4027 SJUD LIABILITY INSURANCE

EXHIBIT I

Remarks to the Florida Senate Commerce Committee on Property and Liability Insurance
By Commissioner Bill Gunter

Mister Chairman and members of the Committee, over the past several months, we have seen some alarming developments in the insurance industry in Florida and across the United States, they include the rapid and significant increase in the cost of commercial property and liability insurance, and the reluctance or outright refusal of many insurance companies to assume certain kinds of property and liability risks.

In order to look at the problem first hand, I have held public meetings around the state. I have asked the business community to come forward with their experiences and ideas. The reaction has been gratifying and the testimony we gathered can serve as a valuable resource and standard against which to measure any proposed solutions to the problem.

Time after time the people told horror stories that left no doubt of the breadth and seriousness of the problem...like the Orlando man whose taxicab coverage went from $8,000 to $80,000...or the owner of a small Orlando garbage company who told me that coverage for his vehicles will increase more than a thousand percent this year. He said, and I quote, "This business will not survive under these tremendous cost increases."

There was the Fort Lauderdale day care center operator who saw her general liability premium go from $5,000 to nearly $15,000 in one year with additional exclusions in the policy, even though the center had no claims whatsoever during its three years of operation. A Dade county children's program director told us that at least 5,000 children are on their waiting list for care, while liability insurance for many child care facilities is being cancelled.

A north Miami Beach Condominium Association's insurance went from $21,000 in 1984 to more than $105,000 in 1985, on two days notice. A homestead C.P.A. said he may have to refuse to sit as a trustee on a self-insurance health trust because directors' and officers' liability coverage as of this date has not been obtained.

A Jacksonville dentist is paying a 300% premium

increase from 1984 to 1985. He told us of others who are paying even more. An auto dealers association officer told us that some car dealers in the panhandle can't find garage liability coverage. He spoke of dealers receiving nonrenewal notices three or four days before their policies expired.

All over Florida we are hearing the same stories: people whose insurance is cancelled though they haven't had a single claim; small business people forced to sell out to larger firms because they can't afford insurance. They are telling us that when the state mandates coverage, it has the duty to see that coverage is available and affordable.

What's at stake here is not just the years of hard work it took small business men and women to put their businesses on a paying basis...but the jobs they provide, and the well-being of local economies. A vast number of Floridians are in a situation that is difficult for some and impossible for others.

For that reason, my department is drafting proposed legislation for the 1986 session to address these issues. I believe the need is clear, the only question is what other steps can be taken in the interim to ease the pain brought on by these cataclysmic changes. In the legislation, I think we need to address these points:

First, to get Florida policyholders off the rollercoaster ride of peaks and valleys in pricing. The insurance industry owes its business customers the kind of pricing stability so they can plan their expenditures, yet somehow the insurance industry has become addicted to a boom and bust, feast and famine approach to setting premiums.

Second, to make sure that the premiums charged bear a proper relation to the risks and losses experienced by the industry. I don't want to see the insurance industry playing catch-up on losses of previous years by demanding premiums that are completely out of line with current losses. I want premiums based on defensible loss experience, not on speculation.

Third, to put the control back into the consumers' hands, I'd like to see small insurance consumers get together and use their combined numbers to their advantage. Just as health care coalition members negotiate health care costs directly with hospitals to make sure

their employee health benefits provide the best care for the dollar, they should also be able to use their collective purchasing strength to get the best deal in property and liability insurance.

Fourth, to find creative ways to increase the capital that is available for reinsurance. The investors that in normal times stand behind companies that write property and liability insurance have backed away from that market. I believe there is capital out there, willing and able to provide the back-up for the kinds of insurance that are too expensive and too hard to find at present.

The Miami-based Insurance Exchange of the America's can be an instrument to expand the reinsurance market in this state. I am convinced that additional expansion is entirely possible with the right kind of encouragement.

Finally, businesses need to perfect the art of risk management in Florida. We're used to thinking that if you manage to avoid losses, your insurance premiums will go down. Lately it seems that rule hasn't worked. We need to see that there <u>are</u> incentives for risk management, and that insurance consumers with low losses are preferred customers.

I believe the preceding five points pretty well describe the solution we want to find. I think that proper responses to most of them can be found in well-considered legislation.

I'm sure you remember the problems we had a few years ago in workers' compensation, and before that in automobile insurance. In both of those areas appropriate legislation was enacted and although insurance costs are rising in nearly all areas, rates in auto and workers' compensation have been substantially more stable than the lines outside the authority of the Department of Insurance.

More recently, we have the example of hospital costs which had been rising at a frightening rate for more than a decade. In 1979, the Florida legislature established a Hospital Cost Containment Board and in 1984, granted it the power to reject dangerously inflationary hospital budgets. In the first year since that second step, we cut rising costs by well over half, so legislation is a tool we have used successfully in the past.

Some companies like Eastern airlines have taken the route of self-insurance. It normally takes a big company to make self-insurance work, but if a number of smaller companies band together and create a large pool, that approach can also work for them. If we are to expand the parameters for allowing this approach -- for instance to professional-like engineers, architects and accountants -- then we must revise our eligibility rules.

This option is a real possibility -- especially for risks like professional liability, day care and commercial fishing boat coverage, that are hard to place -- and for "main street" commercial insurance consumer [illegible]se rates are out of sight. So self-insurance is also a tool that we can use.

I first believe Florida can take steps to attract more capacity. Through incentives, we can promote the establishment of a state of Florida reinsurance facility that will make reinsurance more available for Florida risks. This facility could provide reinsurance to both commercial and self-insurers. So expanding reinsurance capacity is also a tool.

Preventing losses is one of the most effective actions we can take to reduce insurance industry costs. From time-to-time, strings of disasters around the world, from air crashes, to child abuse, to chemical leaks, to lost satellites in space, raise insurance costs of all of us. On the other hand, risk management close to home is a positive response to the current crisis.

It sometimes happens that companies do not reap the rewards of good risk management until after the fact...in some cases not at all. It may be that we need to establish incentives -- possibly tax incentives -- to encourage business and industry to practice good risk management. So risk management is also one of our tools.

I am glad to say there is one thing we have already done that I believe will be of great value to those who feel that they have nowhere to turn for affordable insurance coverage. This is the market assistance plan passed by the legislature during the last session. I believe that in supporting that legislation, you in the Senate showed a vision that is now beginning to yield its reward.

The Market Assistance Plan (MAP), as we call it, is a clearinghouse for hard-to-get insurance coverage. Commercial insurance consumers or their agents call MAP when they can't find insurance. MAP shops all the available markets to place that risk at the best possible price. The most attractive feature of the plan is that it is entirely funded and staffed by the industry. I want to add they have been very cooperative in working with us to set it up.

The draft proposals that we are putting together today will constitute a major step toward helping Floridians deal with what I perceive to be a serious threat to business and professional people across the country.

Our proposals will be ready in 30 days. In the meantime, my staff and I stand ready to help and provide information to you as needed. If any questions are raised by the material before you or anything that I have said, I will be glad to answer them now.

Thank you.

EXHIBIT J

Synopsis of the Pennsylvania Political Subdivision Tort Claims Act

By Charles E. Evans, Esq.
Vice President and Legislative Chairman
Pennsylvania Trial Lawyers Association
October 1985

In 1978, with an effective date in January 1979, Pennsylvania passed a highly restrictive Tort Claims Act, granting broad immunity and limiting damages recoverable against Pennsylvania's political subdivisions. The Act applies to claims against any county, municipality, school district, municipal authority or any authority, board, commission or the like designated to act by or on behalf of one or more political subdivisions.

This legislation is what is known as a "closed-end" immunity statute, which is the most restrictive form. It grants total immunity to every political subdivision in Pennsylvania and its employees regarding liability for personal injury or property damage except in eight defined areas, which constitute exceptions to the immunity grant.

The legislation represented a drastic take-away of important citizen rights and substituted absolutely no new or alternative system of rights or benefits to offset for this take away. It should be noted that the grant of any immunity inherently recognizes the commission of legal wrongs. It does not change the nature of the legal wrongs but simply establishes a special privilege for a particular group who commits the illegal acts.

Areas of Liability Allowed

The statute lists eight areas where a political subdivision may be held liable for personal injuries, death or property damage. They can be summarized as follows:

a. Operation of motor vehicles, and;

b. three separately designated areas, all dealing with concepts of ownership or possession of land. These include dangerous conditions of streets, dangerous conditions of

sidewalks and a real property area.

c. there are two separately designated areas which impose liability for dangerous conditions of certain items such as traffic controls, street lights, water, gas and electrical systems, and;

d. the remaining two areas have little practical effect and very little meaningful application as they provide for liability dealing with personal property of another which is mishandled or lost by a political subdivision and the care and control of certain animals, and;

The Act not only limits potential recovery to the enumerated areas, but creates a more stringent burden of proof for the victim. Where the action is for recovery of dangerous conditions pertaining to streets, sidewalks, traffic controls, street lights or utility systems, the victim, in order to recover, has to establish not merely that the political subdivision had notice of the dangerous condition before the incident, but also that there was sufficient equipment and manpower available in view of other needs that the situation could have been corrected. Frankly, this provision has the effect of granting virtually complete discretion to a political subdivision as to when it would even decide to correct a <u>known</u> danger under its control and maintenance.

Because of the grant of immunity, the following are examples of the types of actions which <u>cannot</u> be brought or claimed against a political subdivision:

a. Negligent use of firearms or weapons such as by police, jail personnel or a school district security force, and;

b. Negligent supervision of school classes, shop classes, sporting or coaching activities, and swimming pools, such as negligent lifeguarding, and;

c. Actions arising out of overzealous police actions such as injuries arising out of arrests or "police brutality" cases.

d. Negligent use or supervision of machinery and power tools such as in vocational departments

of school systems;

e. Inspections of real and personal property such as the negligent issuing of occupancy or building permits in violation of various codes;

f. Actions for medical malpractice such as arising out of a county owned hospital.

It should also be noted that there is not a reasonable federal equivalent cause of action to provide for recovery for some of the immunity areas. Although federal civil right actions certainly exist, the standards for recovery and burden of proof are far different from the ordinary common law standards for personal injury actions and, under recent decision, require more than a showing of mere negligence in order to impose liability.

Damages

Under the Pennsylvania statute, even in those cases where a claim is permitted and the claim can be proved, the innocent victim is limited in the items and amounts which can be recovered. The negligent or liable political subdivision receives the full benefit of any private insurance which was available to the innocent victim meaning that in those instances where private insurance paid property damage, medical bills or work loss, no claim or recovery for those items can be made against the polictical subdivision. General damages in the form of pain, suffering, disfigurement and inconvenience can be had only where there are at least $1,500.00 in medical or dental expenses and there is a permanent injury. These provisions would permit no recovery in a case where, for example, an innocent victim with medical insurance sustained thousands of dollars of medical expenses and severe injuries but made a recovery without a permanent injury.

Finally, there is a cap or ceiling of $500,000.00 placed on all claims, regardless of the number of victims involved, arising out of any one occurrence. Hence, where one incident, accident or ocurrence results in catastrophic injuries or death of a number of persons, the political subdivision can be held to pay only a maximum of $500,000.00 for all victims.

Miscellaneous

This statute contains certain other roadblocks for the claimant. There is a six-month statute of limitations provision which requires that a victim provide a certain form of written notice to the political subdivision of his intention to file a claim. Should that action not be taken, suit would be barred even if filed within the otherwise applicable general limitation period. Additionally, the statute prohibits the entry of "pre-judgment interest" against a political subdivision. This constitutes yet another privilege in that all other wrongdoers in Pennsylvania lawsuits for personal injury, death and property damage can be held liable for "delay damages" should they fail to make a proper offer of settlement and force the victim to try his case in court.

Conclusion

Pennsylvania's "closed-end" immunity statute totally abolishes a substantial number of meaningful claims for death or injuries sustained by innocent persons, victimized by negligence. It further makes proof of liability more difficult even in the areas where claim can be made dramatically restricts the recovery of damages.

EXHIBIT K

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October 22, 1985

Express Mail

William A. K. Titelman, Esquire
Pennsylvania Trial Lawyers
Legislative Counsel
240 North Third Street
P.O. Box 413
Harrisburg, PA 17108

Dear Mr. Titelman:

I was hoping to be able to clear my schedule so that I could be with you on Wednesday, October 23, 1985, to testify before the Senate Banking and Insurance Committee, especially since that Committee is chaired by Senator Holl, who is from Lansdale.

Unfortunately, my schedule does not permit me to be in Harrisburg. However, I would like to report to you and the Committee that my firm represents seven municipal subdivisions in Montgomery County.

We have experienced no increase in claims or litigation involving these Political Subdivisions in the last several years, which we find to be surprising, in light of the fact that our clients have experienced difficulties in obtaining liability insurance and the commissioners and employees have experienced difficulty in obtaining errors and omission insurance.

Our experience verifies the conclusion reported in the New York Times of Sunday, October 20, 1985, which indicated that claims experience is not what influenced the insurance market at the present time, just as the passage of the Political Subdivision Tort Claims Act did not result in reduced insurance premiums.

Very truly yours,
HAMBURG, RUBIN, MULLIN & MAXWELL

By _____
Edward Rubin

ER/mdd

EXHIBIT L

BEST'S INSURANCE MANAGEMENT REPORTS

Supplement To Financial News

September 9, 1985

A.M. Best Company
Oldwick, N.J. 08858
201-439-2200

Financial News | Washington Review | Perspectives | On-Line Reports

Quarterly Earnings Per Share Rise Again

With many investors evidently reading recent industry results as a sign indicating smoother sailing ahead, the stocks on Best's Insurance Index were up overall more than 25% for the second quarter of 1985 when compared with the corresponding quarter of the previous year. This composite gain, the best in more than seven years, follows first-quarter gains of 16%. For the first time in more than three years, all four components of Best's Stock Index showed per-share earnings gains for the quarter.

Life/Health Stocks Continue Three-Year E.P.S. Trend

The life/health index posted the smallest of the quarterly gains, up 8.1%. Buoyed by year-end news of renewed premium growth among life/health companies, particularly in the annuities and universal life fields, life/health stocks have demonstrated a steady if not spectacular popularity with investors, recording gains in 10 of the last 11 quarters. The lone exception was the fourth quarter of 1984, which reflected some write-offs not related to the new tax law that several companies chose to make in the quarter of the tax reserve adjustment.

The second quarter was close to a carbon copy of the first for the life/health index, with three times as many stocks advancing as declining. Large gains were not quite as numerous—10 stocks achieved double-digit increases as opposed to 13 in the preceding period.

Jefferson National Life led in second-quarter earnings growth, up nearly 66%. Other top performers were Torchmark Corp. and Monumental Corp. Six stocks had declines in earnings per share, the largest of which were those of Northwestern National Life and Equitable of Iowa, off 37% and 34%, respectively.

Property/Casualty Index Posts First E.P.S. Gain in Eight Quarters

In the second quarter of 1985, property/casualty stocks on Best's Index staged a turnaround in the longstanding downward direction of operating earnings per share, even though there were slightly more decliners than gainers. Property casualty stocks posted an overall gain of 13.6% when compared with the previous corresponding quarter.

In the first half of 1985, property/casualty stocks on Best's Index have advanced 30%, investor excitement being generated by a reasonable consensus that the longest industry down-cycle in history has finally turned, albeit by a small margin. They were rewarded, on average, by advances twice the size as those reaped by the general stock market.

The largest calculable percentage gain for the quarter was by Hartford Steam Boiler, with an earnings-per-share increase in excess of 156%. Another strong performer was SAFECO Corp., with a gain of almost 51%. Two stocks—Kemper Corp. and St. Paul Companies—followed up a quarterly operating loss in last year's second quarter with a gain in the current time period.

During the second quarter, Mission Insurance's already considerable per-share operating loss plunged still lower. The losses of Fremont General Corp. and Orion Capital Corp. went further into the red, and USF&G recorded a small loss in the second quarter of 1985 after a 60-cent gain a year earlier.

Multiple Lines Stocks Achieve 60% Gain

Among the multiple lines stocks on Best's Index, only one—Travelers Corp.—posted a small decline in earnings per share in the second quarter. CNA Financial Corp. flirted with doubling its per-share earnings and Aetna Life & Casualty actually did so. CIGNA Corp. pulled its previous second quarter earnings out of the red. Overall, the multiple lines index was up 60.7% over the comparable quarter, setting a seven-year record.

Brokers and Agents Enjoy Impressive Earnings Gains

The brokers and agents component of Best's Index was up 50% for the quarter and more than 300% for the first six months of 1985. However, this percentage gain derives from comparison with very low prior year figures, particularly in the case of Alexander & Alexander, whose second quarter 1984 earnings per share was eight cents, and Marsh & McLennan, which recorded operating earnings of only two cents per share in the first six months of 1984 due to losses sustained from unauthorized investment activities.

(N.B.—Per share figures where applicable reflect the use of common and equivalent shares for all time periods where convertible issues are outstanding even though the issues may be dilutive for some or all time periods when computed [illegible] earned from using the common share-only base. Figures for Aon Capital Corp. and Alexander & Alexander are [illegible] due to lack of complete data. Data shown reflects the elimination from reported operating earnings of the gain [illegible] of subsidiaries and affiliates and of sale of home office building. Over the time periods covered in the table there are [illegible])

continued

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

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

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.

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.

2 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 two-year-old 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 afflicted 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 pre-tax 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.

FMC

FMC Corporation
200 East Randolph Drive
Chicago, Illinois 60601

ALASKA

1985

Private Passenger Auto Insurance

and

Homeowners Insurance

A STATISTICAL ANALYSIS

Alaska State Legislature

SENATOR
ROBERT H. ZIEGLER, SR.
307 BAWDEN STREET
KETCHIKAN, ALASKA 99901

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811

Senate

MEMBER
SENATE JUDICIARY COMMITTEE

SELECT COMMITTEE ON LEGISLATIVE ETHICS

WESTERN STATES LEGISLATIVE
FORESTRY TASK FORCE

EXECUTIVE COMMITTEE
WESTERN LEGISLATIVE CONFERENCE
COUNCIL OF STATE GOVERNMENTS

ALTERNATE MEMBER
NATIONAL CONFERENCE OF STATE LEGISLATURES
STATE AND FEDERAL ASSEMBLY
COMMITTEE ON
FEDERAL TAXATION, TRADE AND ECONOMIC DEVELOPMENT

January 17, 1986

All Members of the Senate

I have attached a copy of an editorial from last Wednesday's edition of the "Seattle P.I." which convinces me that other states are in the same boat as we are now pertaining to tort reform.

Robert H. Ziegler, Sr.

Attachment

Seattle Post-Intelligencer
THE VOICE OF THE NORTHWEST SINCE 1863

EDITORIALS

Hold horses on insurance

There's no question that this state's insurance-liability or tort laws need revision to put the brakes on runaway damage awards and out-of-court settlements. Insurance rates have soared to astronomical heights in some areas of coverage, such as medical malpractice, and in some categories have become prohibitive.

The problem is described as a crisis. That may be no exaggeration, but the legislative response ought to be carefully considered, not rushed, and based on solid and reliable data.

While a formidable liability-reform coalition — composed of local government agencies, physicians, child-care organizations, school districts and large corporations — is pressing the new session of the Legislature for immediate legal revisions, a new state task force was named this week to gather more information and to review the many factors involved including insurance company profits and losses.

Retired King County Superior Court Judge Francis Holman, a widely respected jurist and lawyer, is chairman. Members, appointed by State Insurance Commissioner Dick Marquardt, are three lawyers who specialize in defending against liability suits and three whose speciality is representation of plaintiffs or damage claimants. Creation of the task force was suggested by a bipartisan legislative committee last year after a series of hearings throughout the state. It was decided that more hard information is needed, before state laws are revised, and the task force was proposed as the vehicle for obtaining it.

Key issues the task force will address are limits on non-economic damages — awards for such nebulous items as pain and suffering and mental anguish; the payment of awards over time rather than in lump sums; limits on the proportion of damages that can be assessed against secondary defendants, such as cities and counties, when primary defendants are unable to pay, and limits on contingency fees charged by claimants' attorneys.

