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how the legislative discretion should be exercised. The reasons for modifying or abolishing the Collateral Source Rule apply to all tort actions, not just to medical malpractice. Similar crises or potential crises exist in other parts of our torts-compensation system. The cost and administrative delays in automobile compensation led to a variety of attempts to control costs, the most prominent of which has been no-fault legislation. The cost of products liability litigation and compensation is another tort area approaching crisis dimensions. As Jeffrey O'Connell, one of the leading proponents of no-fault approaches to tort liability, has written:

> The main intellectual, rather than political, challenge currently posed by no-fault insurance is the application of the no-fault principle to accidents other than those involving autos, principally to claims arising from medical mistreatment and malfunctioning products. Indeed, the success of no-fault auto insurance has meant that medical malpractice and product liability claims comprise a much greater portion of personal injury claims generally than before the advent of such no-fault laws.
>
> Furthermore, the undesirable characteristics of the present tort liability system are even more evident in medical malpractice and products liability claims than in claims arising out of auto accidents. In medical malpractice and products liability suits, many more victims are left uncompensated. Payment, even when made, is much more delayed. Finally, much more of the premium dollar is spent on legal fees.[57]

If automobile accidents, medical malpractice and injuries from defective products all represent areas of serious cost and administrative problems for our tort system, can there be any justification for abolishing the Collateral Source Rule in one case, but not in the others? And if we decide that these three problem areas require similar treatment by abolishing the Collateral Source Rule, is this not one of those cases where the exceptions would swallow up the rule, because the overwhelming bulk of tort litigation occurs in one of these three areas? Deciding that there ought to be uniform treatment, however, does not determine which way to generalize—whether to retain the rule or to abolish it.

The reasons behind the Collateral Source Rule no longer exist. The widespread and increasing use of liability insurance has virtually eliminated the fault aspects and deterrent operation of the law of tort. Anyone with sufficient assets to pay a tort judgment will almost invariably carry liability insurance. If there is no liability insurer, there is in all probability a judgment-proof tortfeasor. The penalties exacted by the Collateral Source Rule are thus hardly ever paid by wrongdoing

57. O'Connell, *Offers That Can't Be Refused: Foreclosure of Personal Injury Claims by Defendants' Prompt Tender of Claimants' Net Economic Losses*, 77 Nw. U.L. Rev. 58[?] 595-96 (1983).

tortfeasors, but rather by the entire class of insureds under liability policies. Thus, liability insurance becomes a compensatory scheme for accident victims, no different in quality from other compensation schemes, such as health insurance, accident insurance, disability insurance, wage continuation plans, etc. Once the fault orientation to tort liability has been abandoned, the purpose of the tort system is to ensure that accident victims are fully compensated. That end is adequately and fully achieved if the liability insurer behind the defendant is required to pay only the true loss of the plaintiff, which is that amount not covered by the variety of collateral support plans now available to plaintiffs who have been injured.

The ultimate issue is which system of compensation is primary: liability insurance, or the sources of collateral benefits? To the extent that these collateral benefits have not been provided gratuitously by friends and relatives, they have already been funded, either by tax money, by private insurance premiums or as fringe benefits in exchange for the employee's services. Their coverage is almost always broader than just for those accidental injuries where causal fault of a third party can be proved. The allocated cost of these benefits is usually figured free of the ability of the provider to transfer a portion of those costs to a defendant and his insurance carrier through subrogation or assignment. To the extent that there would be a savings occurring from subrogating first party providers of collateral benefits to the third party liability insurer, this savings is often wiped out by the costs of obtaining such transfers. If subrogation or transfer costs exceed recoupment from subrogation, there is an added burden on the total injury compensation system.

V. Special Problems in the Drafting of a Reform Statute

The conclusion that the Collateral Source Rule should be abolished leaves several subsidiary problems unsolved: (a) Should the statute be evidentiary only, so that the deduction of collateral benefits is left to the discretion of the jury, or should the judge be required to deduct the collateral receipts as a matter of law? (b) Should the reform apply to all collateral benefits, or only to some? (c) Should the plaintiff recover in the tort action the premiums and other consideration paid to the provider for the collateral benefits? (d) Should the providers' right of subrogation be abolished as well? The medical malpractice statutes which have abolished the Collateral Source Rule[58] often do not cover one or more of these problems and, to the extent they do, the problems are resolved in very diverse ways.

58. *See supra* note 4.

A. *Issue of Fact for the Jury or Matter of Law for the Judge*

Whether the judge or the jury should have the power to decide on the impact of collateral benefits is not an issue where there is a clear answer, but there are reasons for leaving the matter to the discretion of the jury. First, there may be fact disputes to be resolved, such as whether the plaintiff actually received the benefits, and what they were worth in dollars. Gratuitously rendered benefits, particularly the delivery of services or goods, often pose such issues. In order to leave the ultimate decision to the judge, it would be possible to set up a two tier procedure, whereby the jury in a special verdict [illegible]ld make the necessary fact determinations, quantifying the bene[illegible] and then the judge would deduct the liquidated amount from the [illegible]neral verdict.[59] This procedure would not be frequentl[illegible] because unliquidated [illegible]d gratuitous goods or services are not [illegible]st common or important collateral benefits today. Insurance [illegible]ents, such as property damage settlements, health insurance refunds, or disability payments under private or governmental plans, as well as salary paid under wage continuance plans, are easy to prove and are liquidated.

A more general reason for leaving the deduction to the discretion of the jury arises from the very nature of the general verdict. In arriving at a single final sum as the full compensation for plaintiff's losses, the jury probably balances a number of factors, such as the strength of the liability issue as against the seriousness of the injury, the nature and persuasiveness of the proof on the various items of damage, and the relative fault of the plaintiff as compared with the fault of the defendant. Letting the jury know of and be able to balance the amount of collateral benefits received only adds another factor to be used in arriving at a single just award. Not permitting the jury to know about or to balance these items, but instead requiring the judge to deduct it after the verdict is awarded, gives the element of collateral benefits much greater weight than the other factors because it has been removed from the scales.

Furthermore, the solution to this issue should be related to the answer to the next problem, the types of collateral sources which may reduce the defendant's liability. If the judge is required to deduct them as a matter of law, the collateral benefits should be only those which are clearly liquidated. If the question is one for the jury, a broader range of benefits, including gratuities, could be admissible.

Of those legislatures abolishing the Collateral Source Rule in medical malpractice actions, nine of them chose to leave the issue to the

59. Illinois seems the closest to having adopted such a procedure. *See* ILL. ANN. STAT. § 110, 2-1205 (Smith-Hurd 1983).

discretion of the jury,[60] and five made it a matter of law for the judge.[61] In addition, New York originally left the matter to the jury, but in 1981 amended its statute to make the issue one of law for the judge.[62]

B. *Types of Collateral Benefits Which Should be Admissible*

This is the problem on which the medical malpractice statutes show the greatest divergence. The broadest classification is to cover all collateral benefits of every type and from every source.[63] Another approach is to list quite specifically the collateral benefits for which evidence would be admissible.[64] A good example appears in the Arizona statute quoted above. A third approach is to specify that all collateral benefits are admissible with specific named exceptions. The most common exceptions are death benefits under life insurance policies[65] and insurance purchased with assets of the claimant or members of the claimant's immediate family or paid for by claimant's employer.[66] Another common provision is to limit the collateral benefits to those which are clearly liquidated special damages, particularly payments or reimbursements for medical care, rehabilitative care, and custodial care, as well as for lost earnings.[67]

This welter of approaches to identifying collateral benefits admissible under a statute abolishing the common law Collateral Source Rule raises two important problems: first, whether unliquidated gratuitous assistance given a claimant by friends or relatives should be a collateral benefit reducing a tort judgment, and, secondly, whether life insurance and nonmedical accident insurance should be excluded from admissibility.

There are policy and administrative grounds why the gratuitous unliquidated services should not be used to reduce a tortfeasor's judgment. The administrative reason is the difficulty in proving the receipt, the extent and the value of such services. The policy reason is that we want to reinforce a dwindling tradition in our society, the willingness of family and friends to help someone in need. If the amount of the help could be used to diminish the recovery of the victim in his legal action,

60. *See* the statutes of Arizona, California, Delaware, Kansas, New Hampshire, Rhode Island, South Dakota, Tennessee, and Washington cited *supra* note 4.

61. *See* the statutes of Alaska, Florida, Illinois, Nebraska and North Dakota cited *supra* note 4.

62. N.Y. CIV. PRAC. LAW § 4010, first adopted in 1975, then amended in 1981.

63. *See* IDAHO CODE § 39-4210 (1977).

64. *See* the statutes from Arizona, California and Rhode Island cited *supra* note 4.

65. *See* the statutes from Alaska, Florida and New York cited *supra* note 4.

66. *See* the statutes from Iowa, Kansas, Ohio, South Dakota, Tennessee and Washington cited *supra* note 4.

67. *See* the statutes from Illinois, New Hampshire, New York, Ohio and South Dakota cited *supra* note 4.

this will certainly have a chilling effect on the willingness of such people to make contributions.

Life insurance and accident insurance, except for medical payments, pose much the same issue. A potential victim may in planning for himself or beneficiaries in the event of a serious accident or death choose to provide for certain intangible losses not contemplated by any compensatory scheme. If a planner decides he wants to leave his beneficiaries in a better economic position than would be provided by a wrongful death action, should he not have the freedom to purchase such further protection through private insurance? If he wishes himself to be cared for in the event of a disabling accident more generously than either a tort judgment or other compensatory schemes are likely to provide, should he not also have the power to purchase additional accident insurance? If the purchased protection would be used to reduce the judgment he would receive from a wrongdoer, that would be a disincentive to the exercise of this freedom or power.

The analysis of these two problems suggests that the admissible collateral benefits should be those covering the items of special damage in tort, the medical expenses and loss of earnings. If the impact of the Collateral Source Rule or its abolition is primarily to select which of several compensatory schemes would have primary responsibility for indemnifying the victim, the compensatory schemes which are in competition with the tort system are directed to cover clear economic loss of the victim. The three main types are medical insurance, (either governmental or private), wage continuance plans and private or governmental disability payments. If admissibility is limited to these types, not many collateral benefits of real value will be left out.

C. *Credit for Premiums Paid*

One argument made against abolishing the Collateral Source Rule was that it would discourage victims from purchasing insurance protection.[68] This led some Medical Malpractice Acts to exclude all benefits from insurance purchased by the claimant or by his employer.[69] There would still be strong incentives to continue to purchase insurance because the potential victim never knows whether the loss can be transferred to a wrongdoer. Genuine accidents do occur. To go to the other extreme and permit all collateral benefits to be introduced in diminution of the tort liability of a tortfeasor would work an unfairness. It would give the defendant a windfall—the benefit of the victim's foresightedness in providing insurance protection without the wrongdoer having to pay for that insurance. A widely adopted compromise is to

68. *See* quote from Chief Justice Sundberg, *supra* note 56 and accompanying text.
69. *See* the statutes from Kansas, Tennessee and Washington, cited *supra* note 4.

provide that if the defendant elects to introduce evidence of collateral benefits, the plaintiff is entitled to introduce evidence of the cost of those benefits.[70] The clear import of this is that the jury should diminish the plaintiff's award by the difference between the two. This difference represents the real economic gain which the plaintiff has received from the alternative compensatory schemes and is all the credit the defendant is entitled to.

D. *Abolishing the Provider's Right of Subrogation*

The Collateral Source Rule and the right of subrogation are closely linked. One cannot be altered without requiring changes in the other. This has been recognized by those Medical Malpractice Acts which define the admissible collateral benefits as those for which the provider does not have a right of subrogation.[71] This lets the law of subrogation control the content of the Collateral Source Rule. This is not necessary because state legislatures have the power to abolish the right of subrogation in providers' of collateral benefits except where those benefits are provided by federal governmental programs and federal legislation gives to the provider the right of subrogation.[72]

The state cannot effect the reforms called for by abolishing the Collateral Source Rule, if it leaves the right of subrogation in place. Some of the Medical Malpractice Acts have specifically abolished the right of subrogation in the providers.[73] A powerful argument can be made that unless the admissible collateral benefits are defined in such a way as to retain the rights of subrogation in those providers who have them, a statute revoking the Collateral Source Rule carries with it by implication the abolition of the right of subrogation in the provider.[74] This matter is too important to be left to implication or construction by the courts. The statute should forthrightly address the question and if the decision is made to abolish the Collateral Source Rule, the statute should clearly abolish the right of subrogation as widely as it is in the power of the state to do so. The analysis of this article would call strongly for Congress to abolish the right of subrogation in favor of federal programs of accident or injury compensation.

70. *See* the statutes from Arizona, California, Florida, Kansas and New Hampshire cited *supra* note 4. The statute in New York limits the credit to two years premiums and that of North Dakota to five years premiums.
71. *See* the statute from South Dakota cited *supra* note 4. The Alaska statute excludes from the definition of benefits those payments from federal programs which by law must seek subrogation.
72. An example is 42 U.S.C.A. § 2651 (1973), creating in the United States the right of subrogation against any third person having a tort liability for the reasonable value of the medical care and treatment furnished any victim where the United States is authorized or required by law to furnish su[illegible]atment.
73. *S*[illegible]e statutes from Arizona, California, Florida and Ohio cited *supra* note 4.
74. *See* discussion *supra* note 40.

VI. Conclusion

The Collateral Source Rule is an anachronism based on 19th century fault concepts. This rule has survived into a 20th century legal system where the primary goal is to guarantee that accident victims will be adequately compensated for their losses. The rule was an acceptable anachronism until the rapidly inflating costs of automobile accidents, malpractice actions and products liability claims led to closer scrutiny of our torts system in order to find ways to administer it more efficiently. The Collateral Source Rule creates substantial transfer costs in shifting the duty to pay from one compensatory scheme to another without any corresponding benefit to the victim. If anything, it costs victims something in larger legal fees and costs. The reform which decreases cost with the least harm to our current tort system is to abolish this anachronism.

A carefully drawn statute negating the operation of the Collateral Source Rule in all tort actions should be adopted. Such a statute should leave the question of how much to deduct to the discretion of the jury, should limit the admissibility of collateral benefits to those which are clearly liquidated and cover the items of special damage in torts, should insist that the plaintiff receive credit for all premiums or other consideration paid to the providers of the collateral benefits, and should abolish the right of subrogation in the providers of such collateral benefits to the fullest extent possible.

Thirty Years After *Brown*: Looking Ahead

David Hall*
and George Henderson**

I. Introduction

Brown v. Topeka Board of Education[1] is one of the most famous cases in American judicial history. Its landmark status is beyond dispute and its social significance is overwhelming. Some scholars note that in spite of criticism, *Brown* has been accepted in the political processes at large as a fundamental aspect of constitutional law.[2] Most legal scholars consider *Brown* a landmark decision because it sounded the end of legal racial segregation within the United States of America. Indeed, *Brown* has been hailed as the positive turning point in Black-White attitudes within the country and the defeat of institutional racist policies. From this perspective, *Brown* is a "bright day" in American racial jurisprudence and is often cited as an example of the integrity of the American legal system.

Unfortunately, many of the attributes and accolades accorded *Brown* are misplaced. This article will attempt to show that the real contributions to American jurisprudence made by *Brown* are seldom recognized. While a significant factor in public school education, *Brown* did not bring about the equity sought by the plaintiffs and the class of people whom they represented. Furthermore, it is our contention that *Brown* was incorrectly decided and, consequently, created an educational nightmare from which this country has not totally awakened.

It is very difficult to adequately and accurately judge a significant human event such as *Brown* at the time it occurs. Often, immediate circumstances and needs shape and color society's vision of the event. Therefore, time becomes a necessary condition for an objective and realistic analysis. A historical evaluation of an event frequently proves to be the best judgment of its worth. Ergo the saying emerged: Hindsight is better than foresight.

Because of its great significance to Black Americans, it has been heresy for lawyers and scholars to place the *Brown* mandate in anything other than a sacrosanct category. The authors of this article are among those who have generally questioned the *Brown* mandate and its

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1. 347 U.S. 483 (1954).
2. L. Tribe, American Constitutional Law 52 (1978).

Periodic Payments

"second guessing" an employer's decision to terminate employment in circumstances in which the decision, albeit made for legitimate reasons, is open to "managerial debate" by expert witnesses. For that employer, extensive litigation, culminating in a jury's assessment by a presently undefined standard of "good faith and fair dealing," is a likely prospect whenever the employee decides to challenge an employment termination.

STRUCTURED SETTLEMENTS IN PRACTICE

Dominic P. Carestia*

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I. INTRODUCTION

Settlements in personal injury actions traditionally have been made in the form of a lump sum. Recently, however, increasing numbers of settlements have been made in the form of periodic payments spread over a number of years.[1] Because of this trend,

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1. The number of claims settled with structured settlements has grown from approximately 2,000 in 1979 to over 12,000 in 1983. BUSINESS INSURANCE, February 20, 1984, at 81, col. 1.

Montana attorneys will be presented with increasing opportunities to negotiate claims on a structured settlement basis. The attorney's knowledge of structured settlements and the annuities which typically fund those settlements[2] could make a significant difference in the quality of settlements. The purposes of this article are to provide a basic understanding of structured settlements and to discuss some of the questions which typically arise in structured settlement negotiations.[3]

II. What Is a Structured Settlement?

The term "structured settlement" encompasses virtually any payment scheme other than the traditional lump sum. In contrast with the lump sum, a structured settlement consists of the periodic payout of settlement amounts tailored to meet the claimant's financial needs. Most structured settlements are funded through the purchase by the defendant or its insurer of a single-premium annuity from a life insurance company.

In a given structured settlement the payment scheme might provide any of the following, or a combination thereof: (1) an immediate lump-sum payment for lost wages, incurred medical expenses, special equipment, or home modification; (2) attorney fees in a lump sum or structured over a period of years to take advantage of tax timing; (3) monthly income designed to replace lost wages payable for life or a fixed number of years, and guaranteed for a period certain; (4) an annuity consisting either of monthly or annual payments designed to provide for future medical or rehabilitative expenses; (5) a series of payments to fund future educational expenses; (6) life insurance to provide for children in the event of premature death of the surviving parent; and (7) future lump sums which can serve as inflation stabilizers or opportunity lump sums, or which can fund vacations or other major purchases.

This flexibility creates virtually unlimited opportunity to tailor a settlement to each claimant's specific needs. The structured settlement might be very simple or quite complex. The complexity of the structure, and the ability of that structure to meet the needs of the claimant, are limited only by the creativity of the parties involved and the products available in the structured settlement

2. Approximately $1.5 billion was invested in structured settlement annuities in 1983, and that figure is expected to grow to $3 billion [illegible] 1986. *Id.*

3. A thorough discussion of structured settlements could easily be the subject of an entire textbook. *See* H. Miller, Structured Settlements: The Art of Advocacy Settlements (1983). This article is designed merely to discuss some of the major issues in structured settlement negotiations.

annuity market.[4]

III. Advantages of Structured Settlements

A. *Tax-favored Status*

A key advantage of structured settlements in personal injury actions is their tax-favored status. It therefore is appropriate to begin a discussion of the advantages of structured settlements by focusing on the relevant Internal Revenue Code provisions, revenue rulings, and regulations.

1. *Internal Revenue Code Provisions*

Since its inception the Internal Revenue Code has embodied the concept that all income not specifically excluded is included in calculating gross income.[5] The Internal Revenue Code specifically excludes from income amounts received as compensatory damages resulting from personal injuries.[6] Although various explanations have been set forth to justify the exclusion,[7] most commentators agree that Congress preferred to confer a humanitarian benefit on the injured party.[8] As one commentator stated, "the taxation of recoveries carved from pain and suffering is offensive, and the victim is more to be pitied rather than taxed."[9] The exemption often

4. An example of a structured settlement based on needs is presented *infra* at section III, subsection B.

5. Commissioner v. Glenshaw Glass Co., 348 U.S. 426, 430 (1955). The current Internal Revenue Code language is: "Except as otherwise provided . . . , gross income means all income from whatever source derived . . . ." I.R.C. § 61(a) (CCH 1984).

