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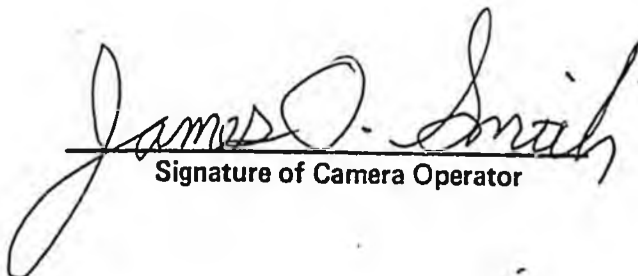

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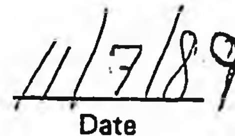

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A Citizen's Guide to Tort Reform

Dear Concerned Citizen:

We have all seen the recent increase in the number of lawsuits in America, as well as the tendency of our courts to hand out more and ever-larger awards. We all know that America is considered to be the most litigious society in the world. As a result, we all are beginning to sense that something is wrong with our legal system.

As chief executive of a large insurance company, I am frequently asked about tort reform, especially about how we can restore the system to one that better matches our common sense notions of fairness and balance — one that provides prompt, just and full compensation to injured victims at a reasonable cost, without so weakening the test of liability that every productive and creative individual in society becomes a potential victim.

For most citizens, the major stumbling block to understanding tort issues is the fact that the issues are technical and complex. For that reason, and in response to requests from a number of consumer organizations, we have undertaken to explain the issues in clear, concise language. We believe that tort reform is a societal issue and that citizens of this country have a stake in — and a need to understand — these issues. The purpose of this guide is to educate rather than persuade; therefore, no recommendations are provided. Instead, we encourage you to look at the facts and judge for yourself what, if any, actions should be taken.

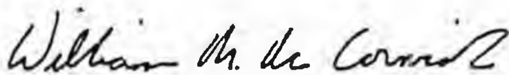
The following pages detail the major legal doctrines and issues which govern our tort litigation system. While there are many more doctrines, the areas outlined in this guide are the most important and the most frequently cited as in need of reform. Each doctrine is outlined in an historical context.

In addition, public policy questions which have been raised are put forth. The final section of this guide highlights proven methods of making your voice known at the legislative level.

Of course, Fireman's Fund does have a position on what reforms might be undertaken. Quite simply, we believe the laws governing tort litigation in America should be tightly defined. This may be best achieved by moving back toward the basic principles still employed in other common law countries and which worked well in the United States until erosion began in the 1960s.

Our position was put forth in my recent speech titled, "The American Tort System: A Time to Rebalance the Scales of Justice." If you would like a copy of this speech, please write to me at Fireman's Fund, 777 San Marin Drive, Novato, California 94998.

Sincerely,



William M. McCormick
Chairman & CEO
Fireman's Fund Insurance Companies

A Citizen's Guide to Tort Reform

An Overview

The legal framework for compensating personal injury in the U.S. is the tort reparations system. Like the rest of the United States legal system, the tort reparations system is adversarial: After hiring an attorney, the injured person—called the plaintiff—files a lawsuit. The defendants named in the lawsuit also retain attorneys who respond to the allegations. The theory behind the adversarial system is that, with both sides represented by lawyers arguing for their clients' best interest, the truth will emerge.

The trial court must decide the facts of the dispute and correctly apply the law. A party disagreeing with the legal basis for the trial court's decision may appeal to a higher court. These higher, appellate courts exist primarily to correct errors in applying the law.

In deciding appeals, appellate courts often must clarify, modify or explain legal rules. Their decisions become legal precedents which are supposed to be followed by other courts in their jurisdiction. These decisions are published in legal reports so lawyers and trial courts can determine what legal rules should be applied in the next case.

About 95 percent of the cases filed are settled or dismissed before trial. Only a small proportion of the lawsuits filed actually result in a trial and verdict. Many of those verdicts are not appealed.

Although most cases are settled out of court, the legal rules applied by courts and the expense of going to court largely determine whether—and for how much—the parties in the lawsuit are willing to settle. If legal precedents make it easier to recover for the specific injury, eliminate defenses that might prevent a finding of liability and/or increase the amount of potential damage awards, the amounts settled in out-of-court situations tend to increase.

Historical Evolution

Tort law is primarily judge-made law. When the United States declared independence, it continued to apply principles from the pre-existing body of English court decisions. These were amplified, explained and altered by later American courts in the tradition of common law, which allows the gradual evolution and change of legal doctrines.

United States tort law varies from state to state but, because state courts tend to regard other states' decisions as persuasive authority, the general trend has been the same almost everywhere in the country: Courts have increasingly eliminated many of the restraints to assigning liability present in the common law of England and in the common law applied in the United States through the 1950s.

The 1960s saw a dramatic increase in the pace of legal change. In the 25 years since then, there has been a fundamental alteration in many of the common law tort doctrines and in the basic balance of the tort reparations system.

The tendency has been to extend the definition of liability, resulting in an expensive and unpredictable tort liability system. Those most impacted by today's system are those who provide important products and services — such as doctors, manufacturers and municipalities — who are now at much greater risk of being sued.