It may be that this session of the Legislature can begin the process of reform by correcting the most glaring deficiencies in state laws, although some lawmakers have expressed dismay over a lack of credible data on which to base their decisions. Before sweeping changes are enacted, the Legislature would be wise to await recommendations of the newly appointed task force.

JUNEAU EYE CLINIC
A PROFESSIONAL CORPORATION
SUITE A
3268 HOSPITAL DRIVE
JUNEAU, ALASKA 99801

PRACTICE LIMITED TO THE EYE

ROBERT N. PAGE, JR., M.D.

December 10, 1985

The Honorable Patrick Rodey
Alaska State Senate
2335 Lord Baranof
Anchorage, AK 99503

Dear Senator Rodey:

I urge your fullest attention to and support of the forthcoming torts reform legislation. The importance of this issue as it relates to the basic economy of virtually every community in the state of Alaska and, for that matter, in the remaining areas of this country, cannot be overstressed. If reform is not achieved in a meaningful way, the impact on the economy and the cost of living in this state will be profound and border on disaster.

More than any other, this issue probably is singularly most responsible for the almost astronomical and certainly unnecessary increase in the cost of doing business nationwide. A reform bill will be introduced by a coalition of Alaska businesses which will allow for the generous and fair recovery on the part of injured parties but will outline certain limits and policy changes in the torts laws, thereby allowing insurance companies to reenter the liability insurance marketplace with premiums which are reasonable and actuarials which are predictable.

This legislation you will find lobbied heavily against by the national and the local bar associations and American Trial Lawyers Association. The American Trial Lawyers Association has offered to match any funds put forward by the state Trial Lawyers Association to fight this legislation, something on the order of four hundred dollars to one.

I urge you to consult your constituents in the realm of small and large businesses with regard to the impact on them of the current state of torts legislation.

Thank you very much for considering this issue which I find vital to the future of the economics of Alaska and the country at large.

Sincerely,

Bob Page

Robert N. Page, Jr., M.D.

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(907) 276-3188

BERNARD P. KELLY
PAUL COSSMAN

December 11, 1985

Pat Rodey
2335 Lord Baranof Drive
Anchorage, Alaska 99503

Dear Pat:

I am enclosing herewith a copy of the omnibus reinsurance bill that was discussed by J. Robert Hunter, the President of National Insurance Consumers Organization, on Friday, December 6, 1985, at the Captain Cook Hotel at our meeting.

This omnibus proposal could be adapted to state law. We have enlisted the support of Avrum Gross, former Attorney General, to aid us in any efforts directed toward legislative drafting. We believe that this omnibus reinsurance proposal could constitute a safety net for reinsurance and for insurance itself for such needy businesses as daycare centers and the smaller cities which are having trouble with insurance, as well as other aggrieved insureds. We believe such a proposal, to the extent of state involvement, could make the state profit if it were properly priced. For help in this effort, we would need to enlist the aid of an actuary, such as Mr. Hunter. We believe the State Department of Insurance should be armed with such an individual, anyway, and some of our proposals would be greater degree of factual reporting by the insurance companies and a rate-making procedure that could be honestly evaluated based upon the data submitted by them, such as details of their investment income, combined premium and investment income, together with their proposed rate increases when they propose them.

We would be willing to help in the drafting of such legislation. We favor more reporting by the insurance companies. In fact, we believe that the problem here is insurance reform, not tort reform. We believe that our state needs a property casualty actuary capable of rate analysis for decisions in rate-making cases and capable of auditing and

monitoring the degree and comprehensiveness of reporting by the insurance industry. We would like to propose such measures at the forth-coming Legislature but stand ready and willing to help in supporting any affirmative effort directed toward a true solution to the insurance crisis.

For the reasons stated at our meeting the other day, we do not believe that taking away the rights of innocent victims is such a solution. The insurance industry has not promised reductions on a quid pro quo basis, based upon certain specific changes in the tort law. We believe they never will do so, and that the threat of the insurance industry pulling out of the state is a hollow one that they are making in all states. As pointed out by Mr. Hunter this is a national problem, that the insurance industry never had it so good as they have it in Alaska. They have made double the profits here that they have made anywhere else and insurance companies are coming into our state rather than pulling out. As you know, we submitted data to that effect at the time of our conference.

Thank you very much for your interest in this matter.

Sincerely yours,

BERNARD P. KELLY & ASSOCIATES

BERNARD P. KELLY

BPK:amm

1840A

OMNIBUS REINSURANCE ACT OF 1985

Section -[1]-(a) Within 30 days after the receipt of an application by any manufacturer, service provider or any group or association representing such manufacturers or service providers, the Commission shall conduct a hearing on the reasonable availability and affordability of adequate commercial general liability insurance and other lines of insurance for that manufacturer or service provider or the members of any group or association of manufacturers or service providers.

(b) The Commission may in its discretion hold hearings to investigate the reasonable availability or affordability of commercial general liability insurance and other such lines of insurance as from time to time become unavailable or unaffordable thereby threatening the health, welfare or commerce of the United States and the various states by making some manufactured good or provided service unavailable or available only at an unreasonable cost.

(c) Within 30 days after the hearing required under subsection (a) or conducted under subsection (b) the Commission shall determine in writing, based upon the record of the hearing conducted pursuant to subsection (a) or (b), whether the insurance described in subsection (a) or (b) is , and will be, reasonably available or affordable to affected manufacturers, service providers or the members of any group or association representing manufacturers or service providers to cover anticipated claims. Such determination, and the basis therefore, shall be published in the Federal Register.

(d)(1) If the Commission determines at any time that:

(A) the insurance described in subsection (a) or (b) is not available or reasonably affordable from the private sector to applicants under subsection (a) or the affected parties described pursuant to subsection (b) to cover anticipated claims;

(B) in order for an applicant under subsection (a) or affected party described pursuant to subsection (b) to have regular operations in the United States, assistance under any of the programs authorized under sections [2] or [3] is necessary; and

(C) the availability of such goods or services from that applicant under subsection (a) or affected party under subsection (b) is essential to promote the public health, welfare or the general commerce of the United States, the Commission is authorized to implement the insurance pool described in section-[2]- and the reinsurance coverage described in section-[3]- with respect to such goods or services. If at any time the Commission determines that one or both of the programs provided for in section -[2]- or -[3]- reasonably assures the availability or affordability of such goods or services in the United States, the Commission may implement the operation of the programs described therein.

(2) to further the purposes of this act and in recognition of the critical situation facing both day care centers in insuring for the specific peril of child abuse and nurse-midwives in obtaining medical malpractice insurance, the Congress makes the necessary determination for the Commission to implement section [2],[3] or both and any other pertinent section under this title for these affected parties. Affected party eligibility under section [1](d)(2) shall not be subject to review by the Commission until 90 days after the enactment of this title.

(3) To the extent feasible, the programs provided for under this title shall be implemented in a manner to insure that:

(A) such programs will not act as a disincentive to improvements in product safety or safe service delivery, and shall operate to promote product safety and safe service delivery through the establishment of models for risk management as may be agreed upon by the Commission, the insurers and the insureds as a prerequisite for eligibility for any of the programs under this title.

(B) each manufacturer or service provider which benefits from such programs will agree that such goods or services shall remain available to the public during the period in which such product manufacturer or service provider or the insurer of such product manufacturer or service provider participates in such programs.

(C) each insurer which benefits from such programs will agree that such insurance as is written during the period in which such insurer or its insured product manufacturer or service provider participates in such programs shall have premiums which are based upon an experience rate.

Section-[2]-(a) After making findings under section [1], the Commission shall encourage and otherwise assist any insurance companies which meet the requirements of subsection (c) and any others set out in this title to form, or otherwise join together in insurance pools for the purpose of assuming, on such terms and conditions as may be agreed upon, such financial responsibility as will enable such companies and other insurers, with federal financial and other assistance under this title, to assume a reasonable portion of responsibility for the adjustment and payment of claims arising from product or service induced injuries, disabilities, illnesses and deaths.

(b) Funds from such insurance pools shall be available only to pay claims resulting from product or service related actions in excess of such amounts as are established each year by the Commission. The Commission may establish differing amounts for each manfacturer or service provider or insurer and each good or service based upon the needs of the manufacturer or service provider or insurer and other relevant factors.

(c) any insurer licensed to operate as such by any state, territory or possession of the United States shall

be eligible for participation in such insurance pools.

(d) Such insurance pools may be funded by premiums paid by manufacturers or service providers to insurers approved by the Commission. If the Commission finds, after notice and public hearing, that the premiums charged by such insurance pools make the insurance from such insurance pool unavailable for manufacturers or service providers, the Commission may amend the terms and conditions of reinsurance under this title to lower premiums to be paid by such manufacturers or service providers.

Section [3](a) In order to further the purposes of this title, the Commission may take such action as may be necessary to make available,to the insurance pools formed or otherwise created under section [2], reinsurance coverage under this section to any insurer or pool for losses assumed by such insurers or pools in accordance with the agreements entered into under subsection (b).

(b)(1) Following the date of enactment of this title, the Commission is authorized to enter into any contract, agreement, treaty, or any other arrangement with any insurer or pool for reinsurance coverage, in consideration of payment of such premiums, fees or other charges by insurers or pools which the Commission deems to be adequate as required under Section-[5]- of this title to obtain aggregate reinsurance premiums and charges for deposit in the Omnibus Reinsurance Fund established under Section-[5]- in excess of the estimated amount of insured product or service induced losses in 1985, and thereafter the Commission may increase or decrease such premiums or charges if it is found that such action is neccessary or appropriate to carry out the purposes of this title.

(A) Reinsurance offered under this title shall reimburse an insurer or pool for its total proved and approved claims for covered losses resulting from product or service induced injuries, disabilities, illnesses and deaths during the term of the reinsurance contract, agreement, treaty, or other arrangement, over and above the amount of the insurer's or pool's retention of such losses as provided in such reinsurance contract, agreement, treaty, or other arrangement entered into under this section.

(B) Such reinsurance contracts, agreements, treaties, or other arrangements may be made without regard to section 3679(a) of the Revised Statutes of the United States (31 USC 665(a)), and shall include any terms and conditions which the Commission deems necessary to carry out the purposes of this title. The terms and conditions of such contracts, agreements, treaties, or other arrangements with insurers or pools, throughout the country, in any one year shall be uniform: Provided, that where necessary to further the purposes of this title, pro rata and other such forms of reinsurance may be include[illegible] such terms and conditions.

(C) Such rei[illegible]ce shall be provided upon such terms and conditions [illegible] subject to such deductibles

and other restrictions and limitations, as the Commission deems appropriate, but no reinsurance shall be available to a product manufacturer, service provider, insurer or pool of insurance which the Commission determines to be uninsurable or to any product manufacturer, service provider, insurer or pool of insurance with respect to which reasonable protective measures to prevent loss, consistent with standards established by the Commission under section [1](d)(3)(A), have not been adopted.

(D) Any contract, agreement, treaty, or other arrangement for reinsurance under this section shall be for a calendar year.

Section 4(a) The Commission shall take such action as is necessary or appropriate to make reinsurance available directly to insurers which participate in pools created under this title for that portion of their business which is related to any distressed line as determined under section [1](d) which is written and not within a pool created pursuant to section [2] of this title.

(b) Such reinsurance may be made pursuant to contract, agreement, treaty, or other arrangement, and pursuant to such regulations as may be reasonably prescribed by the Commission.

DRAFT

Section 5(a) To carry out the programs authorized under this title, the Commission may establish in the Treasury of the United States an Omnibus Reinsurance Fund which shall be available without fiscal year limitations--

(1) to pay reinsurance claims under the reinsurance coverage provided under section [3]; and

(2) to pay reinsurance claims under section [4]; and

(3) to pay such administrative expenses as may be necessary or appropriate to carry out the purposes of this title; and

(4) to repay to the Secretary of the Treasury such sums, including interest thereon, as may be borrowed from him for purposes of such programs under section [5](b).

(b) The reinsurance fund under this section may be financed by:

(1) such amounts as may from time to time be advanced to the fund from the general fund of the Treasury in order to maintain the fund in an operative condition adequate to meet its liabilities; and

(2) premiums, fees, or other such charges which may be collected in connection with the reinsurance coverage provided under section [3]; and

(3) premiums, fees, or other such charges which may be collected in connection with the reinsurance coverage provided under section [4]; and

(4) such amounts as may be raised by the establishment of an uniform surcharge upon premiums paid to

property and casualty insurers.

(A) the Treasury shall, no later than 120 days after the enactment of this title, collect a .0025 (.25 percent) surcharge upon all premiums paid to property and casualty insurers which revenues shall go to maintain the reinsurance fund created under this section in an operative condition adequate to meet its liabilities.

(5) interest which may be earned on investments of the fund; and

(6) receipts from any other source which may, from time to time, be credited to the fund.

Section [6](a) If at any time the Commission makes the determinations described in section [1](d), the Commission may, in carrying out its responsibilities under this title, utilize—

(1) insurance companies and other insurers, insurance agents and brokers , and insurance adjustment organizations, as fiscal officers of the United States,

(2) officers and employees of the Federal Trade Commission, and such other officers and employees of any executive agency (as defined in section 105 of title 5 of the United States Code) as the Commission and the head of any such agency may from time to time agree upon, on a reimbursement or other basis, or

(3) both of the alternatives specified in paragraphs (1) and (2), or any combination thereof.

Section [7](a) The Commission may in the interest of furthering the purposes of this title delegate authority to administer any portion of this title to other appropriate officers and employees of any executive agency (as defined in section 105 of title 5 of the United States Code) as the Commission and the head of any such agency may from time to time agree: Provided that any action taken by any such agency officer or employee shall not be inconsistent with any portion of this title.

(b)(1) The Commission through its Bureau of Competition shall periodically review each plan under this title and the methods and practices by which such plan is actually being carried out in order to—

(A) Assure that such plan is effectively making commercial general liability and other essential lines of liability insurance readily available to such product manufacturers and service providers as is intended and is otherwise carrying out the purposes of this title, and in order to identify any aspects of the operation or administration of such plan which may require revision, modification , or other action to carry out such purposes.

(B) Report to the Congress at least once a year the findings of any such investigation under subsection b(1)(A), or from time to time as may be requested by the Congress to report on the current status of all plans under this title.

Section [8](a) Within 90 days after the enactment of this title and before implementation of the programs contained therein for the benefit of any applicant, affected party, insurer or pool of insurance, the Commission shall prepare and transmit a report to the Congress which shall—

(1) indicate the nature and extent of anticipated use of the insurance industry in the delivery under this title of reinsurance to product manufacturers, service providers, insurers, and pools of insurance.

(2) identify anticipated costs of provision of such reinsurance to product manufacturers, service providers, insurers, and pools of insurance under this title.

(3) identify any potential applicant which has made query to the Commission about such programs as have been authorized under this title and, in the case of affected parties, those which preliminarily might benefit from participation under the programs authorized under this title.

Section [9](a) The Commission, or any agency officer or employees which administer portions of this title as authorized under section [6] and [7], in a suit brought in the appropriate United States district court, shall be entitled to recover from any insurer the amount of any unpaid premiums lawfully payable by such insurer to the Commission or its delegated agent.

(b) No action or proceeding brought under this section may be brought for any amount in excess of that lawfully payable by any insurer to the Commission or its delegated agent and any such action shall be brought within five years of when the right to such payment accrued, except [Provided, where any false or fraudulent conduct warrants, the claim shall not be deemed to have accrued until its discovery.

(c) Any recovery had pursuant to any action or proceeding under this section shall be deposited to the credit of the reinsurance fund created under this title.

LEGISLATIVE BRIEFING SESSION ON THE INSURANCE CRISIS

By the Coalition for Consumers and Victims' Rights

December 6, 1985 **** Moderator: Bernard P. Kelly
Anchorage Attorney

8:30-9:00 a.m. . . . . Coffee

9:00-10:00 a.m. . . . . An Overview
J. Robert Hunter
National Insurance Consumers Organization
Alexandria, Virginia
Formerly - Federal Insurance Administrator

10:00-10:30 a.m.. . . . . Question and Answer Period

10:30-11:30 a.m.. . . . . Medical Malpractice, "An Example of Tort Reform that Didn't Work"
L. Ames Luce, Anchorage Attorney

11:30-12:00 p.m.. . . . . Proposed Legislative Solutions:
A) Joint and Several Liability
Robert Libbey, Anchorage Attorney

12:00-1:15 p.m. . . . . Lunch

1:15-2:00 p.m. . . . . B) Other so-called Tort Reform Proposals Discussed
Joe Young, Anchorage Attorney
Doug Baily, Anchorage Attorney

2:00-2:30 p.m. . . . . Protecting the Consumer and the Innocent
John Suddock, President
Alaska Public Interest Research Group

2:30-2:45 p.m. . . . . Tort Reform Won't Work
Paul Cossman, Anchorage Attorney

2:45-3:30 p.m. . . . . Some Alternatives That Will Work
Millard Ingraham, Anchorage Attorney
J. Robert Hunter

2:30 pm

Alaska State Legislature

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

November 19, 1985

Dear Colleague:

In October, Anchorage legislators received a briefing at the Golden Nugget Hotel about difficulties facing the insurance industry and insureds in Alaska and throughout the nation. It was indicated in the notice you received about that briefing that another session would be scheduled on this subject.

Having heard from the industry and the advocates of amendments to Alaska tort law at the October briefing, we will also have an opportunity next month to hear the perspectives and comments of those with different views. The Coalition for Consumers and Victims' Rights has scheduled a briefing for December 6, 1985, at the Hotel Captain Cook, in the After-Deck room from 8:30 a.m. to 3:30 p.m.

The December 6 briefing will concentrate on the problems faced by consumers and claimants. Consumers' attorneys will present a consumers' perspective and a critique of the tort changes discussed in Ocotber. The keynote speaker will be Mr. J. Robert Hunter, of the National Insurance Consumer Association, who was formerly with the Federal Insurance Administration.

We hope your schedule will allow you to be present so that we can all go to Juneau with both briefings in mind. In your absence, members of your staff would be welcome at this session.

Sincerely yours,

Rep. Marco Pignalberi

Senator Vic Fischer

Senator Joe Josephson

LEGISLATIVE BRIEFING SESSION ON THE INSURANCE CRISIS

By the Coalition for Consumers and Victims' Rights

December 6, 1985 **** Moderator: Bernard P. Kelly
Anchorage Attorney

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2:45-3:30 p.m. . . . . Some Alternatives That Will Work
Millard Ingraham, Anchorage Attorney
J. Robert Hunter

Patrick M. Rodey
Senator

Alaska State Legislature

Senate

1024 W. 6th Avenue, Suite 308
Anchorage, Alaska 99501
(907) 276-6731

During Session:
Pouch V
Juneau, Alaska 99811
(907) 465-3717

November 15, 1985

Bernard P. Kelly
310 K Street, Suite 506
Anchorage, Alaska 99501-2040

Dear Bernard:

Many thanks for your letter and supporting documents relating to "tort reform." I'm pleased that you have taken an interest in presenting the other view and I hope you will be joined by others in the Bar.

While I have several engagements on December 6th, I'll try to come by your presentation. A member of my staff will be present for the day.

Again, I appreciate the material.

Sincerely,

Pat

Patrick M. Rodey

PMR/acp

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(907) 276-3188

BERNARD P. KELLY
PAUL COSSMAN

November 7, 1985

Patrick Rodey
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Pat:

I am enclosing herewith a copy of a letter written by my associate Paul Cossman to the Governor's Task Force on Insurance, which includes some features I think are good information. Exhibit 3, for example, is from Value Line, a stock market service and indicates that the casualty and property insurance business expects an upturn. Value Line is indicating that this is a long-term investment of value for the casualty/property insurance industry which has always been cyclical, that it is expected to rebound and be a very profitable line down the road a couple of years.

We are planning a presentation before legislators of so many that can attend on December 6, 1985, at the Hotel Captain Cook from 9 a.m. until approximately 3 p.m. At that time we hope to present Mr. J. Robert Hunter, former Federal Insurance Administrator, who is a property and casualty actuary. In my opinion, Mr. Hunter is the most knowledgeable person in the country in this alleged insurance crisis. He believes it is a manufactured crisis caused by the insurance industry, that there are solutions to this problem, but not taking away the rights of innocent people. We also intend to put on a number of other panelists, and we think it will be an educational program supported by a lot of data and information which we believe rebut the need for taking away any of the rights of innocent people, which would take place under the proposal of the Coalition for Tort Reform.