6. I.R.C. § 104(a)(2) (CCH 1984). The IRS recently promulgated Rev. Rul. 84-108, 1984-29 I.R.B. 5, 7, which states that damages received by a surviving spouse and child "in consideration of the release from liability under a wrongful death act, which provided exclusively for payment of punitive damages, are includible in the gross incomes of the wife and child respectively." Rev. Rul. 84-108 expressly revoked Rev. Rul. 75-45, 1975-1 C.B. 47, which stated that "any damages, whether compensatory or punitive, received on account of personal injuries or sickness are excludable from gross income."

In revoking Rev. Rul. 75-45, the IRS in Rev. Rul. 84-108 expanded the scope of *Glenshaw Glass*, 348 U.S. at 431, in which the Supreme Court held that punitive damages recovered in anti-trust and fraud cases are includible in gross income. Rev. Rul. 84-108 is reconcilable with *Glenshaw Glass*, and Rev. Rul. 75-45 probably was not. The consistency between *Glenshaw Glass* and Rev. Rul. 84-108 may portend future treatment of all punitive damages as includible in the recipient's gross income.

7. *See* Yorio, *The Taxation of Damages: Tax and Non-Tax Policy Considerations*, 62 Cornell L. Rev. 701, 704-05 (1977).

8. Frolik, *The Convergence of I.R.C. § 104(a)(2), Norfolk & Western Railway Co. v. Liepelt and Structured Tort Settlements: The Policy "Derailed,"* 51 Fordham L. Rev. 565, 565-66 (1983).

9. Harnett, *Torts and Taxes*, 27 N.Y.U.L. Rev. 614, 627 (1952).

has been justified on the theory that the claimant/taxpayer does not gain from a personal injury settlement, but rather is only being made whole. In effect, the damage award or settlement is a restoration of capital.[10]

2. *Revenue Rulings*

A major factor in the rapid emergence of structured settlements was the issuance by the Internal Revenue Service [IRS] of Revenue Ruling 79-220,[11] which interpreted section 104(a)(2) of the Internal Revenue Code in a structured settlement setting.

In Revenue Ruling 79-220, the IRS contemplated a scenario in which the claimant had brought a personal injury action. The insured's casualty insurer settled with the claimant by providing an immediate lump sum, plus periodic payments of $250 per month for the claimant's life or for twenty years, whichever was longer. In the event of the claimant's death prior to the expiration of the twenty year period, the remaining monthly payments were to become part of the claimant's estate. The claimant had no right to commute or accelerate the monthly payments, nor any discretion regarding the funding of payments, as the casualty insurer had provided for those payments by purchasing a single premium annuity. As the owner of the annuity contract, the casualty insurer had the right to change the beneficiary, although the monthly payments were paid directly to the claimant. Additionally, the claimant was in the position of a general creditor regarding the collectibility of those monthly payments, and the casualty insurer set aside no special fund to guarantee those payments.

Because the claimant had no rights in the annuity, which was merely the funding vehicle for the insurer's obligation, the claimant had neither actual nor constructive receipt[12] of the amount used to purchase the annuity. As a result, the IRS ruled, the structured monthly payments were fully excludable from the claimant's income under section 104(a)(2) of the Internal Revenue Code, even though the payments resulted in part from future interest

10. Burnet v. Logan, 283 U.S. 404, 413 (1931).
11. Rev. Rul. 79-220, 1979-2 C.B. 74.
12. 26 C.F.R. § 1.451-2(a) (1984) defines "constructive receipt" as follows:

Income although not actually reduced to a taxpayer's possession is constructively received by him in the taxable year during which it is credited to his account, set apart for him, or otherwise made available so that he may draw upon it at any time, or so that he could have drawn upon it during the taxable year if notice of intention to withdraw had been given. However, income is not constructively received if the taxpayer's control of its receipt is subject to substantial limitations or restrictions.

earnings.[13]

Shortly after issuing Revenue Ruling 79-220, the IRS reviewed a settlement agreement where the defendant's insurer agreed to make fifty annual payments to the claimant.[14] Each annual payment was to be 5% greater than the previous payment. The claimant had no right to accelerate the payments or to change the amount of those payments. The insurer was not required to set aside any assets to secure its obligation to the claimant, and the claimant possessed only the rights of a general creditor against the insurer. The IRS again ruled that the structured settlement payments were exempt under section 104(a)(2) because the claimant had neither actual nor constructive receipt of the present value of those payments.[15]

These revenue rulings permit substantial tax advantages for recipients of properly structured damage settlements resulting from personal injuries. The effect of the rulings is to free investment income within a structured settlement from taxation by treating such income as part of the claimant's damages. Although a personal injury lump-sum settlement itself is not taxable, the income from the investment of that lump sum in stocks, bonds, and certificates of deposit is taxable.[16] Income derived from a lump-sum award is taxable even where the lump sum is retained in the court registry and invested there for the benefit of a minor claimant, the theory being that the minor has "received" the lump-sum award.[17]

Because of the tax-exempt status of periodic payments structured in accordance with Revenue Ruling 79-220, structured settlements can make a significant impact on the total disposable amount of the claimant's award, even for taxpayers in the middle tax brackets. For example, a claimant in the 25% tax bracket needing $2,000 per month to meet his expenses requires a pre-tax monthly income of $2,667, or $32,000 annual gross income. If he were to receive structured settlement payments totaling $24,000 for the year, he would be in the same net financial position. Depending on the claimant's age, a difference of $8,000 per year over the claimant's lifetime could be substantial. As the claimant's tax bracket increases, which generally occurs with the investment income from larger lump-sum settlements, that difference becomes

13. Rev. Rul. 79-220, 1979-2 C.B. 74, 75.
14. Rev. Rul. 79-313, 1979-2 C.B. 75.
15. *Id.* at 76.
16. Rev. Rul. 65-29, 1965-1 C.B. 59.
17. Rev. Rul. 76-133, 1976-1 C.B. 34.

even more substantial.[18]

3. *The Periodic Payment Settlement Tax Act of 1982*

The capstone of the revenue rulings discussed above, The Periodic Payment Settlement Tax Act of 1982 [the Act],[19] was signed into law on January 14, 1983. The legislative history of the Act discusses the reasons for its enactment:

> Despite several revenue rulings that indicate that the Internal Revenue Service considers that periodic payments as personal injury damages are excludable from the gross income of the recipient, the committee believes it would be helpful to taxpayers to provide *statutory certainty* in the area. Likewise, the committee believes that a person who undertakes an assignment of the liability for such payments from the person originally liable should not include amounts received for doing so in gross income to the extent that those amounts are used merely to purchase certain types of property to specifically cover the liability.[20]

The Act amended section 104(a)(2) of the Internal Revenue Code to exclude from gross income damages resulting from personal injuries or sickness "whether by suit or agreement and *whether as lump sums or as periodic payments*."[21]

Prior to the Act, the Internal Revenue Code did not address the nature of structured settlements or their funding vehicles. The Act codified many of the considerations discussed in the prior revenue rulings when it established section 130 of the Internal Revenue Code, which defines those assets which qualify to fund structured settlements,[22] authorizes the assignment of tort liability,[23] and defines those tort liability assignments which qualify:

> (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

18. An economic analysis which compares a tax-advantaged structured settlement to a lump-sum settlement is included *infra* at section III, subsection B.

19. Pub. L. No. 97-473, 96 Stat. 2605, 2605 07 codified as amended at I.R.C. §§ 104, 130 (CCH 1984).

20. H.R. Rep. No 97-832, 97th Cong., 2d Sess. 4 (1982); S. Rep. No 97-646, 97th Cong., 2d Sess. 4 (1982) (emphasis added).

21. I.R.C. § 104(a)(2) (CCH 1984) (emphasis added).

22. I.R.C. § 130(d) (CCH 1984). Although the Code defines qualified funding assets as annuities or obligations of the United States, the great majority of structured settlements are funded by annuities. This article therefore focuses on structured settlements funded by annuities.

23. See *infra*, section V, subsection D, for further discussion of the importance of third-party assignments under I.R.C. § 130.

> 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) [of the Internal Revenue Code].[24]

Because of the constructive receipt issues discussed herein, attorneys involved in drafting assignment agreements should consider drafting their agreements in a manner which tracks section 130 of the Internal Revenue Code. Even in structured settlements which do not involve assignment of contingent liability to a third party, section 130 serves as a partial reference for prior revenue rulings.

B. *Other Advantages of Structured Settlements*

The other advantages of a structured settlement might best be discussed by example. Although there are many types of cases in which a structured settlement might be advantageous,[25] the following survival/wrongful death case is used here for illustrative purposes.

Assume that Mr. Smith was thirty-five years old, earning approximately $35,000 per year, and had the opportunity for increased future earnings. His wife, also age thirty-five, is a homemaker and cares for the couple's two children, ages seven and nine. Mr. Smith was killed in an accident for which the defendant allegedly was at fault. The claimant's attorney is demanding in excess of $1,000,000 to settle the case while defendant's insurer initially

24. I.R.C. § 130(c) (CCH 1984). See *infra*, section V, subsection D, for further discussion of third-party assignments.

25. See *infra*, section V, subsection A, for a discussion of the kinds of cases in which structured settlements are appropriate.

has established settlement authority at $400,000. The case could proceed towards trial, ultimately being settled (likely "on the courthouse steps") for a compromised lump sum of $600,000 to $650,000. Alternatively, the parties could attempt to negotiate a structured settlement, which if effected would result in substantially greater benefit for both the claimant and the insurer.

The needs of the claimant should be the primary factor when considering a structured settlement. In this case, Mrs. Smith needs monthly income. She still has two children to raise and has not been employed recently, having spent all of her time in the home with her children. There also is a potential need for educational funds for the Smith children. Usually, as here, up-front cash is needed for outstanding medical bills and other expenses associated with death or injury.[26]

Mrs. Smith's settlement should allow for the possibility of future inflation and should provide a guarantee of monthly income for some period certain in the event of her premature death. Because she has young children, Mrs. Smith might wish to consider life insurance on herself, as well as demanding that the monthly income be guaranteed, even if Mrs. Smith were to die prematurely. The use of future lump sums is another alternative which she should consider. Future lump sums could serve as inflation stabilizers, opportunity lump sums, or simply as money which can be used for major purchases.

After considering Mrs. Smith's financial needs, the parties settled the case as follows:

STRUCTURED SETTLEMENT

Mrs. Smith

	BENEFITS
Section I	
Up Front Cash to Claimant	$ 35,000
Section II	
Monthly Life Income	
(20 years guaranteed)	
$2,000/month for 5 yrs, then	120,000
$2,500/month for 5 yrs, then	150,000
$3,500/month for 5 yrs, then	210,000
$4,000/month for 5 yrs, then	240,000
$4,750/month for 5 yrs, then	285,000
$5,500/month for 5 yrs, then	330,000
$6,500/month for life thereafter	936,000
Subtotal	2,271,000
Section III	
Education Fund	
Beginning in 9 yrs, $15,000/yr for 4 yrs	60,000
Beginning in 11 yrs, $15,000/yr for 4 yrs	60,000
Subtotal	120,000
Section IV	
Future Lump Sums	
In 7 yrs, $ 10,000	10,000
In 14 yrs, $ 20,000	20,000
In 21 yrs, $ 35,000	35,000
In 28 yrs, $ 50,000	50,000
In 35 yrs, $100,000	100,000
Subtotal	215,000
Section V	
Attorney Fees	
$40,000/yr for 5 yrs	200,000
TOTAL BENEFITS	$2,841,000

26. Up-front cash also plays an important psychological role in establishing with the plaintiff a sense of accomplishment and satisfaction regarding the settlement.

In addition to total benefits of $2,841,000 through Mrs. Smith's normal life expectancy, there are several advantages of this structured settlement. First, the $2,841,000 will be paid to Mrs. Smith in periodic installments according to her needs. There is adequate up-front cash to provide for final illness expenses, immediate purchases, or a protective cushion during the family's first few years of readjustment. The $2,000 monthly income will be in addition to social security benefits and will be increased every five years through age sixty-five to compensate for anticipated inflation. The monthly income has a twenty-year guarantee; if Mrs. Smith dies within the first twenty years, her heirs nevertheless will receive the monthly income through that first twenty years. The monthly income will continue to Mrs. Smith, however, as long as

she lives, even beyond her normal life expectancy. The guaranteed period is beneficial especially for the protection of dependents other than the primary claimant, usually the claimant's children. In addition to Mrs. Smith's regular increases in monthly income, a substantial increase in monthly income will occur after ten years. This increase is designed to coincide roughly with the discontinuance of her social security benefits as her children become independent.

An educational fund is planned for each of the Smith children. Beginning at age eighteen, each child will receive $15,000 per year during his or her anticipated four years of college. If either child postpones college, the funds can be put into savings pending college entrance. If a child does not attend college, the funds can be used in other constructive ways such as assisting in the purchase of a home or entering a business.

Future lump-sum payments are provided in seven-year increments. Although a more substantial future lump-sum package might have been included, Mrs. Smith preferred step increases in her monthly income. The structure nevertheless includes some future lump sums which are to be paid substantially after the trauma of the family's personal loss has passed. These lump sums can be used by Mrs. Smith to augment her investment portfolio or to make major discretionary purchases. All future lump sums are guaranteed: they will be paid either to Mrs. Smith or to her heirs.

Although Mrs. Smith's attorney has structured his fee over a five year period to take advantage of tax timing and to postpone the receipt of income not needed immediately, there certainly is no requirement that fees be structured. As with the claimant's settlement award, the attorney fees can be adapted to suit the needs of the recipient.

The significant payments tailored to fit the claimant's specific needs alone are often enough incentive for claimants to elect a structured settlement. There are additional advantages associated with the settlement, however, which must be considered. The first comes from the sharing of tax benefits by the claimant and defendant. Sharing of the tax benefits results in reduced total cost to the defendant and increased long-term benefits to the claimant. Specifically, the entire cost of the annuity to fund the structured settlement in this case is $542,000. This cost is beneficial to defendant, as it is less than the anticipated lump-sum settlement, and it is certainly less than the $1,000,000-plus potential jury award at trial. The claimant also benefits by avoiding the risk of a defense verdict. Moreover, the settlement provides annual after-tax income

to the claimant substantially in excess of what could have been provided by a lump-sum settlement of $600,000 to $650,000.

An economic analysis of the structured settlement demonstrates its advantage to the claimant over the lump sum. Assuming that the claimant could earn an annual, *after-tax* return of 8% over her entire life expectancy, she would need a lump sum of $752,554 to duplicate the payment scheme of her structured settlement. The sharing of tax advantages results in even more dramatic benefits to both claimants and defendants in larger cases, especially where the claimant's injuries reduce life expectancy and therefore allow the annuity to be purchased at lower than standard rates.

Different assumptions regarding the interest rate used to discount the structured settlement will result in different present values. Specifically, the higher the after-tax interest rate assumed, the smaller the present value of the structured settlement. The 8% after-tax assumption is appropriate, however, even in light of arguments regarding the availability of tax-free municipal bonds and other "higher yield," but taxable, investments.

A taxpayer in a 35% effective tax bracket would have to earn in excess of 12.3% annual interest on taxable investments to duplicate an 8% after-tax return. Taxpayers in higher tax brackets must earn increasingly greater returns to duplicate the 8% after-tax return. Additionally, the 12.3% return must be net of brokerage and management fees and must be earned consistently for the remainder of the claimant's life. Finally, lump-sum investments must include some depletion of principal in order to duplicate the structured settlement payments. If the claimant invests in long-term assets to generate higher interest earnings, she is subject to the timing risk of liquidating those assets when higher market interest rates have depressed the value of her investments.

Regarding municipal bonds, the claimant again must allow for management and brokerage fees and state income taxes. Further, the bonds may be called due at a time when market interest rates are lower than those on the bonds. Finally, the claimant/investor must contend with the speculative risks including default, liquidity, and timing risks associated with municipal bonds and other corporate investments. It would be a rare investment advisor indeed who would *guarantee* a net, after-tax return of 8% per year over a young person's entire lifetime, with systematic reduction of principal to parallel the structured settlement periodic lump-sum payment schemes, and with an investment safety guarantee com-

mensurate with that of an A+ rated life insurance company.[27]

This entire discussion of economic value, however, assumes that the average personal injury claimant will use the lump-sum settlement to systematically provide for the future financial needs that the settlement was intended to fulfill. Certainly some claimants are capable of successfully managing a lump sum settlement; but the proper investment of a lump sum to ensure adequate future income, whatever the economic conditions, is no simple task. Every attorney with experience in personal injury litigation has seen at least one case where the claimant simply did not reap the long-term benefits which the lump sum was intended to provide. One study shows that 90% of the recipients of substantial lump sums of money, whether by settlement, sweepstakes, or lottery, dissipate the entire lump sum within five years of receipt.[28] In light of this very real concern, the structured settlement takes on a greater value to the claimant than simply its estimated economic value.

By accepting a structured settlement, the claimant is relieved of investment responsibilities and concerns. Payments under the structured settlement are assured and the funds are managed by an A+ rated life insurance company, which sends the periodic payments directly to the claimant. With phenomenally large sums of money to invest, and a specialized investment staff, an A+ rated life insurance company usually can generate higher investment earnings than can the average claimant.

The periodic payments received from a structured settlement most naturally duplicate real life. People are paid wages periodically, and the income from a structured settlement duplicates that scheme. Claimants simply do not suffer all of their pain and suffering at once, nor do they realize all of their bills for all of their future needs in advance. Damages and losses occur periodically, and a structured settlement assists the claimant economically and psychologically by providing a natural, periodic-payment scheme. Experience indicates that it is a rare claimant who does not appreciate a secure,[29] tax-free lifetime income void of investment management worries.

Finally, there are benefits beyond those to the parties directly involved in a structured settlement. Society has an interest in en-

27. See *infra*, section V, subsection B, this article, for a discussion of the financial strength of A+ life insurance companies.

28. JOURNAL OF COMMERCE, Mar. 1978.

29. See *infra* section V, subsection B, of this article, for a discussion of the stability of structured settlement annuities provided by A+ rated life insurance companies.

suring that injured claimants do not receive more, or less, than is needed to replace damages. Lump-sum settlements are calculated to compensate the claimant for economic loss through normal life expectancy. If the claimant lives beyond normal life expectancy, the lump-sum settlement will result in a shortfall to the claimant; but if the claimant does not live to normal life expectancy, a windfall results. A structured settlement which provides income for the lifetime of the claimant will guard against both shortfalls and windfalls.

Additionally, by saving some of the cost of a lump-sum settlement, insurers and defendants can pass those savings on to their policyholders and customers, respectively. Society is further benefitted because the structure creates a win-win environment: as a result, many cases are settled rather than tried, thereby easing the burden on the courts. Furthermore, society benefits in those cases where a lump-sum settlement would not have provided its intended, long-term benefits, and the claimant eventually would have become an additional burden on the state.

IV. DISADVANTAGES OF STRUCTURED SETTLEMENTS

Since their inception in the late 1960's in the Thalidomide and other California medical malpractice cases, structured settlements which countermeasure the unpredictability of life expectancies have been "heralded as breakthroughs by both parties to the litigation."[30] If, however, the parties do not consider certain factors in negotiating a structured settlement, the resulting structured settlement may be disadvantageous.

Upon implementation of a structured settlement, neither party can change the payment scheme. The claimant should fully understand the finality of the structured settlement. Those claimants who strongly wish to do as they please with their settlements, despite the risks, may not be candidates for a substantial structured settlement. In those cases, perhaps the best that the claimant's attorney can do is recommend that at least a part of the settlement be structured. If the claimant's expectations about what he can do with the money should prove unrealistic, then the structured settlement can provide a safety net of subsistence benefits.

Potential inflation is a second concern which arises because of the "fixed" nature of a structured settlement. If the structured settlement is to span a substantial period of time, that settlement should allow for potential inflation. The payments provided by a

30. *Periodic Payment Settlements*, BEST'S REV. August 1981, at 28.

structured settlement might be supplemented to allow for inflation in three ways. First, the claimant's monthly income might be increased each year by incorporating an annual growth rate into the structured monthly income. That growth rate typically would be specified at 1% to 6% per year. A 5% annual growth rate on a $2,000 per month income would provide $24,000 the first year, $25,200 the next year, $26,460 the next year, $27,783 the next year, and so on, increasing each year for a period certain or through life expectancy.