Court Costs — The American Rule

Greenwood Village, Colorado, boasts a population of less than 6,000. To date, the town has run up a legal bill of $700,000 in attorneys' fees and court costs to defend itself from suits brought by landowners who object to commercial development.

The Greenwood Village taxpayers are responsible for paying their legal bills—whether the town wins, loses or settles.[1]

Description

Under the American rule, all litigants pay their own costs. Unlike other common law countries, if a plaintiff brings a lawsuit and loses, the defendant is still responsible for his own court costs and attorneys' fees.

Original Justification

The American rule was created to allow all persons full access to the courts.

Subsequent Developments and Operation Today

As discovery and defense costs have risen, and as it has become more difficult to dismiss tort suits at preliminary stages, it is extremely expensive to take cases to court.

Conversely, the cost to the plaintiff is relatively low. Under the traditional contingency fee arrangement, the plaintiff pays no attorney fees if the suit is unsuccessful. The plaintiff is, therefore, only responsible for the filing fees, which are a fraction of the total litigation costs. The result is that it is often cheaper for a defendant to settle even a meritless case out of court than it is to win the case after a jury trial.

Public Policy Questions

▸ Should the American rule doctrine be eliminated, requiring the losing party to pay all court and defense costs, as is done in other countries?

▸ Should the American rule be revised to apply only to certain types of cases, such as those in which the plaintiff is insolvent?

▸ Should the American rule not be applied in cases that are appealed after initial, non-binding arbitration?

Joint and Several Liability

The brakes on a boy's bicycle failed, causing him to cross over onto the wrong side of the street. The child ran head-on into an automobile and was seriously injured. Both the seller and manufacturer of the bicycle were sued. In addition, the City of Los Angeles was named as a defendant because it was alleged that plants growing on private property, over which the city had an easement for possible future street widening, had partially obstructed the view of the cyclist and the driver.

Because the bicycle seller and manufacturer settled their share of the lawsuit for substantially less, the City of Los Angeles was held liable for the entire remaining award of $1.7 million. The case is currently on appeal.[2]

Description

If more than one defendant is found partly responsible for an injury, many states hold them "jointly and severably" liable for all damages. This means that if one defendant is unable to pay his share of the award, the other defendants must pay the amount—in addition to their own share.

Original Justification

The courts believed that if one defendant was insolvent, the burden should fall on the other defendants who bore some responsibility for the accident, rather than on an innocent plaintiff.

Subsequent Developments and Operation Today

The doctrine of joint and several liability creates large liability exposures for such defendants as cities and insured businesses, which undertake many activities and have enough assets to attract lawsuits. This problem is compounded by the greater availability of pain and suffering awards and a general trend toward larger damage verdicts. Such defendants now

have an incentive to spend large amounts of money on attorneys' fees and expert witnesses to avoid a finding of even one percent liability.

Public Policy Question

▸ Does the "deep pocket" philosophy unfairly penalize such defendants as municipalities and insured businesses by holding them accountable for awards beyond their own responsibility?

Comparative Negligence

A New York man was seriously injured when he attempted suicide by jumping in front of an oncoming subway train. He filed a lawsuit claiming that the train engineer should have stopped the train faster. The man recovered $650,000 from the New York Transit Authority.[3]

Description

Comparative negligence allows a plaintiff to recover damages—even if his own negligence or misconduct contributed to the injury. This is a modern doctrine which, in many states, replaces the traditional rule of contributory negligence.

Currently, states adhere to one of three rules:

1. *Contributory negligence:* The plaintiff cannot recover if his negligence contributed in any way to the injury, unless the defendant had the last clear chance to avoid the injury;

2. *Pure comparative negligence:* The plaintiff can recover despite his own negligence, but the amount of recovery is diminished in direct proportion to his own negligence;

3. *Modified comparative negligence:* The plaintiff may recover an amount even if he is partially negligent, but only if he was no more negligent than the other party.

Original Justification

The traditional doctrine of contributory negligence was developed with the belief that the legal system existed to enable fault-free plaintiffs to recover from defendants who were at fault, and that the system should discourage self-injuring behavior.

The more liberal rules of comparative or modified comparative negligence were later developed with the belief that a slight degree of fault on the part of the plaintiff should not prevent all recovery.

Subsequent Developments and Operation Today

Liberalization of the comparative negligence doctrine has made it difficult for judges to dismiss lawsuits at an early stage on the grounds that the plaintiff was clearly responsible for his own injury.

Public Policy Question

▸ Should a plaintiff who is partially at fault for his own injuries be allowed to recover? If so, should there be limits on the amount he can recover?

Punitive Damages

A couple whose car had been rear-ended claimed they were entitled to $17,000 from their auto insurer. The insurance company estimated damages at $4,500. The couple sued. The court, finding in favor of the couple, ordered the insurance company to pay $7.4 million in punitive damages for failure to settle a claim in good faith.[4]

Description

Punitive damages are awarded in addition to the amount necessary to compensate the plaintiff for actual damages. They are assessed to punish the defendant and deter future similar behavior. Under the legal doctrine of vicarious liability, individuals and companies may be held liable for punitive awards based on the conduct of their employees or agents—even if that conduct is unknown to supervisors.