Sincerely yours,

BERNARD P. KELLY

BPK:amm
1677A

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BERNARD P. KELLY
PAUL COSSMAN

October 25, 1985

Dear

This letter supplements my oral testimony of October 8, 1985, before the Task Force on Insurance.

At that hearing I advocated a state-run program to insure or reinsure portions of industries which are experiencing an insurance crisis. (Please find attached to this letter as Exhibit 1 sample legislation which details how such a system could be implemented.) Although this legislation is drafted as a federal statute, it can easily be altered to apply to the State of Alaska.

Mr. Richard Block, President of the Alaska National Insurance Company, indicated that the proposed program is not a feasible method of addressing the insurance crisis. To corroborate his statement, Mr. Block indicated that the Medical Indemnity Corporation of Alaska (MICA) is experiencing problems. This is simply not true. (Please find attached as Exhibit 2 a letter from Art Stanford, the Director of MICA, indicating that MICA is not in any financial trouble.) In addition, I have spoken personally with Mr. Stanford. He indicated to me there is no problem at all with MICA obtaining reinsurance in the coming year. The price of this reinsurance will increase, or alternatively the limits of coverage will decrease, but reinsurance is readily available for MICA. The success of MICA, and the small increase in premium rates relative to that of private insurance companies, indicates the feasibility and desirability of state insurance programs. Currently, the highest rate that a physician would pay for MICA malpractice coverage is $35,431 per year. This premium is for $4,000,000 liability coverage for a physician who is in the highest risk class; i.e., neurosurgeon or orthopedic surgeon.

Dr. David McGuire, President of Alaska State Medical Association, indicated that he pays considerably higher insurance premiums. This could be due to a number of factors, such

as his purchasing occurrence insurance instead of claims made insurance. Perhaps it is because a private insurance company charges more money for higher risk physicians. If Dr. McGuire were insured with MICA, his premiums would be substantially reduced.

Mr. Block indicated that predictability is the largest problem in the insurance industry, not the size of claims awards. However, Mr. Block's "tort reform" proposals do not address this issue. "Tort reform" does not address the concern about future causes of action being created through high risk activities that are currently thought to be low risk. All of the "tort reform" suggestions that have been proferred have nothing to do with limiting a Court's ability to create new causes of action. Thus, predicability is untouched by these "tort reform" proposals.

Mr. Block admits that insurance companies are engaged in cyclical pricing and profligate spending. This is the very problem that must be addressed. Our government has done nothing to stop the cyclical pricing that insurance companies have engaged in. Insurance companies are exempt from federal antitrust legislation due to the McCarran-Ferguson Act. Our State Division of Insurance has done nothing to regulate the cyclical pricing engaged in by insurance companies. Mr. Block believes that competition will keep insurance company premiums low. However, this is not true. The insurance companies are playing off of the public hysteria and acting in concert to raise insurance premium rates dramatically in areas that have no history of high claims. In fact, insurance industry executives and periodicals are already editorializing of the increases in profitability they expect to begin this year. (See Exhibit 3 attached hereto.) This documents the cyclical nature of the profitability of the insurance industry due to investment cycles. (See Exhibit 4 attached hereto.) The State of Alaska must address this wholesale increase in insurance premium rates. The best way to do this is to have the state insure or reinsure those industries that have been hardest hit by rising premiums, yet have no history of high claims.

"Tort reform" will not alter this crisis. Alaska is too small a state and too insignificant in terms of national insurance premiums to make any difference to the national situation. Everyone agrees that the "tort reform" proposals will simply alter the perception of insurance companies by making Alaska appear to be a beneficial market. The argument follows that this will keep the insurers in Alaska rather than pulling them out. However, they will remain and charge the

same exorbitant premium rates that they are currently charging. This will do absolutely nothing to solve the current insurance crisis.

It is much more important to address the real problem. This would be done by implementing the state insurance or reinsurance proposals in the legislation contained herewith.

However, some affected industries are being charged high premium rates due to the high risk they actually present. For example, Alaska's air carriers are charged higher premium rates due to the higher risk they present. (Alaska air carrier accidents involving deaths have increased 60 percent between 1984 and 1985; see Exhibit 5 attached hereto.) Thus, some industries are experiencing increased premium rates due to increased risk. Until these industries practice internal risk management procedures, the insurance companies must increase their premiums to cover the increased risk these industries present. These factors are not addressed by "tort reform," but addressed by decreasing the risk involved in operation.

For all of the above reasons, "tort reform" will not address the current insurance crisis, or do anything to solve the long-term problem. Although the insurance crisis will not be alleviated by any kind of "tort reform," it is clear that this Task Force is considering "tort reform" as one of the answers to the crisis. Thus, I feel compelled to critique each individual suggested "reform" of the tort system and point out why it is not only unwarranted but counterproductive.

Initially I would like to point out that what is contemplated is a wholesale attack upon a tort system that has taken centuries to evolve. Evolution has occurred at a glacial pace, with each change being carefully considered by learned members of appellate courts after detailed briefings by adversary lawyers. Every one of the factors of our tort system has been the subject of a great amount of deliberation after a great amount of briefing and argument. To alter this system upon the simplified requests and proposals of self-interested insurance companies would be a sad mistake for this Task Force. The future effects of gerrymandering with our tort system are unpredictable and unknown. We are dealing with the future rights of people innocently injured due to the negligent, reckless, and intentional actions of tortfeasors. To take these rights away from future victims in order to placate a short-term economic crisis brought on by the greed and stupidity of insurance corporations is ludicrous, and would be a grave mistake.

(1) Putting a cap or maximum limit on non-economic damage awards. This proposal was studied and rejected by the 1975 report of the Governor's Medical Malpractice Insurance Commission. (Please see the relevant pages attached hereto as Exhibit 6.) The commission noted that by eliminating the part of the tort award which exceeds a plaintiff's out-of-pocket expense, the incentive of the injured person and the injured person's attorney to bring suit is eliminated. This will impact upon a plaintiff attorney's willingness to bring a suit, therefore precluding legitimate claimants and victims from having recourse to counsel and the courts for redress of their injuries. The commission also pointed out that where a tort victim is seriously injured and suffers an extreme loss, this can only be adequately compensated by an award exceeding any prescribed limit. The commission, therefore, rejected the imposition of any arbitrary limit upon awards as bad public policy.

Any arbitrary limit on non-economic damage awards would also be violative of the equal protection provisions of the Alaska State Constitution. Seriously injured individuals would not receive full compensation for their injuries while less seriously injured victims would receive adequate compensation. This unfairly discriminates between the two classes of plaintiffs.

(2) Mandating structured settlements. Proponents of structured settlements claim they give a victim integrity, and allow him to keep his dignity and pride. However, a structured settlement would have precisely the opposite effect. It would effectively put an injured victim "on the dole," something like being on public assistance. There is no indication in any literature that plaintiffs spend all of their award at once and end up on public assistance. There is no indication that it is risky to give a plaintiff his award all at one time. To the contrary, a victim often requires a lump sum all at once. Many people need to obtain rehabilitative training and special equipment. The only way to obtain these things is by receiving a lump sum award.

The mandatory structured settlement proposal is the insurance industry's thinly veiled attempt to keep the investment use of award money. This is so the insurance company can use this money for its investment value, exactly as an insurance company does with the premiums it obtains. However, these funds belong in the victim's hands. They are not a windfall. Juries do not calculate awards for their investment values; neither do they calculate inflation in

determining an award. While insurance companies are arguing that plaintiffs are receiving a windfall due to the investment value of tort awards, the same companies claim they are losing great sums of money due to their inability to obtain a return on these same sums of money.

(3) Reversing the collateral source rule. "Tort reform" proponents want to deduct a victim's personal insurance payments from the tort award. A tort victim's receipt of medical payments from his own insurance in addition to payment by the tortfeasor does not constitute double indemnity. The payment of medical bills by the victim's health insurance does not constitute a windfall.

A person pays for health insurance out of his own funds. This health insurance is used to pay his medical bills caused by the tortfeasor's negligence. However, a jury verdict will include payment for medical damages for which a tortfeasor is responsible. This payment burden properly belongs on the defendant tortfeasor, not on the plaintiff. By destroying the collateral source rule, this payment burden would be placed upon the innocent victim, not upon the negligent tortfeasor. This would punish the victim for making payments on his health insurance. A person's monthly payments add up to a significant amount of money over time. Victims should not lose the benefit from these health insurance payments. By destroying the collateral source rule, these people would be denied the benefit of their foresight in having health insurance.

The same situation occurs when a tort victim has health insurance supplied by his employer. Health insurance is generally received as an employee benefit in lieu of a wage increase. Thus, the victim is paying for the health insurance since he is foregoing part of his wages.

Therefore, the victim is always paying for his health insurance. As such it is improper for the defendant tortfeasor to benefit from plaintiff's payments. This is not double indemnity. The victim pays for insurance over the course of time. The defendant tortfeasor is actually reimbursing the victim for these payments when it is the defendant's fault. Therefore, it's inequitable for the defendant to profit from plaintiff's economic investment.

(4) Shortening the statute of limitations. Proponents speak of examples where claims are made decades after defendant's actions. These claims are so rare that they are not statistically significant; proponents cite no statistics or

examples. In fact, only 6 to 10 percent of claims paid have been made more than 36 months after the date of the tortfeasor's actions. That statistic comes from Mr. Richard Block, the prior Commissioner of Insurance, State of Alaska. Mr. Block points out that "these figures are not large, suggesting that the concern of the carriers...might be partially unwarranted."

Mr. Block is correct. Claims made more than 36 months after the date of the tortfeasors' actions are so few that they are insignificant. On the other hand, it is unfair to arbitrarily cut off a victim's cause of action purely because the victim is unaware of the injury done to him. Any disadvantage to the defendant in pursuing an older claim is equally visited upon the victim.

(5) Doing away with joint liability; making liability several only. This would punish the victim for a tortfeasor's unavailability or for being judgment-proof. If one of the tortfeasors is unavailable or judgment-proof, then that loss must be allocated. In allocating that loss, fairness dictates it should fall upon a defendant tortfeasor, not the innocent victim. Doing away with several liability would discourage defendants from being careful with whom they work, and from maintaining a high standard of care for their co-workers. In short, defendants would not be responsible for any of their co-defendant's actions. For example, in a hospital/physician relationship a hospital would no longer share the financial responsibility for a physician's negligence where the physician does not carry malpractice insurance and is judgment-proof. Since the hospital would not be financially responsible for the doctor's negligence, there would be no encouragement for a hospital to require physicians to have malpractice insurance. Thus, any loss would be reallocated from a defendant hospital to an innocent tort victim.

(6) Establishing sliding scale attorney fees. Over-all remuneration is not high for plaintiffs' attorneys. Although there are high visibility large verdicts, these are few. Contingent attorney's fees are generally 33 1/3 percent. Any fee that an attorney charges is limited by the disciplinary rules of the Alaska State Bar Association. Stories of attorneys recovering 60 percent of a plaintiff's verdict are ridiculous and untrue. Expenses and costs incurred in prosecuting a lawsuit are not part of the attorney's fees. The tort victim must expend these funds in order to prosecute the case: to hire experts, to investigate, to pay for witness travel, etc. If a plaintiff's attorney loses a case, the costs

usually are not repaid by the tort victim. Therefore, these funds are paid out of the attorney's pocket. The attorney's fees on the winning cases must cover these lost costs and expenses.

Defense attorneys generally earn more money than plaintiffs' attorneys. If legislation decreases plaintiffs' attorneys' fees, this imbalance will become even more pronounced. If this happens, defense attorneys can "paper" plaintiffs' attorneys even more successfully. This is sometimes the case where a defense attorney files many interrogatories, requests for production, deposition notices, and other discovery requests which are not required for the defense of a suit yet serve to harrass the plaintiff's lawyer. Since a plaintiff's attorney would receive even less remuneration for his time, there would be less of a desire to take cases for legitimate tort victims. In this manner, insurance companies would decrease the number of valid negligence suits which are prosecuted due to the diminished return for the plaintiff's attorney.

A proposal to limit plaintiffs' attorneys' fees does not address the issue of defense attorneys' fees, which are a major part of the defense costs. At present ISO is even considering a form proposal which would include within the insurance policy limits the defense attorneys' fees. This would not serve to decrease the defense attorneys' fees in any manner whatsoever. What this would do is further decrease the tort victim's recovery by diminishing the policy limits available to him.

Any proposal to limit the plaintiffs' attorneys' fees because it infringes upon the tort award of the victim directly contradicts the proposal to repeal Rule 82 attorneys' fees. Rule 82 exists to help cover the cost of attorneys' fees so more of the award gets to the tort victim. The purpose of Rule 82 is to perform exactly what the proponents of repealing Rule 82 are complaining about: getting more money to the victim. The two proposals, 1) limiting plaintiffs' attorneys' contingency fees, and 2) repealing Rule 82 attorneys' fees, are internally inconsistent and illogical.

(7) Taking away prejudgment interest. Prejudgment interest controls defendants' desires to delay a case in order to have the investment use of settlement or award money for as long as possible. The prejudgment interest rule encourages settlement by creating a financial penalty for defendant's delay in settling valid cases. Such a delay also makes

plaintiff more desperate. Often victims have bills piling up and are unable to obtain rehabilitation due to lack of funds.

Tort victims wish to settle their cases as quickly as possible. They want to get the bad legal experience over with as soon as possible, and get on with their lives. They wish to get the settlement money so they can begin rehabilitation and become productive persons once again. Tort victims do not delay settlements just to increase the amount of their award. If that was what a tort victim wished to do, he could obtain a better return on the settlement amount than the 10 percent court award that is currently available. There is only one reason why a tort victim would not want to settle as soon as possible: to wait until he has stabilized medically to see what the complete extent of his injuries really are. This is necessary so that a tort victim does not settle a case and months later find that he has major medical injuries which he wasn't aware of at the time of settlement. Insurance companies would like to see the prejudgment interest rule repealed because this would, once again, give them the investment value of the funds and make it profitable for them to delay settlement of cases.

(8) Repealing punitive damages. Proponents of repealing punitive damages claim that they are trying to protect companies from being driven out of business. Tort victims do not put anyone out of business by claiming punitive damages. Punitive damages punish a corporation, not destroy it. During trial evidence is introduced as to the financial wealth of the defendant. Damages are assessed accordingly; i.e., to punish the defendant, not destroy him.

The only way to regulate corporations is via economic punishment; no other "hammer" exists. What is being punished generally is corporate behavior, not individual behavior. Thus, criminal sentences and fines are inappropriate. In addition, it is often difficult to get overworked District Attorneys to pursue these criminal actions and obtain the desired outcome. Therefore, "private attorneys general" are necessary to modify corporate misbehavior. Limiting punitive damages limits the effectiveness of that "hammer." That hammer needs to be determined relative to the financial wealth of a particular defendant. The problem with limiting punitive damages is the same problem that would exist with any "ratio" determination between actual damages and punitive damages. It would not take into account the wealth of the defendant and punitive damages could be limited to a point where it would have no punitive effect.

Actual malice should not be required for an award of punitive damages. This would exempt from punitive damages corporate entities whose conduct is reckless and undertaken with indifference to human life. Punitive damages are needed to rectify corporate misbehavior and protect the public.

Punitive damage awards should not be given to the state. The purpose of punitive damages is to stop behavior of the defendant via punishment. The behavior to be stopped is the cause of the tort victim's injury. Therefore, it makes more sense to give the punitive damages to someone who is in the class of people who are injured by defendant's conduct than it does to give the damages to people who have absolutely no connection with the conduct.

Aside from the problems individually with each and every one of these particular "tort reforms," it has been demonstrated that these reforms have no effect whatsoever upon insurance premium rates. Many of these "tort reforms" were enacted in states in the mid-1970's as a response to the medical malpractice insurance crisis. Most states enacted some reforms, in varying combinations, to be applied solely to medical malpractice cases. This was done in an effort to lower the price of medical malpractice insurance premiums. Professor Frank A. Sloan, of Vanderbilt University, undertook a study of this legislation. Professor Sloan, an economist, concluded that there is "no indication that individual state legislative actions or actions taken collectively had their intended effects on premiums." Journal of Health Politics, Policy & Law, Vol. 9, No. 4, Winter 1985, "State Responses to the Malpractice Insurance 'Crisis' of the 1970's: an Empirical Assessment," by Frank A. Sloan, Vanderbilt University. Professor Sloan concludes that the sources of premium inflation are national in scope. Therefore, deliberate actions taken at state level have no effect upon the nationwide insurance industry in setting insurance premium rates.

Alaska should pay particular attention to Professor Sloan's conclusions. Since Alaska is an extremely small state, writing very few of the national insurance premium dollars, any tort reforms enacted in Alaska would have no effect whatsoever upon the national insurance rates. Insurance companies are not going to undertake independent actuarial studies of Alaska just to charge lower premium rates here.

This Task Force should pay particularly close attention to Professor Sloan's article (attached hereto as Exhibit 6). Professor Sloan's article details what we can expect to find in

1995 as a result of any tort reforms that are undertaken today. It is actually an opportunity to assess the changes, and their effects, before they are made. The "tort reforms" undertaken in response to the malpractice insurance crisis had no effect upon insurance premiums. Such "reforms" will have no effect upon this insurance crisis either.

The American tort system is a complex system of balancing victim's rights and defendant's rights. It is documented that "tort reform" changes in this system have no effect upon the insurance premium rates that are the subject of this Task Force's attention. Therefore, this Task Force should not recommend any changes in the tort system, but should look toward the modification of insurance practices to obtain a change in insurance rates and insurance availability. To do otherwise would be to prescribe a solution that does not address the problem.

Sincerely yours,

BERNARD P. KELLY & ASSOCIATES

PAUL COSSMAN

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Enc.
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EXHIBIT 1

Omnibus Reinsurance Act of 1985

PROBLEM: Many insureds are facing crises in availability and affordability of liability insurance. States, municipalities, environmental concerns, product manufacturers and medical professionals are among the hardest hit. Most day care centers and nurse-midwives cannot find coverage and if they are lucky enough to do so, the cost is prohibitive.

The twin crises of availability and affordability of liability insurance may force manufacturers and service providers out of the normal course of their business. If day care centers close, some families with marginal incomes might lose their homes as well as a second paycheck. Lower cost, high quality care birthing centers may be forced to close, as indeed some have. Products which are safe and beneficial might be kept from markets and physicians or surgeons may quit practice because of unavailable or unaffordable liability insurance. Society cannot function properly when its commerce is so disrupted.

SOLUTION: A federally sponsored reinsurance program to ease availability and affordability of liability insurance in distressed lines of property/casualty insurance.

PRECEDENT: In the late 60's the federal government set up a riot reinsurance program. The federal government agreed to reinsure carriers for the specific peril of concern (riot) in exchange for their forming pools to assure full coverage (including fire, liability, etc.) in distressed areas. The federal government collected reinsurance premiums (and made $125 million) and also required insurers to impose certain safety requirements upon risks they undertook. (See, 12 USC 1749bbb, 42 USC 4011 (1968)).

IMPLEMENTATION: Legislation would have to be passed to give some federal agency stand-by authority to declare certain lines of property/casualty insurance "distressed" and eligible for reinsurance from the federal program. The "distressed" determination would have to be made upon application or at the agency's discretion. Initial funding would be from borrowing authority from the Treasury, later paid back through the collection of reinsurance premiums and a surcharge upon all property/casualty premiums paid. A surcharge of .25 percent upon all premiums paid would generate about $300 million per year and with interest would make almost $6 billion available to reinsure distressed lines at the bottom of the next underwriting cycle.

OUTCOME: Distressed lines of property/casualty insurance will be stabilized against the vagaries of the underwriting cycle. Reasonably safe risks like most day care centers and nurse-midwives will be able to obtain essential insurance. Society will not be faced with the lack of products or services because of unavailable or unaffordable insurance.