A second method of accounting for inflation is to provide a step increase in the monthly income every five or ten years. An advantage to the step-rate approach is that the monthly income can be increased in a nonconstant manner to better address the needs of the claimant. In Mrs. Smith's structure, for example, the monthly income will increase substantially at the time her social security benefits are discontinued.

The third method by which potential inflation can be factored into the structured settlement equation is through the use of future lump sums. Future lump sums, designed to serve as periodic inflation stabilizers, might be payable every five or ten years, for example, and also would increase over time.

Finally, potential problems exist regarding attorney fees if the structured settlement agreement makes no provision for attorney fees or for guaranteed payments following the claimant's death. Assume, for example, that the claimant's lawyer has assisted the claimant in negotiating a structured settlement providing $2,000 per month for life to the claimant; but when the claimant dies, the payments cease. Assume further that claimant's attorney earns a large contingency fee at the conclusion of the settlement negotiations. The claimant receives $2,000 per month for six months and then dies. Because the structured settlement was based on a life-time-only annuity, the claimant's estate receives no benefits. If the attorney has received his fee at the time of the claimant's death, the claimant's personal representative may be motivated to seek remedies against the attorney because no further benefits will be paid, and because the attorney's fee now appears excessive. If, on the other hand, the attorney has not yet received full payment at the time of the claimant's death, it is likely that the claimant's estate will not have sufficient funds to pay the attorney the balance of his contingency fee. Inclusion of at least some guaranteed payments in the structured settlement may help insulate the claimant's attorneys from both kinds of exposure.

V. Questions Frequently Asked

The remainder of this article is devoted to those questions which often arise in structured settlement negotiations. Although this discussion certainly is not exhaustive, the author hopes that the discussion provided here will be of assistance to lawyers involved in structured settlement negotiations.

A. *What Kinds of Cases Are Candidates for a Structured Settlement?*

Because of the tax advantages which attend structured settlements in cases where damages result from personal injury or sickness,[31] personal injury cases are prime candidates for structured settlements. Personal injury cases, however, are not the only cases where structures are appropriate. Structures also have been used to settle property damage claims, wrongful termination claims, and even to fund divorce settlements. A structured settlement should be considered in any case where periodic payments might benefit the claimant.

One of the areas in which the use of structured settlements has grown most rapidly is workers' compensation. Settlements and awards for personal injury or sickness in workers' compensation cases also are excluded from gross income.[32] The same tax benefits which have been discussed in reference to personal injury actions also attend workers' compensation settlements.

One of the most significant cases in the workers' compensation area, and one which affects structured as well as lump-sum settlements, is *Willis v. Long Construction Co.*[33] In *Willis* the Montana Supreme Court held that the question of whether a permanently and totally disabled claimant is entitled to a lump-sum settlement is to be determined by the trial court, based on the claimant's best interests.[34] Moreover, when a lump sum is appropriate, it "cannot be discounted to present value."[35]

Regarding the claimant's "best interests," Professor Larson's

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31. See *infra*, section III, for discussion of the tax implications of structured settlements.

32. I.R.C. § 104(a) (CCH 1984) provides that "gross income does not include—(1) amounts received under workmen's compensation acts as compensation for personal injuries or sickness."

33. ___ Mont. ___, 690 P.2d 434 (1984).

34. *Id.* at ___, 690 P.2d at 439.

35. *Id.* at ___, 690 P.2d at 438. At the time of this writing, the Montana Legislature was considering S.B. 281, 49th Leg. (1985), which would amend Montana's Workers' Compensation laws to permit discounting of lump-sum permanent and total disability awards to present value in certain limited situations.

comments are worthy of note:

> Since compensation is a segment of a total income insurance system, it ordinarily does its share of the job only if it can be depended on to supply periodic income benefits replacing a portion of lost earnings. If a partially or totally disabled worker gives up these reliable periodic payments in exchange for a large sum of cash immediately in hand, experience has shown that in many cases the lump sum is soon dissipated and the workman is right back where he would have been if workmen's compensation had never existed. . . . The only solution lies in conscientious administration, with unrelenting insistence that lump-summing be restricted to those exceptional cases in which it can be demonstrated that the purpose of the Act will best be served by a lump-sum award. Enough experience has been gained by now to prove that a broad statutory requirement such as that the granting of a lump sum must be in the best interest of the worker is no guarantee against abuse of the practice. The Council of State Governments' committee examined this problem in depth, and concluded that both the substantive and administrative provisions of the typical act should be tightened. As to the substantive, its recommended draft limited lump sums to cases in which such payments would be in the best interest of the *rehabilitation* of the worker; and as to the administrative, it recommended that this should be allowed only when this course had been approved by a rehabilitation panel.[36]

The author does not purport to thoroughly analyze *Willis* in this article. Nevertheless, a certain troubling aspect of the *Willis* decision must be addressed. Although *Willis* seems to have been decided on statutory grounds, the court's rationale regarding present value is inconsistent with the fundamental economic theory commonly referred to as the "time value of money." The present value of $500 per month for twenty years, for example, is not $120,000 unless that present value is incapable of earning investment income throughout the twenty year period. Yet $120,000 is the present value of those future benefits according to *Willis*. Money received today, however, can be invested to generate investment income. Assuming that the money received today can earn 5% interest per year, the present value of $500 per month for the next twenty years is $75,763. Even assuming this conservative interest rate, the economic present value is substantially less than the "*Willis* value."

The practical effect of *Willis* is to significantly limit the use of

36. A. LARSON, 3 THE LAW OF WORKERS' COMPENSATION § 82.71 (1983).

lump-sum settlements in workers' compensation cases involving permanent and total disability. In most cases this is probably a good result, as receipt of a large lump sum generally is not in the claimant's best interests. Insurers will be extremely reluctant to pay the total, nondiscounted value of all of claimant's future benefits in one lump-sum. Moreover, significant numbers of nondiscounted lump-sum settlements could seriously threaten the long-term viability of the workers' compensation system.

Willis, however, does not foreclose the opportunity to settle permanent and total disability workers' compensation cases on a structured basis. Structured settlements should be considered in workers' compensation cases, as they afford tax advantages which can be shared by both parties and provide periodic payments in the claimant's best interests. In applying structured settlements to workers' compensation situations, an annuity can be used either to duplicate or to enhance benefits under the workers' compensation act. One form of enhancing the benefits is to provide guarantees of the periodic payments to protect the claimant's dependents in the event of the claimant's death. Additionally, it sometimes is possible to increase the claimant's benefits because the injuries may justify lower than standard annuity rates, based on reduced life expectancy. A structured settlement which duplicates or enhances the benefits provided by law, in conjunction with some up-front cash, can bridge the gap between the economic present value and the "*Willis* value" in workers' compensation cases, and can assist in effecting improved settlements.

B. *How Secure Is a Settlement Funded by a Life Insurance Company Annuity?*

Throughout this article the author has made a conscious effort to refer only to A+ rated life insurance companies when discussing the annuities which fund structured settlements. This and other ratings of life insurance companies have significance relative to the safety and stability of an annuity-funded settlement.

The A.M. Best Company, an independent company engaged in the analysis of financial size and management of life insurance companies, each year publishes ratings of over 1500 life insurance companies and is regarded as the authority in its field. A.M. Best's rating classifications are: A+ (excellent), A (excellent), B+ (very good), B (good), C+ (fairly good), C (fair), and omitted. These ratings indicate the long-term ability of a company to discharge its obligations to policyholders based on: "(1) competent underwriting; (2) cost control and efficient management; (3) adequate

reserves for undischarged liabilities of all types; (4) net resources adequate to absorb unusual shock; and (5) soundness of investments."[37] A.M. Best also categorizes life insurance companies according to financial size. The financial size categories are based on policyholders' surplus (roughly the equivalent of retained earnings), and range from Class I ($250,000 or less) to Class XV ($100,000,000 or more).[38]

Although the structured settlement annuity market is rather small and specialized by insurance industry standards, there are several A+ rated life insurance companies in Class X or better which actively seek structured settlements annuity business. By purchasing a single-premium annuity from one of these larger A+ rated life insurance companies, the risk of nonfunding of the structured settlement can be minimized.

The issue of bonding arises occasionally regarding the safety and stability of the structured settlement. Bonding the performance of the life insurance company under the annuity contract typically costs 4% of the annuity premium. That is a substantial sum for "guaranteeing" the performance of the companies recommended here. It is this author's opinion that bonding a life insurance company which has several billion dollars in assets and millions, perhaps billions, in policyholders' surplus is an unnecessary expense. The money which could be spent purchasing a bond is better spent providing additional benefits for the claimant.

C. *How Assured Are the Tax Benefits Associated with a Structured Settlement?*

There certainly are no guarantees that tax laws will remain static. Perhaps at some time in the future municipal bond income will be taxable, Individual Retirement Account contributions will not be deductible, or damages resulting from personal injury will be included in gross income. The policy embodied by section 104(a)(2) of the Internal Revenue Code, which excludes personal injury compensatory damages from gross income, has been tested over time in American tax policy. Additionally, the revenue rulings promulgated in 1979 were codified in 1982 to provide "statutory certainty"[39] regarding the exclusion from gross income of periodic payments of compensatory damages in personal injury actions. The

37. A.M. BEST COMPANY, *Best's Agent's Guide to Life Insurance Companies* v-vi (10th ed. 1983).

38. *Id.* at vi.

39. H.R. REP. No 97-832, 97th Cong., 2d Sess. 4 (1982); S. REP. No 97-646, 97th Cong., 2d Sess. 4 (1982).

very strong trend is toward increased use of structured settlements, and every indication points in the direction of continued encouragement of periodic payment schemes.

It is not merely the soundness of the structured settlement concept which suggests continued tax-favored status. Reports from both the Senate Committee on Finance (submitted by Senator Robert Dole) and the House Committee on Ways and Means (submitted by Representative Dan Rostenkowski), in recommending passage of the Periodic Payment Settlement Tax Act of 1982, stated that the Act "will have a negligible revenue impact."[40] The Senate report states that the "Treasury Department agrees with this statement."[41] The Senate report further concludes that the Act "is not expected to have an inflationary impact on prices and costs in the operation of the national economy."[42] The Senate and House reports are evidence of congressional assurance that the law of structured settlements will not be changed by efforts to generate additional taxes or to address inflation. Because structured settlements have negligible effect on these concerns, one logically could conclude that there is no reason to change the laws to the detriment of the sound public policies which those laws currently encourage. At the very least, one would expect that if the law ever were to change, a grandfather provision would be applicable to existing structured settlements.

D. *What Is the Purpose of the Third-Party Assignment Under Section 130 of the Internal Revenue Code?*

The third-party assignment authorized by section 130 of the Internal Revenue Code allows the defendant to assign contingent liability on the settlement to a third party. That third party is typically a life insurance reinsurer, or some other subsidiary or parent of the life insurance company issuing the annuity. The self-insured defendant or the defendant's liability or compensation insurer may wish to assign contingent liability to a third party so that the primary insurer can permanently close its file on the case. Without the assignment, the defendant would be contingently liable for the periodic payments if the life insurance company providing the annuity were unable to meet its obligations under the annuity contract. If the annuity is issued by a substantial, A+ rated life insurance company, this possibility is extremely remote.

40. H.R. REP. No 97-832 at 5 (1982); S. REP. No. 97-646 at 5 (1982).

41. S. REP. No 97-646 at 5 (1982).

42. *Id.* at 6.

The third-party assignment can protect the claimant as well in certain cases. Assume that the claimant is concerned about the financial future of the defendant, who is a self-insured, susceptible to substantial future liability claims from numerous other claimants or potential claimants.[43] Assume further that the claimant's fears are warranted, and the defendant goes bankrupt. If there has been no assignment, the bankrupt defendant owns the annuity. There is a good possibility that a bankruptcy court could redirect the payments under the annuity as all of the general creditors of the defendant seek to share in defendant's unsecured assets. If the third-party assignment has been effected, the defendant's bankruptcy has no effect on the claimant. The assignee, rather than the bankrupt, owns the annuity, and the claimant will continue to benefit from the structured settlement.

As with other issues in structured settlements, the assignment decision must be made on a case-by-case basis. Whether an assignment should be utilized depends on several factors, primarily the goals of the claimant and the defendant, as well as the comparative financial strengths of the defendant and the potential assignee.

E. *What Should Be Done to Ensure the Tax-Free Status of a Structured Settlement?*

Lawyers involved in structured settlements should review the Internal Revenue Code sections, revenue rulings, and regulations previously discussed in this article.[44] It is extremely important to be cognizant of constructive receipt[45] issues at all times during the negotiation of a structured settlement. Once a claimant is in constructive receipt, the tax-favored status has been lost.

A common mistake is to specify in the settlement agreement that the claimant may change the beneficiary on the annuity. This may seem practical, but it does not comport with Revenue Ruling 79-220. The right to change the beneficiary can be construed as an ownership right or enough control to place the claimant in constructive receipt. The solution to this specific problem is to name the claimant's estate as the succeeding beneficiary, and then direct by will the periodic payments payable after the claimant's death.

Another issue which arises during structured settlement negotiations, and which may have constructive receipt significance, is the cost of the annuity. The most conservative argument suggests

43. Alternatively, the claimant may be concerned about the longevity of a liability carrier involved in writing policies in volatile areas of liability.

44. See *supra*, section III, subsection A.

45. See *supra* note 12 for the definition of "constructive receipt."

that to avoid any potential constructive receipt problems, the defendant and its insurer should not reveal to the claimant the cost of a structured settlement funding annuity. One can argue, however, that simply knowing the cost of a structured settlement, in and of itself, does not put the claimant in constructive receipt of the amount invested in the annuity.[46] At the other extreme is the situation where the claimant is offered a choice between a cash settlement and the structured settlement which that exact amount of cash would purchase. In such case the claimant probably is in constructive receipt of the cash sum, whether it is actually received or is used to purchase the annuity, because he or she "could have drawn upon it during the taxable year."[47]

Negotiating a structured settlement on the basis of cost has the potential of placing the claimant in constructive receipt. Where the line between the two scenarios discussed above will be drawn is subject to speculation until the courts address the issue. Perhaps extreme caution is appropriate until that time. It is not wholly unreasonable, however, for the claimant's lawyer to want to know the cost of the structure, as his fee may be based on a percentage of the cost of the settlement. In those cases where cost is not disclosed, the claimant's lawyer can engage the services of a consultant who can approximate the cost of the annuity.

F. *What Is the Minimum Settlement Below Which a Structured Settlement Is Not Feasible?*

Generally, structured settlements for less than $10,000 are not feasible. As with other structured settlement considerations, however, minimum premium determinations should be made on a case-by-case basis. One need that a smaller settlement can fill is an education fund for an injured minor. For example, a structured settlement funding annuity costing approximately $10,000 today can provide a child age ten with $7,500 per year for four years beginning at age eighteen. Moreover, the beneficiary of that college fund will take the $30,000 tax-free.

46. Private Letter Ruling 8333035 stated that knowledge of the cost of the annuity "is not determinative in deciding a question of constructive receipt, but that *unqualified availability is decisive.*" (Emphasis added). In that particular taxpayer's situation, based on information submitted in a prior ruling request, Private Letter Ruling 8325054, knowledge of the cost of the annuity did not cause the taxpayer to be in constructive receipt of the amount invested in the annuity.

47. 26 C.F.R. § 1.451-2(a) (1984).

VI. Conclusion

Attorneys traditionally have been trained to evaluate cases in terms of lump-sum values. With the advent of structured settlements, however, attorneys have begun to analyze the needs of injured claimants and survivors, and to provide periodic payments to better meet those needs. This needs-oriented approach has resulted in widespread and ever-increasing use of the structured settlement as a settlement device. That success can be attributed only to the fact that structured settlements can provide real benefit to both claimants and defendants.

Claimants' attorneys who only a few years ago were cautious of this strange new settlement device are now making settlement demands in the form of structured settlements. Attorneys involved in structured settlement negotiations need to be sufficiently informed to properly evaluate structured settlement proposals. The lump-sum criteria is an insufficient measure of the value of structured settlements. Rather, those attorneys who settle cases on a structured basis should evaluate the structure in light of its ability to meet the claimant's needs, and its ability to insure that a claimant who has experienced the trauma and loss of a personal disaster not also be visited by a financial disaster resulting from inability to manage a lump-sum settlement. The structured settlement is a dynamic vehicle for providing that assurance, and in the process it provides real benefit to claimants, defendants, and society.

ESSAY

THE TEMPTATIONS OF CREON: PHILOSOPHICAL REFLECTIONS ON THE ETHICS OF THE LAWYER'S PROFESSIONAL ROLE*

Thomas Huff**

It is certainly more than a little presumptuous for a philosopher to address Montana attorneys on the subject of their professional ethics. You might, understandably, insist that only a practicing attorney would be qualified, through education and personal experience, to offer views on such issues. I must admit I have no ready response to this claim except perhaps to say that there are times when distance allows for perspective, and I hope this is one of those times.

As lawyers, you are subject to a variety of temptations. There are, of course, the usual temptations of private gain manifest in laziness, dishonesty, or thievery. If you succumb to these temptations you will be subject to immediate and thorough censure by your profession and the public. More often, however, if there are moral errors which tempt you, they are errors of professional role rather than errors of private gain. These are more subtle, less easily recognized temptations. They show up as failures of ethical insight and moral sensitivity. It is the kind of moral error which comes from too great an identification with role—what I will call the temptations of Creon—that will be discussed in this brief essay.[1]

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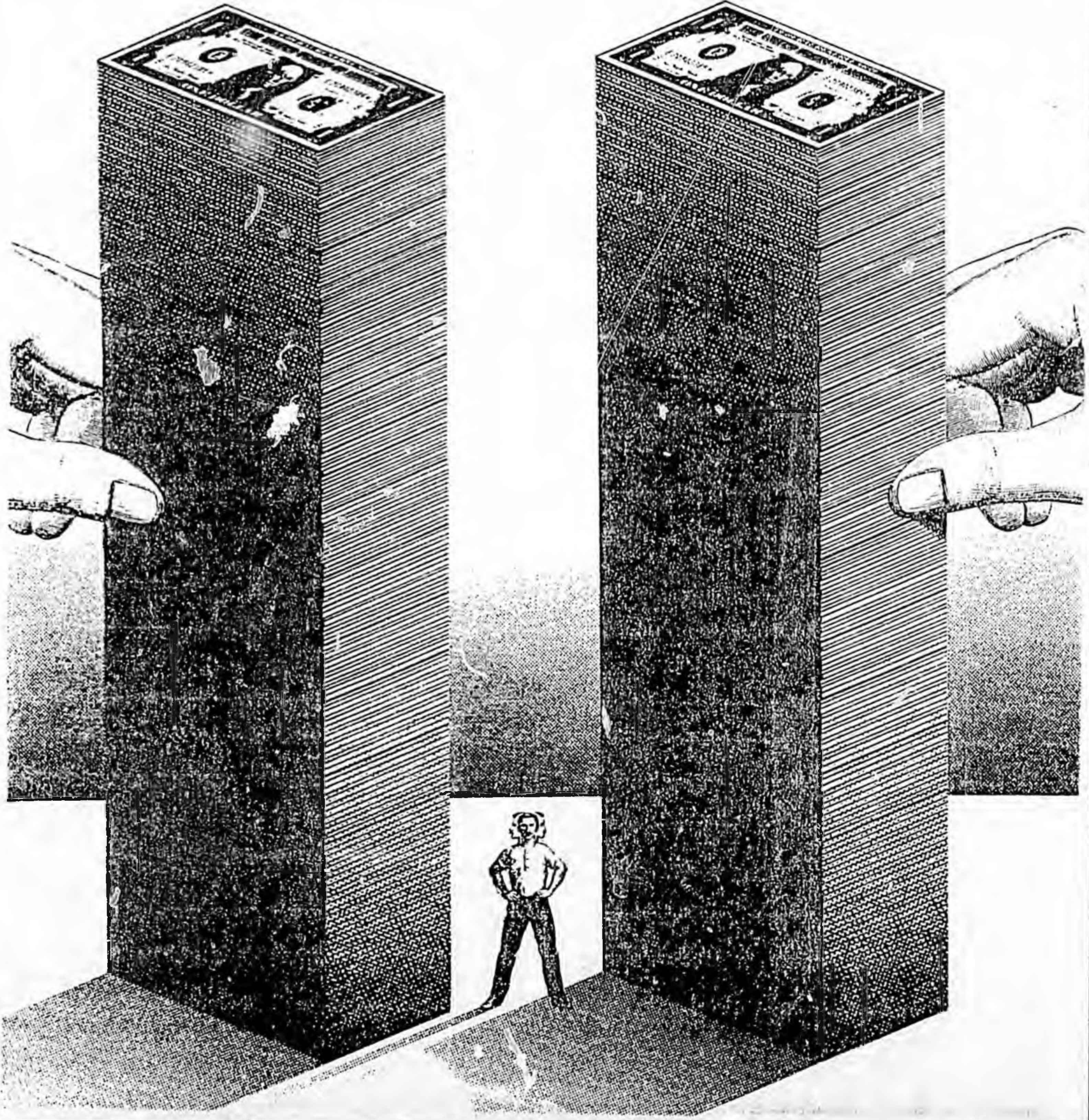
1. Though I have synthesized the issues of this essay in what I hope are fresh and enlightening ways, little that I say here is new. I have therefore cited the appropriate cur-



#3464

BY JOSEPH FRANCIS CUNNINGHAM

A typically erudite opinion by D.C. Superior Court Associate Judge Schwelb in the recent case of *Taylor v. Douglas Distributing Corp.*, 112 Wash. L. Rptr., 1417 (7/18/84) on application of the collateral source rule in D.C. awakened some memories. While the collateral source concept is certainly not new, experience suggests that an understanding of its reach is not shared by all. Occasionally defense attorneys, and even judges, have been known to bristle at the idea that a plaintiff would dare to seek redress in money damages for a sum already partially or wholly reimbursed by the plaintiff's employer, insurance company, or other source. However, far from being a socialistic plot to enrich the plaintiff doubly, a second recovery from a tortfeasor of amounts already received from an independent payor is a well-sanctioned concept of our law, both here and in other jurisdictions.[1]

Indeed, as the leading case in the District, *Jacobs v. H. L. Rust Co.*,[2] indicates:

> The collateral source rule provides that when a tort plaintiff's items of damages are reimbursed by a third party who is independent of the wrongdoer, the plaintiff may still seek full compensation from the tortfeasor even though the effect may be doubled recovery.