Original Justification

Despite the general notion that civil law was to recompense injury rather than punish wrongdoers, the following rationale was advanced to support punitive awards under English common law:

First, the punitive damage award allowed juries to help compensate for such factors as anguish and embarrassment, which the courts were reluctant to compensate during the formative stages of common law.

Second, this doctrine was developed at a time when there was a shortage of public prosecutors and many cases of outrageous conduct were not covered by criminal law. Punitive damages filled a void: They provided individuals with an economic incentive to litigate for personal injury in cases where the defendant should be deterred from future willful and wanton misconduct.

The American Tort System: A Time to Rebalance the Scales of Justice

William M. McCormick
Chairman & CEO
Fireman's Fund Insurance Companies

Delivered to
Commonwealth North
Anchorage, Alaska
January 7, 1986

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William M. McCormick, 45, is Chairman and Chief Executive Officer of Fireman's Fund Insurance Companies, a position he has held since 1983. He is also President of Fireman's Fund Corporation. Prior to joining Fireman's Fund, Mr. McCormick held various positions within American Express Company, where he rose to President of American Express Travel Related Services Company, Inc. He began his business career as a management consultant with McKinsey & Company, Inc. Mr. McCormick, who holds a Master's Degree in nuclear physics, served in the U.S. Navy as a lieutenant on the Atomic Energy Commission staff of Admiral H.G. Rickover.

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The American Tort System: A Time to Rebalance the Scales of Justice

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George Bernard Shaw once wrote, "The road to hell is paved with good intentions." Probably no statement better describes the state of our tort system in this country.

With the best of intentions, the scales of a system designed to render justice have been tipped. The balance has moved so far toward the desire to compensate all injuries and all losses that the overall cost to society has become too high. We have reached a point where exposure to liability is becoming almost limitless and incalculable, making everyone — governments, businesses and individuals — a victim.

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

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

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

• A little league player was injured when a fly ball hit him on the head. His parents sued the coaches on the theory that they were negligent in putting their son in the outfield. The parents recovered a settlement. As a result, the athletic league may have to disband because it cannot afford liability insurance. And coaches everywhere are beginning to worry about whether their contribution of time is worth the new risk.[1]

• A man was hurt when a drunk driver crashed into the phone booth he was using. The California Supreme Court held that the manufacturer of the phone booth could be held liable for the man's injuries.[2]

• A burglar accidentally fell through a painted-over skylight while he was stealing lights from the roof of a public school. He sued the school district and recovered $260,000 in damages plus a continuing income.[3]

• In New York City, a man attempted suicide by jumping in front of a subway train. The man was injured but did not die; he sued, claiming the driver should have put the brakes on faster. The New York Transit Authority paid $650,000.[4]

• A man sued for emotional damages after seeing a leopard kill a neighbor's child at the circus. He was awarded more than $1 million. The child's parents, who had not witnessed the accident firsthand, received $120,000.[5]

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

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

1800s–1960s: Historical Stability

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

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

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

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

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

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

Plaintiffs could usually get damages for intangible pain and suffering only if there was an accompanying physical injury. And punitive damages — punishment awards over and above compensation for injury — were available only for truly outrageous conduct. In other words, tort laws were defined in such a manner that one only obtained redress for cases of true negligence, not for the personal risks of everyday life.

1960s–Today: The Erosion of Justice

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

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

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

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

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

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

Not only has legal doctrine been substantially altered, the dollar value of awards has ballooned. The tort system today has more million dollar winners than a state lottery. You may think that the high awards you read about are aberrations, but in 1984 the average product liability verdict was over a million dollars. The average medical malpractice award was $950,000.[9]

Courts today also have become more liberal in awarding punitive damages. Recently, an insurance company disputed the proper settlement

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

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

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

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

The System Today: Expensive and Unpredictable

But while these statistics point out some of the dimensions of what has happened to our legal system in the past 25 years, there is another aspect that is harder to quantify and that is the cost of uncertainty as to what the law is. Just over a hundred years ago, U.S. Supreme Court

Justice Oliver Wendell Holmes wrote: "The tendency of the law must always be to narrow the field of uncertainty."

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

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

Defendants often pay huge settlements just to avoid the uncertainty of court judgments. One particularly successful plaintiff attorney in Los Angeles recently bragged to a journalist that defendants "are so afraid of going before the jury . . . that they are ready to settle a $10,000 claim for $100,000."[8]

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

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

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

For example, the City of New York, which is large enough to be self-insured, pays claims itself. In 1983, New York City paid claims totaling $78 million. That was $78 million the city could

have spent on police protection, subway improvements or road repair. By the year 2000, New York City expects to pay more to settle lawsuits than it pays to provide fire protection.

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

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

The Societal Cost of Litigation

But money is just money. If everything gets more expensive because we decide to maintain our current tort liability system, somehow we will all muddle through. Our standard of living will go down a bit, we'll be a little less competitive in international markets, and a number of small companies will go out of business. What is more frightening, however, is that soon there may be some necessary products and services that are no longer available at any price.

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

Non-profit organizations and local government boards are now having trouble finding anyone willing to serve because they cannot afford insurance to protect their board members from lawsuits. Community service is rewarding, but for most of us it's not so rewarding that we would

risk our homes and savings in a lawsuit — just for the privilege of volunteering personal time.