OMNIBUS REINSURANCE ACT OF 1985

Section -[1]-(a) Within 30 days after the receipt of an application by any manufacturer, service provider or any group or association representing such manufacturers or service providers, the Commission shall conduct a hearing on the reasonable availability and affordability of adequate commercial general liability insurance and other lines of insurance for that manufacturer or service provider or the members of any group or association of manufacturers or service providers.

(b) The Commission may in its discretion hold hearings to investigate the reasonable availability or affordability of commercial general liability insurance and other such lines of insurance as from time to time become unavailable or unaffordable thereby threatening the health, welfare or commerce of the United States and the various states by making some manufactured good or provided service unavailable or available only at an unreasonable cost.

(c) Within 30 days after the hearing required under subsection (a) or conducted under subsection (b) the Commission shall determine in writing, based upon the record of the hearing conducted pursuant to subsection (a) or (b), whether the insurance described in subsection (a) or (b) is , and will be, reasonably available or affordable to affected manufacturers, service providers or the members of any group or association representing manufacturers or service providers to cover anticipated claims. Such determination, and the basis therefore, shall be published in the Federal Register.

(d)(1) If the Commission determines at any time that:

(A) the insurance described in subsection (a) or (b) is not available or reasonably affordable from the private sector to applicants under subsection (a) or the affected parties described pursuant to subsection (b) to cover anticipated claims;

(B) in order for an applicant under subsection (a) or affected party described pursuant to subsection (b) to have regular operations in the United States, assistance under any of the programs authorized under sections [2] or [3] is necessary; and

(C) the availability of such goods or services from that applicant under subsection (a) or affected party under subsection (b) is essential to promote the public health, welfare or the general commerce of the United States, the Commission is authorized to implement the insurance pool described in section-[2]- and the reinsurance coverage described in section-[3]- with respect to such goods or services. If at any time the Commission determines that one or both of the programs provided for in section -[2]- or -[3]- reasonably assures the availability or affordability of such goods or services in the United States, the Commission may implement the operation of the programs described therein.

(2) to further the purposes of this act and in recognition of the critical situation facing both day care centers in insuring for the specific peril of child abuse and nurse-midwives in obtaining medical malpractice insurance, the Congress makes the necessary determination for the Commission to implement section [2],[3] or both and any other pertinent section under this title for these affected parties. Affected party eligibility under section [1](d)(2) shall not be subject to review by the Commission until 90 days after the enactment of this title.

(3) To the extent feasible, the programs provided for under this title shall be implemented in a manner to insure that:

(A) such programs will not act as a disincentive to improvements in product safety or safe service delivery, and shall operate to promote product safety and safe service delivery through the establishment of models for risk management as may be agreed upon by the Commission, the insurers and the insureds as a prerequisite for eligibility for any of the programs under this title.

(B) each manufacturer or service provider which benefits from such programs will agree that such goods or services shall remain available to the public during the period in which such product manufacturer or service provider or the insurer of such product manufacturer or service provider participates in such programs.

(C) each insurer which benefits from such programs will agree that such insurance as is written during the period in which such insurer or its insured product manufacturer or service provider participates in such programs shall have premiums which are based upon an experience rate.

Section-[2]-(a) After making findings under section [1], the Commission shall encourage and otherwise assist any insurance companies which meet the requirements of subsection (c) and any others set out in this title to form, or otherwise join together in insurance pools for the purpose of assuming, on such terms and conditions as may be agreed upon, such financial responsibility as will enable such companies and other insurers, with federal financial and other assistance under this title, to assume a reasonable portion of responsibility for the adjustment and payment of claims arising from product or service induced injuries, disabilities, illnesses and deaths.

(b) Funds from such insurance pools shall be available only to pay claims resulting from product or service related actions in excess of such amounts as are established each year by the Commission. The Commission may establish differing amounts for each manfacturer or service provider or insurer and each good or service based upon the needs of the manufacturer or service provider or insurer and other relevant factors.

(c) any insurer licensed to operate as such by any state, territory or possession of the United States shall

be eligible for participation in such insurance pools.

(d) Such insurance pools may be funded by premiums paid by manufacturers or service providers to insurers approved by the Commission. If the Commission finds, after notice and public hearing, that the premiums charged by such insurance pools make the insurance from such insurance pool unavailable for manufacturers or service providers, the Commission may amend the terms and conditions of reinsurance under this title to lower premiums to be paid by such manufacturers or service providers.

Section [3](a) In order to further the purposes of this title, the Commission may take such action as may be necessary to make available, to the insurance pools formed or otherwise created under section [2], reinsurance coverage under this section to any insurer or pool for losses assumed by such insurers or pools in accordance with the agreements entered into under subsection (b).

(b)(1) Following the date of enactment of this title, the Commission is authorized to enter into any contract, agreement, treaty, or any other arrangement with any insurer or pool for reinsurance coverage, in consideration of payment of such premiums, fees or other charges by insurers or pools which the Commission deems to be adequate as required under Section-[5]- of this title to obtain aggregate reinsurance premiums and charges for deposit in the Omnibus Reinsurance Fund established under Section-[5]- in excess of the estimated amount of insured product or service induced losses in 1985, and thereafter the Commission may increase or decrease such premiums or charges if it is found that such action is necessary or appropriate to carry out the purposes of this title.

(A) Reinsurance offered under this title shall reimburse an insurer or pool for its total proved and approved claims for covered losses resulting from product or service induced injuries, disabilities, illnesses and deaths during the term of the reinsurance contract, agreement, treaty, or other arrangement, over and above the amount of the insurer's or pool's retention of such losses as provided in such reinsurance contract, agreement, treaty, or other arrangement entered into under this section.

(B) Such reinsurance contracts, agreements, treaties, or other arrangements may be made without regard to section 3679(a) of the Revised Statutes of the United States (31 USC 665(a)), and shall include any terms and conditions which the Commission deems necessary to carry out the purposes of this title. The terms and conditions of such contracts, agreements, treaties, or other arrangements with insurers or pools, throughout the country, in any one year shall be uniform: Provided, that where necessary to further the purposes of this title, pro rata and other such forms of reinsurance may be included on such terms and conditions.

(C) Such reinsurance shall be provided upon such terms and conditions as subject to such deductibles

and other restrictions and limitations, as the Commission deems appropriate, but no reinsurance shall be available to a product manufacturer, service provider, insurer or pool of insurance which the Commission determines to be uninsurable or to any product manufacturer, service provider, insurer or pool of insurance with respect to which reasonable protective measures to prevent loss, consistent with standards established by the Commission under section [1](d)(3)(A), have not been adopted.

(D) Any contract, agreement, treaty, or other arrangement for reinsurance under this section shall be for a calendar year.

Section 4(a) The Commission shall take such action as is necessary or appropriate to make reinsurance available directly to insurers which participate in pools created under this title for that portion of their business which is related to any distressed line as determined under section [1](d) which is written and not within a pool created pursuant to section [2] of this title.

(b) Such reinsurance may be made pursuant to contract, agreement, treaty, or other arrangement, and pursuant to such regulations as may be reasonably prescribed by the Commission.

Section 5(a) To carry out the programs authorized under this title, the Commission may establish in the Treasury of the United States an Omnibus Reinsurance Fund which shall be available without fiscal year limitations--

(1) to pay reinsurance claims under the reinsurance coverage provided under section [3]; and

(2) to pay reinsurance claims under section [4]; and

(3) to pay such administrative expenses as may be necessary or appropriate to carry out the purposes of this title; and

(4) to repay to the Secretary of the Treasury such sums, including interest thereon, as may be borrowed from him for purposes of such programs under section [5](b).

(b) The reinsurance fund under this section may be financed by:

(1) such amounts as may from time to time be advanced to the fund from the general fund of the Treasury in order to maintain the fund in an operative condition adequate to meet its liabilities; and

(2) premiums, fees, or other such charges which may be collected in connection with the reinsurance coverage provided under section [3]; and

(3) premiums, fees, or other such charges which may be collected in connection with the reinsurance coverage provided under section [4]; and

(4) such amounts as may be raised by the establishment of an uniform surcharge upon premiums paid to

property and casualty incurers.

(A) the Treasury shall, no later than 120 days after the enactment of this title, collect a .0025 (.25 percent) surcharge upon all premiums paid to property and casualty incurers which revenues shall go to maintain the reincurance fund erected under this section in an operative condition adequate to meet its liabilities.

(5) interest which may be earned on investments of the fund; and

(6) receipts from any other source which may, from time to time, be credited to the fund.

Section [6](a) If at any time the Commission makes the determinations described in section [1](d), the Commission may, in carrying out its responsibilities under this title, utilize—

(1) insurance companies and other insurers, insurance agents and brokers , and insurance adjustment organizations, as fiscal officers of the United States,

(2) officers and employees of the Federal Trade Commission, and such other officers and employees of any executive agency (as defined in section 105 of title 5 of the United States Code) as the Commission and the head of any such agency may from time to time agree upon, on a reimbursement or other basis, or

(3) both of the alternatives specified in paragraphs (1) and (2), or any combination thereof.

Section [7](a) The Commission may in the interest of furthering the purposes of this title delegate authority to administer any portion of this title to other appropriate officers and employees of any executive agency (as defined in section 105 of title 5 of the United States Code) as the Commission and the head of any such agency may from time to time agree: Provided that any action taken by any such agency officer or employee shall not be inconsistent with any portion of this title.

(b)(1) The Commission through its Bureau of Competition shall periodically review each plan under this title and the methods and practices by which such plan is actually being carried out in order to—

(A) Assure that such plan is effectively making commercial general liability and other essential lines of liability insurance readily available to such product manufacturers and service providers as is intended and is otherwise carrying out the purposes of this title, and in order to identify any aspects of the operation or administration of such plan which may require revision, modification , or other action to carry out such purposes.

(B) Report to the Congress at least once a year the findings of any such investigation under subsection b(1)(A), or from time to time as may be requested by the Congress to report on the current status of all plans under this title.

Section [8](a) Within 90 days after the enactment of this title and before implementation of the programs contained therein for the benefit of any applicant, affected party, insurer or pool of insurance, the Commission shall prepare and transmit a report to the Congress which shall—

(1) indicate the nature and extent of anticipated use of the insurance industry in the delivery under this title of reinsurance to product manufacturers, service providers, insurers, and pools of insurance.

(2) identify anticipated costs of provision of such reinsurance to product manufacturers, service providers, insurers, and pools of insurance under this title.

(3) identify any potential applicant which has made query to the Commission about such programs as have been authorized under this title and, in the case of affected parties, those which preliminarily might benefit from participation under the programs authorized under this title.

Section [9](a) The Commission, or any agency officer or employees which administer portions of this title as authorized under section [6] and [7], in a suit brought in the appropriate United States district court, shall be entitled to recover from any insurer the amount of any unpaid premiums lawfully payable by such insurer to the Commission or its delegated agent.

(b) No action or proceeding brought under this section may be brought for any amount in excess of that lawfully payable by any insurer to the Commission or its delegated agent and any such action shall be brought within five years of when the right to such payment accrued, except [provided] where any false or fraudulent conduct warrants, the claim shall not be deemed to have accrued until its discovery.

(c) Any recovery had pursuant to any action or proceeding under this section shall be deposited to the credit of the reinsurance fund created under this title.

EXHIBIT 2

MICA insurance story corrected

I would like to correct some statements purportedly made by me as reported in your article "Insurance Costs Soar" (Sept. 15). To begin with, the Medical Indemnity Corporation of Alaska is not "in serious financial trouble" as the Daily News reported. MICA is concerned (as are all other insurers in Alaska) with soaring claims frequency and claims cost, as well as dramatically escalating reinsurance premiums. Those factors simply and clearly translate into higher premium costs to our policyholders. I hoped to convey to your reporter that unless those issues were squarely addressed when all of MICA's policies were renewed, we clearly could be in serious financial trouble. However, that financial trouble does not exist at this time and we intend to take the necessary fiscally sound steps to ensure that it does not occur.

The article further suggested MICA's cash or surplus funds have been drained to "low levels." Again, a mis-statement. That statement might be accurate if we do not get the necessary rate increases at the end of the year.

I point out that MICA's reports to the state show our policyholder surplus funds were minimally impacted in 1984. However, actuarial predictions are that without premium increases in 1986, our assets (i.e. policyholder surplus funds) will be substantially reduced. The policyholder surplus provides a cushion to absorb unexpected and substantial loss or reinsurance payments in excess of our yearly earned premium and investment income.

— Art Stanford

Anch Daily News
10-2-85

Publication: Value Line

EXHIBIT 3

INSURANCE (PROPERTY/CASUALTY)

The property/casualty insurance group started 1985 with a mixture of earnings reports that ranged from surprisingly poor to surprisingly good. But generally speaking, the stocks of these companies retain Wall Street's favor, as investors look forward to a strong recovery for this industry.

Indeed, this recovery does seem to be at hand, given the sellers' market in most lines of commercial insurance. Experience will vary widely among insurers, however. This is especially true in light of the fact that *personal* auto insurance seems to have gone off course. Moral of the story: Be selective. We favor the stocks of *Progressive Corp.* and *St. Paul Cos.* for year-ahead relative market performance.

As for the longer term, it remains our view that investors should keep an eye on legislative and judicial developments.

The Price Is Right

While March-quarter earnings reports ran the gamut, most fell in the mediocre-to-poor category. In all cases, this at least partly reflects the lingering effects of prior years' commercial price wars. These wars were fostered by the high-interest-rate environment of the late Seventies and early Eighties, as insurers abandoned their concern for underwriting profitability in a rush to garner investable premium dollars.

The pendulum started to swing again in mid-1984, however. Inadequate prices had combined with high claims frequency (particularly in the liability lines) to produce record underwriting losses, and investment income was no longer a sufficient offset. So insurers began moving aggressively to raise prices, and this trend has been steadily accelerating. Prices on standard commercial coverages are, in many cases, 40%-60% higher than they were a year ago. In especially troubled lines such as professional liability, prices double year-ago levels aren't unheard of. Tighter underwriting standards are also in effect, and some undesirable business has been left homeless as a result.

Higher insurance prices have translated into higher stock prices, as can be readily seen by comparing the prices of P/C insurance equities with those which prevailed in mid-1984. *Chubb Corp.* gave the group an extra push in April with its surprisingly-strong earnings report, which Wall Street apparently viewed as a taste of things to come. The fact that this spurred a rally despite lackluster reports from other P/C insurers indicates to us that the recovery psychology is firmly entrenched among investors.

Several insurers have seized the opportunity to raise capital at favorable prices. *Chubb Corp., Continental Corp.* and *USF&G Corp.* have all offered equity this year, and *St. Paul Cos.* has sold convertible debentures. *Orion Capital* and *Progressive* are joining this group.

It's important to note that although all insurers are enjoying higher prices for their commercial coverages, recovery prospects are very much a function of a given company's business mix. Consequently, investors considering commitments in this group of stocks must scrutinize individual company reports with care. Also remember that, regardless of pricing patterns, these companies are in the business of assuming risk. A negative surprise, such as a natural disaster or a major industrial accident, could trip up earnings recoveries. Insurance stock investors must be ready to ride out such disappointments. We discuss yet another reason for caution in the next section.

INDUSTRY TIMELINESS: 72 (of 91)

Personal Auto Insurance: A Wreck?

GEICO, which had posted sustained underwriting profits and earnings growth throughout the prolonged property/casualty downturn, gave Wall Street a start by reporting an underwriting loss and an earnings decline in the March quarter. The company complains of rising auto claims frequency and severity, which has rendered its present pricing structure inadequate. Similar problems are evident at other companies with a large exposure to personal auto, for example, *SRI Corp.* and *SAFECO.*

This trend isn't uniform; claims patterns in the P/C industry never are. *Ohio Casualty*, for example, reports *declining* claims frequency. But it's clear that personal auto insurance is under considerable pressure at present. Reasons for this include rising litigation activity and larger court-awarded damages. Policy prices won't catch up to the claims problem for at least several months.

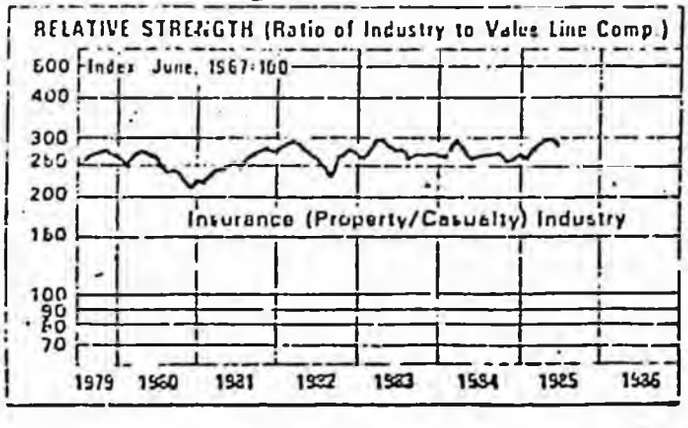
The Legal Environment

We have just alluded to the problem of social inflation, the growing number and size of damages awarded in lawsuits. This problem has led insurers to tighten up on policy terms, raise prices dramatically in liability lines and, in some cases, withdraw from certain classes of business altogether; medical malpractice insurance is a case in point. How legislators answer industry pleas for judicial reform may well be an important determinant of the shape of the insurance business over the years ahead.

President Reagan's tax reform proposals include a complex mechanism that, in essence, would require P/C insurers to account for the time value of money when subtracting loss reserve provisions from taxable income. In other words, they would have to recognize investment income that will be earned on loss reserves between the time when they are established and the time when they are paid out. It is entirely possible that some sort of legislation on this point will eventually be passed, raising the industry's taxable income. But under current market conditions, at least some of the burden could probably be passed through to customers. The effects of such a law would be further mitigated by loss carryforwards which most of these companies are accumulating.

Investment Advice

We think that taxation and legal issues will take a back seat to immediate profitability concerns in terms of influencing stock price action in this group over the next six to twelve months. We recommend, therefore, that purchases of P/C stocks be confined to predominantly commercial insurers, given the current turmoil in personal auto. *Progressive* is a timely exception to this guideline, however. *St. Paul Cos.* is also likely to outpace the year-ahead market averages. *R.W.F./H.S.K.*



losses were estimated at $40 million.

Damage in New Jersey was estimated at $25 million, while losses in Rhode Island were reported at $20 million.

In both North Carolina and Virginia, insured property damage was estimated at $10 million, while losses of $5 million were reported in Maryland, Pennsylvania and Maine. Insured damage in Delaware was estimated at $3 million. New Hampshire and Vermont each showed insured losses of $2 million.

In addition, insured damage to vehicles and boats in the 13-state area was estimated at $28 million.

The estimate of insured property damage does not include flood losses covered by the National Flood Insurance Program.

Hurricane Gloria was assigned Catastrophe Number 82 by Property Claim Services. The insurance industry designates an event a catastrophe when the insured loss is expected to exceed $5 million.

• • •

NAII sets program for Chicago meeting

DES PLAINES, IL — The outlook for state insurance regulation, the national economy, and current trends in insurance management will be among the major topics when the National Association of Independent Insurers holds its 40th annual meeting November 10-14 in Chicago.

An estimated 1,600 persons are expected to attend the meeting at the Hyatt Regency Hotel.

In announcing the program for the NAII's anniversary meeting, NAII President Lowell R. Beck said that speakers will include John Naisbitt and Patricia Aburdene of the Naisbitt Group, co-authors of *Re-Inventing the Corporation*; Sam Donaldson, chief White House correspondent for ABC News; U.S. Senator Alan K. Simpson of Wyoming, senate majority whip; Commissioner Bruce W. Foudree of Iowa, president of the National Association of Insurance Commissioners, and Louis Rukeyser, host of television's "Wall Street Week."

Isom to speak

Also among the program participants will be Gerald A. Isom, president and chief executive officer of Transamerica Insurance Company, Los Angeles; Frank J. Barrett, vice chairman, president and chief executive officer of the Central National Insurance Company, Omaha; and Barbara Stewart, president of Stewart Economics, Inc.

NAII Chairman Bradford W. Mitchell, chairman, president and chief executive officer of the Harleysville Mutual, will preside at the business sessions.

