne by the attorney under a contingent fee contract, cost the same—and are diagrammed as MC on the model. The intersecting points of the attorney, client, and aggregate marginal benefit curves with the attorney marginal cost line are significant and labelled A, B, and C for reference. Marginal benefit curves are incremental and reflect probabilities of recovery and risks of loss, and it is assumed that attorney and client marginal evaluations of expected value to them of additional units of legal effort are in a ballpark range of reasonable accuracy. The vertical dash lines from points A, B, and C, to the horizontal scale enable measurement of the units of legal effort expended at such critical points and permit the following logical deductions:

A. From a self-interest point of view, an attorney is motivated to expend only 4+ units of effort—because the expected value *to him* of effort past that point is less than the cost to him of that effort.

B. From his self-interest point of view, a client would like an attorney to continue expending units of legal effort all the way to 17 or point D—continuing beyond point B, since the marginal costs of additional units of legal effort are borne solely by the attorney.

C. To maximize the expected value with equal weight to the interest of both the attorney and the client, under a contingent fee contract where the attorney bears the marginal costs—the units of legal effort should be 12+ or the point at which the aggregate marginal benefit curve intersects the MC line.

From an ethical point of view, it seems clear that an attorney should continue legal efforts at least to point C on the model and our contingent fee rules should encourage

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proof. (See section 100055.1.) There is nothing in the statute to support appellant's contention that the preceding year's corporate configuration should be the factor utilized in determining revenue vehicle mileage in the preceding year.[3]

Appellant argues that any reading of the statutes, other than its own, avoids the legislative intent by enabling the District to buy out only so much of an existing system as to put the remainder of that existing 1508 system outside of the statutory definition. However, the Legislature has clearly shown by section 100055.1 that it has such an intent by providing that the District could not establish service until it had completed purchase of the existing system *or any part thereof.* Clearly, an otherwise "existing system" could fall outside of the definition as a result of a partial purchase. Since appellant as it existed in 1973 was not an existing system within the statutory definition, there was no restriction imposed upon respondent which precluded establishment of the San Jose—Fremont run. Nothing in the Act prevents competition between the District and a system which is not an existing system as defined in the Act.

In light of this conclusion, appellant's other contentions need not be addressed.[4] The judgment of the trial court is affirmed.

SCOTT, Acting P. J., and BROWN (Judge of the Superior Court, assigned by the Chairperson of the Judicial Council), J., concur.

3. Had there never been a connection between the Santa Clara Division and the rest of appellant's system, purchase of the Santa Clara Division would clearly have satisfied the statute. Competition with appellant's Oakland Division would have been permitted by the statute because appellant would not have had the required minimum of 40 percent of its revenue miles in Santa Clara County.

76 Cal.App.3d 509

Hill SAYBLE and Sayble and Raphael, a Professional Corporation, Plaintiffs and Appellants, 1509

v.

Frances FEINMAN, Defendant and Respondent.

Civ. 50732.

Court of Appeal, Second District, Division 2.

Jan. 4, 1978.

Hearing Denied March 2, 1978.

Attorneys, who represented client in wrongful death claim which resulted in settlement for client of $200,000 cash payment plus life annuity of $2,500 per month, commenced declaratory relief action to have phrase "28⅓% of any money recovered" in contingent fee contract prepared by them construed. The Superior Court, Los Angeles County, Delbert Wong, J., entered judgment in favor of client's interpretation of contract, and attorneys appealed. The Court of Appeal, Beach, J., held that whether meaning of phrase "28⅓% of any money recovered" was clear and precise or was ambiguous and uncertain, client's interpretation that attorneys were entitled to 28⅓% of life annuity portion of settlement only as she received funds in each monthly installment was correct, rather than attorneys' oppressive, inflexible interpretation that they were entitled to 28⅓% of present cash value of annuity.

Judgment affirmed.

1. Contracts ⇐176(1)

Construction of written contract is essentially judicial function to be exercised

4. One of appellant's other contentions should be commented upon. The trial court specifically found no fraud committed by respondent, and appellant contends this was error. The evidence appellant produced did not establish fraud as a matter of law. Therefore we must accept the finding of the trial court, as the trier of fact, that appellant did not sustain its burden of proof on this issue

according to generally accepted canons of interpretation.