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

And American vaccine makers are being driven out of the business as well. There is only one maker of whooping cough vaccine in the United States, and they are talking about getting out of the business. Why? Because the vaccine, which saves thousands of lives every year, is not perfectly safe: It causes unavoidable injury in three out of every one million children. As a result, the manufacturer has attracted more than 100 lawsuits over the last three years, amounting to almost $2 billion in claims. The entire U.S. market for all vaccines amounts to only $250 million.[9]

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

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

What Is the Problem?

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

• Full compensation for injured parties;

• Deterrence of negligence or punishment of outrageous behavior;

• Deterrence of self-injuring behavior;

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

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

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

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

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

There are no doubt even more parts to the problem. The result, however, is clear: We in America have the most unpredictable, expensive

and litigious tort system in the world. This is no longer a problem just for lawyers, for the insurance industry or for the courts. The time for leaving decisions to narrow categories of experts is over. The costs — both economic and societal — are too great.

What Is the Solution?

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

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

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

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

Citizens Must Act

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

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

- Is fault still important?
- Where do we draw the line on defining and assigning liability?
- Should there be limits on financial damages?
- When does ease of suit cripple the productive elements of society?

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

The key is to become involved. When citizens are involved, legislative change happens. Last fall in California, Lee Phelps, a retired Marine, founded a lobbying group to protect property owners from being sued by criminal trespassers who injure themselves on their property. To overrule the California Supreme Court case that held otherwise, Lee Phelps raised and spent $5,000. He faced opposition from the California Trial Lawyers Association, which had contributed over half a million dollars to candidates last year. But he got the measure passed.[10] So something can be done.

The following are some solutions we might consider:

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

- Product liability when there is no negligence on the part of the manufacturer and where the

injured parties' own negligence contributed to the problem;

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

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

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

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

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

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

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

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

integrated system and piecemeal solutions will not do.

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

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

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

Footnotes

[1]Associated Press, July 10, 1985.
[2]*Wall Street Journal*, December 3, 1985.
[3]*Business Week*, August 26, 1985.
[4]*Underwriter's Report*, November 7, 1985.
[5]*Journal of Commerce*, December 5, 1985.
[6]*Forbes*, July 15, 1985.
[7]United Press International, May 11, 1985.
[8]*New York Times*, May 8, 1985.
[9]*Forbes*, November 18, 1985.
[10]*San Francisco Chronicle*, December 8, 1985.

For further information please refer to *A Citizen's Guide to Tort Reform*, which may be obtained by writing:

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FIREMANS FUND
INSURANCE COMPANIES

Subsequent Developments and Operation Today

Today, the courts generally award pain and suffering and mental anguish damages without resorting to the category of punitive damages. In addition, there has been a dramatic change in the climate of legal regulation: A well-developed criminal law and extensive framework of government regulation act to deter invasions of personal rights.

While the original justification for punitive damages has grown less persuasive, these damages have become increasingly larger and easier to obtain. Today, instead of demanding an injury be "willful and wanton," or that the defendant's conduct be wrongdoing of an outrageous character, many states now permit punitive awards when the defendant's conduct amounts to the equivalent of gross negligence.

Unlike compensation for actual injury, punitive damages are unpredictable, making it difficult for both sides to agree on a reasonable settlement. Often, plaintiffs are encouraged to bring lawsuits involving only minor injuries because of the potential for a large punitive award.

Public Policy Questions

▸ Who should be held accountable for the payment of punitive damages: the defendant's insurance company or the specific defendant deemed to be responsible for the conduct?

▸ Should punitive damages be paid to the plaintiff, who has already been economically compensated for his injury, or should they accrue to a general fund established and administered by the state?

▸ Should caps be placed on punitive damages—either dollar limits or ratios of economic awards—in order to allow for some predictability and certainty within the system?

Contract Interpretation

In California, a man's homeowner's insurance policy specifically excluded coverage for earthquakes. The man did not purchase special earthquake insurance coverage. When an earthquake damaged his home, the man filed a lawsuit demanding that his insurer pay for the repairs.

The man argued that the construction of the house affected the way it was damaged in the earthquake. Since construction errors were covered by the insurance policy the insurer was ordered to pay $47,000 in repair costs, along with $1 million in punitive damages for failing to settle the claim earlier.[5]

Description

When one of the defendants in a lawsuit has an insurance policy, there is sometimes the question of whether the defendant is covered by the terms of the policy. To resolve the question, the courts generally apply the rule that if the contract is ambiguous it should be interpreted to provide coverage.

Original Justification

Since the party drafting the contract is in the best position to protect itself by making the wording clear, courts resolve ambiguities in favor of the other party. Insurance companies generally write the terms of insurance policies, so courts construe ambiguities against them.

Subsequent Developments and Operation Today

Many courts have gone beyond this general rule to find insurance companies responsible — even in some policies which clearly exclude the damage being sued for. In some states, insurers have a duty to make good faith settlements. They may be held liable for huge punitive damage awards for failing to settle, even when the policy

excludes the claimant's claim. Therefore, more dubious claims are paid, resulting in a higher cost being passed on to consumers.

Public Policy Question

▸ If coverage is specifically and clearly excluded in a policy, should the insurer be required to pay?