A reception for all convention registrants is scheduled for the evening of November 11, and the meeting will conclude with the banquet and program of entertainment, which will feature Melissa Manchester.

• • •

D'Auria joins IIAA in educational post

NEW YORK — Patrick E. D'Auria has joined the Independent Insurance Agents of America as assistant director of education, IIAA Executive Vice President Jeffrey M. Yates has announced.

D'Auria will be involved in all aspects of the association's membership educational programs. He will prepare educational materials, conduct seminars, and work with IIAA's state associations to help implement the wide variety of educational programs now available to Big "I" members countrywide.

D'Auria has more than ten years of educational experience as a high school teacher, counsellor, and administrator. Additionally, he has conducted a number of training programs for agency personnel and was an independent agent for three years.

D'Auria received a B.A. in education from Saint Thomas Aquinas College in Rockland County, N.Y. He also has attended the Fairfield (CT) University Graduate School of Education.

Publication: Insurance Week

EDITORIAL COMMENT

Ever the optimist

Experts are beginning to temper predictions of tremendous shortfalls in insurance capacity partially due to unprecedented infusion of new capital. This, of course, in part stems from the unprecedented need to shore up diminished surpluses.

Nevertheless, in spite of gloomy forecasts of continuing property and casualty insurance underwriting losses, in some ways the prospect for profitable results has never been better. Impressed by the poor operating results for insurers in 1984, which have been abundantly documented, both regulators and insureds are convinced of the need for higher premiums.

The calamitous rate war is over and the newer problem of finding somebody to write the risk at any price has arrived.

For those insurers ready to return to the business of underwriting there has never been more good business available at a potentially profitable rate. For investors the need for more property/casualty capital may be a rare opportunity.

Although there are many experts predicting sad days ahead for insurers, there are definite signs that this resilient business may bounce back quicker and higher than ever before.

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Headed back

Long road to profit foreseen by Spellman in address to CAIIA

By RON GILLMEISTER

OAKLAND — The insurance industry is turning the corner this year, according to J. Stephen (Steve) Spellman, western regional vice president of the Insurance Services Office, San Francisco. Speaking at the 38th annual meeting of the California Association of Independent Insurance Adjusters at the Hyatt Regency Hotel here October 2-3, he said that the insurance industry "has a long way to go to restore profitability to our industry." He predicted that the capacity crunch would get worse in the next two years with probable additional rate increases of from 30-35% in commercial lines in the next two years.

"This year is clearly the year the market turned," he stated. "We have hit the bottom and are headed back up. The results this year are going to be better than the results last year but unfortunately they are not going to be a lot better.

"The hole the industry dug for itself in the last five years is very deep," Spellman added. "What does ISO think the results are going to be in 1985? Premiums are way up . . . in the first half of this year, premiums are up 18%. If we project that for the whole year . . . we expect we will be writing $140 billion in 1985. This compares to writings of $118.5 billion in 1984. He indicated losses also are up. Last year's loss ratio was 116%; he continued, ". . . this year we think there will be an improvement. We think it will be somewhere between 116 and 117%. So we're headed in the right direction for the first time in five years."

Regarding the capacity crunch, Spellman said it was bad this year but would be worse in 1986 and still worse in 1987. He indicated the capacity shortage would reach $62 billion this year with 90% of the shortage in commercial lines. He added that the industry would be unable to "serve the needs of 25% of the commercial lines market in 1987."

He did say ISO was modifing its shortage projection because more capital was being funneled into the industry. He said ISO had indicated only $1.5 billion would be invested in 1985 but already the rate has hit $5 billion for the year. He felt that despite the added capital there would still be a shortage of capacity.

In for criticism

"Whether its 25%, 20% or 15%," he stated, "we're going to be facing a serious problem of capacity shortage in 1955, 1986 and 1987. We're going to be in for a lot of criticism. We're going to be in for a lot of regulation from regulators and legislatures.

He said the problem of under-reserving also was going to get worse. He said in 1982 an ISO study indicated companies were under-reserved by 10% and it was "a lot more than 10% today." He added, "The worst is over . . . 1985 will be a better year but it won't be great." He said premiums were up 30-35% this year and would go up another 30-35% in 1986 and 1987.

Spellman told the adjusters that the ISO is owned and operated by 1300 property and casualty insurance companies. "Basically we provide four services," he said. "We're the largest statistical agent in the insurance industry . . . making up the largest data base of insurance experience that exists in the country." His office also makes advisory rates and develops, publishes and distributes commercial and personal lines manuals. It also develops standard forms.

Property forms revised

He said ISO was rewriting four property forms — commercial property (glass & fire), crime, inland marine and boiler and machinery in addition to the new claims made commercial general liability policy.

In separate talks both attorney William L. Garrett of Silveira, Garrett, Goul, Curry & Mattos, Merced, and Bob Naylor, Republican assemblyman from the San Mateo 20th district, took swipes at the liberal state supreme court. Naylor called for a "no" vote against Chief Justice Rose Bird and the other two liberal justices who are up for confirmation by the voters in 1986. He said the judges are blocking both legislative and initiative processes. He is a candidate for the U.S. senate seat currently filled by Alan Cranston.

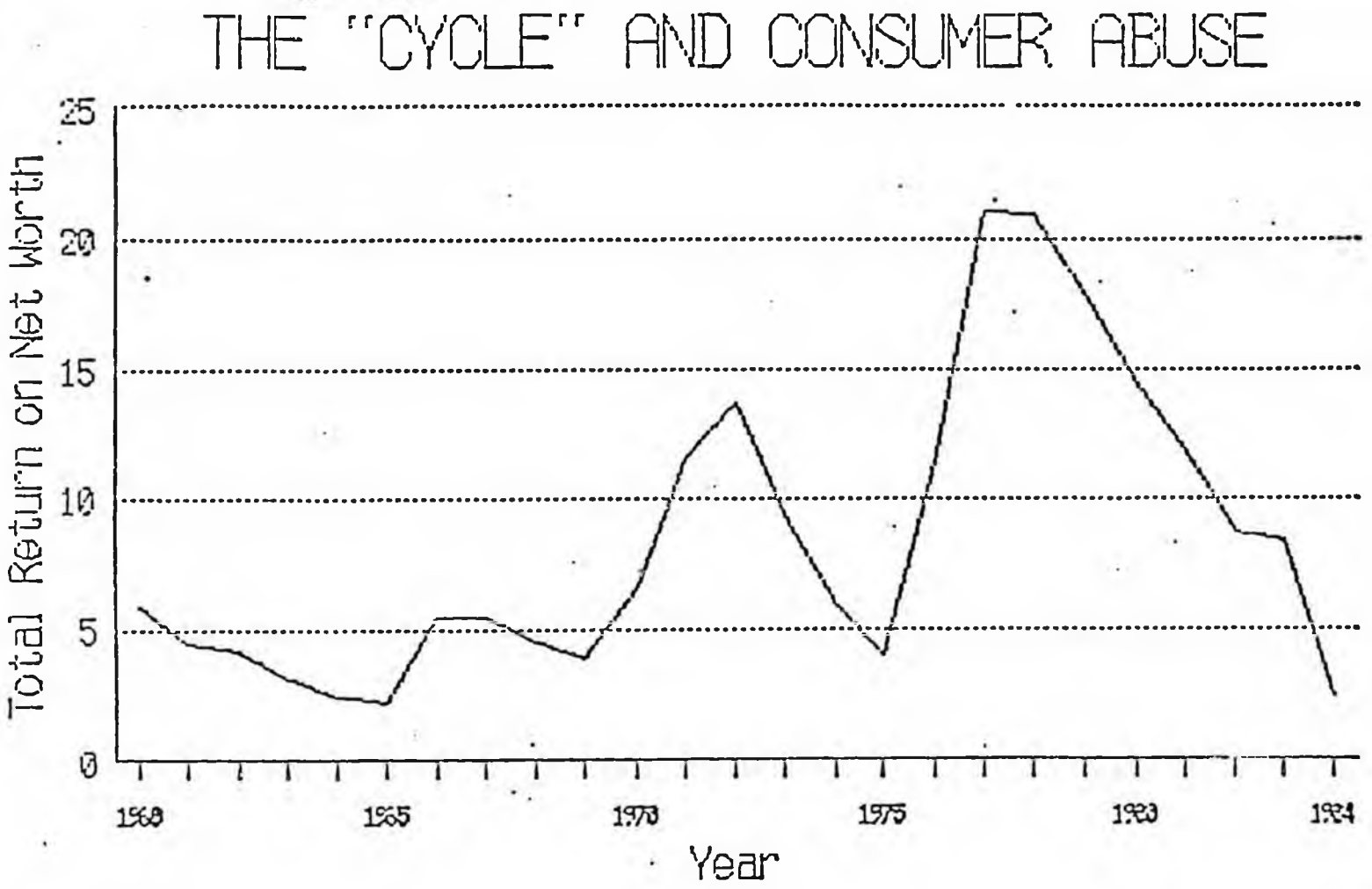
Garrett expressed concern over the judicial activism of the state supreme court and the state courts of appeal. He said "law is too important to be left to lawyers and judges" and said the activity of the courts was "anti-democratic" because they make changes in the law without input from affected parties and they are not accountable for their actions. He discussed both "Cumis and Bogard" and their impact on the industry.

Rounding out the convention was Paul Kayfetz, engineering photographer, Bolinas, California, who showed films and described the use of photographic and optical techniques in making measurements, developing information and demonstrating physical relationships.

STATE FARM TO RAISE WASH. AUTO RATES

BLOOMINGTON, IL — State Farm Mutual will raise auto insurance rates in Washington an overall average of 10% effective November 1. Changes will vary by coverage and risk classification.

EXHIBIT 4



SOURCE: Citybank Economics and Insurance Services Office.

EXHIBIT 5

Aviation accidents

THIS HASN'T BEEN the best of years in Alaska from the standpoint of the number of violent deaths recorded. There have been far too many tragic accidents involving automobiles, off-road vehicles, boats and airplanes. Especially airplanes. This is a flying country and death is no newcomer on the aviation scene in the 49th State.

But this year has been particularly bad, as new statistics from the National Transportation Safety Board attest. The shocking word is that the number of people killed in Alaska air crashes climbed by more than 60 percent. That includes a more than two-fold increase in deaths involving commercial carriers.

IN THE LAST year, 60 people died in 212 air accidents compared to 37 deaths in 195 crashes the year before. Twenty-four of those 60 deaths occurred on commuter or air taxi flights, compared to 10 the year before.

What's the cause?

The head of the NTSB in Alaska, Jim Michelangelo, is rather blunt in his assessment of the rise in fatalities in commercial accidents. He places the blame on carriers taking chances to make up for losses in 1984, which he says was an economically slow year for a number of in-state operators.

Well, maybe so. But we trust there are ways to police the commercial operators to make sure the public is protected.

THERE IS a special concern about the sharp rise in fatalities among private pilots. What's to be done about that is more difficult to address, as far as we can tell.

Safety lectures drill pilots during their training days. They hear over and over again, in a thousand different ways, repeated warnings about how to do things properly.

But accidents happen. And as the population grows, so too — sad to say — will air mishaps. Like automobile accidents, the number seems to rise in direct proportion to the population. In both cases, only one phrase, repeated over and over again, may help. Think safety. Think safety. Think safety.

Anchorage Times, October 17, 1985

Alaska air carrier fatalities on increase

Officials fear passenger, pilot safety may take back seat to economics

By LARRY CAMPBELL
Daily News reporter

The number of people killed in Alaska air crashes rose by more than 60 percent in the past year, including a more than two-fold increase in deaths involving commercial carriers, according to the National Transportation Safety Board.

And federal officials believe the rates are up because in-state commercial carriers are letting economic conditions override safety considerations.

Figures from the safety board's Anchorage field office show that 60 people died in air accidents during the past year, compared to 37 the year before. Of those, 24 people lost their lives on commuter and air taxi flights, compared to 10 commercial flight deaths the previous year.

The safety board keeps records according to its fiscal year, which begins Oct. 1 and ends Sept. 30.

The figures also show the total number of accidents increased slightly, to 212 from 195. During the same period, general aviation accounted for fewer accidents, 158 compared to 167, but commercial carrier accidents nearly doubled, to 54 from 28. No major airlines were involved in incidents this year.

The new statistics indicate that what might have appeared as a trend toward a stabilization in accident and death rates has now taken a dramatic turnaround, especially among fly-for-hire operations.

"I think we saw the numbers down last year because there was just a lot less traffic, anyway," said Jim Michelangelo, chief of the safety board in Alaska. "Of the carriers we've talked to, they said that people weren't flying as much then. It takes a lot of money to fly up here from the Lower 48 and go out to bag a moose, or whatever, and people weren't spending it last year.

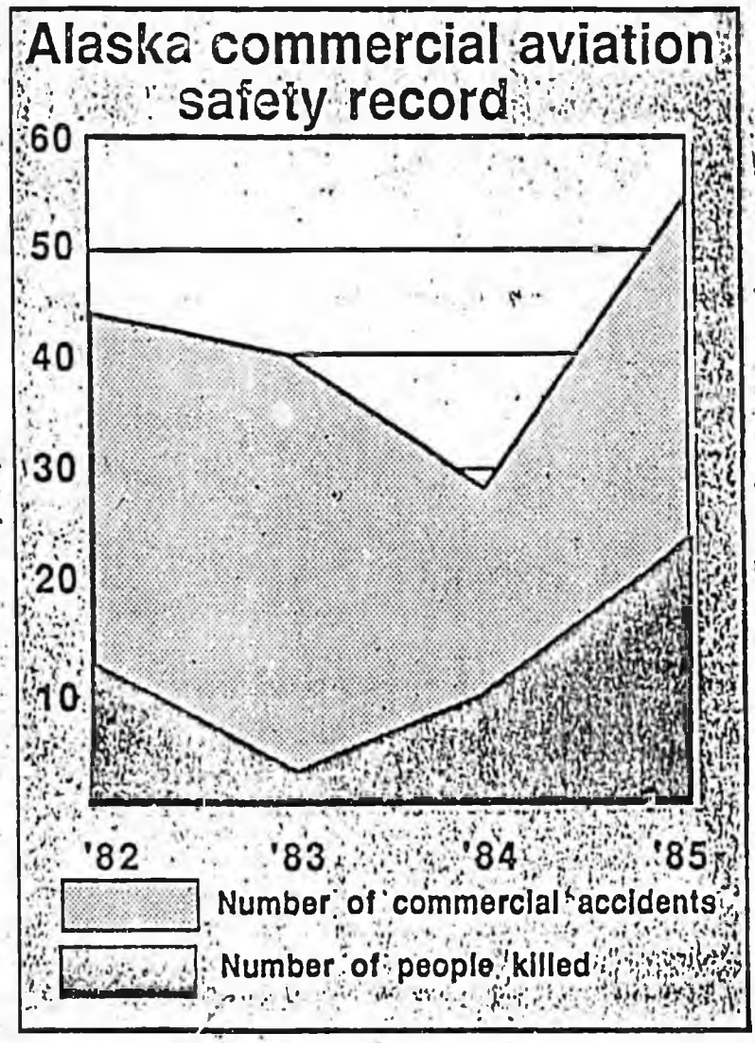
"In '85, we think a lot of carriers may have been saying, 'Let's take a chance and see if we can make up for last year.' "

Michelangelo says his accident reports back up his theories that more pilots, including commuter and air taxi operators, decided to take chances during the past year.

"Of the (accidents) that we've investigated, the majority were because guys just took off and ignored everything," he said, including such things as aircraft airworthiness, weather conditions, proper aircraft loading, airstrip conditions and other problems that probably should have grounded flights.

Finding answers to stem the increase in accidents and deaths is the responsibility of the Federal Aviation Administration. That agency is finding that it may be dealing with a problem of too many air carriers fighting for too few customers. Common sense among the carriers took the back seat, some believe.

See Page C-3, ALASKA



Source: National Transportation Safety Board; Daily News chart

Passengers urged to think about air safety

With the number of deaths in small commercial airline accidents more than doubling this past year, some federal and private industry officials are now saying that the person buying the ride must assume some responsibility for air safety.

More commuter and air taxi operators are taking potentially fatal gambles in the air in an effort to remain financially aloft, officials say. And as federal inspectors and private industry try to combat that problem, the public must begin to take extra care of itself.

"It's the situation where a customer comes in and you say you won't fly because the weather's

See Page C-3, PASSENGERS

Anchorage Daily News, October 11, 1985

Passengers

Continued from Page C-1

too bad. Then you watch him walk down the road and go to your competitor," said Grant Thompson, vice president and general manager of Cape Smyth Air Service in Barrow. "That hurts. But you just have to bite your lip and go about your business."

The pilot who flies when others won't is taking a risk not worth the payoff, but it happens, said Steve Wilbur, of Wilbur's Flight Service and president of the Alaska Air Carriers Association. He says that pressure from customers combines with skyrocketing business costs to sometimes push companies into dangerous situations.

"I doubt seriously that there is one carrier that could not afford to lose just one trip," Wilbur said. "But the problem is that if you lose that one customer — say a survey company that needs to get to a site — you've probably lost him forever. He'll never come back, and that could be a big loss."

Ther are currently more than 250 commuter and air taxi companies scattered throughout the state. While that number hasn't fluctuated much since the boom traffic era a few years ago, there is less business to support them, said Federal Aviation Administration spokesman Paul Steucke.

"What passengers have to realize is that you don't want to push the pilot and the company," Steucke said. "If a pilot says he can't take you because it's unsafe, maybe you shouldn't walk down the street to the next carrier.

"In today's world, passengers would be wise to assume more responsibility than just paying for a ticket."

Alaska air carrier crash deaths on increase

Continued from Page C-1

"One thing we've noticed recently is that operators have expressed difficulties in maintaining a business," said FAA spokesman Paul Steucke. "The boom situation of a few years ago when there were lots of customers isn't there anymore. And it may be having an effect on companies — the care of aircraft, the way they fly and under what conditions."

While federal officials bemoan the figures, however, private commercial pilots say they think the total numbers don't tell the entire story, according to Steve Wilbur, president of the Alaska Air Carriers Association.

"What neither agency can tell you adequately is the number of flying hours on the whole," Wilbur said. "We're concerned about the rise in accidents as well, but we don't think just looking at the numbers tells us what's really happening, where it's happening."

The association, through its Alaska Aviation Safety Foundation, will soon begin to compile that kind of statistics, Wilbur said.

"We need evidence to put us in the right direction. When we have that, we'll be able to tell exactly what problems are and where they're happening. Then we'll be able to find real solutions," Wilbur said.

The foundation also is distributing safety literature and video tapes for distribution to pilots statewide through a program it began last year.

Both federal officials and private operators agree that final responsibility for aircraft safety sits with the lot. But they agree that it w be difficult to ensure th pilots observe safety regu tions.

Wilbur says that what needed is not more regu tions, but more FAA insp tors touring the entire sta making it known to outlyi operators that they will scrutinized. He would al like to see more pilots, p vate and professional, ta advantage of regular traini sessions such as the FAA a nual safety clin : schedul for Oct. 19 and 20.

"The bottom line is the gu in the left seat," Wilbur sai "If he hasn't remembere what he's learned, he's goi to bust an airplane.

"That's a problem of att tude. And I'm not sure th anyone knows how to de effectively with that yet."