The essence of this exception to the prohibition of double recovery in litigation is that the wrongdoer should not benefit from his bad conduct simply because a plaintiff through foresight or good fortune is capable of obtaining reimbursement elsewhere.[3] It is considered better that an injured party receive double recovery than that a wrongdoer be relieved of liability for damages, especially since one purpose of accessing damages is to deter negligent conduct and encourage due care in the future. *Reid v. District of Columbia.*[4]

As expressed above, the collateral source doctrine seems rational and intelligible. How then does one explain the Court of Appeals decision in *The Designers of Georgetown, Inc. v. E.D. Keys and Sons*?[5] In this case the issue was whether the defendant was entitled to credit for a sum already paid to plaintiff by the defendant's insurance company for a business interruption loss. Such business interruption policies, of course, are rich sources of litigation, due to their complexity and the body of interpretive rules governing loss payment. *See*, for example the Maryland cases of *Bogley v. Middleton Tavern*,[6] and *Polkes and Goldberg Insurance, Inc. v. General Insurance Co. of America.*[7]

In the *Keys* case the matter was compounded further by plaintiff's counsel, who failed to argue on appeal that the plaintiff had *not* been reimbursed by the carrier for lost profits, as the trial court concluded in denying recovery to the plaintiff for the amount paid to it by the insurance company. Profit, of course, is not the salient concern to the insured under a business interruption policy. Emphasis should be placed instead on the policy definition of "earnings." The trial court's conclusion predicated on "profit" was not challenged on appeal, however, and the omission laid the groundwork for further mischief in the Court of Appeals opinion.

The appellant correctly stated controlling case law on the collateral source rule in the District and quoted from the Restatement of Torts, § 920, Comment e (1939) as follows:

> ...Usually the collateral contribution necessarily benefits either the injured person or the wrongdoer. Whether it is a gift or the product of a contract of employment or of insurance, the purposes of the parties to it are obviously better served and the interests of society are likely to be better served if the injured person is benefited than if the wrongdoer is benefited....

Surprisingly, and simplistically, the Court of Appeals' panel rejected this principle and upheld the trial court's allowance of a credit to plaintiff's award, reflecting the amount of insurance proceeds paid it for its business interruption loss. It based its decision on two points. First, the insured had agreed under the terms and conditions of its policy to subrogate its recovery to the modest amount paid by the carrier and, second, the recovery of "lost profits," already reimbursed by insurance, would amount to a double recovery. As to the latter point, it is not surprising that no cases were cited by the

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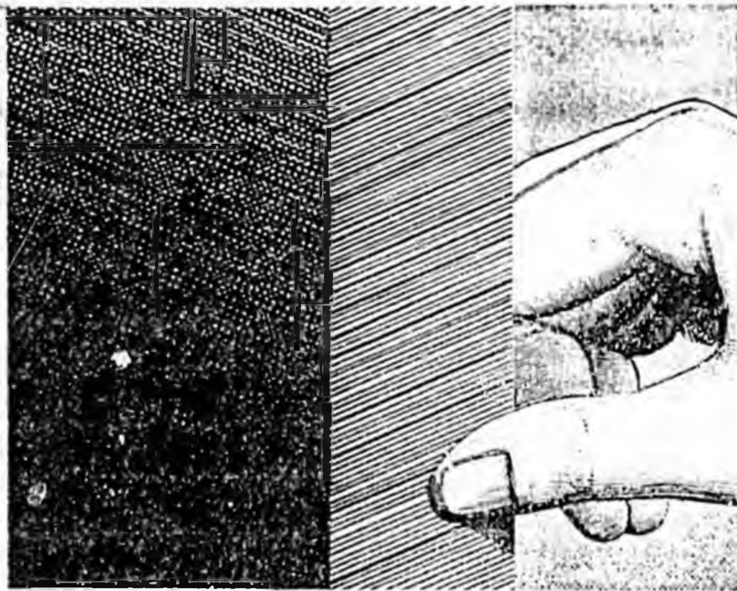
Illustration by John Pack.



court in support of its conclusion since, as we have seen, double recovery has been an acceptable consequence when acknowledged insurance payments are made to a plaintiff. More interesting is the reference by the court to the standard subrogation clause in the policy as a bar to recovery by the insured plaintiff. The insured had argued in its brief that:

> Finally, the collateral source rule is not affected by the fact that the insurer may be subrogated to the rights of the insured against the tortfeasor, as this is merely a matter of the ultimate right to recover the proceeds as between the insurer and the insured. *Rexrood* v. *Kansas Power & Light Co.*, 192 Kan. 343,388 P.2d 832 (1964). See 22 Am.Jur. 2d *Damages*, Sec. 211, pp. 295,296.
>
> In *Barus* v. *Peck*, 83 So.2d 783 (La. App. 1955), where the court answered this issue, stating [sic] as follows:
>
>> The party liable has no interest in the question of whether there is insurance, but is responsible to the owner of the damaged automobile to the extent of the damage. The other party and his insurer may adjust between themselves the question of how much each is entitled to recover out of the judgment against the party who is liable. 83 So.2d, at p. 784.
>
> See also *Powers* v. *Ellis*, 2231 Ind. 273, 108 N.E.2d 132 (1952); *Moidel* v. *Peoples Natural Gas Co.*, 397 Pa.212, 154 A.2d 399 (1959); 22 Am.Jur.2d, *Damages*, Sec.206.
>
> The Designers anticipates that Appellee will argue in its brief that its subrogation settlement with The Designers' insurer, the Maryland Casualty Co., included this business interruption loss, and that not to allow the deduction would force said Keys [sic] to pay twice. This anticipated argument bears little weight because the court did not deduct the $2,145.24 on the basis of a double payment by Keys, but rather, so to avoid a so-called "double recovery" by The Designers. (Memorandum Opinion, p.5).
>
> Moreover, to the contrary of what Appellee Keys is expected to contend, the subrogation claim settlement did not include business interruption loss, but only the property damage. The burden of proof in this regard to provide mitigation of damages was on Keys, as defendant below, and no evidence on this factual issue was ever introduced it.[8]

All of the above suggests a fair basis for the proposition that insurance proceeds, both legally and factually, were beside the point as to an ultimate damage award. In response, the Court of Appeals cited a single case, *Motors Insurance Co.* v. *Home Indemnity Co.*[9] However, it failed to indicate in any way why this case was dispositive on the issue. A short look at the case may suggest why it has little to do with the matter at hand. Rather than dealing with the collateral source doctrine in any significant way, the case turned on the efficacy of a release signed by the plaintiff's insurer. It held that one insurer's release of any and all claims against a defendant who reimbursed the subrogated insurer for payments it had made to the insured did not bar a second action by another insurer against the same defendant for monies that insurer had paid to its insured, thus gaining independent subrogation rights. Indeed the court itself stated that "the basic question on this appeal"[10] was whether the release involved relieved the tortfeasor of liability to a non-party to such release. In concluding this issue in the negative, not only did the court avoid resting its decision on the collateral source rule, it failed to even mention it. So much for the precedent upon which the odd result in *Keys* is based!

It only remains to point out that the *Keys* decision flies in the face of other, well-reasoned decisions from the District and other jurisdictions, and also contradicts the premise upon which the collateral source doctrine rests. As to the former, Judge Schwelb in *Taylor* cited the oft-referenced case of *Rexwood* v. *Kansas Power and Light Co., supra*, which concluded that the existence of an insurer's viable right of subrogation does not bar its insured's recovery against a tortfeasor—the right being personal to the plaintiff and the subrogation matter being one between insurer and insured. He also cited *Brown* v. *American Transfer & Storage Co.*[11] for the sensible proposition that:

> The insurer and the defendant are not joint debtors so as to make the payment or satisfaction by the former operate to the benefit of the latter; nor is there any legal privity between the defendant and the insurer so as to give the former the right to avail itself of a payment by the latter. The policy of insurance is collateral to the remedy against the defendant, and was procured solely by the plaintiff at his expense, and to the procurement of which the defendant was in no way contributory.... It cannot be said that the plaintiff took out the policy in the interest or behalf of the defendant, nor is there any legal principle which seems to require that it be ultimately appropriated to the defendant's use and benefit.[12]

It is also worth pointing out that the fact that benefits provided to a plaintiff for which the provider has a subrogated right to recover against the defendants historically has not also barred recovery by a plaintiff in the federal court for the District of Columbia. *Hudson* v. *Lazarus*.[13] Apparently the Court of Appeals panel in *Keys* overloaded the binding precedential effect of opinions by the D.C. Circuit Court.[14] In the federal court here, when plaintiff's claim for recovery dovetails insurance proceeds paid to it for which the insurer is subrogated, recovery against the defendant is not denied, as in *Keys*, giving the potential tortfeasor a windfall, but rather the case is viewed as being brought by the insured for the benefit of the insurer,

and so proceeds. *Link Aviation Inc.* v. *Downs*.[15] Consequently the *Keys* decision, for whatever value it may have, has created a conflict of the governing case law in this jurisdiction between the local and federal courts—hardly a happy or politic result.

As to its policy implications, those broader, common sense considerations inherent in resolving collateral source questions, it may be seen that *Keys* immunizes the tortfeasor from recovery by a plaintiff if the defendant can show that the plaintiff has been fully reimbursed by his own insurer (or arguably *any* provider of benefits). To force a tortfeasor to pay damages in such circumstances, the insurer/provider would be required either to join the suit as a plaintiff or to institute separate litigation itself—both courses breeding duplication and delay. This is especially so when one considers that were the plaintiff allowed recovery against the tortfeasor regardless of the monies paid by the insurer provider, the latter would face few problems in obtaining a pay-over of funds expended on its insured beneficiary since it has an absolute right to recovery of such funds from the payee regardless of asserted contract defenses. *City Stores Co.* v. *Lerner Shops*.[16] And ultimately, regardless of the unnecessary obstacles created by *Keys* to the insurer's recovery, the basic premise of collateral source recovery is clearly violated by the denial of recovery to an insured plaintiff simply because the protection he/she purchased from an independent source is provided in full by that source. Seen in this historical light, *Keys* is obviously an aberration.

However, a number of relatively current decisions from our Court of Appeals, ignored in *Keys* but certainly still good law, suggest that ample precedent exists for future decisions consistent with collateral source precedents here and elsewhere. *Cf. District of Columbia* v. *Jackson*,[17] *Morgan* v. *District of Columbia*,[18] *Reed* v. *District of Columbia*.[19] Yet for the present *Keys* remains isolated and unexplained, and the course of the collateral source issue, uncertain. ■

FOOTNOTES

[1] An imaginative attempt to stretch the collateral source concept across the District's borders into Maryland may be seen in *Dennison* v. *Head Construction Co.*, 54 Md. App. 310, 468 A.2d 868 (1983) where the Court of Special Appeals rejected a claimant's contention that payment of D.C. worker's compensation benefits should not be a set off to any Maryland benefits sought. The Court correctly pointed out, after review of the Maryland cases involving the rule, that it was inapplicable in a case not involving tort issues, such as the compensation claim.

[2] 353 A.2d 6 (D.C. App. 1976).

[3] The rule does not apply to reduction of verdicts by the amount the plaintiff's earlier received in settlement with other alleged tortfeasors, even if the latter is subsequently determined to be free of fault. *Kassman* v. *American University*, 178 U.S. App. D.C. 263, 546 F.2d 1029 (1976).

[4] 391 A.2d 776, amended, 399 A.2d 1293 (D.C. App. 1978).

[5] 436 A.2d 1280 (D.C. App. 1981).

[6] 288 Md. 645, 421 A.2d 571 (1980), reversing 42 Md. App. 314, 400 A.2d 15 (1979).

[7] 60 Md. App. 162, 481 A.2d 808 (1984).

[8] Brief of Appelant, pp. 41, 42.

[9] 281 A.2d 58 (D.C. App. 1971).

[10] 281 A.2d at 59.

[11] 601 S.W.2d 931 (Tex. 1980).

[12] 601 S.W. 2d at 935.

[13] 95 U.S. App. D.C. 16, 19, 217 F.2d 344, 346 (1954).

[14] *M.A.P.* v. *Ryan*, 285 A.2d 310 (D.C. App. 1971).

[15] *Link Aviation, Inc.* v. *Downs*, 117 U.S. App. D.C. 40, 41, 325 F.2d 613 (1963).

[16] 133 U.S. App. D.C. 311, 410 F.2d 1010 (1969).

[17] 451 A.2d 867 (D.C. App. 1982).

[18] 449 A.2d 1102, vacated, 452 A.2d 1197, rehearing, 468 A.2d 1036 (D.C. App. 1982).

[19] 391 A.2d 776, amended 399 A.2d 1293 (D.C. App. 1979).

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Feds rethink liability rules

Acknowledging that the nation is facing a huge liability-insurance crisis, the Reagan administration will look at ways to overhaul that part of the civil justice system that deals with tort liability.

Richard K. Willard, assistant attorney general of the Justice Department's civil division, says the administration has set up a tort-policy working group to address "the crisis of the tort system in a comprehensive and responsible manner." He made the announcement Oct. 25 at the fall membership conference of the American Consulting Engineers Council in Colorado Springs, Colo.

The interagency working group, created by Attorney General Edwin M. Meese III and chaired by Willard, "will consider a broad range of policy issues." It will report to the President's Domestic Policy Council. "We will recommend appropriate legislative, regulatory and litigative responses at the federal level," said Willard.

The administration spokesman cautioned ACEC against expecting quick fixes from the federal government for a problem that has reached unprecedented proportions. "It is important to keep in mind that the crisis of the tort system has been developing over many years and has many aspects," he said.

According to the Justice Department, insurers suffered the worst underwriting losses last year since the San Francisco earthquake of 1906—$21 billion. It predicts that demand for coverage this year will exceed insurers' ability to provide it by about $7 billion, with the shortfall growing to $62 billion by 1987.

Willard attributes much of the problem to "activist judges and tort lawyers who see no bounds to the ever increasing expansion of tort liability." He says they use tort law not only to deter "undesirable conduct," but also to "restructure society and administer a massive social insurance scheme." Some of the problem areas he expects the group to study include no-fault insurance, strict-liability doctrines, size of awards, punitive damages and attorneys' fees.

Meanwhile, in New Jersey, a dispute between state officials and insurers of high-risk businesses reached a new plateau last week. Three insurance associations filed a lawsuit in state superior court challenging a Sept. 16 emergency order by Gov. Thomas W. Kean. The controversial order bars insurers from increasing premiums, reducing liability coverage and cancelling certain lines of coverage (ENR 10/3 p. 14).

The filing reportedly followed the breakdown of negotiations between the groups and the state's insurance department on a compromise plan for future coverage to high-risk businesses. The insurance groups fear that the department may make Kean's sweeping order permanent when it expires Nov. 16. Insurers claim it is arbitrary and unconstitutional. ■

Justice's Willard: Hits "activist judges."

(E1)

President's Page

THERE is a growing movement in this country of defendants and their attorneys who are regularly being victimized at the courthouse by our civil justice system to better their situation for themselves and for the benefit of all citizens. To correct that system so that fairer results may be obtained for both the plaintiff and defendant, you should join that movement. If you are unaware of that movement, you should find it now in your state. If the movement has not taken roots in your state, you should plan it and nurture it as others are doing. We are all seeking a system of justice which provides reparation to the injured without undue enrichment or unearned windfalls for those on the plaintiff side. We strive for a system which will cease victimizing the defendant and the general public which pays the cost of that defendant's product and the general public which indirectly pays for the insurance premium to insure that defendant.

This is a movement which will stop the senseless and misleading double recovery by a plaintiff through the collateral source rule. We seek to terminate a scheme which fraudulently requires the general public which pays all forms of insurance premiums to pay for medical bills, salary replacement and other benefits one time through the medical insurance policy of the plaintiff or his employer and a second time through the liability policy of the defendant. It is a senseless policy which needlessly increases the cost of goods for which everyone must pay and enables a plaintiff to be paid twice for the same loss. The public which pays for the insurance system in this country should not have to pay twice.

This is a movement which will nullify the efforts of a plaintiff attorney in a multi-defendant case to place at least 1% blame of an accident on the innocent but solvent or well-insured defendant, thus requiring him to pay for 100% of the damages. Frequently, it is his solvency that is the only reason that particular defendant was named in the lawsuit. If we are going to have a system of negligence and comparative negligence so that plaintiffs are responsible only to the extent that they are negligent, then the system should be equally fair and hold defendants responsible only to the extent that their negligence was a cause of the accident.

This is a movement which will preserve a contingent fee system to fairly allow injured parties to seek a recovery, yet prevent the continued siphoning of an engorged portion of the injured party's recovery into the coffers of plaintiffs' attorneys who have become the robber barons of the 20th century with their 40% and 50% contingent fee contracts. If defendants or juries find an award should be settled upon or found for an injured party, then the injured party should receive the substantial portion of that award and the plaintiffs' bar not become unduly enriched. If a large sum is to be awarded to a needing and seriously injured plaintiff, then a substantial portion should indeed go to that injured party and not continue a system that allows 40% or more to be drained off to the treasure house of the plaintiffs' bar. A structured contingent fee system would retain the concept yet reduce the plaintiff attorney's percentage as the recovery became larger.

This is a movement that will eliminate or restructure punitive damages for those few unusual situations in which a defendant has shown a cruel, heedless and reckless disregard for the rights of others, with there being some previously established, relatively high, identifiable standard which a defendant has almost intentionally violated; and, also, a system in which a reasonable relationship exists between the actual damages suffered and the punitive damages assessed.

This is a movement that will preserve a structure of awarding money for such items as pain and suffering and impaired earning capacity only for those who experience it; and will ensure that such payments will be made over a period of time so that the benefits may be received by the injured party and not frittered away through poor advice or poor investments; and, so that if the injured party does not continue to live over a period of time, a windfall of recovery will not go to relatives who were not involved in the accident and who did not experience the loss for which the money was to have been paid.