Strict Liability

An overweight man with a history of heart disease suffered a heart attack while he was trying to start a Sears lawnmower. He sued Sears, charging that the mower's pull rope required too much force. A Pennsylvania jury awarded the man $1.2 million, plus an additional $550,000 in punitive damages because Sears did not promptly settle the claim.[6]

Description

The strict liability doctrine allows courts to hold a defendant liable for an injury—even if the defendant was not negligent. The plaintiff simply must prove that he was injured while using the product the way it was intended and that the injury might have been prevented if the product had been designed or manufactured differently.

Original Justification

Strict liability doctrines in English common law grew partially out of purely technical pleading rules and partially from property law concepts. The strict liability standard for extremely hazardous activities, such as blasting, grew out of the belief that some activities were so dangerous that, even when carried out with the utmost care, anyone who undertook them could be held liable for causing injuries.

The justification for strict liability for product-caused injuries was that manufacturers were in the best position to discover and prevent hidden defects and that if a product was dangerous the cost of that danger should be assessed through the tort liability system.

Subsequent Developments and Operation Today

Because strict liability was not based on negligence, American courts were initially hostile to the adoption of this doctrine. In some states,

strict liability was considered a violation of the state constitutional requirement that defendants be given due process of law.

By the mid-1900s, however, American courts were applying the strict liability doctrine in two areas: (1) those engaging in ultrahazardous activities were held strictly liable for injuries they caused, regardless of how careful or prudent they had been, and (2) in a certain number of cases involving adulterated foods and beverages, defendants who made and packaged the products were held liable without a requirement of showing negligence.

Beginning in the early 1960s, a number of state courts adopted strict liability as the standard for all manufactured products. If a customer is injured while using the product in the way it was intended, he can sue. It is now no longer a defense to argue that the product was designed and manufactured in a reasonably prudent manner.

While strict liability for manufacturers initially applied only to hidden dangers or product defects, some states have extended the doctrine to apply to products even where the danger was obvious.

Greater availability of large punitive and pain and suffering awards, coupled with the doctrine of joint and several liability, has meant that manufacturers are now faced with the prospect of enormous liabilities—regardless of the extent of care used when manufacturing a product.

Public Policy Questions

▸ Should products which are unavoidably dangerous, yet socially desirable (such as drugs and vaccines), be exempt from the strict liability standard as long as prescribed, protected procedures are followed?

▸ Should obvious negligence on the part of a plaintiff release a manufacturer from his responsibility for an injury?

Proximate Cause

A New York doctor left his car with an attendant in a parking lot. While moving the car, the parking attendant hit a security guard. The guard sued. The New York Court of Appeals held that the guard could recover $75,000 from the doctor and his auto insurance company, even though the doctor's sole involvement in the accident was to leave his car in the lot.[7]

Description

Proximate cause is a doctrine which originally limited the liability of a person to the relatively direct and foreseeable effects of his actions. The defendant was only held liable if his negligent act or omission was an immediate cause of injury and not superseded by someone else's later unforeseen negligent act or omission which more directly caused the injury.

Original Justification

The doctrine of proximate cause was adopted to provide a common sense boundary for what otherwise might be limitless liability for relatively innocent acts.

The original doctrine of proximate cause took into account that an almost limitless number of events can contribute to an accident or injury. For example, an alarm clock which fails to go off could make a man late for work and the fact that his car takes an unusually long time to warm up could make him even later. These events could conceivably combine to make the man so nervous about being late that he drives recklessly and strikes a pedestrian as he careens around a corner.

Those who formulated the common law recognized that not every act which indirectly contributes to an accident is a basis for liability. In the example cited above, a case could be made that if the alarm clock had not malfunctioned and if the car had started more promptly, the accident

might not have occurred. The original doctrine of proximate cause would have held that the reckless driver should be held liable for the injury.

Subsequent Developments and Operation Today

The doctrine of proximate cause has always been a somewhat flexible one, and the courts have steadily expanded the scope of liability. In addition, statutes or judicial decisions in many states now make bartenders liable for injuries caused by drunk drivers.

Some area courts have gone so far as to drop the requirement of showing actual causation, holding that where the plaintiff is unable to prove which of several possible defendants' products injured him, the defendants can be held liable in proportion to their market share.

Public Policy Question

- Should courts return to traditional proximate cause analysis, requiring plaintiffs to prove that the defendant's acts directly contributed to their injury?

Pain and Suffering/Mental Distress

A New Jersey man took a neighbor's child to the circus. While there, a leopard mauled and killed the child. The man recovered $1 million for the emotional trauma caused by witnessing the incident. By comparison, the boy's parents, who were not present at the circus, recovered $120,000 for the death of their child.[8]

Description

In addition to compensating for economic loss such as medical expenses, the courts now award general damages for pain and suffering to cover physical pain, mental anguish, emotional distress, etc.

Original Justification

English common law severely limited the availability of general damages for pain and suffering. It was thought that emotional injuries without accompanying physical injuries were too difficult to evaluate, too easy to fabricate and often too trivial to justify compensation.

Subsequent Developments and Operation Today

The awards for pain and suffering that accompany other injuries have become increasingly large. In addition, some courts now allow recovery for mental distress caused by seeing or hearing about injuries to others, as well as for a variety of emotional traumas that occur without physical injury.