2. Appeal and Error ⇐842(8)

A reviewing court is free to adopt its own construction of a contractual clause on attorney fees, resolving any uncertainties in favor of a fair and reasonable interpretation.

3. Appeal and Error ⇐1169(1)

Appellate court must determine that trial court's interpretation of written contract is erroneous before it may properly reverse a judgment.

4. Attorney and Client ⇐148(3)

If meaning of phrase "28⅓% of any money recovered" in contingent fee employment contract of attorneys representing client in wrongful death claim was clear and precise, rather than ambiguous and uncertain, language of contract would be followed. West's Ann.Civ.Code, § 1638.

5. Contracts ⇐154

Where one construction would make contract unusual and extraordinary and another construction, equally consistent with language employed, would make it reasonable, fair, and just, latter construction must prevail.

6. Contracts ⇐147(1)

Court of Appeal looks to contract itself and interprets it so as to give effect to intent of parties. West's Ann.Civ.Code, §§ 1639, 1643.

7. Attorney and Client ⇐148(1)

In view of uncertainty as to what would have been reasonable intentions of attorneys and client when contingent fee contract was made had they anticipated that part of client's settlement for her husband's wrongful death claim would be life annuity, words of contract were to be understood in their ordinary and popular sense, rather than in their strict legal meaning, unless there was evidence parties intended to use words in technical sense or to give words special meaning. West's Ann. Civ.Code, § 1644.

8. Contracts ⇐143(3)

Court of Appeal has neither power to make for parties a contractual arrangement which they themselves did not make nor to insert in agreement language that appealing party wishes were there. West's Ann. Code Civ.Proc. § 1858.

9. Attorney and Client ⇐148(3)

If meaning of phrase "28⅓% of any money recovered" in contingent fee employment contract prepared by attorneys representing client was clear and certain, client's interpretation that attorneys were entitled to 28⅓% of life annuity portion of settlement only as she received funds in each monthly installment was correct, rather than attorneys' interpretation that they were entitled to 28⅓% of present cash value of annuity, in that claimant did not recover any money from annuity until actually receiving each monthly payment.

10. Attorney and Client ⇐148(3)

Even if meaning of phrase "28⅓% of any money recovered" in contingent fee employment contract prepared by attorneys representing client was ambiguous, client's interpretation that attorneys were entitled to 28⅓% of life annuity portion of settlement only as she received funds in each monthly installment was correct, rather than attorneys' interpretation that they were entitled to 28⅓% of present cash value of annuity, in that any uncertainties were to be resolved against oppressive, inflexible interpretation of attorneys as contract preparers.

11. Attorney and Client ⇐148(3)

Attorneys' interpretation that phrase "28⅓% of any money recovered" in contingent fee contract prepared by them entitled them to 28⅓% of present cash value of life annuity portion of client's settlement for her husband's wrongful death claim was unreasonable and absurd, where there was every indication client would continue to pay attorneys 28⅓% of annuity as she received funds in each monthly installment and under attorneys' interpretation they were entitled immediately to 80% of money recovered thus far. West's Ann.Civ.Code, §§ 1638, 1643.

Memel, Jacobs,
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and appellants.

Tannenbaum, N
Stanton, Los An
respondent.

[511] BEACH, Assoc

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Memel, Jacobs, Pierno & Gersh, by Stanley K. Jacobs, Los Angeles, for plaintiffs and appellants.

Tannenbaum, Neiman & Billet by Paul L. Stanton, Los Angeles, for defendant and respondent.

[511] BEACH, Associate Justice.

Hill Sayble and Sayble and Raphael, a professional corporation, appeal from a judgment in favor of Frances Feinman construing the terms of payment in a contingent fee retainer agreement between appellant attorneys and respondent client.

FACTS:

Respondent Frances Feinman retained appellant attorneys to represent her claims arising out of the wrongful death of her husband. The parties entered into an attorney retainer agreement drafted by appellants. The contract provides in relevant part: "Attorney(s) shall be paid 28⅓% of *any money recovered* in this matter . . ." (Emphasis added.)