It is a movement for justice to preserve the American jury system, and the other goals it will obtain will continue to be listed as these coalitions gain momentum throughout the country.

The movement demands the attention of the defense trial lawyer. In your area, it may carry the name of Project Justice or Coalition for Tort Reform or some other title. Regardless of its title, you will find it composed of a group of dedicated men and women who believe in our court system and want to preserve a personal injury reparation or recovery system that will provide a proper award, where justified, for an injured party and the plaintiff's attorney, yet not allow an unjust enrichment. There are many around you who have joined or want to join such a movement. Your leadership, energy and talents are needed to add to or to assemble the members of this coalition. You, as a defense trial lawyer, have unique knowledge of the steps that are needed to preserve the present system and correct its abuses.

Each state has organizations of defense trial lawyers, physicians, hospitals, engineers, school districts, city governments, manufacturers, distributors and other ordinary citizens of all walks of life, who want the availability of a fair and economically functioning court system which operates under laws which in turn have been fairly written to allow a proper allocation of loss without punishment of the casually involved defendant or the one who is only momentarily negligent.

Earlier presidents on this page have quoted sources who correctly have described as a war the present confrontation between a greedy and insatiable plaintiffs' bar on the one hand and a citizenry on the other hand who want a personal injury litigation system that will allow a fair recovery where appropriate but which does not over-compensate an injured party nor unfairly punish the defendant. This country does not need to create financial dynasties among the plaintiffs' bar because of an unconscionably high contingent fee rate at 40% or more of all recoveries no matter how large. Our movements will assist the judiciary and the legislators in rectifying the abuses of the present system, thus allowing courthouses to exist as places where plaintiffs and defendants alike may expect to receive fair justice rather than runaway monumentally high recoveries obtained on even slight misconduct, accentuated by gargantuan legal costs.

Realize that without the effort of such movements, there will be no change in the present disastrous trend. There will be no sanctuary of a firm but fair judicial system in our lifetime in which the injured party and the defendant may find a correct distribution of the losses on a reasonable basis and at a cost which injured plaintiff and allegedly liable defendant can afford for legal services.

The active and continued participation of you, the defense trial lawyer, is vital to this movement. Statutes and court rules are complicated, and the meanings and implications frequently are understood only by plaintiff lawyers and defense lawyers. Unless we alert the public to the abuses that are presently occurring; unless we inform them of how those abuses are being wrought and how they should be corrected; unless we help them to organize and to finance their goal to have a fair and economically functioning jury system, then the forces of a plaintiffs' bar which already have overreached all reason will continue to prevail.

You, the defense lawyer, must contact the groups within your community and state to acquaint them to the losses that are now occurring. You must take

the lead to help them in their goal to organize a system that will allow the injured to appropriately recover and the defendant to pay only when a fair law requires — and then only an appropriate amount. You must initiate the effort to insure that the fees provided to the plaintiffs' attorneys are earned by them and are not a riskless and unearned pilferage from the needed support of an injured plaintiff or the needed assets for a defendant's continued existence.

Find and organize your coalition now in your state for better legislation and fairer judicial opinions. This is not a question necessarily of Democrat versus Republican or conservative versus liberal. It is a question of finding persons who will realize service as a legislator or a judge means we need a system that will function and serve the needs equally of both plaintiff and defendant.

All that is wanted by the defense side of the docket is a fair court system at a reasonable cost to operate. The present system is neither fair nor of reasonable cost. The system never will be, unless you start working now with others to improve it.

THOMAS H. SHARP, JR.
President

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FYI

12/27/85

City leaders tag insurance as No. 1 legislative priority

by Dean Fosdick
Associated Press

JUNEAU — Tort reform will be high on the Alaska Municipal League's list of legislative priorities next session, according to its president, who expressed concern Thursday about a number of communities being forced to operate without any insurance protection.

Dan Keck said, however, he isn't sure that lawmakers will be able to put a quick fix on high insurance rates or the non-availability of policies.

"We would like to see a solution, but I don't know if we can get it done next session," Keck said in a telephone interview from Sitka. "We do want some kind of tort reform at the state and national levels."

Along with other organizations, the municipal league is studying moves toward setting a cap on non-economic legal awards (pain and suffering), limiting attorney fees and modifying liability awards based on the ability to pay.

"At the very least, we've got to educate judges and juries that municipalities don't have an unlimited amount of money," he said.

"We can't continue as it is," Keck said. "We have some com-

See Cities, page A-10

Cities list concerns

Continued from page A-1

munities operating without any insurance. Absolutely none."

Many insurance companies rushed into the market or cut premiums because of high profits from favorable interest rates, league officials said. But many of those same companies recently quit writing policies or raised their rates through the roof after interest rates came tumbling down officials said.

"This has hit municipalities and others viewed as high risks by the insurance industry especially hard, leaving many unable to get or afford insurance," the league said in its December newsletter.

Along with tort reform, the league is looking at self-insurance. That would put municipalities in a better position to control coverage and rates during swings in the economy, the league said.

Among the league's other legislative priorities:

- Ensuring that state revenue sharing and municipal assistance programs are maintained at least at current levels, or around $140 million. And
- Pushing for the full, 80 percent reimbursement share on school construction debt.

"We don't know yet what the state's going to do with foundation formula funding," Keck said, a reference to the way the state's education money is split among local school districts.

"We're hoping that the legislature appropriates enough money to meet school bond needs around the state," he said.

LEGISLATOR COPY (B1)

The Alaska Economic Report

January 27, 1986

SEA-AIR SHUTS DOWN, CASUALTY OF SOARING INSURANCE COSTS: Seair Alaska Airlines, a veteran bush Alaska carrier has temporarily suspended operations and laid off some 165 employees, a victim of sky-high liability insurance costs as well as new competition on rural routes. Insurance costs increased more than 100% this year, Seair spokesmen said. The company is still trying to get insurance sufficient to keep two Bethel-based Twin Otters operating. The airline had scheduled flights to Kodiak, Bethel, Aniak, St. Mary's and Prudhoe Bay.

The Attack on Joint and Several Liability

By James Granelli

• In Los Angeles a driver high on drugs went through a stop sign and was broadsided by another motorist. A 16-year-old passenger in his car was crippled and brain-damaged in the 1979 crash. Last March a jury returned a verdict of $2.16 million against the driver—and the City of Los Angeles. The city had failed to trim bushes that partly obstructed the view of the driver and was found to be 22 percent liable. But unless the award is overturned on appeal, the city will pay nearly all of it. The negligent driver has no money and three co-defendants settled for their insurance policy limits—a total of $200,000. (*Sills v. City of Los Angeles*, C-333504, San Fernando Superior Court.)

• In New York City 12 persons were killed and scores injured in a 1970 gas explosion caused by a restaurant owner who turned on a partly installed gas main that had been inspected by the city. A jury found the city 4 percent negligent, but the verdict exposed the city to millions of dollars in damages because the defendants most at fault were bankrupt. But the city was lucky: the verdict was reversed on other grounds in 1983. (*O'Connor v. City of New York*, 447 N.E.2d 33.)

• In San Diego a university soccer player was a passenger in a car on the scenic Torrey Pines Road when a speeding drunk driver crossed the center line on a curve and smashed into the car, killing two of his teammates and rendering him quadriplegic. The drunk driver offered his insurance policy limits of $25,000. The city also was named as a defendant on a claim for faulty road design. Rather than risk a jury trial, the city settled in 1983—for $1.6 million. (*Duggan v. City of San Diego*, Civ. 484152, San Diego Superior Court.)

Across the nation these judgments and settlements have become more common, especially in catastrophic injury cases. Public entities, often dragged into cases as defendants with scant liability exposure, find themselves the target defendants forced to pay off the entire judgment when codefendants can't pay. The real villain, public officials say, is the doctrine of joint and several liability.

Changing the ancient doctrine

[illegible] states have limited or abolished the doctrine in recent years. Municipal officials and some lawmakers want the doctrine changed, and pending legislation in California and New York—home of the nation's largest personal injury verdicts—would doom the joint-and-several rule, if enacted.

Developed over centuries by English and American courts, the rule dictates that when a person is injured by the joint acts of several people, liability is indivisible. That means, in practical terms, a plaintiff can collect an award from the defendants most able to pay—those with "deep pockets."

The rationale is basic fairness. "Who should suffer, the innocent victim or one of the wrongdoers who can afford to pay?" said James Frayne, executive director of the California Trial Lawyers Association. He and CTLA president Robert B. Steinberg of Los Angeles also contend that the joint-and-several rule acts as a deterrent—forcing cities, for instance, to trim trees that could obscure a motorist's vision and lead to an accident—and keeps a penniless victim from going on welfare.

"These cases are not that easy to win," Steinberg said. "So when the city is included, the jury has got to be pretty darned convinced the city was at least partially liable."

"The nature of the beast is such that it's the single greatest problem that cities face in liability issues," said California State Assemblyman Alister McAlister, who is supporting a colleague's proposal to limit the liability of public bodies. And Jay Biggins, consultant to New York City's Office of Management and Budget, complained, "The entire public treasury is considered available to each and every plaintiff. They're treating government as the ultimate insurer."

The League of California Cities has compiled figures from 134 cities statewide on cases involving joint and several liability. It found that those cities paid more than $15.5 million in settlements and judgments during the fiscal year ending in June 1984. Two years earlier the same cities paid out $4.5 million. That kind of a hike has forced insurance carriers either to raise premiums drastically—300 percent to 450 percent for one group of California cities—or to stop writing liability policies for public entities.

It is the hand of the insurance industry that the plaintiffs' trial bar sees behind the current efforts to abolish or modify the rule.

"Insurance companies have sold public entities a bill of goods that would save them millions and millions of dollars if they could have the joint-and-several rule changed," said Frayne. Although his group killed four bills to limit the rule in the last five years, Frayne admits the fight this year will be the toughest ever. Not only is the League of California Cities better organized, he said, but more legislators are sensitive to the needs of local governments because they once served on those bodies.

Even if no state changes the rule this year, lobbyists for public entities believe that change is inevitable. "We're very confident that, at some time, we will succeed because the joint-and-several

Illustrations by Chuck Slack

problem becomes more severe every year," said Kenneth Emanuels, who heads the lobbying team for the California league. State Sen. John F. Foran, who introduced one of those previous bills and reintroduced it this session, said, "I've never seen a bill as controversial as this one pass in the first or second session."

A new generation of lawsuits

One reason joint and several liability has become more of a problem for public entities is that more plaintiffs are going to court. It used to be that injured persons whose own negligence, no matter how minor, contributed to their injuries could not sue anyone else. Contributory negligence is still the rule in five states, but the rest of the nation has adopted comparative negligence statutes, which allow partly negligent plaintiffs to recover damages—minus the percentage of their own fault—from others who caused their injuries. Most of the "comparative" states bar recovery if the plaintiff is 50 or 51 percent negligent.

As comparative negligence opened courtroom doors to a new generation of lawsuits in the 1970s, public officials began questioning whether the rationale for joint and several liability used for non-negligent plaintiffs ought to apply in cases brought by partly negligent plaintiffs. Fairness, they claim, also dictates that plaintiffs bear more of the responsibility for their own negligence.

"If you give more people the opportunity to recover damages, you also should give them the risk of assuming an unrecoverable judgment," said David Lyons, legal counsel to the legislative service bureau in Iowa, one of nine states that have modified the rule. Five other states have abolished it.

But it is the innocent plaintiff, the one who would not be barred by any contributory negligence law, who forms the biggest obstacle to those seeking to change the rule. "If we go to the legislature with all potential allies on our side and we don't have an answer for how we can take care of innocent victims, we'll have a hard road ahead," said San Diego City Attorney John W. Witt.

The Iowa rule

Iowa thinks it has at least one answer. After the Iowa Supreme Court adopted pure comparative negligence in December 1982 and retained joint and several liability in a case a year later, the legislature went into action, Lyons said, with an idea of preventing "someone who's more at fault" from benefiting in a lawsuit. First, the legislature adopted a modified 50 percent comparative fault law; then it altered the joint-and-several rule.

Under the Iowa law, joint and several liability remains in effect against defendants who are more at fault than the plaintiff. But a defendant less negligent than a plaintiff pays only the percent of the award for which he is liable. So if a plaintiff is 20 percent negligent, one defendant is 10 percent negligent and another defendant is 70 percent negligent, the plaintiff can collect only 10 percent of any award from the first defendant but could collect either 70 percent or the full 80 percent of the award from the second defendant.

In Minnesota the same facts would present a different outcome under that state's modified joint-and-several rule, said Michael K. Steenson, a tort law professor at William Mitchell College of Law in St. Paul. The state retains the rule except in cases with a judgment-proof defendant. In those cases the share of damages from that defendant is reallocated to all others, including a partly negligent plaintiff.

In some states that have abolished joint and several liability, court decisions have reimposed it in limited situations. In New Hampshire, for instance, the rule is revived when, because of immunities or procedural bars, the plaintiff can collect from only one defendant. Kansas, New Mexico, Ohio and Vermont also have abolished the rule.

No more deep pockets

Foran's California bill provides that all defendants would pay for pain and suffering losses "based on their fault rather than on the size of their pocketbooks," he says. In other words, if a city is 20 percent liable, it would only pay 20 percent of any award for pain and suffering, the noneconomic damages that provide plaintiffs with most of the money against public entities. The bill would not limit the amount of money defendants would have to pay for such damages as medical expenses or lost wages. An identical bill, introduced in February 1983, was amended to apply only when a defendant was less than 40 percent liable. The amended version died in committee.

"There must be comparable degrees of fault," Foran maintains. "Equity de-

States abolishing joint and several liability

New Hampshire and Vermont

Abolished the rule in favor of several liability in 1981. N.H. Rev.Stat.Ann. Sec. 507:7-a; Vt. Stat.Ann. Tit. 12, Sec. 1036.

Kansas

Abolished the rule in 1978 case that interpreted a 1976 comparative negligence statute. *Brown v. Keill*, 580 P.2d 867, held that the rule does not apply in comparative negligence cases but that several liability does.

Ohio

Abolished the rule in favor of several liability in 1980. Ohio Rev.Code Sec. 2315.19(A)(2).

New Mexico

Abolished the rule in favor of several liability through state supreme court decisions that adopted comparative negligence. *Scott v. Rizzo*, 634 P.2d 1234 (1981); *Bartlett v. New Mexico Welding Supply Inc.*, 646 P.2d 579 (1982).

States with limitations on joint and several liability

Nevada, Texas, Indiana, Louisiana, Oregon, Pennsylvania

Limited the rule so that it applies only when plaintiff's negligence is less than defendant's. Otherwise, several liability applies when plaintiff's negligence is greater than defendant's. Nev. Rev.Stat. Sec. 41.141(3) (1975); Tex. Rev.Civ.Stat.Ann. Art. 2212(a) (Vernon's Supp. 1982, 83, 85); Indiana SB-287 (1985); La. Civ. Code Ann. Art. 2324 (1982); Or. Rev.Stat. Sec. 18.485 (1983); 42 Pa. C.S. Secs. 7102(b), 8322 et seq; *General State Authority v. Sutter Corp.*, 452 A.2d 75 (1982).

Iowa

Limited the rule so it would not apply to defendants found to bear less than 50 percent of total fault assigned to all parties, leaving them liable for their several amount. Iowa 1984 Act, Secs. 668.1-668.3, 619.17.

Minnesota

Limited the rule only to point at which the share of an uncollectible defendant's damages would be reallocated among all others, including partially negligent plaintiff. Minn. Stat.Ann. Sec. 604.01(1).

Oklahoma

Limited the rule to cases where damages cannot be apportioned or when plaintiff is not at fault. *Lawbach v. Morgan*, 588 P.2d 1071 (1978); *Boyles v. Oklahoma Natural Gas Co.*, 619 P.2d 613 (1980).

Sources: City of New York Law Department; Michael K. Steenson, William Mitchell School of Law, St. Paul, Minn; Ohio Municipal League.

mands that a defendant found 10 percent at fault pay only 10 percent of the verdict. One injustice shouldn't provoke another injustice. As more flagrant cases come to the forefront, people will come to realize this isn't free money. It's taxpayers' money. And if we don't do something, we'll have to curtail other services."

But California Assemblyman Elihu Harris, who chairs the judiciary committee that killed Foran's previous bill, is troubled by the proposal. First, he said, potential "deep pocket" defendants—manufacturers, hospitals and insurance companies—are better able to handle the burden of paying damages than the injured victims are.

Harris also believes that statistics are misleading. "I want hard examples," he said. "Statistics on cases settled could mean defense lawyers are lazy. There are not many cases, and those cases that exist are decided by jurors who will have to pay the verdicts in taxes."

Limiting liability

Arguments to abolish or modify the joint-and-several rule may have more merit, he said, if they are limited to the public sector and to cases in which liability is only incidental or passive, such as an accident caused by a speeding drunk driver on a road others have used safely. But a 1982 bill abolishing joint and several liability for only California public entities was defeated when other target defendants sided with the trial lawyers to urge its defeat.

New York City officials, however, think a bill limited to local governments will pass the state legislature. "We think public entities are distinguishable from other defendants because they're looking out for the public welfare," said city consultant Biggins. "The indications are that other target defendants—doctors, hospitals and so forth—won't go over to the trial lawyers' side to fight this bill." To ensure support, the city sent management and budget liaison McGrath to cities throughout the state on a year-long mission to explain the effects of joint and several liability on small cities as well as larger ones.

Ceilings on awards

New York City's proposal goes further than just abolishing the joint-and-several rule for public entities. Besides allowing public entities to pay only their proportionate share of liability, the bill would put a ceiling of $150,000 per individual and $450,000 per occurrence or any award and would force plaintiffs to prove they had incurred at least $2,500 in medical expenses before they could collect damages for pain and suffering. The last provision, Biggins said, is "an attempt to establish objective standards" for pain and suffering. "We're not saying people shouldn't be compensated, we're just saying the numbers are not foreordained in heaven," he said.

In California and New York officials and attorneys for local governments believe the joint-and-several rule is creating a crisis. In California, especially, the tax-limiting initiative known as Proposition 13 has made it difficult for public bodies to raise funds. Some local leaders bemoan what they see as an impending spiral: By paying accident victims, cities

have to shift funds from other budgets such as street repairs, leaving potholes or untrimmed bushes that might contribute to accidents and lead to more victims suing the cities.

But other states also are feeling squeezed by the rule. Colorado, Florida and Michigan, for instance, have legislative bills pending or planned for this year. "We see the rule as a major potential problem," said Tami A. Tanoue, staff attorney for the Colorado Municipal League, which is supporting a current bill in the state legislature. In Florida last year, the Florida Medical Association supported a ballot initiative to abolish joint and several liability, but the state Supreme Court struck it from the ballot because it improperly included other issues.

In Michigan settlements and judgments against the state transportation department alone last year hit some $14 million, said State Sen. Alan Cropsey, who noted that payments have been rising dramatically in the last five years. An April 1982 state appellate court decision helped to spur awards against the department by rejecting the state's claim for contribution and letting the joint-and-several rule force the state to pay nearly three times the amount of its liability, said Assistant State Attorney General Carl Carlsen.

In that 1982 case a trucking firm had settled a personal injury suit for $150,000. In a later trial against the codefendant state, the plaintiff won $1,299,400 but was found to be 60 percent negligent. The state, which was 10 percent negligent, had argued that the trucking firm should contribute to the award by paying another $239,820 for its 30 percent share of the blame. But the court ruled that the amount of the settlement was the only setoff the state was entitled to. Carlsen said that with several liability the state would have had to pay only $129,940, instead of $369,760. *Bacon v. Michigan Department of Transportation*, 115 N.W. 2d. 382.

Cropsey said such cases have forced the state to settle more lawsuits to avoid the possibility of higher jury verdicts. As Los Angeles Deputy County Counsel Charles V. Tackett put it: "Many situations are extremely dangerous financially, and if we can work out a deal where we have a sure loss rather than the potential for an extraordinary loss, we take it."

Journal

James R. Granelli is a reporter for the Los Angeles Times.