Public Policy Questions

- Should pain and suffering awards be allowed only when there is an accompanying physical injury?
- Should there be limits on the amount and/or type of pain and suffering claim?

Additional Issues

Several other issues which are not doctrine-related may require further study. These issues include:

Contingency Fee Arrangements

Plaintiff attorneys today can earn upwards of 40 percent of a total award verdict. No other profession in the world can command an agent fee which is this high. We might want to consider placing limits on attorneys' contingencies, based on how the case is settled (settlement, arbitration or judgment) or on the size of the award or settlement, or on costs.

Nuisance Lawsuits

Each year, thousands of groundless lawsuits are filed with the hope of coercing an easy settlement. The high costs of defense frequently make it cheaper to settle a lawsuit than to win it.

Courts are becoming more receptive to the idea of imposing costs and attorneys' fees upon litigants who bring frivolous suits. Although there is obvious difficulty in determining when a lawsuit is "frivolous," many have proposed increased use of these sanctions to deter the use of frivolous suits which clog the court system and coerce settlements.

Alternate Dispute Resolutions

Tort litigation is time consuming and expensive. Alternative dispute resolutions (ADRs), such as negotiation, arbitration and mediation, have been suggested as a method to ease the expense and back-up in our tort reparations system. ADRs might be deemed mandatory and binding for claims falling under a pre-set limit, thus allowing the judicial system to free itself to deal with cases involving larger claims in a more timely fashion. If the case were appealed to a trial court, then the losing party would be required to pay litigation costs. The same rule would also

apply if the plaintiff appealed and received an identical or lesser award compared to that achieved in ADR.

Jury Verdict Responsibility

Any consumer knows how difficult it is to establish a budget. Juries today are asked to determine an award to an injured victim simply by guessing how that victim should be fairly compensated. Some have suggested requiring juries to itemize awards in the same way any budget is itemized in order to more accurately reflect the costs of the injury. These awards might be itemized to reflect specific medical expenses incurred to date, future estimated medical losses, days lost from work, etc.

Caps on Damages

Many have suggested placing limits on damages, specifically non-economic damages, such as pain and suffering or punitive damages. Recommendations include placing top dollar limits on specific types of non-economic damages or limiting these awards to a certain ratio of the economic damage award.

Apportionment of Damages

Joint and several liability, coupled with comparative negligence, can require a defendant to pay for the total cost of an injury, even if he is only slightly responsible. Some have recommended that the judge or jury determine the extent (percentage) to which each defendant would be held financially responsible for payment of an award. Those who support apportionment of damages believe this would allow for more flexibility within the system, without eliminating the ability of an innocent victim to be fairly and justly compensated for an injury.

Tort Reform: What You Can Do

In America, it is our right — some would argue our obligation — to make our voices heard. That's what makes democracy work.

There are various steps you can take to directly impact tort reform in your state:

▸ Write your legislator and request his/her opinion regarding tort reform in your state.

▸ Respond to the letter, indicating your support for or opposition to your legislator's stance.

▸ Use the media: When you see a story about tort reform in a newspaper or magazine, write a letter expressing your opinion on the subject. (This is one of the most effective methods of speaking directly to legislators.)

▸ Get involved in a grassroots organization which supports your stance on tort reform. Your local state representative should be able to help direct you to an appropriate group. If no such organization exists, consider starting one with others who share your opinions.

William M. McCormick recently presented a speech, titled "The American Tort System: A Time to Rebalance the Scales of Justice," in which he urged reform of the American tort system. Mr. McCormick, 45, is Chairman and Chief Executive Officer of Fireman's Fund Insurance Companies, a position he has held since 1983. He is also President of Fireman's Fund Corporation. Prior to joining Fireman's Fund, Mr. McCormick held various positions within American Express Company, where he rose to President of American Express Travel Related Services Company, Inc. He began his business career as a management consultant with McKinsey & Company, Inc. Mr. McCormick, who holds a Master's Degree in nuclear physics, served in the U.S. Navy as a lieutenant on the Atomic Energy Commission staff of Admiral H.G. Rickover.

Sources

1. *Business Week*, August 26, 1985.

2. League of California Cities, "California Cases Involving 'Deep Pocket' Claims," March, 1985.

3. *Underwriter's Report*, November 7, 1985.

4. United Press International, May 11, 1985.

5. *Wall Street Journal*, June 16, 1983.

6. *Forbes*, July 15, 1985.

7. *New York Post*, December 7, 1984.

8. *Journal of Commerce*, December 5, 1985.

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FIREMAN'S FUND
INSURANCE COMPANIES

ISSUES FOR DISCUSSION WITH RESPECT TO
CSSB 377 (JUDICIARY)

I. OVERVIEW OF JUDICIARY CS

Section 1. Includes "purpose" language explaining the motivation behind the legislation. The language was taken from the state of Washington's recent tort reform legislation.

Sec. 09.17.010. Non-economic damages. Explains what type of damages constitute non-economic damages.

Sec. 09.17.020. Punitive damages. Allows for an award of punitive damages with half of the award going to the plaintiff and half to the state's general fund. Attorney's fee awards will be based upon the entire punitive award.