Appellants and respondent agree that at the time of the making of the contract, neither party contemplated a settlement other than a lump sum of cash. Appellants achieved an out-of-court settlement for respondent with a cash payment of $200,000, plus an annuity of $2,500 per month for her lifetime. Respondent's life expectancy at the time of settlement was 46.7 years.

Prior to the acceptance of the settlement in the wrongful death action, a dispute arose between the parties as to the amount and method of payment of attorneys' fees. Appellants contend that they were entitled immediately to their entire fee as a lump sum of 28⅓ percent of the $200,000 paid to respondent in cash plus 28⅓ percent of the present cash value of the annuity portion of the settlement. Respondent agreed that appellants were entitled to 28⅓ percent of the $200,000; but she maintained they were entitled to 28⅓ percent of the annuity only as she received the funds in each monthly installment.

[512] Pursuant to respondent's authorization and direction, the settlement of the original action was consummated without the resolution of the dispute. The parties were subsequently unable to resolve their dispute, and appellants commenced a declaratory relief action seeking the court's interpretation of the retainer contract and a declaration of the rights and duties of the parties under that agreement. The trial was bifurcated to permit the court to construe the retainer agreement as a matter of law without the presentation of evidence. The matter was submitted on the facts admitted by the pleadings and the stipulation of facts.

The court entered judgment in favor of respondent's interpretation of the contract and concluded as a matter of law that appellants were entitled to be paid 28⅓ percent of the settlement funds received to date by respondent, plus 28⅓ percent of each monthly payment of the life annuity portion of the settlement, as and when received by her and not before. This appeal followed.

CONTENTIONS ON APPEAL:

1. The trial court's findings and decision are not binding on the question of law presented.

2. The trial court misconstrued how the contingent fee retainer contract is to be applied to the annuity portion of the wrongful death settlement. Appellants contend that they have earned all their fees and are now entitled to receive 28⅓ percent of the present cash value of the annuity portion of the settlement in addition to the 28⅓ percent of all funds received to date.

DISCUSSION:

1. *The findings of the lower court are not binding on the question of law presented.*

[1-3] The construction of a written contract is essentially a judicial function to be exercised according to generally accepted canons of interpretation. A reviewing court is free to adopt its own construction of a contractual clause on attorneys' fees,

resolving any uncertainties in favor of a fair and reasonable interpretation. (*Ecco-Phoenix Electric Corp. v. Howard J. White, Inc.*, 1 Cal.3d 266, 272, 81 Cal.Rptr. 849, 461 P.2d 33.) But an appellate court must determine that the trial court's interpretation of a written contract is erroneous before it
513 may properly reverse a judgment. (*Parsons v. Bristol Development Co.*, 62 Cal.2d 861, 866, 44 Cal.Rptr. 767, 402 P.2d 839.)

2. *The court below properly interpreted the phrase "any money recovered" as it applies to respondent's life annuity.*

Here we are called upon to construe a provision of an attorney's contingent fee employment contract. The parties stipulated that when the contract was made, neither one considered a settlement other than by a lump sum of cash. Neither party contends that the contract is ambiguous or that it has been modified.

Nevertheless, appellants contend that unforeseen contingencies, such as the life annuity portion of respondent's settlement, are to be handled in light of the purpose of the contract and the mutual intentions of the parties at the time the contract was made. Appellants argue that their expectations resulting from such a "mutual intention" entitled them to receive immediately 28⅓ percent of the discounted present cash value of respondent's life annuity once the settlement became final. They argue that the trial court's interpretation of the retainer agreement was clearly erroneous and contrary to basic contract law in holding that they are entitled only to 28⅓ percent of the monthly payments as and when paid to respondent and not before. For the reasons that follow, we disagree with appellants and affirm the trial court's judgment.

[4, 5] The general rules pertaining to the interpretation of contracts have been succinctly summarized elsewhere (see *Moss Dev. Co. v. Geary*, 41 Cal.App.3d 1, 9, 115 Cal.Rptr. 736) and need not be repeated here. Whether the meaning of the phrase "28⅓% of any money recovered" is clear and precise or is ambiguous and uncertain does not alter the result in the case at bench. If the meaning is clear, the language of the contract will be followed. (Civ.Code, § 1638.) Moreover, where one construction would make a contract unusual and extraordinary and another construction, equally consistent with the language employed, would make it reasonable, fair, and just, the latter construction must prevail. (*Rost v. Bryson*, 118 Cal.App.2d 489, 258 P.2d 72.)