EXHIBIT 6

11. Editors, "Capitation: Stranglehold on Pharmacy," *National Association of Retail Druggists Journal* 103 (July 1981): 35–41.
12. See Note 1, supra.
13. HCFA derives its authority to grant waivers from the amendments to the Social Security Act. Section 1115 of the Act deals specifically with demonstration projects and the waiver outlined in this section has thus become known as an 1115 waiver.
14. HCFA never formally or informally notified the DSS (or UI) before, during, or after the pilot study that administrative waivers were required, though it was aware of the pilot study.
15. DSS committed to the expanded project during its planning stage, but the implementation took place under another commissioner. In addition, other changes occurred in key posts within the department, and commitment and assurances had to be obtained again.
16. After the capitation experiment was in operation for a few months, the DSS Commissioner asked the System Development Corporation, the Medicaid fiscal intermediary, for an assessment of what capitation was costing or saving the state. SDC responded that despite the administrative cost overruns, the plan was saving money. However, one must consider a possible bias towards this conclusion, since the company profited by these additional administrative expenses and had a self-interest in perpetuating the program in its current form. Two other reports on the financial status of the experiment were received—one from the DSS staff and the other from the UI. The findings of both these reports conflicted with the SDC report.
17. DSS suggests that the early termination was due to financial problems exclusively. Others, including members of CIP, feel that their lobbying efforts moved the influential legislator to apply political pressure to DSS to terminate the project. As mentioned above, this occurred at a time when DSS was in the process of requesting supplemental appropriations from the state legislature.
18. D. Campbell and J. Stanley, *Experimental and Quasi-Experimental Designs for Research* (Chicago: Rand McNally, 1963).
19. R. S. Hanft, "Use of Social Science Data for Policy Analysis and Policy-Making," *Milbank Memorial Fund Quarterly/Health and Society* 59 (Winter 1981): 596–613.
20. P. Rossi and H. Freeman, *Evaluation: A Systematic Approach* (Beverly Hills: Sage Publications, 1982).
21. A. Kaluzny and J. Veney *Health Service Organizations: A Guide to Research and Assessment* (Berkeley: McCutchan Publishing, 1980); J. McKinlay, ed., *Research Methods in Health Care* (New York: Prodist, 1973); D. Campbell and J. Stanley, *Experimental and Quasi-Experimental Designs for Research* (Chicago: Rand McNally, 1963); P. Rossi and H. Freeman, *Evaluation: A Systematic Approach* (Beverly Hills: Sage Publications, 1982).
22. H. Freeman et al., "Social Experiments," *Milbank Memorial Fund Quarterly/Health and Society* 59 (No.3, 1981): 340–373.

State Responses to the Malpractice Insurance "Crisis" of the 1970s: An Empirical Assessment

Frank A. Sloan, Vanderbilt University

Abstract. Almost all states enacted legislation in response to the rapid rise in malpractice insurance premiums which occurred during the mid-1970s. After describing the types of statutory changes enacted, this study evaluates the influence of these changes on levels and growth of premiums paid by general practitioners, ophthalmologists, and orthopedic surgeons during 1974–78. The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, had their intended effects on premiums. Several explanations for this result are explored.

The medical malpractice "crisis" of the mid-1970s involved both a dramatic increase in premiums, and a reluctance on the part of many companies to write medical malpractice insurance policies. From 1974 to 1977, malpractice premiums almost doubled, following several years of relative calm.[1] The increased premiums were perceived by the public and their elected representatives as potential sources of medical care cost inflation; and it was feared that nonavailability of coverage might lead to nonavailability of certain types of needed medical services. As a result, virtually all states took some type of legislative action to ensure the availability of malpractice insurance at a reasonable price.[2] With isolated exceptions,[3] both the rate of premium inflation and availability problems have largely abated since this period of crisis.[4] Yet some observers have predicted that the late 1970s and early 1980s have been only a temporary calm before another storm.[5]

There is substantial variation in malpractice insurance premiums—among physician specialties and across states, as well as over time. In the mid-1970s, premiums in a high-risk specialty, orthopedic surgery, were about six times as great as those for the lowest-risk ("Class 1") specialists, including pediatricians and general practitioners who do no surgery.[6] The reason for such interspecialty variation in premiums is reasonably well understood: claims against physicians in surgical subspecialties in particular are much more frequent than in fields without a hospital orientation, such as general/family medicine and pediatrics.[7]

Partial support for this study came from contract #500-78-0018 between the U.S. Health Care Financing Administration and Vanderbilt University. The views expressed here are the author's, and do not necessarily reflect the view of either organization. The author is grateful to Nanette Fancher and Robert Hays for assistance in this research.

Journal of Health Politics, Policy and Law, Vol. 9, No. 4, Winter 1985.

Sources of interstate (and intertemporal) variation are much more complex. As an illustration of interstate variation in premiums within a specialty, premiums paid by orthopedic surgeons in 1974 varied from a high of $8,352 (in New York) to a low of $479 (in North Carolina), a more than seventeen-fold difference.[8] As will be discussed more fully below, the correlations in premiums paid for standard coverage levels by physicians in various specialties within a state are high, as are correlations among annual changes in premiums by specialty. Thus essentially the same degree of interspecialty and interstate dispersion has been preserved since 1974.

To date, no one has isolated the effects of specific legislative actions on either the price or availability of malpractice insurance. Statutory changes potentially affect the frequency of claims, the likelihood of judicial determination in favor of the plaintiff, and the size distribution of settlements. Expected payouts of insurers, as well as projected administrative costs and profit margins, are in turn reflected in premiums.[9] Thus, by affecting elements of expected payouts, statutory changes could have reduced premiums directly. Alternatively, the publicity effect surrounding legislative activity may have caused the public (and, for that matter, juries) to become more cost-conscious, when in fact the direct constraining impact of the laws themselves was rather minimal. Or the legislative initiatives may have unintentionally fooled insurers, by creating anticipations that both the frequency and magnitude of settlements would decrease when in fact these were not to occur.

The next two sections provide some pertinent conceptual and empirical background information on the malpractice insurance crisis of the mid-1970s, and describe specific legislative responses to the crisis at the state level. Empirical specification of premium regressions designed to assess the effects of these legislative responses, and explanation of empirical results obtained from this procedure, are provided in the third section, followed by a brief discussion of implications.

Background

Concepts. Insurers set premiums (P) to cover expected benefit payments (B) and administrative expense (A):

$$P = B + A . \tag{1}$$

Benefits payments can be expressed as the product of the number of claims (C), the probability of a decision favorable to the plaintiff (Q), and the mean dollar settlement if the plaintiff wins (X):

$$B = CQX . \tag{2}$$

Administrative expense consists of legal expenditures on behalf of medical defendants, other administrative expense (A_O), such as for marketing, and profit (π):

$$A = CY + A_O(N) + \pi , \tag{3}$$

where Y is the legal expense incurred by the insurer per claim, and N is the number of enrollees. To simplify, let $A^* = A_O(N) + \pi$, where A^* is a constant. This simplifying analytical assumption is justified since increased expense and profit rates are not generally considered to be reasons for the rise in malpractice insurance. Then, substituting (2) and (3) into (1), the premium equation becomes

$$P = C(QX + Y) + A^* . \tag{4}$$

Totally differentiating (4), it is apparent that the change in premiums depends on changes in the number of claims, in the probability of the plaintiff winning, in the insurer's legal cost per claim, and interactions among these changes, as well as changes in premium pricing policy as reflected in any change in A^*.

The number of claims filed by unsatisfied patients in a given state and year plausibly reflects the expected settlement net of legal fees ($QX - F$), patient relationships with physicians, and characteristics of such patients—including their degree of aversion to risk and to litigation. Legal fees per case depend, inter alia, on the number of lawyers per capita population. The probability of the plaintiff winning (Q) and the mean settlement size (X) would logically depend on the nature and extent of the iatrogenic injury, the defendant's conformance with medical standards in his/her local community, and characteristics of laws regarding malpractice in the state. Litigation (and presumably iatrogenic injury) is more likely when a surgical procedure has been performed. Apparently X also depends on patient income: patients with high opportunity costs of time have been found to obtain higher settlements, holding other factors constant.[10] But to the extent that affluent persons demand care from higher-quality doctors, Q should be lower. Thus, the effect of time cost—or its proxy, income per capita—on QX cannot be determined in advance of empirical research.

This brief discussion implies that empirical analysis should describe the type of medical procedures performed, variables from the lawyer's market pertinent to fee-setting, and patient characteristics (including income), as well as the legal environment. Ideally, one would also want to understand insurer pricing policy (which, in part, reflects elements of A^*), and how insurer expectations of future benefit outlays are formed. The latter phenomena, however, are difficult to measure empirically.

Previous empirical studies. Two published studies by economists have examined interstate variations in premiums and frequency of malpractice incidents. Using regression analysis, with states as observational units for years 1970 and 1972, Reder related the malpractice premium paid by surgeons to four explanatory variables: (1) operations per surgeon; (2) nonfederal attorneys per capita population; (3) number of "key doctrines" favorable to plaintiff adopted by the state; and (4) state per capita income.[11] Only two of the four independent variables showed statistically significant impacts on premiums: per capita income and legal doctrines. The positive effect of per capita income suggests that the effect of any tendency for higher-income persons to select higher-quality doctors is more than offset by a combination of effects of patient income on settlement size and on the propensity to sue.

Feldman assessed state differences in the number of malpractice incidents per 1,000 state population in 1970.[12] He included as explanatory variables surgical operations per 1,000 population, per capita income, lawyers' earnings, variables representing ten legal doctrines bearing on the processing or outcome of malpractice cases,[13] and (in one regression) a measure of defensive medicine. He found that the number of incidents rises with increases in surgical operations and in income, and falls with increases in lawyers' earnings. He also found that the plaintiff's return net of the payment for legal fees ($QX - F$) falls with increases in the lawyer's wage.

A legal variable constructed as the sum of the ten individual binary variables showed that states with laws more favorable to plaintiffs have more suits, a finding consistent with Reder's analysis; however, when the individual legal variables were included as separate explanatory variables, Feldman obtained few statistically significant parameter estimates. Feldman also expected that "defensive medicine" would reduce the occurrence of malpractice claims. He measured this factor with a variable defined as the weighted average of office visits by Medicare patients which entailed laboratory tests, x-rays, and consultations with other physicians. Feldman's results suggest more definite roles for income, frequency of surgery, and lawyer price-availability than for either legal doctrines or "defensive medicine" as determinants of interstate variation in the number of malpractice suits. Characterizing the nature of tort law by state at a given point in time, in terms of its relative impacts on plaintiffs versus defendants, is extremely difficult, and measurement errors could partially account for the legal variables' insignificance. A more accurate picture may be obtained by relating changes in incidents or premiums to changes in laws.

Dynamic factors. Many of the potential determinants of temporal change in malpractice costs and insurance premiums are not captured by analysis of a single cross-section; and of the dynamic factors, many are common to all specialties and states: technological change in the health field; rising patient expectations about the efficiency of medical care; loss of close relationships between providers and patients due to the rise in physician specialization; increased litigiousness of society; changes in quality of medical care; changes in attitudes of juries; and (for premiums, though not for malpractice incidents) returns on insurers' investments.

There is no consensus about the origins of the mid-1970s crisis, or, for that matter, why it passed. The industry justified substantial premium increases on grounds that insurers were losing money at their then-current malpractice insurance rates. However, profitability not only depends on loss ratios, but also on returns on investment of insurer reserves.[14] Insurers suffered paper losses in the 1974-75 stock market, and this development may have been contributory. Critics of the insurance industry, such as Law and Polan, have stated that—with a few exceptions, such as New York and California—insurance companies in the mid-1970s acted on the basis of events having little to do with their local

situations. Law and Polan argued that the broad-scale panic was due at least in part to the actions of a single company, Argonaut, which had responded decisively to its adverse loss experience in several markets.[15] Rather than assessing their own situation, other companies simply panicked. According to this psychological view of the crisis, matters eventually settled down after time allowed more objective assessments of the situation. Others have attributed the end of the crisis to fear of countersuits and lack of lawyer familiarity with the new state malpractice statutes, which might have the effect of delaying the filing of suits, even if the statutes themselves had no long-term effects.[16]

State Legislative Responses

The crisis of the mid-1970s provided the impetus for numerous legislative proposals applying to actions alleging medical malpractice. Legislators assumed that, if new laws could reduce the number and dollar amounts of malpractice awards, insurers would be in a better position to predict recoveries, and therefore would maintain coverage at reasonable rates and assure availability of malpractice insurance. Statutory changes were quite narrowly focused on medical malpractice, and many of them were tested in the courts in the late 1970s and early 1980s.[17] This section briefly describes most of the major legislative changes, the effects of which are to be evaluated below. These legislative proposals may be classified into three general categories: tort modifications, alternatives to trial, and insurance provisions.

Tort modifications

Limiting provider payments to plaintiffs. Several states enacted laws placing a dollar maximum on the amount providers are required to pay in medical malpractice cases. A limitation on provider liability was often imposed in conjunction with a limitation on plaintiff recovery. A ceiling on either the provider's liability or plaintiff's recovery potentially shifts some costs of damages to plaintiffs. Conversely, to the extent that awards had been "excessive" heretofore, particularly for such subjective items as "pain and suffering," the savings accrue to physicians and the public at large. Although these laws potentially reduce premiums, they will be successful only to the degree that settlements would otherwise have exceeded the ceilings, and/or that the initiation of malpractice suits is discouraged by a decline in ($QX - F$). Unfortunately, data are not available for comparing the frequency distribution of settlements to the ceilings in states which enacted these limitations.

In some states, patient compensation funds have been established to pay plaintiffs for damages incurred above the statutorily-determined limit on provider liability. These funds are financed by adding a surcharge to each physician's

premium—a surcharge often set so as to subsidize the premiums of physicians in high-risk specialties. The main effect of such funds, if any, is likely to be on amounts of insurance (i.e., liability limits) purchased by physicians, rather than on the premium for a specific amount of coverage (such as a $100,000/$300,000 policy).

Limiting use of the res ipsa loquitur *doctrine*. The doctrine of *res ipsa loquitur* applies when a plaintiff can show (1) that the event only could have occurred as a result of negligence, (2) that harm was caused while the instrumentality causing the injury was exclusively controlled by the defendant, and (3) that the plaintiff did not contribute to the injury.[18] This doctrine may be useful to plaintiffs when, for lack of specific information, the plaintiff cannot develop a prima facie case against the defendant.

Courts in a number of states expanded applicability of the doctrine of *res ipsa* in the early 1970s.[19] Since 1975, this trend has been reversed: state legislation has delineated situations in which *res ipsa* can be applied (e.g., to foreign objects left in the body, or radiation burns); and in some states (e.g., Washington), the use of *res ipsa* in malpractice cases has been virtually eliminated. A study of medical malpractice claims reported that plaintiffs were slightly more likely to win when the *res ipsa* doctrine was used;[20] hence limiting use of *res ipsa* may have had some but probably not a dramatic effect on premiums.

Tightening the statute of limitations. Statutes of limitations have received considerable attention in discussions of medical malpractice insurance. One reason is the lengthy time-lag which often occurs between the date an injury occurs and the date the claim is first made. Time-lags are particularly problematic in this area since malpractice insurance has typically been sold on an "occurrence" basis—that is, the insurer protects the provider against any claim that may eventually arise from a litigatable "event" that occurred during the policy years. Insurers have maintained that the persistent threat of a suit compels them to maintain substantial reserves; in any case, rate-setting is made more difficult by the possibility of delayed suits.[21]

Furthermore, there is empirical evidence that claims filed five years after the injury are more than twice as expensive as the average award.[22] Thus late claims represent a substantial risk to the insurer, and one can expect a risk premium to be charged for indemnifying physicians against such claims. State legislatures modified existing statutes of limitations to establish definite, presumably shorter, periods during which a medical malpractice action must be brought. However, the new limits contain exceptions which, in conjunction with interpretations of state courts, could have important implications for the effectiveness of the new limits.[23]

Clarifying informed consent. The doctrine of informed consent requires that a provider disclose information pertinent to the nature, purpose, and risks associated with a proposed medical treatment. Unfortunately, while the doctrine's intent is clear, whether patients were in practice properly informed is difficult to

document. During the mid-1970s, many experts held that ambiguity created by this doctrine was in itself a source of litigation, and several states added precision to the doctrine of informed consent to insure uniform definition and application.

Imposing contingent-fee regulation. It is often argued by physicians and others that payment of lawyers on a contingent-fee basis for work on malpractice cases increases the total number of claims.[24] Assuming patients are risk-averse, a plausible assumption for plaintiffs in the aggregate, economic theory supports this assertion.[25] Unfortunately, there is no empirical evidence on whether or not the method of lawyer compensation has an independent effect on the frequency of suits or on settlement amounts. Since 1975, several legislatures have limited attorneys' fees in medical malpractice cases either by empowering state courts to determine reasonableness of attorneys' fees, by statutorily fixing a percentage ceiling for contingent fees, or by adopting a sliding scale which bases the contingency-fee percentage on the amount of recovery. The latter two approaches at least have the potential of reducing lawyers' incentives to accept malpractice cases; the first is weakened by courts' reluctance to interfere with the attorney–client relationship.[26]

Adding collateral-source provisions. The collateral-source rule makes it impossible for the court to apply benefits received by an injured party from sources other than the defendant as an offset to compensation due from the defendant. Hence a medical malpractice plaintiff may collect benefits from a variety of sources, the sum of which may be substantially in excess of damages incurred. A number of states enacted legislation during the mid-1970s to limit such duplication of payments. Two types of laws have been enacted. One type permits introduction of evidence of payments received from collateral sources, allowing the jury to consider such evidence in determining the defendant's obligation to the plaintiff; the other approach requires that there be an offset.[27] These changes have been controversial. Proponents of the collateral-source rule have argued that the rule preserves patients' incentive to purchase insurance, and that the reduction in defendants' liability may reduce the deterrent effect of liability.[28]

Eliminating the ad damnum *clause*. The *ad damnum* clause is part of the plaintiff's initial pleadings, stating the amount of monetary damage incurred and the settlement requested. Although the *ad damnum* clause may be seen as no more than the presentation of an initial asking price, it may influence the jury to award a larger settlement. More recent legislation eliminates *ad damnum*; but some laws now also require that the defendant be informed during pre-trial discovery of the precise amount of recovery sought by the plaintiff.[29]

Imposing a locality rule. Historically, health care providers have been expected to render care consistent with the general standard of care in their community. Because of improved communication and more uniform professional training, courts in many states have interpreted "community" quite broadly, encompassing regional if not national standards. There are two major reasons for dissatisfaction with this trend. First, many providers argue that this broad interpretation

leads to the use of "hired guns"—providers who specialize in testifying on the plaintiff's behalf. Second, adherence to regional and/or national norms may require that many physicians orient their practices to higher standards, which in turn results in more costly care. In response to this dissatisfaction, several states during the mid-1970s adopted rules requiring use of a local standard of care and/or of local expert witnesses.[30]

Alternatives to jury trial

Mandating use of a pretrial screening panel. During the mid-1970s, more than half of the state legislatures established pretrial screening panels to which cases must be submitted before they proceed to trial. Statutes vary substantially in terms of panel composition, procedural details, and admissibility of findings at subsequent trial. Virtually no other "reform" has elicited as much challenge in the courts as the concept of pretrial screening, principally because the panels are viewed as interfering with a plaintiff's right to a jury trial.[31]

Irrespective of the constitutional issues, there is some reason to believe that panels may not be effective in terms of reducing premiums. First, for any cases not settled during the pretrial hearing, and many are not, rather than substitute for the jury trial the panel adds another layer of proceedings. Second, although proceedings of the panels are less formal than a full-scale trial, substantial legal expenses may be incurred, especially in states where decisions of the panels are admissible at trial. Third, the existence of an informal and initially less expensive adjudication mechanism may in itself encourage the filing of claims.[32]

Allowing for binding arbitration. Binding arbitration differs from pretrial screening in that the decision of an arbitration board is final; unlike screening, arbitration is not followed by a jury trial. Proponents of arbitration argue that it reduces malpractice costs by resolving disputes in a less formal setting, through a panel of experts rather than a jury (which is both nonexpert and subject to emotionalism). These contentions are debatable.[33] Although, in principle, arbitration may be either compulsory or voluntary, no state to date has mandated compulsory arbitration, probably because of doubts about its constitutionality.[34]

Insurance provisions

Creating joint underwriting associations. Enabling legislation for the establishment of non-profit joint underwriting associations (JUAs) has been passed in the majority of states, but implemented in only a few. A JUA is a pooling arrangement composed of commercial liability insurers with business in the state. All JUA statutes require that premium rates be established on a self-sustaining basis: if losses occur, member companies may be assessed to cover the deficit. In some states, assessments may be recouped by subtracting the assessment due the state from the premium tax, or by instituting a surcharge on premiums paid by providers. JUA surpluses are to be used for premium reductions. Statutes normally expire two or three years after enactment; depending on state statute, the JUA may be the exclusive carrier, or may compete with others.[35] In some states where JUAs are monopolists, they have been subject to criticism by doctors for their high rates.[36] JUAs may be a better solution for the problem of malpractice insurance availability than for the cost problem.