THE ANCHORAGE NEIGHBORHOOD HEALTH CENTER

REGRETS TO ANNOUNCE THAT ITS FAMILY PRACTICE PHYSICIANS CAN NO LONGER ACCEPT ANY NEW PREGNANT WOMEN

For the past three years, our Family Practice Physicians have provided quality pre-natal care to the Anchorage community with a flawless record. In spite of this, our annual malpractice premium has increased to over $200,000 plus additional costs of up to $350,000 to purchase necessary insurance "tails."

This compares to our last year premium of $45,000.

The Center will continue to provide pre-natal care to women currently enrolled in our practice until they deliver.

We will also continue to provide a full range of medical and dental services, other than pre-natal care.

IMPORTANT ISSUES IN 1986

Legislative Committee members determined that there were four important issues for 1986 and they are:

1. INSURANCE CRISIS - Getting the State laws changed that regulate the settlements and awards (tort reform). We must begin to change these laws so that insurance companies will continue to write insurance in Alaska and nationwide. We agreed to the 14 issues that the Citizens Coalition for Tort Reform are drafting legislation on and we agree to include the three additions regarding requirements for insurance companies. We must have insurance coverage available at a reasonable rate.

2. SAFETY & ENFORCEMENT - Enforcement by Public Safety on the requirement that every commercial vehicle shall have insurance and that proof of insurance shall be filed with the Division of Motor Vehicles. There has been absolutely no enforcement of this portion of HB 133 that passed last year. The effect to those that have provided the required coverage is that they can't compete with those that are operating without insurance.
   Additionally the Department of Public Safety has not drafted regulations on the truck inspection legislation and the truck drivers licensing. We must be prepared to seek funds for Public Safety so that they can do these requirements. Need to meet with Commissioner Sundberg in Juneau and ask him why they aren't enforcing the insurance regulations and why no regulations have been drafted to cover inspection and licensing. Board of Directors will meet with Sundberg in Juneau during the February 1st meeting.

3. Attempt to have the lift axle regulation changed this session. Try to get a friendly legislator introduce a bill that would allow the usage of the lift axle. Truck Regulations going into effect on January 18th that would disallow usage of the lift axle will decrease the weight allowable on all loads now using the axle. Need to meet with Commissioner Knapp while we are in Juneau during the February 1st meeting.

4. Alaska Railroad- Need to express our concerns to Legislators over the way we feel the Railroad is heading. Express our concerns that the State not get into the barge and freight shipping by waterways and make that a part of the Railroad.

ACTION ITEMS:

1. THAT the ATA develop position papers on the above four important issues. These would be used to send to members and be given to Legislators during the Legislative Brunch.
2. THAT the ATA mail out the voting record of Legislators to all their members and that we let Legislators know that we have done so.
3. THAT the ATA write a letter to supportive Legislators and thank them for their support and THAT the ATA write a letter to non-supportive Legislators and ask them the reason for their non-support on various issues.
4. THAT the ATA hold community meetings in Fairbanks and Anchorage with owner/operators on the insurance crisis seeking their support in passing tort reform legislation.
5. And THAT the Executive Committee approve the Three (3) Major Concerns and the Four (4) Important Issues in 1986, which would include the recommendations contained within the Major Concerns and Important Issues.

MEETING ADJOURNED AT 8:55AM.

Next Legislative Committee Meeting will be held February 20th, 1986 at 7:30 am in Anchorage.

Senator Vic Fischer

Alaska State Legislature
Pouch V • Juneau, Alaska 99811 • (907) 465-4954

M E M O R A N D U M

TO: Anchorage Caucus members

FR: Senator Vic Fischer

RE: Effect of insurance rate increases on Anchorage social service organizations

DT: January 28, 1986

Attached is a summary of the effect of increased insurance rates on 17 nonprofit service providers in Anchorage. The summary is the result of a letter I sent in December to over 50 organizations that had requested Anchorage Social Service Block Grant proposals for FY'86.

Most of the organizations are having or expect to have trouble obtaining general liability insurance coverage. A few organizations that did not have trouble this year have insurance coverage through their national office.

Increased premiums range from one organization's low 1.5 percent to another's overwhelming 600 percent. None of the increased premiums reflect any increased insurance coverage: most higher premiums are coupled with substantially less coverage.

My impression from the limited response is that the problem is just begining. When unexpectedly high insurance rate premiums are coupled with reduced federal and state budgets, nonprofit social and health service providers face major budget reductions. I anticipate that next year we'll see requests for help to offset Anchorage social service providers insurance premiums. The alternative will be greatly reduced services.

I believe this whole aspect of the "insurance crisis" will need to be faced by the legislature to avoid drastically reduced health and social services to the people of Anchorage.

cc. Honorable Tony Knowles, Mayor
Dave Walsh, Chair, Anchorage Assembly

During Interim • 1024 W. 6th Avenue, Suite 204C • Anchorage, Alaska 99501 • (907) 278-3654

SUMMARY OF RESPONSES

1. ARE YOU HAVING TROUBLE GETTING INSURANCE?

   8 organizations responded yes;
   5 responded no;
   4 are insured through their national organization

   Those with national coverage stated that without the pool they would probably have difficulty obtaining insurance.

   Of those organizations that had difficulty obtaining insurance, the problem ranged from finding a carrier in Alaska to finding a carrier who would provide adequate coverage.

2. WAS YOUR PREMIUM CANCELLED?

   6 yes;
   7 no
   4 no answer

3. WERE YOU NOTIFIED PRIOR TO CANCELLATION?

   3 yes;
   4 no;
   9 no answer

4. HAS THE COST FOR YOUR INSURANCE PREMIUM RISEN SUBSTANTIALLY?

   14 yes;
   3 no answer

   Of those who responded yes, the increase ranged from 1.5 to 600 percent; most of the increases were between 30-60 percent.

5. HAS THE COVERAGE EXPANDED TO REFLECT INCREASED PREMIUMS?

   13 no;
   4 no answer

6. ARE YOU REQUIRED BY FEDERAL, STATE or MUNICIPAL CONTRACT TO HAVE INSURANCE?

   15 yes;
   2 no answer

7. IF YOUR PREMIUM INCREASED WILL YOU REQUEST A BUDGET INCREASE?

7 yes;
4 no;
6 no answer

8. WHAT WILL YOU DO IF YOU DON'T RECEIVE ADDITIONAL OUTSIDE ASSISTANCE?

Responses varied from close down, reduce type and quality of services, eliminate employee benefits, reduce operating costs, and attempt private fundraising.

* * * * * * * * * * *

ORGANIZATIONS THAT RESPONDED TO THE QUESTIONNAIRE

1. Rural Alaska Community Action Program, Inc.
2. The Volunteers of America
3. American Red Cross
4. National Federation of the Blind of Alaska
5. Family Connection
6. Southcentral Counseling Center
7. Childbirth Education Association
8. Love Alaska Ministries
9. The Center For Children and Parents
10. Alaska Legal Services Corporation
11. The Employment and Training Center of Alaska
12. Hope Cottages
13. The Salvation Army
14. Alaska Treatment Center
15. Alaska Children's Services, Inc.
16. The Association for Stranded Rural Alaskans in Anchorage
17. Big Brothers/Big Sisters of Anchorage

America's Liability Explosion: Can We Afford the Cost?

Robert H. Malott
Chairman and
Chief Executive Officer
FMC Corporation

Northwestern University Law School
Corporate Counsel Institute
October 10, 1985

FMC

America's Liability Explosion: Can We Afford the Cost?

1

I am delighted to have this opportunity to discuss a concern that is uppermost in my mind—namely, the destructive and rapidly escalating trend toward liability litigation in this country and the implications that this trend portends not only for industry but for society as a whole.

It is a trend that is costing the American public billions of dollars each year, it is undermining the competitiveness of U.S. industry, and it is threatening the very existence of some businesses in this country. Yet it is a trend that the vast majority of the American people has either failed to understand or has persistently chosen to ignore.

Additional copies are available from:

FMC Corporation
Communications Dept.
200 E. Randolph Drive
Chicago, IL 60601

America's Liability Explosion

The disturbing truth is that America has become the most litigious society in the world. Last year, one out of 15 Americans filed a private civil lawsuit of some kind. In all, over 13 million private civil law suits were filed in state and federal courts.

No less than the highest court in the land is appalled at the situation. As Chief Justice Warren Burger lamented in a recent speech, our society today "has an almost irrational focus—virtually a mania—on litigation as the way to solve all problems."

In some instances, the grounds for resorting to litigation strain credulity. Let me cite just a few examples that sound more like stories out of Ripley's "Believe It or Not" than examples of responsible American jurisprudence:

Item: Two Maryland men decided to dry their hot air balloon in a commercial laundry dryer. The dryer exploded, injuring them. They sued the manufacturer of the dryer and ended up winning nearly $900,000 in damages.

Item: An overweight man with a history of coronary disease suffered a heart attack while trying to start a Sears lawnmower. He sued Sears, charging that too much force was required to yank the mower's pull rope. A jury in Pennsylvania awarded him one million dollars, plus another $500,000 in pre-judgment interest.

Item: A tw[illegible]ld child being treated in the hospital for bronchial spasms suffered brain damage from a drug overdose. Although the hospital staff had clearly exceeded the dosage level prescribed by both the attending doctor and the drug manufacturer, the child's parents successfully sued the company producing the drug. The jury award? Nine million dollars in compensation and $13 million in punitive damages.

If you think these are isolated cases of absurdly generous liability awards, you are wrong. Last year, awards of a million dollars or more were given in more than 360 personal injury suits—an incredible 13 times the number 10 years ago.

The list of those affected by liability litigation runs the full spectrum of American business—including product manufacturers, retail stores, doctors, architects, and stockbrokers to name just a few.

Even ministers are being sued for malpractice. In cases currently pending before state courts, they are being accused of seduction, breaching confidentiality, failing to recommend professional help, and offering incorrect advice. In the wake of these claims, some 40,000 ministers have bought malpractice insurance, while others have become reluctant to counsel members of their congregation and are sending them to psychiatrists instead. Where will this end? Is no group sacrosanct in our litigation-prone society?

Insurance Industry Hit Hard

Among those hardest hit by the surge in litigation has been the insurance industry. Last year, the property-casualty insurance industry suffered a staggering pretax loss of nearly four billion dollars—its worst loss since the San Francisco earthquake of 1906.

To halt the red ink, insurance companies have resorted to a host of defensive measures—hiking rates, canceling coverage, narrowing the conditions of their policies and, in some cases, simply closing up shop.

As a result, businesses nationwide are facing a precipitous decline in liability coverage—if they can get coverage at all—at costs that range anywhere from 25 to 500 percent over their previous premiums.

FMC, as an example, had its premium increased 350 percent this year for less than one-half the coverage we enjoyed in 1984, and this was after an extensive search of all alternatives in the worldwide insurance market.

Companies in particularly high risk areas—such as sporting good manufacturers, cement companies, and machine tool builders — are going without insurance, either because the costs are prohibitive or because coverage is unavailable at any price.

It would seem that insurance companies are trying to tell this country that something is seriously wrong with our system of liability. Indeed, Lloyd's of London, the single largest insurance underwriter in the world, has indicated it may withdraw from its U.S. activities if it does not see some action on tort law reform.

What is causing the problem? I attribute the current situation to the following: first, the ambiguity of current liability laws; second, an increasing acceptance of the concept of victims' *entitlement* to compensation; and third, the contingency system for compensating the legal profession.

The Expanding Definition of Liability

Since the early 1960's, the concept of liability for product-related injuries has been relentlessly expanded by both state and federal courts.

First, the courts created a new legal theory, strict liability, to enable claimants to recover damages for injuries caused by defectively manufactured products. This happened because the courts believed that business—rather than the injured party—should bear the cost of manufacturing errors, regardless of fault.

Then, the concept of strict liability was extended from defects in manufacturing to defects in a particular product's design, in its operating instructions, or in its safety warnings. In essence, the focus of product liability was shifted from the conduct of manufacturers to the condition of the product itself.

However, unlike the test for manufacturing defects, there are no clearcut standards to guide judicial decisions on the adequacy of a product's design or its safety warnings. Although some 30 states have now enacted product liability statutes, no two are alike. Consequently, cases based on similar facts, but tried in different states, can produce strikingly different and often contradictory judgments.

In an FMC case concerning a construction worker who had driven a crane into high voltage lines, an Illinois court ruled *against* FMC for not providing adequate safety warnings and for not installing automatic warning devices, even though the devices available at the time the crane was manufactured were not reliable.

Yet courts in two other states, in similar cases, ruled that the crane manufacturers were *not* liable, because the hazard of driving a steel boom into electrical lines was obvious. Any resulting injury was therefore the responsibility of the crane operator.

Such inconsistency in product liability judgments has produced enormous confusion among manufacturers and consumers alike, with neither side knowing what rights or responsibilities they have and what limits, if any, there are on liability.

Entitlement to Compensation

Another factor contributing to the chaos in liability law is the growing "attitude of entitlement" in compensating injury victims, even in those cases where it is obvious that the manufacturer cannot be charged with responsibility or, at a minimum, responsibility is shared between the manufacturer and the injured party.

A decade ago, injured persons whose own carelessness was responsible for injury could not successfully prosecute. However, since the mid-1970's, 10 states have adopted comparative fault standards, which allow plaintiffs to recover damages even if they share responsibility for their injuries. By adopting the concept of comparative fault, these states have precipitated a whole new generation of lawsuits and are encouraging increasing numbers of people to seek compensation through suit or the threat of litigation.

Underlying this attitude toward victims' compensation is the assumption that the insurance industry—fed by corporate premiums—has a bottomless pool of funds to compensate the injured, no matter how tenuous their claims. Indeed, in some cases, courts and juries have seemed far more concerned with compensating the plaintiffs than in establishing the liability of the manufacturer.

Witness the recent litigation over Agent Orange. The judge pressured the seven corporate defendants to pay $180 million in death and disability compensation to Vietnam veterans and their families even though, as he said later, he did not believe there was any medical evidence to support their claims.

Lucrative Contingency Fees

The third factor contributing to the number and cost of liability claims is the contingency system for determining legal fees.

Because plaintiffs do not incur liability by initiating action, they are encouraged to pursue injury suits even if the evidence for their claims may be relatively weak. Similarly, with liability awards now reaching a million dollars or more, lawyers have a powerful incentive to keep filing liability cases, even if the prospect of winning any one case is highly uncertain. In short, by eliminating the financial risk of bringing a case to trial, contingency fees are encouraging both plaintiffs and trial lawyers to clog the courts with suits.

In addition, contingency fees tend to increase the size of injury awards, as juries factor in the cost of legal counsel when determining the total size of damages for the plaintiff. This cost is far from insignificant.

Indeed, if one considers the legal fees for both plaintiff and defendant, it becomes clear that more money is being paid today to adjudicate a claim than the compensation being paid to victims.

According to a study by the Rand Institute For Civil Justice, only 37 percent of the amounts paid for compensation and legal fees typically goes to the claimant. The balance—or 63 percent of the assessed damages—goes to pay the legal fees of the litigants.

Because of high contingency fees and the potential for lucrative awards, liability lawyers have an enormous stake in preserving the status quo. I can assure you the plaintiffs' bar is well aware of this and is effectively organized to resist change.

Who Pays? We All Do

Who ends up paying for our current mania for litigation? It's obvious that we all do. The growing tide of liability litigation is imposing enormous costs on consumers, on business, and on society as a whole.

As consumers, we are paying not only through higher product prices but also through the reduced availability of many products and services. Already, astronomical legal settlements and escalating insurance premiums have forced more than a few companies to drop product lines or, in some cases, to go out of business.

This trend is cutting across all segments of U.S. industry, as the following examples illustrate:

- In the past decade, 10 of the 13 U.S. firms making football helmets have had to stop production, due to runaway jury awards.
- In 1983, Merrell Dow was forced to discontinue production of the drug Bendectin, although the Food and Drug Administration approved the drug for treating women who suffered nausea during pregnancy. The reason? The cost of liability insurance for making Bendectin had reached 10 million dollars a year, or over 80 percent of the company's annual sales from the drug.
- And today, the continued production of small aircraft in this country is being seriously threatened by burgeoning liability costs. This year, those costs to general aviation airframe manufacturers will amount to $100 million, requiring an average increase of $50,000—or 50 percent—to the cost of the average plane. Such cost increases have already led one manufacturer, Beech Aircraft Corporation, to shut down its plant in Wichita, Kansas, and eliminate up to 12,000 jobs.

Perhaps the most pernicious example of this trend is the decline in production of the DPT vaccine, which is used to prevent diphtheria, tetanus, and pertussis—commonly known as whooping cough—among young children.

Since the introduction of the vaccine in the 1920's, the number of deaths in the United States from pertussis each year has declined dramatically—from one in 10,000 to one in 10 million. Yet, nearly a dozen companies have dropped out of the DPT market in the last ten years, leaving only one U.S. producer of the vaccine and creating dangerous nationwide shortages. The reason? Excessive liability costs.

The problem is that the courts focus on compensating the pain and suffering of those injured—not on serving the needs of society as a whole. This attitude is not only adversely affecting the American public but is significantly increasing the costs of doing business for many U.S. companies and undermining their ability to compete. According to a study by the Commerce Department last year, the insurance costs that U.S. companies face for product liability coverage are many times higher

than those facing manufacturers in Europe and Japan. In fact, some U.S. manufacturers of machine tools and textile machinery must support liability premiums that are *20 to 100 times* greater than those paid by their foreign competitors.

FMC's own experience corroborates this. Over the last five years, our total insurance expenses in the United States, including self-insured losses, have cost five times as much as our insurance premiums in international markets. These differences in liability costs can create a major competitive disadvantage for domestic manufacturers in both local and foreign markets.

For some companies, the costs of product liability litigation are not only hurting their ability to compete, but are forcing them to seek refuge under Chapter 11 of the federal bankruptcy laws. Since the Manville Corporation made history in 1982 by declaring bankruptcy at least three other companies have followed suit.

In 1983, the James Hunter Machine Company, a small Massachusetts manufacturer of textile machinery, was forced to file for bankruptcy after being in business for 136 years because it faced liability claims totaling over $17 million.

Last year, Aquaslide 'N' Dive Corporation, the nation's largest manufacturer of diving boards and swimming pool slides, also sought protection under federal bankruptcy laws, because it did not have enough insurance or assets to cover potential liability claims.

Most recently, the A. H. Robins Company has filed for bankruptcy, due to liability suits for injuries related to the Dalkon Shield, the intrauterine birth control device the company removed from the market in 1974. By July of this year, Robins had already paid nearly $500 million in awards, settlements, and legal expenses to dispose of approximately 9,000 liability suits. Yet another 5,000 claims are still pending and more are expected.

Time to Revamp Liability Laws

This situation is absurd. How many more companies must be forced into Chapter 11 before we realize that it is time to revamp our liability laws? We are rapidly approaching the point where the competitive ability of U.S. manufacturers is being determined more by the vagaries of state laws and jury awards than by the price or quality of their products.

In considering potential areas for reform, it is instructive to compare our system of liability with that prevailing in Western Europe and Japan, where the incidence of product liability claims is far lower and the average size of awards is much smaller. In my view, there are three factors that account for these differences in the frequency and cost of liability litigation.

First, contingency fee arrangements are not allowed in Western Europe or Japan. Instead, plaintiffs must pay their attorneys during the course of litigation and they risk paying the legal costs for the defense if they lose.

Second, damage awards in Europe and Japan usually only cover actual expenses and loss of income. Punitive damages and awards for pain and suffering are not readily available in Europe, and they are nonexistent in Japan.

As a result, plaintiffs must bear a significant financial risk in bringing a case to trial, and generally they have lower expectations for awards. These two factors alone act as a major disincentive to litigation.

Third, and most important, the Europeans and the Japanese have a totally different attitude toward litigation than do Americans.

Europeans generally believe that, if a product is made safely, it is up to the consumer to use it safely. The Japanese are even more conservative in their approach to litigation. They rarely use the legal system to resolve disputes and, in fact, tend to consider litigation as a form of harassment.

In contrast, Americans tend to be keenly aware of the availability of legal redress for accidental injury and appear to be willing to pursue such a course without reservation. They rely on the courts not only to settle disputes, but also to provide extensive compensation for injuries, often with little regard for who is at fault and with *no* regard for the costs they are imposing on business and society.