[6, 7] We look to the contract itself and interpret it so as to give effect to the intent of the parties. (Civ.Code, §§ 1639, 1643; *Advance Medical Diagnostic Laboratories v. County of Los Angeles*, 58 Cal.App.3d 263, 269, 129 Cal.Rptr. 723.) But the parties herein stipulated that when the contract was made, they contemplated only a lump sum settlement. Consequently, it is uncer-
514 tain what would have been the reasonable intentions of the parties had they anticipated that part of the settlement would be a life annuity. In such circumstances, the words of the contract are to be understood in their ordinary and popular sense, rather than in their strict legal meaning unless there is evidence the parties intended to use them in a technical sense or to give them a special meaning. (Civ.Code, § 1644; *Berman v. Dean Witter & Co., Inc.*, 44 Cal.App.3d 999, 119 Cal.Rptr. 130.)

"Money," in the ordinary and popular sense, means something generally accepted as a circulating medium of exchange issued under governmental authority.[1] Appellants' stipulation that their only expectation was that the settlement would be a "lump sum of cash" indicates they used the word money in the retainer contract in its ordinary sense. This is consistent with respon-

1. The Random House Dictionary of the English Language defines money as: "1. gold, silver, or other metal in pieces of convenient form stamped by public authority and issued as a medium of exchange and measure of value. 2. See *paper money*." Black's Law Dictionary (4th ed.) defines money as: "In usual and ordinary acceptation it means gold, silver, or paper money used as circulating medium of exchange, and *does not embrace* notes, bonds, evidences of debt, or *other personal or real estate*." (Emphasis added.)

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In California, "'Money' means a medium of exchange authorized or adopted by a domestic or foreign government as a part of its currency." (Com.Code, § 1201, adopting U.C.C. § 1201.) The Uniform Commercial Code Comment 24 to section 1201 states: "The test adopted is that of sanction of government . . . . which recognizes the circulating medium as a part of the official currency of that government." Likewise, "Money, checks, deposit accounts, and the like are 'cash proceeds.' All other proceeds are 'noncash proceeds.'" (Com. Code, § 9306.) This sharp distinction between money and other forms of personal property is also apparent in Code of Civil Procedure section 17.[2]

In the instant case, respondent does not, in fact, recover any *money* from her annuity until she actually receives each monthly payment. The life annuity is a promise of future payments which may or may not occur. Respondent properly contends that had appellants provided in their own contract that their fee would be 28⅓ percent of "the recovery," or "the full recovery," or "the value of the entire recovery," or "the amount realized," then their argument might be persuasive. However, appellants did not use such language in drafting their retainer agreement, and they cannot now alter that phrase to include what they claim they meant to say specifically to apply to a situation they were more qualified to anticipate than the client they, in their fiduciary capacity, undertook to serve and protect.

[8] This court has neither the power to make for the parties a contractual arrangement which they themselves did not make nor to insert in the agreement language that appellants now wish were there. (Code Civ.Proc., § 1858; *Pauley v. Faucett*, 124 Cal.App.2d 406, 269 P.2d 89.)

[9] If anything prevented the immediate payment of all attorneys' fees as soon as the settlement became final, it was appellants' failure specifically to express that intention in the contract. Respondent has and continues to fulfill her obligation to pay attorneys' fees according to the unambiguous terms of the contract. Therefore, under the hypothesis that the meaning of the phrase "28⅓% of any money recovered" is clear and certain, the interpretation of respondent and the court below is correct.

[10] Since appellants prepared this contract and in light of the oppressive nature of their interpretation of the clause at issue even if it can be argued the contract is ambiguous, we resolve any uncertainties in favor of a fair and reasonable interpretation and against the inflexible construction urged by appellants. (*Ecco-Phoenix Electric Corp. v. Howard J. White Inc.*, *supra*, 1 Cal.3d 266, 272, 81 Cal.Rptr. 849, 461 P.2d 33.)