Allowing formation of health care mutual insurance companies. A few states have recently enacted legislation authorizing creation of insurance companies owned and operated by associations of physicians. These firms assess physician members a one-time special charge (about one year's premium), which is refundable if the company succeeds.[37] Since these mutual companies are run by physicians, they presumably have a special incentive to control premium increases.

Empirical Specification and Results

Overview. The regression analysis presented here extends the work of Reder and Feldman.[38] It focuses on the role of legal variables during a period of rapid change in malpractice insurance premiums. The analysis is based on a time series of cross-sections covering the years 1974 through 1978, with the state as the observational unit. All continuous variables are expressed in logarithmic form; all binary variables enter linearly. Two alternative types of equations are specified: (1) premium levels, and (2) annual percentage change in premium levels. In the latter, the dependent variable is the difference in the logarithm of premiums in a given specialty between a year and the year immediately preceding it. This difference (multiplied by 100) yields a percentage change. When the premium equation is in difference form, the regressions span 1975–1978 (annual changes for 1974-75 through 1977-78). None of the previous studies have examined changes in premiums over time.

Dependent variables. The dependent variables refer to premiums paid by physicians in three fields—general practitioners who do no surgery, ophthalmologists, and orthopedic surgeons—deflated by a state price index that varies across states and over time (with 1967 = 1.0).[39] Premiums are defined for a policy offering $100,000/$300,000 coverage.[40]

Premiums for various specialties in a state are highly correlated: pair-wise correlations between general practitioners, ophthalmologists, and orthopedic surgeons based on these state data are all 0.92 or higher; correlations between annual percentage changes in premiums in the three fields are also high, all 0.91 or higher. These correlations imply either that all the physicians in a given state share the financial consequences of adverse experience of a few specialties, or that claim experiences among specialties within a state tend to move together. The former possibility is far more likely.

Table 1. Explanatory Variable Definitions, Means, and Standard Deviations

Variable Name	Definition	Mean	Std. Dev.
Y	Real per capita income	3717.0	503.0
OPSPOP	Surgical operations per 1,000 population	0.0812	0.0164
LAWPOP	Lawyers per 10,000 population	12.4	11.7
MDPOP	Patient care physicians per 10,000 population	13.0	4.4
LRECOV	Provider liability limited	0.18	0.38
LLIM	Recovery by plaintiff limited	0.23	0.42
PTCOMP	Patient compensation fund established	0.18	0.38
RESIPS	Use of *res ipsa loquitur* limited	0.22	0.41
ICON	Informed consent clarified	0.32	0.47
CONFEE	Contingency-fee regulation imposed	0.27	0.45
SLIM	Statute of limitations tightened	0.50	0.50
CSOUR	Collateral-source provisions added	0.24	0.43
ADDAM	*Ad damnum* clause eliminated	0.40	0.49
LOCAL	Locality rule imposed	0.22	0.41
SCREEN	Use of pretrial screening panels mandated	0.40	0.49
ARBIT	Binding arbitration provided	0.17	0.38
JUA	JUA major insurer in state	0.06	0.24
SELINS	Health care mutal insurance company implemented	0.08	0.28
T74	Year = 1974	0.19	0.39
T75	Year = 1975	0.20	0.40
T76	Year = 1976	0.20	0.40
T77	Year = 1977	0.20	0.40

Explanatory variables. The focus of the regression analysis is on the impacts of legislative changes on levels and rates of change in malpractice premiums. To isolate the impacts of legal influences on the dependent variables, it is necessary to consider the other possibly influential factors that were reviewed in the conceptual discussion above, such as patient income, availability of lawyers, and case-mix. The premium equations contain three control variables similar to those included by Reder and Feldman: per capita income (deflated by the state price index)—Y; surgical operations per 1,000 population—OPSPOP; and lawyers per 10,000 population—LAWPOP. In addition, the number of physicians primarily engaged in patient care (as opposed to administration, research, and/or teaching) per 10,000 state population—MDPOP—is included. Although a higher surgery rate may be expected to lead to a higher incidence of malpractice claims, a higher physician–population ratio may have the opposite effect, since patient access improves with increases in the physician–population ratio. More specifically, patients' office waiting time falls, and the length of time physicians spend with patients rises.[41] Thus, even if medically defined quality is not altered, patients may feel better about their doctors and thus be less prone to sue them.[42] As an alternative to MDPOP, a variable indicating physician availability in the specialty corresponding to the premium was entered as an explanatory variable; results were virtually identical to those shown below.

When premiums are expressed as levels, it is appropriate to control for the legal environment prior to the mid-1970s. Preliminary regressions contained a legal variable to describe the application of tort law by state, as constructed by Feldman, and, alternatively, a legal index based on parameter estimates from Feldman's regression (which had malpractice claims frequency as the dependent variable).[43] Neither legal variable showed a discernible impact on premiums once other explanatory variables were included, and both were dropped from the regressions without having a consistent effect on the parameter estimates on the remaining variables. Binary variables representing each state were added to account for omitted state effects on premiums.

Variables depicting legislative responses to the malpractice crisis of the mid-1970s are shown in boldface in Table 1.[44] The variables ordinarily assume the value 1 for the year a malpractice "reform" was enacted by the state legislature and for succeeding years, and are zero otherwise. There is, however, one exception: when a reform was subsequently overturned by judicial decision, the variable assumes the value zero in the year in which the decision was reached and thereafter. Correlations among the "legislative response" variables are almost always positive, and most often in the 0.2 to 0.4 range. The highest correlation, not surprisingly, is between limitation on recovery and the patient compensation fund (0.63).[45]

Finally, time variables *T74* through *T77* represent time-related effects common to all states. Several alternative specifications were explored in order to gauge the time-phasing of responses to recent legislation and other explanatory variables, all using premium levels as the dependent variable. In one, a lagged dependent variable was included (Koyck lag specification). Results from these regressions imply that around 90 percent of the response to a change in an explanatory variable takes place in the year following the change, quite a rapid response. Alternatively, explanatory variables for both the current *and* the preceding year were included in the same regression. The resulting parameter estimates were very unstable because of multicollinearity.

Empirical results

Regressions with premium levels as dependent variables are presented in Table 2. The first, second, and fourth regressions also contain individual state binary variables, not shown. The state binary variables should account for factors responsible for any continued interstate differences in real premiums that are not explained by the first set of explanatory variables (from *Y* through *MDPOP*).

If legislative changes were effective, legislative change variables should dem-

Table 2. Premium Level Regressions

Explanatory Variables	Dependent Variables: 1. General Practitioner Premium		2. Ophthalmologist Premium	
	Coeff.	S.E.	Coeff.	S.E.
Y	0.42	(0.66)	0.44	(0.70)
OPSPOP	1.016[c]	(0.60)	1.11[c]	(0.63)
LAWPOP	1.020	(0.80)	1.31	(0.85)
MDPOP	−0.22	(0.87)	−0.49	(0.93)
LRECOV	−0.080	(0.088)	−0.027	(0.093)
LLIM	0.046	(0.093)	0.046	(0.098)
PTCOMP	0.039	(0.10)	0.0005	(0.11)
RESIPS	0.001	(0.094)	−0.037	(0.010)
ICON	−0.009	(0.085)	0.046	(0.090)
CONFEE	−0.011	(0.100)	0.013	(0.11)
SLIM	−0.047	(0.072)	−0.020	(0.077)
CSOUR	0.012	(0.094)	0.038	(0.099)
ADDAM	0.10	(0.087)	0.079	(0.084)
LOCAL	0.18[b]	(0.08)	0.11	(0.089)
SCREEN	−0.19[a]	(0.07)	−0.19[a]	(0.071)
ARBIT	0.26[a]	(0.09)	0.29[a]	(0.096)
JUA	0.13	(0.11)	0.080	(0.12)
SELINS	0.16[c]	(0.09)	0.048	(0.098)
T74	−0.21	(0.17)	−0.13	(0.18)
T75	0.074	(0.14)	0.063	(0.15)
T76	0.09	(0.11)	0.077	(0.11)
T77	0.065	(0.061)	0.070	(0.065)
Constant	5.16		6.37	
	R^2 = 0.87		R^2 = 0.84	
	$F(69,166)$ = 16.4		$F(69,166)$ = 12.4	

a. Statistically significant at the 1% level (two tailed test).
b. Statistically significant at the 5% level (two-tailed test).
c. Statistically significant at the 10% level (two-tailed test).

onstrate negative effects on real premiums. But, as Table 2 shows, there are more positive than negative coefficients for the variables *LRECOV* through *SELINS*. The most consistently significant coefficients are for screening panels (*SCREEN*), arbitration (*ARBIT*), and, to a lesser extent, mutual insurance companies (*SELINS*). But of these, only the screening variable shows a negative impact on premiums.

The fact that the regression results are quite similar for the three specialties is not surprising, in view of the high simple correlations among premiums in the

Table 2, continued

Explanatory Variables	Dependent Variables: 3. Orthopedic Surgeon Premium*		4. Orthopedic Surgeon Premium	
	Coeff.	S.E.	Coeff.	S.E.
Y	0.28	(0.34)	0.51	(0.71)
OSPOP	−0.23	(0.44)	1.11[c]	(0.64)
LAWPOP	0.88[a]	(0.23)	1.04	(0.87)
MDPOP	0.25	(0.24)	0.17	(0.94)
LRECOV	0.019	(0.11)	−0.16	(0.09)
LLIM	0.11	(0.11)	0.024	(0.10)
PTCOMP	0.11	(0.12)	0.046	(0.11)
RESIPS	−0.088	(0.13)	0.052	(0.10)
ICON	0.28[a]	(0.11)	0.022	(0.091)
CONFEE	0.24[b]	(0.11)	−0.031	(0.11)
SLIM	0.016	(0.089)	0.0009	(0.078)
CSOUR	−0.15	(0.12)	−0.013	(0.10)
ADDAM	−0.15	(0.10)	0.13	(0.085)
LOCAL	0.069	(0.11)	0.093	(0.090)
SCREEN	−0.16[c]	(0.09)	−0.15[b]	(0.072)
ARBIT	0.25[a]	(0.10)	0.18[c]	(0.097)
JUA	−0.099	(0.16)	0.11	(0.12)
SELINS	0.31[b]	(0.14)	0.13	(0.10)
T74	–	(–)	−0.18	(0.18)
T75	–	(–)	0.15	(0.15)
T76	–	(–)	0.15	(0.11)
T77	–	(–)	0.090	(0.07)
Constant	4.69		6.63	
	R^2 = 0.36		R^2 = 0.86	
	$F(18,217)$ = 6.9		$F(69,166)$ = 14.6	

* Both time and state binary variables omitted from this regression.
a. Statistically significant at the 1% level (two-tailed test).
b. Statistically significant at the 5% level (two-tailed test).
c. Statistically significant at the 10% level (two-tailed test).

three specialties. The only one among the first set of explanatory variables (from *Y* to *MDPOP*)[46] to show a significant impact on premiums in more than one regression is the surgery rate (*OPSPOP*), which loses significance when the time and state binary variables are omitted (regression #3). The size of the *OPSPOP* coefficient is about the same for GP premiums as it is for the surgical specialists,

Table 3. Annual Change Regressions

Explanatory Variables	Dependent Variables: 1. General Practitioner Premium Coeff.	S.E.	2. Ophthalmologist Premium Coeff.	S.E.	3. Orthopedic Surgeon Premium Coeff.	S.E.
LRECOV	−0.010	(0.064)	0.0001	(0.069)	−0.040	(0.070)
LLIM	0.040	(0.066)	0.018	(0.072)	0.027	(0.072)
PTCOMP	−0.012	(0.071)	−0.0003	(0.079)	0.014	(0.079)
RESIPS	0.043	(0.077)	0.040	(0.085)	0.089	(0.085)
ICON	−0.056	(0.067)	−0.055	(0.073)	−0.057	(0.073)
CONFEE	0.0002	(0.06)	0.007	(0.071)	−0.018	(0.071)
SLIM	−0.006	(0.053)	0.019	(0.058)	0.012	(0.058)
CSOUR	0.007	(0.07)	0.030	(0.078)	0.018	(0.078)
ADDAM	0.050	(0.061)	0.039	(0.067)	0.053	(0.067)
LOCAL	0.032	(0.070)	0.012	(0.077)	−0.026	(0.077)
SCREEN	−0.071	(0.053)	−0.081	(0.058)	−0.044	(0.058)
ARBIT	0.11[c]	(0.06)	0.12[c]	(0.07)	0.074	(0.067)
JUA	0.034	(0.092)	0.026	(0.101)	−0.011	(0.10)
SELINS	−0.009	(0.082)	−0.065	(0.090)	−0.060	(0.090)
T75	0.38[a]	(0.07)	0.31[a]	(0.073)	0.45[a]	(0.073)
T76	0.19[a]	(0.06)	0.17[b]	(0.07)	0.21[a]	(0.07)
T77	−0.064	(0.060)	0.069	(0.066)	0.076	(0.066)
Constant	−0.070		−0.075		−0.081	
	$R^2 = 0.21$ $F(17,174) = 2.8$		$R^2 = 0.14$ $F(17,174) = 1.7$		$R^2 = 0.23$ $F(17,174) = 3.1$	

a. Statistically significant at the 1% level (two-tailed test).
b. Statistically significant at the 5% level (two-tailed test).
c. Statistically significant at the 10% level (two-tailed test).

implying that a doctor who does no surgery also is made to face a higher premium when the surgery rate rises. The coefficient for *LAWPOP* (the lawyer ratio) always exceeds its standard error, and it is statistically significant when the time and state binaries are dropped (regression #3).

One reason for the positive signs on the legislative response coefficients may be that states with a serious problem—i.e., those with high premiums—were more likely to enact remedial legislation. Analysis of the annual growth rate in real premiums, the dependent variable in Table 3, should be much less subject to this selectivity problem. But the legislative variables in this table, viewed collectively, have no impact on premium inflation. In fact, excluding the time variables, the *F*-statistic for the equation never exceeds 0.63, far below conventional levels of statistical significance. Regressions including changes in control variables *Y* through *MEDPOP*, not shown here, are similar to those reported in Table 3.

A Brief Discussion

Whereas many of the potential sources of premium inflation are national in scope, deliberate action has been undertaken mostly at the state level. The empirical results of the study presented here give no indication that individual state legislative actions, or actions taken collectively, have had their intended effects on premiums.[47] The publicity resulting from considerable legislative activity may have made juries and perhaps potential plaintiffs more aware of the cost consequences of malpractice suits. If so, this effect probably extended beyond the boundaries of any particular state.

Another possibility is that past frequency of claims and size distribution of settlements in a state are only weakly related to premiums in the state. Premiums are set on the basis of expected outlays, and insurers may not have based their expectations for the future on past experience. Unfortunately, state-specific data on claims frequency and dollar amounts of settlements are not available for 1974 and thereafter. However, correlations among 1974 premiums, claims filed, cases won by plaintiffs, and mean size of awards for 1970 are surprisingly low (0.3 or less).[48] Certainly, adverse insurer experience in a given year should be reflected in higher premiums in later years, so that higher correlations were anticipated. There is a need for more "hard" empirical evidence on how insurers *really* form expectations and set premiums.

Finally, lawyers are often held accountable for the increased tendency to seek legal recourse. Even though the lawyer variable is insignificant in regressions containing binary variables for states, the sign on the lawyer coefficients remains positive and substantial in size. Without the state binary variables (see regression #3, Table 2), the lawyer variable has a positive impact on premiums, significant at the one-percent level. Viewing the empirical evidence in its entirety, the notion that a 10 percent increase in a state's lawyer/population ratio leads to almost a like percentage increase in premiums, as the coefficients imply, is a distinct possibility.

Notes

1. See N. T. Greenspan, "A Descriptive Analysis of Medical Malpractice Insurance Premiums, 1974–1977," *Health Care Financing Review* 1 (Fall 1979): 65–71, for 1974–77 trends. Pre-1974 data on premiums are available from M. C. Kendall, "Expectations, Imperfect Markets, and Medical Malpractice Insurance," in *The Economics of Medical Malpractice*, ed. Simon Rottenberg (Washington, D.C.: American Enterprise Institute, 1978), p. 176.
2. There are numerous accounts of legislative responses; a few document court decisions in this area. See, for example, K. S. Abraham, "Medical Malpractice Reform: A Preliminary Analysis," *Maryland Law Review* 36 (No. 3, 1977): 489–531; American Arbitration Association, *Statutory Provisions for Binding Arbitration of Medical Malpractice Claims* (Washington, D.C.: U.S. National Center for Health Services Research, DHEW Pub. No. (HRA) 77-3165, October 1976); American Medical Association, "State Health Legislation Report," May 1977; American Medical Association, "Selected Important Court Decisions Relating to Medical Malpractice Legislation" (Chicago: AMA, Public Affairs Division, 1 December 1978); P. E. Carlin, "A Snapshot of State Legislative Enactments in the 1970 Sessions Relating to Malpractice" (Washington, D.C.: George Washington University, Intergovernmental Health Policy Project,

mimeo, 1980); Editors, *Duke Law Journal*, "Comment: An Analysis of State Legislative Responses to the Medical Malpractice Crisis," in *Medical Malpractice: The Duke Law Journal Symposium* (Cambridge, Mass.: Ballinger, 1977), pp. 241–92; B. J. Jacobs, "Overview of State Legislation Pertaining to Professional Liability of Physicians," *Clinical Obstetrics and Gynecology* 20 (March 1977): 25–54; S. Law and S. Polan, *Pain and Profit: The Politics of Malpractice* (New York: Harper and Row, 1978); A. J. Lipson, *Medical Malpractice: The Response of Physicians to Premium Increases in California* (Santa Monica, Calif: Rand Corporation, #R-2026-PSEC, November 1976); Medical Liability Commission, *Legislative Index for Health Services Research* (Rockville, Md.: U.S. National Center for Health Services Research, December 1976); M. H. Redish, "Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications," *Texas Law Review* 55 (May 1977): 759–800; R. E. Stromberg, "Case Law Update" (San Francisco: National Health Lawyers Association, mimeo, May 1979); D. G. Warren and R. Merritt, eds., *A Legislator's Guide to the Medical Malpractice Issue* (Washington, D.C.: Georgetown University, Health Policy Center, 1976).