In my opinion, this litigation mentality cannot continue. The costs have simply become too great. Our runaway liability system is contributing significantly to

higher prices, it is reducing choices to consumers, it is seriously impacting the availability and cost of insurance and it is impairing the international competitiveness of U.S. industry.

The Challenge Before Us

The challenge before us is to arrest the dangerous trend toward excessive litigation and ever rising damage awards. Although this trend will not be reversed overnight, I propose that we begin with federal reform of our nation's product liability laws.

It is imperative that the United States have uniform, nationwide standards of product liability. A federal bill should include:

- A fault-based standard for judging the adequacy of product design and the appropriateness of safety warnings.
- A clear presumption that a product conforming to mandatory government safety requirements is reasonably safe.
- A statute of limitation on the time period during which manufacturers can be held liable for a defective product.
- A standard limiting the number and size of punitive damage awards for injuries from a particular product defect.
- A standard requiring that damages reflect the extent to which plaintiffs contributed to their injuries.
- A clear presumption that government contractors are not liable for injuries resulting from equipment or systems built to government specifications.

These are the central goals that the business community has sought to achieve in nearly a decade of effort to reform product liability law. Participating in that effort have been the Business Roundtable, the National Association of Manufacturers, the U.S. Chamber of Commerce, and more than 200 other trade associations and corporations.

Yet despite their concerted efforts, federal reform of product liability law remains at a standstill. Repeatedly, product liability legislation has been thwarted by the competing claims of different interest groups or subordinated to other, more pressing issues on the Congressional agenda.

Efforts to gain support for product liability reform in the American Bar Association have also been blocked, first at the San Francisco convention two years ago and more recently in New Orleans. This has been largely due to the enormous influence of the trial bar.

I challenge all of you, as leaders in the legal profession, to join the fight for product liability law reform. We need your help to broaden public awareness of the current crisis in product liability but, even more importantly, we need your help to counteract the political power of the trial lawyers. As vigorous supporters of the status quo, they have placed a virtual stranglehold on efforts to enact federal product liability legislation—and given the legal profession an unfortunate reputation for being more concerned with protecting its own interests than with serving the interests of society as a whole.

I urge you to stand up and be counted. Make product liability reform an issue within your company, with your trade associations, and with your outside counsel. Let them know why the issue is important to you and why it should be important to them.

Above all, I urge you to make it an issue with your congressmen. It is imperative that we maintain pressure in Washington for federal preemption. If Congress keeps brushing the issue aside, we will continue to see increasing numbers of U.S. companies succumbing to the weight of excessive litigation, exorbitant legal fees, and escalating damage awards. That is a price we can no longer afford. The time to bring our runaway liability system under control is now.

Robert H. Malott

Robert H. Malott is Chairman of the Board and Chief Executive Officer of Chicago-based FMC Corporation.

Mr. Malott joined FMC in 1952. He was elected President and Chief Executive Officer in 1972. In 1973 he was also elected Chairman of the Board. He relinquished the title of President in 1977.

Mr. Malott received his A.B. degree from Kansas University and his M.B.A. from Harvard Graduate School of Business Administration.

He is a member of The Business Council; The Business Roundtable; Harvard Business School Board of Directors of the Associates; and the Boards of the Chemical Manufacturers Association; The Hoover Institution; Argonne National Laboratory; and the Advisory Council, J.L. Kellogg Graduate School of Management, Northwestern University. He is a Trustee of The Chicago Council on Foreign Relations, American Enterprise Institute, and the University of Chicago. In addition, he is a member of the Boards of Directors of Amoco Corporation and United Technologies Corporation.

Actuarial Analysis of American Medical Association Tort Reform Proposals

September, 1985

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September 11, 1985

Mr. Kirk Johnson
General Counsel
American Medical Association
535 North Dearborn
Chicago, Illinois

Dear Mr. Johnson:

We have completed our review of the potential medical professional liability cost savings related to the American Medical Association (AMA) proposed National Professional Liability Reform Act of 1985 (the Bill). This report describes our approach, our conclusions and a number of important limitations related to this type of analysis.

APPROACH

The objectives of this project were as follows:

1. To identify the potential one-time savings in medical professional liability cost attributable to the four tort reforms in the Bill. (We did not attempt to assign a value to the peer review, discipline and risk management aspects of the Bill.)

2. To identify the potential reductions in medical professional liability claim severity trend rates attributable to the Bill.

Our approach to achieving this objective included the following steps:

1. Estimate the medical professional liability premium (including self-insured costs) in the United States in 1984.

2. Estimate a range of potential savings for each of the four tort reforms in the Bill separately and combined. The bill language we evaluated is included in Appendix A.

3. Estimate the potential impact on claim severity trend rates of the reforms in the Bill.

SUMMARY OF CONCLUSIONS

The next three sections describe the results from each of the three areas.

Estimated Premium

Table 1 below summarizes the result of our review of medical professional liability costs in the United States in 1984. Appendix B describes the sources of these estimates.

Table 1

Estimated Medical Professional Liability Premium Costs in the United States

	Item	Amount in Millions
1.	U.S. Direct Written Premium 1984	$2,258
2.	Joint Underwriting Associations (JUA) not included in 1	120
3.	Patient compensation funds (PCF), Catastrophe funds (Cat Fund) and other "pay-as-you-go" financial mechanisms	166
4.	Hospital self-insurance programs and hospital programs insured outside the United States	200
5.	Total	$2,744

The $2.7 billion total somewhat underestimates the 1984 cost since we could not identify a source which would permit us to estimate the cost of all governmental self-insurance programs nor the amount of premiums paid directly to non-United States insurers.

Our experience with medical professional liability insurers, JUA's and PCF's indicates that costs have been increasing at more than 15% per year since 1984. By 1986, medical professional liability costs are therefore likely to exceed $3.6 billion.

Potential Initial Savings

Table 2 below summarizes our estimates of the potential savings for each of the four tort reform components for a typical state.

Table 2

Potential Initial Savings from Reform Bill

Item	Potential Savings ("Typical" State)
Periodic Payments	6%
Collateral Source Offset	8%
Limitation on Non-Economic Damages	12%
Contingency Fee Limitation	9%
Total	28%

Applied to the 1984 medical professional liability costs of $2.7 billion, the potential initial savings is approximately $800 million. Applied to the estimated 1986 medical professional liability costs of $3.6 billion, the potential initial savings is approximately $1.0 billion.

Appendix C describes the models used to develop these estimates. In addition to the cautions in the LIMITATION section below, the following should be considered:

1. To realize the potential savings it is necessary that law impact claim settlements to the same extent as court awarded claims, even though the statutory language only applies specifically to court awards. In the extreme case, if the law had no effect on settlements the value of the savings when applied only to court awards would be approximately 5%.

2. The savings will vary from state to state based on considerations which are discussed in Appendix C. Application of models to a range of state situations implies that the range of savings within which the experience of most states is likely to fall would be 23% to 33%.

3. The potential initial savings might not be fully reflected in cost reductions immediately after passage of a state law. Insurers and JUA's might be reluctant to decrease rates by the full amount of potential savings until the effectiveness of the law could be tested. PCF's generally charge premiums based on expected claim payments. For several years after passage of state law claim payments will reflect the prior law, and PCF charges will not be immediately affected. Self-insurance costs may be subject to considerations like those of insurers if the self-insurance program is fully funded or like those of PCF if the self-insurance program is not fully funded.

If the laws were applicable to claims reported on or after the effective date then it could take three to five years to realize the full initial cost savings. If laws were applicable to claim occurrences on or after the effective date then it would take two to three years longer (five to eight years) to realize the full initial cost savings.

Impact on Trends

The element of the Bill which we anticipate will have a significant effect on claim severity trends is the limitation on non-economic damages. Appendix C describes the manner in which the impact of the law on cost trends has been estimated.

We believe the reduction in trend over the 1986-1989 period for a typical state will approximate 4% per year, with most states realizing a trend savings ranging from 3% to 6%. The trend reduction in the typical state is equivalent to $80 million per year at 1984 cost levels and $100 million at 1986 cost levels. The annual savings will continue to increase since rising cost levels will increase the $2.7 billion base ($2.0 billion after the law change) and inflation will increase the potential for non-economic loss in excess of $250,000 per claimant.

LIMITATIONS ON RESULTS

The following limitations should be considered in utilizing these results:

1. The projected potential savings rely on models which depend critically on the judgments which are applied. We believe the judgments are reasonable. Other reasonable judgments could result in significantly different results.

2. The actual savings which might result from passage of these tort reforms will depend on factors such as plaintiff behavior, attorney behavior and court interpretations which cannot be predicted in advance. Actual results may therefore differ significantly on these projections.

3. There are a number of studies underway (the GAO study for example) which are gathering statistical and non-statistical information. If such information were currently available it could significantly affect our judgments and conclusions. As part of this project we are not responsible for updating this report to reflect information which becomes available after the report is issued.

4. The Bill is currently in outline form. Actual bill language could produce results which differ from the intended results. We have relied on interpretations from AMA Counsel regarding the intentions of the bill language.

   We assume that the agency responsible for administering the Bill would prepare minimum criteria which any state law would need to meet in order to become eligible for the benefits under the Bill. Appendix A comments on some elements which must be included in the actual operation of a state law in order to realize the potential savings.

We appreciate this opportunity to assist the American Medical Association on this important and challenging project.

Sincerely,

Allan Kaufman

Allan Kaufman, F.C.A.S.

AK/dmk

AMERICAN MEDICAL ASSOCIATION

Analysis of Tort Reform Proposals

Appendix A - Tort Reform Proposals

(1) Periodic Payments - Such state liability reform shall include provisions:

(A) that periodic payments shall be made for all future damages when such damages exceed $100,000;

(B) for mandatory periodic payments of such future damages over the lifetime of the beneficiary or until the damages are fully paid, whichever comes first; and

(C) that if a plaintiff dies prior to full payment of damages, the party obligated to make such payment shall retain any sums not yet paid out in accordance with the payment schedule, provided, however, that the court shall have the discretion to order continued payments necessary for the support of the plaintiff's spouse or children.

(2) Collateral Source Rule - Such state liability reform shall provide:

(A) that in an action for damages for medical injury, the damages awarded shall be reduced by amounts paid or to be paid from all collateral sources including:

(i) government disability or sickness programs;

(ii) government or private health insurance;

(iii) employer wage continuation program; and

(iv) other sources intended to compensate the plaintiff for such medical injury.

(B) that the amount that the judgment is reduced shall equal the difference between the total amounts received from collateral sources and the amount directly paid by the plaintiff to secure such amounts.

(3) Noneconomic Damages - Such state liability reform shall provide that in a judgment for medical injury not more than $250,000 may be awarded as damages for noneconomic losses.

(4) Contingency Fees - Such state liability reform shall provide that the attorney representing a medical injury claimant may not receive as a fee more than 33 1/3% of the first $150,000 of damages, 25% of the next $150,000 of damages, and 10% of the balance of any damages awarded to such claimant. The Court awarding a judgment shall be authorized to increase the permissible fee upon a petition containing evidence which in the opinion of the Court justifies additional compensation.

AMERICAN MEDICAL ASSOCIATION

Analysis of Tort Reform Proposals

Appendix A -- Comments on Interpretation of Reform Bill for Valuation Purposes

To realize the potential savings the Bill must be interpreted to accomplish the following:

(1) Periodic Payments:

a. Claimant's attorney fee should be paid periodically in the same fashion as the award or settlement amount.

b. The period of payment of future damages is estimated when the award (or settlement) is made. Amounts paid for medical costs and non-economic damages terminate at the earliest of the following two dates: (1) when the claimant dies; or (2) when the originally estimated period of payment for future damages expires.

(2) Collateral Source

a. Government programs to which an offset applies include the following: medicare, medicaid and public assistance (with respect to services rendered prior to the award or settlement date) social security retirement and disability income, veterans benefits, workers' compensation benefits and benefits to military personnel and their dependents.

b. Where public or private sources of medical benefits or income replacement coverage now permit the public or private source to place a lien on a professional liability award or permit subrogation against the professional liability tort feasor, the lien and subrogation rights must be superceded by the revised collateral source rule.

c. A mechanism must be established to permit the professional liability insurer to offset the claimants future collateral source benefits under programs such as employer sponsored health insurance against amounts of damages awarded for future medical expenses without penalizing the claimant if those benefits are not available at all times in the future. One method to accomplish this objective is to permit the professional liability insurer to issue a health insurance policy which would provide coverage for gaps in benefits awarded by a court or agreed to in a settlement if collateral sources of those benefits are not available in the future.

AMERICAN MEDICAL ASSOCIATION

Analysis of Tort Reform Proposals

Appendix A -- Comments on Interpretation
of Reform Bill for Valuation Purposes

(3) Non-economic Damages

The $250,000 limit is to apply to each injured patient, no matter how many health care providers are held to be negligent.

(4) Contingency Fees

a. The contingency fee schedule applies to the amount awarded to the claimant no matter how many health care providers are held to be negligent.

b. The contingency fee applies to the award or settlement amount after reduction for collateral source offsets.

AMERICAN MEDICAL ASSOCIATION

Analysis of Tort Reform Proposals

Appendix B - Sources for Table 1

1. A.M. Best Company. Covers insurers reporting to A.M. Best. These amounts are gross of reductions for reinsurance which the insurers might purchase.

2. From JUA financial statements as follows

State	Written Premium (Millions)
Florida	4.2
Massachusetts	65.6
New Hampshire	8.0
New York	6.8
Pennsylvania	4.7
Rhode Island	11.5
South Carolina	5.2
Texas	4.0
Wisconsin	10.4
Total	120.4

3. From PCF and CAT Fund financial reports

State	Assessments (Millions)
Florida	55.0
Indiana	9.5
Kansas	15.0
Louisiana	1.0
Nebraska	0.1
New Mexico	0.9
Pennsylvania	66.2
South Carolina	1.0
Wisconsin	17.3
Total	166.0

4. Hospital self-insurance programs:

   a. Hospital professional liability costs constitute approximately 25% of total medical professional liability costs (NAIC Study).

   b. We estimate that 20% to 40% (use 30%) of hospital professional liability costs are self-insured or insured directly through non-United States insurers and thus those costs are not included in items 1 - 3 above.

   c. The total of items 1 - 3 therefore constitutes all but 7.5% of total costs (7.5% is 30% of 25%). The self-insured segment is calculated to increase the total of items 1 - 3 from 92.5% (100% - 7.5%) to 100%.

AMERICAN MEDICAL ASSOCIATION

Analysis of Tort Reform Proposals

Appendix C - Description of Models

A. Limitations on Non-Economic Damages to $250,000 per Award

1. The distribution of claim size amounts is assumed to follow a log-normal distribution.

   a. The coefficient of variation of the distribution is assumed to equal 2.5 in all states.

   b. A variety of average claim size amounts assuming no policy limit were tested.

   c. For multiple defendant claims the award amounts are assumed to be distributed as the sum of highly correlated log normal distributions, each with the mean and coefficient of variations described in (a) above. (The distribution of the number of defendants is based on the 1974 - 1978 NAIC Study).

2. The non-economic damage component of the award amount is assumed to closely relate to the total award as follows:

   a. The non-economic damage amount of the unlimited awards is closely correlated to the total award, e.g., a fixed percentage.

   b. Award amounts for non-economic damages are assumed to equal 54% of the limited award amount at 1974-1978 closed claim cost levels. This percentage varies over time depending on the relationship between award size and typical policy limit.

   c. Non-economic damage award amounts are assumed to be log normally distributed with a coefficient of variations of 2.5 and a mean equal to a percentage of the total award which depends on the factors described in 2.b.

3. Legal defense costs are assumed to be equal to 25% of indemnity amounts before the limitation. Legal defense costs are assumed to be unchanged by the limitations (the defense costs become a higher percentage of the reduced indemnity costs).

4. The effect of the policy limit on reducing awards and settlements is assumed to reduce non-economic damage amounts to zero before recoveries for economic loss are affected.

5. Since there is significant uncertainty in the actual distribution of non-economic damages by size of claim, and there is some evidence that non-economic damage compensation is a larger portion of the total cost on small claims than large claims, the savings indicated by the model described above are reduced by safety factors of 40% to produce the value shown in Table 2.

6. Claim amounts on settlements are assumed to follow the pattern of savings calculated for amounts awarded by juries.

B. Limitation on Contingency Fees

1. The claim size distribution model is the same as that described in A.1 above.

2. Claims are assumed to settle such that the plaintiff receives the same unlimited award amount with the revised contingency fee schedule as the plaintiff would have received under the old contingency fee schedule. Specifically this means the following:

   a. For unlimited claim amounts below the policy limit, the amount paid by the insurer or self-insurer is reduced by an amount equal to the reduction in the contingency fee.

   b. For unlimited claim amounts exceeding the policy limit by large amounts the plaintiff receives a greater net award (net of contingency fee) but the insurer pays the same amount.

   c. For unlimited claim amounts between the levels described in 3.a and 3.b above, the insurer pays somewhat less and the plaintiff receives a somewhat greater award net of contingency fee.

3. Legal defense costs are assumed to follow the pattern described in A.3 above.

4. Claim amounts on settlements are assumed to follow the pattern of savings calculated for amounts awarded by juries.

C. Periodic Payments

1. Jury instructions commonly require the jury to consider future interest income (the time value of money), and inflation and mortality in establishing awards. If juries on the average reached conclusions which correctly considered these factors then passage of a periodic payment law might have no impact indemnity payments.

   The Bill provides that periodic payments for medical and non-economic damages will be made for the shorter of the following two time periods: (1) life expectancy as determined by the jury; (2) actual time until the claimant dies. This element of the bill produces a savings (referred to below as mortality savings) compared to the present system even if juries properly considered interest, inflation, and mortality.

2. If juries do not properly consider interest, inflation and mortality then it is hypothesized that the jury errs in favor of a larger award to the plaintiff.

   In at least one jurisdiction (Pennsylvania) juries are instructed to assume interest and inflation are equal and offsetting factors. This instruction biases awards upward because in the long run interest rates exceeds inflation rates.

3. Low, medium and high estimates of savings result from assuming the following:

   a. Low savings result from assuming that juries are instructed to consider interest, inflation and mortality and that on the average the jury awards correctly reflect these variables.

   b. High savings result from assuming that juries treat interest and inflation as offsetting factors.

   c. Medium savings result from assuming jury results between (a) and (b).

4. The savings resulting from the assumption in 4a-c are calculated considering the following:

   a. A distribution of claimants by age and degree of injury (source: NAIC 1974 - 1978 study).

   b. The claim size model described in A.1a - A.1c.

   c. Average limited and unlimited claim size amounts as described in A.1.

   d. Assumptions regarding the portion of future and past damages by claimant age and degree of injury (Actual data on this subject is not available).

5. Legal defense costs are assumed to follow the pattern described in A.3.

6. Claim amounts on settlements are assumed to follow the pattern of savings calculated for amounts awarded by juries.

D. Collateral Source Offset

1. The coverage provided by health, and long-term disability insurance to the U.S. population through employer sponsored, privately purchased and public insurance is estimated from public information sources. (Primarily the Statistical Abstract of the United States - 1985).

2. The portion of awards related to medical care and wage loss is estimated from the NAIC 1974-1978 Closed Claim study.

3. In some awards, the award amount does not fully cover the medical costs and wage loss. In these cases the collateral source offset merely recognizes the situation that already exists, and no savings is projected.

4. Legal defense costs are assumed to follow the pattern described in A.3.

5. Claim amounts on settlements are assumed to follow the pattern of savings calculated for amounts awarded by juries.

E. Comments on Terminology

UNLIMITED CLAIM SIZE AMOUNT/UNLIMITED AVERAGE CLAIM SIZE

The use of claim size distributions to approximate the actual claim amounts results in predictions of claim amounts greater than those observed in practice. Reasons for the difference between theoretical distributions and actual observations include the following: (1) the amount of insurance coverage available may limit the amounts paid; (2) primary and excess insurance coverage data often cannot be combined to produce total limit data; (3) courts, particularly in the appeal process, may limit the maximum award amounts.