[11] We also note that appellants have already received fees in excess of $56,000 (28⅓ percent of the $200,000 lump sum) plus 28⅓ percent of each monthly annuity payment received to date by respondent pursuant to that portion of the settlement. There is every indication respondent will continue to fulfill her contractual obligation hereafter. To agree with appellants would be to hold that they are entitled immediately to some 80 percent of the money recovered thus far. Such an interpretation of a contingent fee contract would be unreasonable and absurd. (Civ.Code, §§ 1638, 1643.)

We need not address the essentially impossible task of rewriting this contract to reflect what the parties might have said had they anticipated the problem of how a contingent fee contract is to be applied to a tort recovery part of which is to be paid in installments as an annuity. (Code Civ. Proc., § 1858; *Milstein v. Security Pac. Nat. Bank*, 27 Cal.App.3d 482, 487, 103 Cal.Rptr. 16.) We conclude that the trial court's interpretation of the disputed phrase, "money recovered," was proper.

The judgment is affirmed.

ROTH, P. J., and FLEMING, J., concur.

2. Code of Civil Procedure section 17 states in pertinent part: "The words 'personal property' include money, goods, chattels, things in action, and evidences of debt."

EXEMPT ORGANIZATIONS REQUIREMENTS • TESTS UNRELATED INCOME

[¶ 3001] EXEMPTION FROM TAX ON CORPORATIONS, CERTAIN TRUSTS, ETC.

Sec. 501. [1954 Code] (a) EXEMPTION FROM TAXATION.—An organization described in subsection (c) or (d) or section 401(a) shall be exempt from taxation under this subtitle unless such exemption is denied under section 502 or 503.

(b) TAX ON UNRELATED BUSINESS INCOME AND CERTAIN OTHER ACTIVITIES.—An organization exempt from taxation under subsection (a) shall be subject to tax to the extent provided in parts II, III and VI of this subchapter, but (notwithstanding parts II, III and VI of this subchapter) shall be considered an organization exempt from income taxes for the purpose of any law which refers to organizations exempt from income taxes.

(c) LIST OF EXEMPT ORGANIZATIONS.—The following organizations are referred to in subsection (a):

(1) Any corporation organized under Act of Congress which is an instrumentality of the United States but only if such corporation—

(A) is exempt from Federal income taxes—

(i) under such Act as amended and supplemented before the date of the enactment of the Tax Reform Act of 1984, or

(ii) under this title without regard to any provision of law which is not contained in this title and which is not contained in a revenue Act, or

(B) is described in subsection (l).

(2) Corporations organized for the exclusive purpose of holding title to property, collecting income therefrom, and turning over the entire amount thereof, less expenses, to an organization which itself is exempt under this section.

(3) Corporations, and any community chest, fund, or foundation, organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, or to foster national or international amateur sports competition (but only if no part of its activities involve the provision of athletic facilities or equipment), or for the prevention of cruelty to children or animals, no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in subsection (h)), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of any candidate for public office.

(4) Civic leagues or organizations not organized for profit but operated exclusively for the promotion of social welfare, or local associations of employees, the membership of which is limited to the employees of a designated person or persons in a particular municipality, and the net earnings of which are devoted exclusively to charitable, educational, or recreational purposes.

(5) Labor, agricultural or horticultural organizations.

(6) Business leagues, chambers of commerce, real estate boards, boards of trade or professional football leagues (whether or not administering a pension fund for football players), not organized for profit and no part of the net earnings of which inures to the benefit of any private shareholder or individual.

(7) Clubs organized for pleasure, recreation, and other nonprofitable purposes, substantially all of the activities of which are for such purposes and no part of the net earnings of which inures to the benefit of any private shareholder.

(8) Fraternal beneficiary societies, orders, or associations—

(A) operating under the lodge system or for the exclusive benefit of the members of a fraternity itself operating under the lodge system, and

(B) providing for the payment of life, sick, accident, or other benefits to the members of such society, order, or association or their dependents.