3. *Medical World News*, "New York State Doctors are Threatened with Staggering Increases in Malpractice Premiums," 25 May 1981, pp. 18–19.
4. According to American Medical Association, *SMS Report* (Vol. 1, October 1982), malpractice premiums did not rise in real terms between the mid-1970s and the early 1980s. Also see E. K. Adams and S. Zuckerman, "Variation in the Growth and Incidence of Malpractice Claims," *Journal of Health Politics, Policy and Law* 9 (Fall 1984): 475–488.
5. See, for example, C. L. Rosenberg, "Why a New Malpractice Crisis is Coming," *Medical Economics*, 28 April 1980, pp. 109–14; and *Medical World News*, 1981.
6. Greenspan, "A Descriptive Analysis," p. 66.
7. U.S. Department of Health, Education, and Welfare, *Medical Malpractice Claims* (Washington: U.S. Department of Health, Education, and Welfare, Pub. No. HCFA-02108, 20 October 1978), Table 4-18; S. R. Henderson, "The Malpractice Insurance Situation and its Effects on Medical Practice," in *Profile of Medical Practice, 1978*, ed. J. C. Gaffney (Chicago: American Medical Association, 1979), p. 10; and American Medical Association, *SMS Report*.
8. The source is unpublished data from Nancy Greenspan, Health Care Financing Administration; premiums are for a "standard" $100,000/$300,000 policy.
9. See, especially, All Industry Medical Malpractice Insurance Committee, "The Problems of Insuring Medical Malpractice" (Hartford, Conn.: Aetna Life and Casualty, mimeo, November 1975); and Kendall, "Expectations."
10. M. W. Reder, "Medical Malpractice: An Economist's View," *American Bar Foundation* 1976 (No. 2, 1976): 511–63.
11. Ibid.; and M. W. Reder, "An Economic Analysis of Malpractice," *Journal of Legal Studies* 5 (No. 2, 1976): 267–93. Although the direction of effect cannot be determined a priori, there are strong conceptual arguments for including per capita income. The role of operations per surgeon is much less clear. Since most suits may be traced to care rendered in the hospital, and a high proportion to surgery in particular, there is reason for including a variable representing hospital and/or surgical activity. See M. H. Rudov, T. I. Myers, and A. Mirabella, "Medical Malpractice Insurance Claims Files Closed in 1970," in *Appendix to Report of the Secretary's Commission on Medical Malpractice* (Washington, D.C.: U.S. Government Printing Office, DHEW Pub. No. (OS)73-89, 16 January 1973), pp. 1–25; and U.S. Department of Health, Education, and Welfare, *Medical Malpractice Claims*, several tables. However, the ratio of operations to surgeons may be high in states with few operations but with even a greater scarcity of surgeons. Also, since practice seems to make perfect, a high workload may be associated with higher rather than lower quality. See, for example, A. B. Flood, W. R. Scott, and W. Ewing, "Does Practice Make Perfect? Part I: The Relationship Between Hospital Volume and Outcome for Selected Diagnostic Categories," *Medical Care* 22 (February 1984): 98–114.
12. R. Feldman, "Determinants of Medical Malpractice Incidents: Theory of Contingency Fees and Empirical Evidence," *Atlantic Economic Journal* 7 (July 1979): 59–65.
13. Both Reder and Feldman took their legal variables from S. Dietz, C. B. Baird, and L. Berul, "The Medical Malpractice Legal System," in *Appendix to Report of the Secretary's Commission on Medical Malpractice*, pp. 87–167.
14. J. F. Hastings, "Medical Malpractice Background Papers," in *An Overview of Medical Malpractice*, 94th Congress, U.S. House of Representatives, Committee on Interstate and Foreign Commerce (Washington, D.C.: U.S. Government Printing Office, 17 March 1975), pp. 3–49; All Industry Medical Malpractice Insurance Committee, "Problems of Insuring Medical Malpractice"; Law and Polan, *Pain and Profit*; P. Munch, "Causes of the Medical Malpractice Insurance Crisis: Risks and Regulations," in Rottenberg, ed., *The Economics of Medical Malpractice*.
15. Law and Polan, *Pain and Profit*, p. 171.
16. See, for example, Rosenberg, "Why a New Malpractice Crisis."
17. See, for example, American Medical Association, "Selected Important Court Decisions."
18. Editors, *Duke Law Journal*, "Comment"; and Editors, *Northwestern Law Review*, "The Application of Res Ipsa Loquitur in Medical Malpractice Cases," *Northwestern Law Review* 60 (January-February 1966): 852–75.
19. Editors, *Duke Law Journal*, "Comment," p. 252; American Medical Association, "Selected Important Court Decisions."
20. U.S. Department of Health, Education, and Welfare, *Medical Malpractice Claims*, p. v-7.
21. All Industry Medical Malpractice Insurance Committee, "Problems of Insuring Medical Malpractice."
22. U.S. Department of Health, Education, and Welfare, *Medical Malpractice Claims*, p. v-6.
23. Exceptions are listed in Editors, *Duke Law Journal*, "Comment," pp. 254–5.
24. See, for example, Dietz, Baird, and Berul, "Medical Malpractice Legal System"; and American Surgical Association, "Statement on Professional Liability, September 1976," *New England Journal of Medicine* 295 (2 December 1976): 1292–6.
25. Feldman, "Determinants of Medical Malpractice Incidents."
26. Editors, *Duke Law Journal*, "Comment," p. 268.
27. American Medical Association, *State Health Legislation Report*, p. 4.
28. Abraham, "Medical Malpractice Reform."
29. American Medical Association, *State Health Legislation*.
30. For further discussion, see Abraham, "Medical Malpractice Reform."
31. Recent court cases are listed in American Medical Association, "Selected Important Court Decisions." See A. R. Holder, *Medical Malpractice Law*, 2nd Edition (New York: John Wiley and Sons, 1978), pp. 403–18, for a description of screening panels.
32. Abraham, "Medical Malpractice Reform."
33. Ibid., p. 577. Arbitration panels may in fact be more lenient. See W. Wadlington, "Alternatives to Litigation, IV: The Law of Arbitration in the U.S.," in *Appendix to Report of the Secretary's Commission on Medical Malpractice*, pp. 346–423. More favorable empirical evidence on cost-effectiveness of arbitration is presented in D. H. Heintz, "Arbitration of Medical Malpractice Claims: Is It Cost Effective?" *Maryland Law Review* 36 (1977): 533–65. Arbitration has encountered opposition from trial lawyers. See C. L. Rosenberg, "Which Malpractice Reforms Protect You Best?" *Medical Economics*, 28 April 1980, pp. 148–67.
34. Redish, "Legislative Response."
35. See American Medical Association, *State Health Legislation Report*, p. 10.
36. R. W. Rhein, "Malpractice: Grim Outlook for '76," *Medical World News*, 12 January 1976, pp. 71–83.
37. See American Medical Association, *State Health Legislation Report*, p. 11; and *Medical World News*, "Malpractice '77: 50-State Picture Improves," 10 January 1977, pp. 21–3.
38. See Reder, "An Economic Analysis"; Reder, "Medical Malpractice"; and Feldman, "Determinants of Medical Malpractice Incidents."
39. The state index is described in F. A. Sloan, "Physician Supply Behavior in the Short Run," *Industrial and Labor Relations Review* 28 (July 1975): 549–69.
40. Premium data came from the Telephone Survey of Malpractice Insurance Companies conducted by the Health Care Financing Administration. See Greenspan, "A Descriptive Analysis," for a brief description of the Survey. The first figure of the liability limit ($100,000 above) represents the annual limit per case; the second is the annual limit for all cases against the provider.
41. See F. A. Sloan and J. Lorant, "The Allocation of Physicians' Services: Evidence on Length-of-Visit," *Quarterly Review of Economics and Business* 16 (Autumn 1976): 85–103; and F. A. Sloan and J. Lorant, "The Role of Waiting Time: Evidence from Physicians' Practices," *Journal of Business* 50 (October 1977): 486–507.
42. It is also true that utilization rates rise. To the extent that some "unnecessary" care is given, patients may be more likely to sue.

43. Feldman's index is similar to Reder, "Medical Malpractice."
44. "Legislative Response" variables are based on sources listed in Note 2 above.
45. The correlations are presented in Vanderbilt University, *Analysis of Survey Data on Physician Practice Costs and Incomes* (Nashville: Vanderbilt University, Health Policy Center, 1981. Final Report, Contract No. HCFA 500-78-0018 with the U.S. Health Care Financing Administration), p. 180.
46. Since Y through MDPOP are all continuous variables, associated coefficients are elasticities.
47. Many observers at the time were quite optimistic. See, for example, C. E. Welch, "Medical Malpractice," *New England Journal of Medicine* 292 (26 June 1975): 1372–76.
48. The 1970 data were used in Feldman, "Determinants of Malpractice Incidents." I am grateful to Roger Feldman for making these data available for my study.

State Rate-Setting and Its Effects on the Cost of Nursing-Home Care

John Holahan, The Urban Institute

Abstract. The paper uses data from nursing-home cost reports to analyze the effectiveness of different approaches to nursing-home reimbursement. Our research has produced considerable evidence on the effect of states' efforts to reduce the rate of increase in nursing-home costs. First, homes in states with flat-rate reimbursement systems were found to have lower rates of increase than homes in other states, while there were no consistent differences between the results of prospective and retrospective systems. Second, efficiency incentives, inflation-projection methods, and the level of ceilings on rates appear to be very important, regardless of the general reimbursement method. For example, prospective systems with weak efficiency incentives, generous inflation adjustments, and high percentile ceilings have lesser cost-containment effects than prospective systems with stringent inflation allowances and low percentile ceilings. There is also evidence that the inherent weakness of the cost-containment incentives in retrospective systems can be offset by low percentile ceilings and efficiency bonuses.

Introduction

Financing nursing-home care has been a major problem, both for individuals needing care and for state governments. National nursing-home expenditures more than doubled in the five years from 1976 to 1981, growing from $11.4 billion to $24.2 billion. Medicaid expenditures for nursing-home care grew by 18.6 percent from 1979 to 1980, and by 17.6 percent from 1980 to 1981.[1] The purpose of this paper is to examine the effects of public policy on the cost of nursing-home care.

Of the two public programs that pay significant amounts for nursing-home care—Medicaid and Medicare—the Medicaid program has a much stronger effect on costs throughout the industry. Thus the principal issue is whether the reimbursement policies of state Medicaid programs significantly influence the rate of change in nursing-home costs. Since Medicaid programs pay for about 50 percent of the costs incurred by nursing homes, the program has a significant influence on the cost structure of individual nursing homes, and presumably a considerable influence on cost levels and the rate of change in those levels, for the industry as a whole.

In order to analyze the determinants of rates of change in nursing-home costs,

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Notes on Meeting with Michael Schneider, Kevin Bruce, and Roger Poppe at 12:30 lunch, October 29, 1985 at the Cpt. Cook Quarterdeck regarding Tort Reform in the insurance industry (his phone is 277-4551)

Informal Notes taken in meeting with a lawyer who specializes in representing injured individuals.

I. Background

He was at the Insurance Briefing that was put on for the legislators on October 25 at the Red Lion, regarding the Insurance Crisis and Tort Reform. He said there was a lot of distortions and half-truths at that meeting, and so he was trying to meet with various legislators and their staffs to counteract it. He is a lawyer who makes a speciality of representing injured individuals, and there are only a small handful of them, mostly members of the Association of Trial Lawyers. He made the following points:

II. Points to consider:

A. The judicial system as it is set up in Alaska is such that if you tinker with any one part of it as far as the insurance cases go, you would have to alter all of it, and it could cause serious problems. It was set up basically the way it was to try to cut down on court time and expense, and deal fairly with all parties concerned. For example, if you get rid of the subrogation procedure, then maybe it is appropriate to toss out the collateral source rule now operating.

B. Our Supreme Court in Alaska rejected the idea of structured settlement (Mike Szymanski will be putting in a bill on this), With structured settlement, you lose on inflation, but you gain in other ways over the long term.

C. With the annuity approach, one thing to look at is that our jury award is currently tax free, but with an annuity, you may not have a tax free situation, which is what the Insurance industry is pushing for. It may end up hurting the injured party. It may also hurt them in another way. Suppose you get a settlement which allows you to get $3,000 a month in todays dollars, but if you calculate that amount with the discount rate for 40 years into the future, it will end up meaning the insurance companies will be paying out about $35 a month in todays dollar value and buying power. Conversely, that means that an injured party can't live on $35 a month in todays terms, so in his old age 40 years from now he can't either. Also, for reasons too complex for me to follow, an annuity is a sophisticated form of taxation, so the client loses.

D. Insurance companies like to try to drive a wedge between the injured party and his lawyer by offering cash settlement to the lawyer for his fee, and an annuity to the plantiff, so that they end up being at odds with each other on this issue, so that the lawyer is tempted to "sell his client down the river" so to speak by encouraging him to settle without telling him the implications of it over a 40 year span.

E. In the elaborate example they gave in their presentation last week, the insurance company showed how after all the lawyers fees, etc are taken out, the injured party gets some $1.5 million on a $2.5 million settlement. It sounds like a lot of money, but due to inflation and buying power, etc, the reduced future actual value is not enough to allow you to live on the interest, so you have to start drawing on the principal, and go in a downward spiral from there, in your old age.

F. Actually, despite what the insurance companies tell you, that they can't settle cases on a structured basis right now, the truth is that they can. So, sometimes the injured party's lawyer will encourage a structured settlement for his client if he thinks the clients will throw the money away frivolously and not be able to hold on to it.

G. Also, we need to look at special vs. general verdicts. The insurance industry wants awards itemized, so they can focus on "reforms" or changes in the various areas. If you itemize an award, it gives the insurance companies more grounds for later court appeals on each item.

H. Further, on any case that gets appealed, the insurance company continues to collect interest on the settlement amount until it is finally awarded, so it is in their interest to appeal all cases.

I. What will happen if Rule 82 should be canned. It forces the client to pay the defendants attorneys fees. If eliminated, it will force more cases to trial rather than to a court settlement or a settlement out of court, because the plaintiff has nothing to lose by continuing.

J. The current judicial system has a complex system of incentives whose basic purpose and thrust is to settle a case as soon as possible, preferably avoiding a trial, which clutters up the case dockets. The system is designed thus to settle cases, not try them. If you remove the pre-judgement interest, for example, you remove the impetus to force the insurance companies to settle. Other aspects of the system are designed to force the plaintiff to settle.

K. The insurance companies have two major problems they have to cope with: a) tough rates b) disasters

L. If you read the actual trade literature that the insurance industry is talking to one another with, you find out they are peddling an entirely different story. They aren't talking about crisis, but about them simply being in a down cycle in a cyclical industry. And that all they have to do is stick it out for two years and they will be on an upswing again, its just a market slump and capacity crunch, nothing more.

M. If you want the bottom line on what is going on, only a handful of lawyers in this town defend plaintiffs in these cases, and there are major huge law firms that are getting rich defending the insurance companies. If you don't believe that, just look around town and see that many of the downtown large buildings are owned by law firms who defend the insurance companies.

N. He feels that an average plaintiff's lawyer in these insurance cases gets an estimated average annual salary of some $90,000, with a range of $60,000-$130,000. The defendant lawyers make much much more than this. You see, he is in a high risk industry so that he may take a case that is potential a $500,000 settlement, but the odds of him settling that case are only about 30%, so that means he only gets his fee, which is directly linked to a successful settlement, about 30% of the time. So in other words, they only get paid on about 1 out of every 3 or 4 cases, so they have to do a lot of work with no immediate return.

O. Also, note that in California, where they already have a lot of Tort Reform legislation passed,and California's approach has not bailed them out of the problems the insurance industry is having. The insurance companies themselves are getting sued directly.

P. He said that on December 6, the Association of Trial Lawyers is going to hold its own legislative briefing session to present the other side of the story, that of the injured parties. It is basically consumer oriented in its approach.

Q. They are also thinking of putting out a broadside that counters, point by point, the 15 Tort Reform suggestions being proposed by the insurance industry.

R. Finally, if the insurance industry is in such big trouble, how come havent we read about any of them going bankrupt? Or laying off a lot of employees as a means of cutting back on operating expenses?

DAY CARE

Day care is an essential support service for many families who must have all adult members working in order to maintain the family. Provided in small family day care homes or in larger centers, day care is an essential part of Alaskan life styles.

Insurance is a very real and urgent problem in day care, and that problem is demonstrated by the fact that:

- family day care homes are unable to purchase insurance, and incur tremendous liability potential with no assistance
- day care centers in operation for years with no claims against policies have been dropped without notice and have gone without insurance for several weeks unknowingly. Other centers have just been dropped
- When insurance is available, it costs substantially more--at least $2000.00 more per year, and in one instance $20,000.00 more per year
- insurance is written for six months periods, reducing the ability to budget and anticipate an adequate fee structure
- almost all policies currently being written exclude sexual abuse, child abuse and in one instance exclude neglect
- the new concept of insurance -the claims made style- may eventually require an additional coverage on previous years of potential claims in order to meet past needs...and this coverage is projected to be quite expensive

While day care is a needed service, it is expensive to provide. It requires adequate space per child and is a labor intensive service. The recent changes in the insurance field are introducing an element of instability which is going to make it impossible for some day care providers to continue in the field.

There is no apparent reason for the major increase in fees. Day care liability claims total for the entire four years -1980, 81, 82, 83- were less than $1000.00. Insurers are frightened by the rare and highly public sex abuse scandals which have recently been identified.

Solutions? We don't know the insurance field. But we can tell you that day care needs insurance which is available and affordable. Parent fees are the support of the field, and cannot rise indefintely. We will support any proposal which works to restore predictability in insurance. Mediation or arbitration, statutes of limitations, caps on judgements, structured fees and contingent fee structures, limiting claims against the plaintifs judgement are somethings which make sense to us. They may not all be practicable or possible in Alaska. But we need help, or day care is in big trouble.

ALASKA STATE SENATE

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BUDGET & AUDIT
HEALTH, EDUCATION & SOCIAL SERVICES
RULES
TRANSPORTATION

SENATE CHAIR, ANCHORAGE CAUCUS

October 14, 1985

Dear Colleague:

We are all aware that various industries are facing difficulties retaining insurance coverage. With this fact in mind, I would like to inform you of a legislative briefing which will address the topic of availability and pricing of commercial insurance. The briefing is scheduled on Friday, October 25 in Anchorage at the Captain Cook. For your information, I have enclosed a copy of the agenda. I would encourage your attendance at this meeting.

Please note that this briefing will present to us the views and recommendations of segments of the insurance industry itself. I believe we may find it appropriate to hear other perspectives (consumers, claimants and their attorneys), as well, before session convenes.

With best wishes, I am

Sincerely,

Joe P. Josephson
State Senator

JPJ:rak
Enclosure

LEGISLATIVE BRIEFING
AVAILABILITY AND PRICING OF COMMERCIAL INSURANCE
AGENDA
October 25, 1985

8:30-9:00 Coffee and Pastries

9:00 Seminar on the factors that affect insurance availability and pricing.

1. The role and operations of the several components of the insurance industry.

Richard L. Block

2. National trends in insurance pricing, market availability and solvency. Changes in exposure and how these factors are interrelated.

James Meenahan*

3. How these factors affect the availability and pricing of insurance in Alaska. The impact of certain factors that affect Alaska insurance markets.

John George
Roger Schoenneger

10:15 The judicial environment-its impact on insurance pricing and availability.

1. Procedural and coverage related court decisions.

Buck Bragg

2. Substantive tort law court decisions.

Keith Brown

11:00 Coffee and pastries.

11:15 Seminar on workers' compensation rehabilitation legislation. HB____(1983) revisited.

1. Is the program rehabilitating injured workers as intended?

Jackie McKlintock

2. What is the true cost of the program to employers.

Mary Pierce

3. What procedural or litigation problems has the new law presented.

Robin Wilcox

12:15 Lunch.

1:30 A review of possible answers.

1. Insurance industry responses by changing coverages-the claims made form.

Don Koch

2. A review of possible state legislative options tried in the past. M.I.C.A. a case study.

Roger Holmes

3. Modification of the judicial system. Proposals for changes in the tort law and procedural and coverage rules.

Mike Thomas
Tom Findlay

3:15 The response by the administration.

Loren Lounsbury

3:30 Adjourn.

* Not confirmed

SPEAKERS PANEL
(In Order of Appearance)

Richard L. Block - President of Alaska National Insurance Company, Attorney and past Director of Division of Insurance, State of Alaska.

James Meenahan - President of John F. Sullivan & Company, Reinsurance Brokers, Seattle. Past Executive Vice President, Fireman's Fund Insurance Company.

John George - Director Alaska Division of Insurance, formerly Risk Manager, State of Alaska.

Roger Schoenneger - Executive Vice President, Bayly Martin & Faye National Insurance Brokerage Firm. Roger manages one Anchorage office.

Buck Bragg - Assistant General Counsel, State Farm Insurance Company, Bloomington, Illinois.

Keith Brown - Anchorage attorney with Hagens, Brown & Gibbs, specializing in insurance liability defense.

Jackie McKlintock - Director, Division of Workers' Compensation, State of Alaska.

Mary Pierce - Risk Manager, Carr/Gottstein Companies. Member of Workers' Compensation Board.

Robin Wilcox - Attorney, Faulkner, Banfield, Duggan and Holmes. Specializing in Workers' Compensation defense.

Don Koch - Chief Market Surveillance, Alaska Division of Insurance.

Roger Holmes - Partner in Anchorage law firm of Biss and Holmes. Specializing in medical malpractice defense and general counsel to Medical Indemnity Corporation of Alaska.

Mike Thomas - Partner in Anchorage law firm of Robertson, Monagle, Eastaugh & Bradley. Alaska counsel for American Insurance Association.

Tom Findlay - Juneau attorney. Alaska counsel for Alliance of American Insurers.

Loren Lounsbury - Commissioner of Commerce and Economic Development, State of Alaska.