The theoretical claim sizes which should be observed if none of these forces operated are referred to as unlimited claim size amounts. The average size of the unlimited claim size amounts is referred to as the unlimited average claim size. The unlimited average claim size is generally larger than claim sizes observed actual experience.

LIMITED CLAIM SIZE AMOUNTS/LIMITED AVERAGE CLAIM SIZE

The observed claim size amounts and the average of limited claim size amounts are modeled using the unlimited distribution and then capping all claims at an amount referred to as the policy limit. This limitation may be the actual policy limit, if the policy limit is the major limiting force on claim amounts. The policy limit may also be interpreted as the maximum award amount sustainable in an appeal court.

F. Combined Effect of all Reforms

1. If the effects of the various reforms were independent, the combined savings could be calculated by multiplying the complements of the individual savings.

2. For this analysis we assume that savings through the elements of the law interact and reduce the opportunity for savings in other areas. For example, reduced economic damage recoveries through application of the collateral source offset and the limit on non-economic damages reduces the percentage savings resulting from the revised contingency fee schedule (since the amount of savings depend on the size of the award). The adjustment for this interaction is a 10% reduction in the savings calculated on a multiplicative basis.

3. It is possible that the reforms will operate synergistically on the system and produce greater savings than we have projected by reducing legal defense costs, reducing the number of claims filed, etc. On the other hand, it is possible that the savings will be less than we have projected as court decisions operate in ways which we cannot forecast.

G. Impact on Trend Rates

1. The limitation on non-economic damages is the element of the law which would have the largest effect on future trend rates. The revised contingency fee schedule has a small effect on trend rates.

2. We used the models described in this Appendix, Section A (for the limitation on non-economic damages) and in Section B (for the limitation on contingency fees), to calculate differences between trend before the law and trend after the law over the 1985 - 1988 period for a variety of initial unlimited claim sizes and policy limits and a variety of trends in unlimited claim sizes and policy limits.

(6)

by MORTIMER B. ZUCKERMAN
Chairman and Editor-in-Chief of *U.S.News & World Report*

THE NATIONAL LOTTERY

An epidemic of costly litigation is sweeping the country, and the time to halt it is now.

Witness the efforts of lawyers after any disaster, such as an airplane crash or the tragedy at Bhopal, India. They rush to the scene and descend upon the distraught survivors and relatives. They rent movie houses and auditoriums to make their pitch for clients. In law offices all over the country, lawyers are hard at work finding and convincing people to file suit. It used to be that lawyers tried to persuade their clients to settle disputes. No longer.

The pot of gold for lawyers is a huge fee or a participation of up to 50 percent in court awards. Staggering court awards in cases whose results seem to violate common sense have made it worthwhile for the lawyers. Recently, a man attempted suicide by jumping in front of a New York subway train. He sued the Transit Authority because the train stopped in time to save his life but not quite soon enough to avoid some physical damage to him. He collected more than $600,000.

And what about the tenant, celebrating his birthday on a Sunday afternoon, who drowned when he drunkenly tried to walk along the bottom of his apartment-house swimming pool in the full view of his wife and 15 close friends? His wife successfully sued the landlord's insurance company.

The result? Soaring premiums for liability insurance to cover this increased and indeterminate financial exposure. Legal costs and insurance have become an increasing component of the price of goods and services. Even the availability of some consumer services is being curtailed.

Personal-injury awards, especially jury awards, are out of touch with reality. They are often based on estimates of how much money the defendants have rather than whether they are at fault. The awards have become a means to redistribute wealth rather than a measure of fault or a deterrence to undesirable conduct. It may appear to a jury that an insurance company, individual, corporation or government with "deep pockets" is paying the claim. The truth is that millions of "little pockets" are actually paying the cost either through higher prices for products and services or through higher insurance bills.

It is time to re-examine the manner in which the nation's judicial system deals with injured parties.

First, a method must be developed to tilt the judicial system against increased litigation. One approach would be to compensate a successful defendant for the cost of the defense against an unsuccessful plaintiff. The obvious benefits would be a more serious and thoughtful analysis of a claim prior to bringing a lawsuit and a reduction in the number of frivolous claims. It would also bring pressure to bear on achieving a reasonable settlement of the matter prior to running up large legal fees.

Second, the states should follow the example of California in limiting contingent fees to lawyers. These fees theoretically balance economic power for those who cannot afford the cost of bringing a case on an hourly basis. In practice, however, contingent fees have fostered an atmosphere of a no-cost lottery for clients. The California bill caps the contingency fees at 40 percent of the first $50,000 of the settlement, ranging downward to 10 percent of any award above $200,000.

Third, damages awarded for "pain and suffering" and other noneconomic losses should be capped. California has set a limit of $250,000, controlling the awards in medical-malpractice suits for such vague matters as grief, mental distress, etc.

One of the great principles of American jurisprudence has been access to justice through the court system. But the right to swing your arm stops at the point of another man's chin. The right to access to the courts must not be permitted to bury our society under a mountain of legal pleadings that raise insurance bills for all. To permit this abuse is to turn the courts into a national lottery in which the winning names are the lawyers and certain plaintiffs who are picked by judges and juries, while each of us, every day, is the loser. ■

MEMORANDUM

TO: Representative Steve Rieger
FROM: William Lovell and Lisa J. Rubenstein
DATE: January 20, 1986

RE: Sectional Analysis of House Bill 481, "An Act relating to civil actions on tort reform"

Pursuant to your request, I have prepared this sectional analysis of House Bill 481, referenced above.

SECTION 1

Section 1 of H.B. 481 creates a new chapter, AS 09.17.

Sec. 09.17.010 PUNITIVE DAMAGES -- This section requires that punitive damages awarded by a judge or jury accrue to the State of Alaska instead of the plaintiff. Punitive damages would be deposited in the General Fund. In effect this section treats punitive damages in a civil case the same as a fine in a criminal case.

This section reduces the financial incentive for persons to seek punitive damages in cases where such damages are not warranted. In cases where the defendant acts recklessly or with malice in causing the injury, the victim would still have the option of seeking punitive damages to punish the defendant and to deter him in the future.

Sec. 09.17.020 ITEMIZED VERDICTS -- This provision requires a jury in personal injury cases to itemize the dollar amount of damages it is awarding for (1) medical and related expenses, (2) lost income, and (3) other economic loss. Within each of these three categories, the jury must list the sum it is awarding for expenses which have already been incurred and the amount it is awarding for anticipated future losses.

This provision prevents juries from arbitrarily selecting a damage award figure and requires them to determine awards based on actual and anticipated damages.

Sec. 09.17.030 PERIODIC PAYMENTS -- (a) This subsection provides that where a judge or jury awards damages of $50,000 or more the judge must order that the judgement award be distributed through periodic payments instead of in a lump sum if either the plaintiff or the defendant requests it. If there is some question whether the defendant will make the required payments on a timely basis, the judge can order him to post a bond as security.

This provision prevents a claimant from being overcompensated for an injury by being able to recover the full amount of his damages plus the income earned from

investing a lump sum award. Most states adjust lump sum awards to reflect expected investment income, but, because of a 1967 Alaska Supreme Court decision, Alaska does not.

(b) If periodic payments are mandated under (a) above and the claimant dies, payments would continue to the claimant's spouse or children. If the claimant leaves no dependents, payments would terminate.

This subsection requires that payments only be continued as long as they are needed for the support of the victim or the victim's immediate family. Once the need for support has ended, payments will not continue to go to a claimant's estate for the benefit of creditors and distant heirs.

(c) A defendant may be held in contempt of court for failing to make the required periodic payments and can be held liable for any damages the claimant suffers as a result of his non-payment.

This subsection provides an incentive for defendants to make timely payments.

(d) Once all periodic payments have been made and the defendant has satisfied the judgment, any bond which may have been posted as security must be returned to the defendant.

(e) This subsection allows periodic payments judgments to be recorded in the real estate recording office just as judgments granting lumps sums currently are. This provision prevents a recorded judgment from becoming a lien on a defendant's property until the time the payment becomes due. Currently a judgment which has not been completely paid off becomes a lien on a defendant's property as soon as it is recorded.

Sec. 09.17.040 VERIFICATION OF CLAIMS -- This requires that many papers filed in court including suits and countersuits be signed by the claimant or the claimant's attorney. This provision mirrors Alaska Rule of Civil Procedure 11 but it goes further than the rule in that it also requires the plaintiff or the attorney to verify that the pleading is true. Filing a false claim could result in a party being held in contempt of court.

Verification of claims discourages potential plaintiffs from filing unjustified lawsuits for the sole purpose of forcing an insurance company or defendant to settle an unmeritorious claim out-of-court to avoid the cost of defending the suit in court.

Sec. 09.17.050 EFFECT OF CONTRIBUTORY FAULT -- This section codifies a 1975 Alaska Supreme Court decision which adopted what is known as the "pure" form of comparative negligence. Under this system, the plaintiff's damages are reduced in

proportion to the amount of negligence attributed to the plaintiff. For example, if a plaintiff was 90 percent at fault for his injury and the defendant was 10 percent responsible, where damages amounted to $100, the plaintiff could only collect $10 from the defendant.

Although this section does not change current law or practice, by codifying the judicial decision, it prevents the court from modifying this decision in a future case.

Sec. 09.17.060 APPORTIONMENT OF DAMAGES -- (a) This subsection directs the jury or judge to specify (1) the claimant's total damages and (2) the proportion of fault each party had in causing the accident including the claimants.

(b) This subsection describes how the jury should establish each party's fault. In determining the relative fault of the parties involved in the accident, the jury must consider each party's conduct and the degree to which each party's conduct caused the accident or injury.

(c) This subsection sets forth the procedure used to determine the actual amount of total damages for which each party is responsible. Once the jury has determined total damages and the percentage of fault of each party, damages are multiplied by the percentage figures to determine the amount each defendant owes.

Sec. 09.17.070 EFFECT OF RELEASE -- This provision permits a plaintiff to enter an out-of-court settlement with one defendant while maintaining a suit against another defendant who is not willing to settle. If the plaintiff receives a cash settlement from one defendant out-of-court, this amount is subtracted from the total damages sustained before the remaining damages are allocated among the non-settling defendants.

Sec. 09.17.900 DEFINITIONS -- (1) Under this section's definition of "fault", a party can be judged at fault for an injury if the party in question is negligent; engages in certain activities where negligence is not required in order to be held liable such as detonating explosives; violates a warranty; assumes a risk that a reasonable person normally would not assume; misuses a product such as a prescription drug; fails to take reasonable steps to avoid an injury that could have been been prevented; does not take steps to minimize an injury once it has occurred such as failing to seek medical care after sustaining an injury; or fails to comply with professional standards established by statute.

(2) "Future damages" is defined to include medical expenses, the cost of a nurse or nursing home if it is required during convalesce, wages the plaintiff could have

collected if it were not the accident, along with non-economic losses such as pain and suffering.

SECTION 2

Section 2 of the bill repeals Chapter 16 of Title 9 which is the Uniform Contribution Among Joint Tortfeasors Act adopted in 1970. This law applies where there are two or more defendants who are judged to be liable for an injury to the plaintiff. Under existing language if the plaintiff collects 100 percent of his damages from the deep pocketed defendant who was 10 percent at fault for causing the victim's injury, that defendant could then sue a second defendant who was 90 percent at fault to be reimbursed. This recovery would no longer be necessary when judgments are made on the basis of several liability.

SECTION 3

This section directs the governor to study the tort compensation system and make recommendations for additional changes by January 31, 1987. He is also required to recommend standards for professional conduct so judges and juries would have a standard against which to judge doctors, lawyers, architects, and other professionals in malpractice cases.

SECTIONS 4 THROUGH 7

These sections identify portions of the bill which have the effect of amending court rules established by the Alaska Supreme Court. Under Article IV, Section 15 of the Alaska Constitution, legislative amendment of court rules requires a two-thirds vote of the members of each house. The following sections have the effect of amending court rules: those related to itemized verdicts, periodic payments, verification of claims, and apportionment of damages.

SECTION 8

APPLICABILITY -- The act applies to all injuries and accidents occurring the day after the act becomes effective. It does not apply to lawsuits already in progress or to injuries or accidents occurring before the date of enactment where lawsuits have not yet been filed.

SECTION 9

EFFECTIVE DATE -- The section provided for an immediate effective date.

Tort Reform:

A Comprehensive Solution To The Crisis in Civil Justice and Insurance

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Civil Justice: Unnecessarily Inefficient and Costly

A tort is literally a wrong. Tort actions seek to redress wrongs in a court of law. A close look at how the tort reparations system works in 1986 reveals that it's not working. The system is mired in inefficiency, punctuated with greed and demonstrably unable to deal with the great bulk of its caseload in a timely and fair manner.

It often takes three to five years to settle a case. Only 30 to 40 per cent of the costs of reaching a settlement go to victims, and that does not include costs of the court system.

The economic costs to society are staggering and difficult to precisely quantify. It is clear that the hefty increases in insurance rates affect the price of nearly every product or service we purchase. *It is a tax—a tax imposed by default, without full political and social evaluation of its impact.*

A society that can send men to the moon ought to be able to settle liability claims in a more effective way. Most other western countries do.

The Comprehensive Solution

The tort reparations system needs a thorough overhaul. Alaska can no longer afford the luxury of having its courts administer a giant lottery where a victim may win a fortune, but more likely will find the pot at the end of the rainbow empty.

Alaska and other states have been dabbling in tort reform for ten or 15 years and there is adequate evidence major changes in the tort reparations system are essential. The fundamental goal of tort reform is to restore predictability to the tort system.

All manner of solutions to the insurance crisis have been proposed including tighter regulation of insurance companies, state-backed insurance funds and reform of the tort system. More regulation may be useful and a state-supported fund may provide temporary relief to some. However, *without stopping the flagrant abuses of the tort system, liability will continue to be a serious problem for business, government and consumers.*

The following proposals address the major faults of the tort system. They are intended to restructure the process to allow more efficient and effective dispute resolution. These reforms would get a higher proportion of damage payments into the hands of plaintiffs while protecting the rights of defendants and the public which ultimately pays the bills.

Joint and Several Liability

If more than one defendant is found partly responsible for an injury, each can be held "jointly and severally" liable for all damages. This means that if one defendant is unable to pay, the other defendants must pay the entire award. *Responsibility should be apportioned according to the degree of fault and each defendant's requirement to pay damages should reflect his share of responsibility for the injury.*

Noneconomic Awards

Noneconomic awards compensate a victim for intangible losses— loss of consortium, pain and suffering, traumatic experiences and other things for which no established economic value exists. *A limit on this kind of arbitrary award will help establish consistency and fairness in this no-man's land. We suggest a maximum award of $250,000 per incident. The U.S. Supreme Court has upheld such a law in another state.*

Structured Settlements

Damages awarded for predicted future losses should be computed at their present economic value. The injured party would have an option to accept lump-sum payment at present value or accept structured payments running over a period of years and equal to the total award. *This guarantees financial support and care for a long time, often for life.*

Collateral Income Sources

Insurance payments which have been made to an injured party should be disclosed to the jury and should be protected from recovery in the event the victim receives an award. *Under current rules, juries cannot be told about existing medical or other insurance coverage.* If the injured party receives an award, the insurance companies which have fulfilled their obligations may sue for repayment from the victim.

Sliding Contingency Fees

Plaintiff attorneys today can take upwards of 40 percent of a total award verdict. A sliding scale will increase the proportion of the award which actually goes into the victim's pocket as the size of the award increases. *Where the sliding scale is now in effect, lawyers still work on contingency fees, but victims recover a greater share of awards. The U.S. Supreme Court has upheld this principle.*

Itemized Jury Awards

Jury awards for damages should specify amounts for monetary losses, noneconomic losses, future losses, past expenses and other losses. *This will help to eliminate arbitrary awards based upon showmanship or prejudice and introduce an element of rationality in award construction.* An itemized award which is grossly unfair to either the victim or defendant can be more effectively appealed than a lump-sum award.

Rule 82

Rule 82 is unique to Alaska. It is a device to increase attorneys' fees above the agreed level by order of the court. The rule was originally adopted to apply in certain public interest lawsuits, but it has been extended to cover most liability suits. *It simply adds up to 10 percent to the cost of awards without serving the originally intended public purpose.*

Arbitration

Tort litigation is time consuming and expensive. Claims under $50,000 should be required to go to arbitration before being heard in Superior Court. Either party would be free to appeal the arbitration decision to the courts, however the results of the arbitration could be admitted in evidence at any subsequent trial. *Experience indicates that the effect would be to reduce the number of cases going to court, lower the costs of resolution and ultimately get more money into the hands of victims without great delays.*

Notice of Policy Cancellation

Individuals, businesses and professionals have been suddenly cut off from their insurance programs. *Companies should be required to give 60-day notice of changes in coverage.* This would avoid drastic disruptions in people's ability to earn a living.

Pre-judgment Interest

Interest is often paid on awards. It should accrue from the date an action is filed. Currently, interest accrues in many cases from the date of the occurrence—even if no claim is filed for years. *A defendent should not be required to pay interest covering that period of time when he may have had no knowledge of his liability.*

Wrongful Death Statute

Where there are no dependents, wrongful death monetary awards should be limited to $25,000. *A wrongful death is always unfortunate, but it is questionable public policy which permits—even encourages—distant relatives and lawyers to reap a windfall at the expense of other policy holders and the public.*

Punitive Damages

Punitive damages is the civil justice system's way of punishing defendants for conduct particularly offensive to society, therefore, punitive damages should be paid to the State of Alaska. *Society as a whole should share the benefits of punitive damages (which are rarely covered by insurance).*

Statute of Limitations

The current statutes of limitation must be clarified to make sure that lawsuits are brought within a reasonable time. Recent court decisions make it possible to file suits in the distant future, making risks totally unpredictable. The alternatives to a functional statute of limitation are insurance devices which effectively establish these limits without benefit of public policy considerations. *These devices (claims-made policies) can cause severely reduced public protection and even reduced availability of some goods and services.*

Frivolous Suits/Untrue Allegations

An Indiana woman purchased a box of Cracker Jacks. The usual prize was not in the box, so she filed suit against the manufacturer. Someone had to defend the suit, even if it was only to ask for dismissal. A responsible legal system should require that plaintiff attorneys certify that the facts have been reviewed and there is reasonable and meritorious cause for filing the action. This certification should be made in writing. *Rules have been adopted by the U.S. Supreme Court and ten states to curb these abuses of our court system.*

Full Disclosure

Essential data should be made available to state regulatory authorities on a quarterly or semi-annual basis to allow proper regulation of regulated companies regarding reserves, premium rates, loss ratio, investment and other data so as to properly protect people of Alaska.

Comparative Negligence v. Contributory Negligence

When the claimant has contributed to the accident, his or her degree of fault should diminish the award proportionate to the degree. This would reduce damages where the claimant contributed to the mishap. As an example, in single car-auto accidents, cities have been successfully sued by the drivers for faulty road design or maintenance, even where the drivers have been proven to have been drinking or using drugs.

Who is the Citizens Coalition for Tort Reform?

The Citizens Coalition for Tort Reform is an organization composed of representatives from a broad cross section of Alaskan businesses and professions.

They include these companies, associations and agencies:

Alaska Air Carriers
Alaska Broadcasters Association
Alaska Chapter, American Institute of Architects (A[illegible])
Alaska Dental Society
Alaska General Contractors
Alaska Chapter, American Optometric Association
Alaska Movers Association
Alaska Oil Marketers Association
Alaska Rental Association
Alaska Section, Fairbanks Branch, American Society of Civil Engineers
Alaska Society of Professional Engineers
Alaska State Health Association (Hospitals)
Alaska State Medical Association
Alaska Support Industry Alliance
Alaska Truckers Association
Alaska Visitors Association
Anchorage Board of Realtors
Anchorage Restaurant and Beverage Association (ARBA)
Cabaret Hotel and Restaurant Retailers (CHAR)
Childbirth Educators
Daycare Operators Association
Fairbanks North Star Borough
Financial Managers
Hotel and Motel Association
Insurance Brokers and Agents Association
Nurse Midwives Association
Pension Consultants
Professional Physical Therapists Association
Risk Management Association
Southern Alaska Association of Life Underwriters

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