Sec. 09.17.025. Damages incurred while intoxicated or committing a felony cannot be recovered by a plaintiff more than 50% responsible for his injuries.

Sec. 09.17.030. Itemized verdicts. Provides for the factfinder's itemization of damage awards. Apportions the total amount between non-economic and economic categories, with further break-down in the economic category.

Sec. 09.17.040. Verification of claims. Either the party or his attorney must sign the complaint, counter-claim, cross-claim or answer submitted in an action and verify the truth of the allegations.

Sec. 09.17.050. Contributory fault. Codifies existing law regarding comparative fault.

Sec. 09.17.055. Collateral benefits. Provides that after a damage award, the defendant may provide the factfinder with evidence of the claimant's compensation for his injury from collateral sources lacking a right of subrogation. The claimant may then provide evidence of the amount of his attorney's fees and the premiums paid for the collateral source insurance coverage. The court will offset the excess collateral source income from the damage award.

Sec. 09.17.060. Apportionment of damages. Modifies the current common law rule of joint and several liability to limit a defendant's exposure to no more than twice the percentage of fault allocated to that party if he is less than 50% responsible for the total damage.

Sec. 09.17.070. Releases. Reduces any damage award by the amount a plaintiff receives from a settling defendant.

Sec 09.17.900. Definition. Defines the term "fault."

Section 3. Mandatory arbitration. Requires arbitration of tort claims seeking less than $75,000 in damages.

Section 4. Offers of judgement. Modifies prejudgment interest rules to provide for a 5% increase or decrease in the interest rate on a damage award if an offeree rejects a settlement offer and receives a less favorable judgment at trial.

Section 5. Prejudgment interest. Interest runs from date of accrual of the cause of action.

Section 6. Confirmation of award. Modifies the existing rule to account for the new arbitration requirement.

Section 7. Appeal of arbitration award. Provides the mechanism for appealing an arbitration award.

Section 8. Awards. Repeals existing collateral source rules and structured settlement rules.

Section 9. Review of attorney's fees. Provides for judicial review of a party's attorney's fees

Section 10. Attorneys' fees for arbitration awards. Provides for the award of attorney's fees for an appeal of an arbitration award if the prevailing party improves his award position by more than 10 percent.

Section 11. Superior Court jurisdiction. Provides superior court jurisdiction for appeals of arbitration awards.

Section 12. District court jurisdiction. Provides District Court jurisdiction for appeals of arbitration awards of less than $25,000.

Section 13. Right of contribution. Repeals existing law with respect to contribution among joint tortfeasors.

Sections 14 - 18. Rules of Civil Procedure. These sections amend the rules of civil procedure affected by the proposed legislation.

Section 19. Applicability. Specifies that all causes of action accruing on or after the Act's effective date are subject to sections 1 - 13 of the Act.

Section 20. Effective date. The Act takes effect immediately.

II. ISSUES UP FOR CONSIDERATION

A. <u>Alternative dispute resolution.</u>

1. Use of a "private judge" hired by the parties to resolve their dispute. Patterned after the California procedure.

2. Requirement of either mandatory arbitration or adjudication in small claims court of claims involving less than $75,000 in damages prior to initiating a court action. A trial <u>de novo</u> in District Court or Superior Court would be be available following the arbitration or small claims proceeding.

a. Modification of Rule 82. A party seeking a trial <u>de novo</u> would pay his opponent's attorney's fees and costs if he did not improve his position by more than 10% over the award in the initial proceeding.

2. Mandatory arbitration of contribution claims. Proposal to require defendants to arbitrate claims of contribution.

B. <u>Collateral Sources.</u>

1. Should this information be provided to the factfinder <u>prior</u> to the damage award?

2. Should all evidence of collateral source income be excluded from consideration by the factfinder in order to encourage responsible behavior such as self-insurance?

III. INSURANCE REFORM

1. eaningful tort reform can only be accomplished if comprehensive insurance reform is simultaneously undertaken.

a. Should a tort reform bill be passed in the absence of insurance reform?

2. Potential areas of reform.

a. Disclosure on a closed claim basis of all claims paid or settlements made with respect to the insurance of Alaska risks.

b. Insurance premiums based on the insured's claim history. Proposal that premiums should be higher for those with a history of

successful claims than for those who never seek payment on claims.

c. Notice of cancellation of policy. Proposal to extend notice period to 60 days prior to cancellation with immediate return of unused premiums.

d. Caps on increase in premiums. Proposal to limit the amount by which premiums may be increased in a given time period.

3. <u>Alternatives to Traditional Insurance Coverage.</u>

a. Should the state actively pursue alternative forms of risk management, <u>e.g.</u>, the use of reciprocals and pooling arrangements?

- Should the legislature loan reciprocals funds to establish their required reserves initially?

b. Comprehensive state reinsurance program.

- CSHB 589 (L&C) proposes the establishment of state disability insurance.