(9) Voluntary employees' beneficiary associations providing for the payment of life, sick, accident, or other benefits to the members of such association or their dependents or designated beneficiaries, if no part of the net earnings of such association inures (other than through such payments) to the benefit of any private shareholder or individual.

(10) Domestic fraternal societies, orders, or associations, operating under the lodge system—

(A) the net earnings of which are devoted exclusively to religious, charitable, scientific, literary, educational, and fraternal purposes, and

(B) which do not provide for the payment of life, sick, accident, or other benefits.

(11) Teachers' retirement fund associations of a purely local character, if—

(A) no part of their net earnings inures (other than through payment of retirement benefits) to the benefit of any private shareholder or individual, and

(B) the income consists solely of amounts received from public taxation, amounts received from assessments on the teaching salaries of members, and income in respect of investments.

(12)(A) Benevolent life insurance associations of a purely local character, mutual ditch or irrigation companies, mutual or cooperative telephone companies, or like organizations, but only if 85 percent or more of the income consists of amounts collected from members for the sole purpose of meeting losses and expenses.

(B) In the case of a mutual or cooperative telephone company, subparagraph (A) shall be applied without taking into account any income received or accrued—

(i) from a commercial telephone company for the performance of communication services which involve members of the mutual or cooperative telephone company,

(ii) from qualified pole rentals, or

(iii) from the sale of display listings in a directory furnished to the members of the mutual or cooperative telephone company.

(C) In the case of a mutual or cooperative electric company, subparagraph (A) shall be applied without taking into account any income received or accrued from qualified pole rentals.

(D) For purposes of this paragraph, the term "qualified pole rental" means any rental of a pole (or other structure used to support wires) if such pole (or other structure)—

(i) is used by the telephone or electric company to support one or more wires which are used by such company in providing telephone or electric services to its members, and

(ii) is used pursuant to the rental to support one or more wires (in addition to the wires described in clause (i)) for use in connection with the transmission by wire of electricity or of telephone or other communications.

For purposes of the preceding sentence, the term "rental" includes any sale of the right to use the pole (or other structure).

(13)(A) Cemetery companies owned and operated exclusively for the benefit of their members or which are not operated for profit and any corporation chartered solely for the purpose of the disposal of bodies by burial or cremation which is not permitted by its charter to engage in any business not necessarily incident to that purpose, no part of the net earnings of which inures to the benefit of any private shareholder or individual.

(14)(A) Credit unions without capital stock organized and operated for mutual purposes and without profit.

(B) Corporations or associations without capital stock organized before September 1, 1957, and operated for mutual purposes and without profit for the purpose of providing reserve funds for, and insurance of shares or deposits in—

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April 23, 1986

The Honorable M. Mike Miller
Chairman of House Judiciary Committee
PO Box 5
State Capitol
Juneau, AK 99811

Dear Representative Miller:

Thank you very much for your response to my letter regarding the tort reform issue. You raise some very cogent concerns and questions. It is certainly a most complex issue and the vested interests that are involved do not make it any easier to understand. Not very many people to whom I have spoken nor any of my colleagues are under the illusion that a tort reform will bring about any immediate changes in liability rates or insurance company policies. I think that a wait-and-see policy on the part of insurance companies is not only expected but probably lies. Legislation regarding the liability issue is bound to go through a process of appeals and amendations before any final product is obtained. Until all of the turmoil settles down, it would be hard to expect insurance companies to make any changes in policy since the changes that have been made are design to protect them from the present escalation.

I am sure that you are familiar with the report of the Tort Policy Working Group established by the Attorney General. Enclosed is a copy of a summary that provides many of us with a working guideline for our deliberations regarding this problem. Even though quick or immediate resolution of the problem, that is to say some reduction of current liability rates and the like, may not be forthcoming, it is clear that stopping the process of unrestrained, uncontrolled and unreviewed liability, lay suits and awards is a sine quanon of any lasting solution to the problem.

I would hope that the other representatives and senators in the Legislature are as open minded and thoughtful as you show yourself to be regarding these issues. Thank you very much for taking time out of your busy schedule to respond to my letter and address yourself to the questions I raised.

Very truly yours,

David T. Mayschak, M.D.

DTM:ljb

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

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 seven 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,