SCOTT WETZEL SERVICES:

OUTSTANDING REHABILITATION CASES:
TOTAL CASES: 19

1981	1982	1983	1984	1985
2	1	2	9	5

AVERAGE COST PER CLAIMANT: $ 7,740 *

ALYESKA PIPELINE:

1984 & 1985 CASES
TOTAL CASES: 6

1984	1985
4	2

Average Cost 1984 =$3,250 Average Cost 1985 =$5,473.50

DIVISION OF WORKERS' COMPENSATION:

ALL REPORTED CASES

	1982	1983	1984	1985
TOTALS	270	224	94	10
AVERAGE COST	$3,804	$3,595	$2,907	$1,384

	Ending In 1982	Ending In 1983	Ending In 1984	Ending In 1985	Incomplete
1982 CASES Total = 270	16 6%	87 32%	63 23%	39 14%	65 24%

	1983	1984	1985	Incomplete
1983 CASES Total = 224	15 7%	90 40%	49 22%	70 31%

	1984	1985	Incomplete
1984 CASES Total = 94	17 18%	33 35%	44 47%

	1985	Incomplete
1985 CASES Total = 10	8 80%	2 20%

SUCCESSFUL?

SCOTT WETZEL SERVICES:

NO.		PERCENTAGE
4	Successfuls	21%
7	Possibly Successfuls	
8	Unsuccessfuls	

ALYESKA PIPELINE:

All Cases Unsuccessful

DIV. OF WORKERS' COMPENSATION: **

NO.		PERCENTAGE
46	1982	17%
62	1983	28%
26	1984	28%

*SWS Manager reports rehab. cases running an average between $3,000 and $5,000.
**Based on "Returned to Work" and "Released for Work" codes.

FOR IMMEDIATE RELEASE
August 15, 1985

For further information, contact:
Bob Hunter, (703)549-8050

INSURANCE COMPANIES "ON STRIKE" NADER/NICO CHARGE: FEDERAL SOLUTION SOUGHT

Washington, DC, August 15 – Ralph Nader today charged the insurance industry with "going on strike to extort excessive rates from the public." Nader also said that states were "failing to adequately protect consumers and stop the hemorrhaging." He called for federal action to make insurance available when insurers "abdicate their responsibilities."

Nader was joined by ex-Federal Insurance Administrator Robert Hunter, President of the National Insurance Consumer Organization (NICO). Hunter, an actuary, released a major NICO study of insurer profitability, stating that; "While insurer profits were low last year, a modest rate adjustment of about five percent was all that was needed to gain an acceptable profit level. Instead, we see massive cancellations and price increases of up to 1000% for day care centers, municipalities, environmental clean-up firms, fishing fleets, transit authorities, nurse-midwives and others. This is an unjustified raid on peoples' pocketbooks and the states are letting them get away with it," Hunter charged.

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Good morning! I am Bob Hunter, President of NICO.

We are here this morning to discuss a mounting crisis in America, a crisis which involves every man, woman and child: the nation is losing its liability insurance. (See chart of headlines.) Day care centers are losing their insurance and are being forced to close, perhaps driving second breadwinners out of work or creating new latchkey children. Nurse-midwives are losing their insurance and the lower cost birthing centers are shutting down. Doctors are marching on state capitals because insurance is unavailable or costs have skyrocketed. Cities, Transit authorities, even whole states are losing their liability insurance. One of the leading auto insurers in the District of Columbia has pulled out. The list goes on and on.

And prices have skyrocketed. As this chart shows, the cost of insuring an auto in America has gone up at 9.1% for the first 6 months of 1985, exceeding the rate of change for all of 1984. 1/ The annualized rate of change is 18.2%

What is going on here? Are these practices of insurers justified?

The answer is "NO!" What we are witnessing is a manufactured crisis intended to bloat insurer profits and reduce victim's rights.

Property-Casualty insurance has a cyclical profitability, as this chart shows. 2/ In 1984, if you accept the insurer's whopping reserve increases as valid (quite a large leap of faith), they earned a 3% rate of return on net worth (equity). That is too low. It would indicate that their premiums were about 5% short. If their premiums had been 5% higher, they would have earned a rate of return on net worth of about 15%, more than enough for an industry of the low to average riskiness of Property/Casualty insurance. 3/

A five percent premium shortfall is not a crisis. Yet we see all of the cancellations and mammoth price increases such as:

- A 70% increase for OB/GYNs in Maryland (totally unjustified — per analysis, attached).
- 300% to 900% increases in lawyer and architect malpractice insurance premiums around the country.
- Increases of 200% to 500% for the day care centers who can get insurance. Many can't.
- 300% to 1000% increases for public transit authorities.

The statistics don't justify any of this!

What is going on?

If you look again at the cycle chart you will see that 1984 was a typical "bottom-of-the-cycle" year. The last time it happened was in the mid-1970's when I served as Federal Insurance Administrator. At that time, the country observed the twin crises of medical malpractice and product liability unavailability and skyrocketing premiums.

After insurers abandoned the medical and product manufacturer lines, the federal government reviewed the situation. I was fortunate to be part of the interagency working group that found that there was no justification for the insurer actions. 4/ We concluded that the insurers had just panicked from lack of data.

But look at what happened; their profits skyrocketed to all time record levels. They learned that the state regulators would, during the panic, give away the store in rate increases. They also learned that state legislators would act to reduce victims' rights in the wake of the panic (over half the states did so 5/).

They are applying the lessons they learned in the mid-1970's very well today — to day care centers, to nurse-midwives, to doctors, to product manufacturers, and so on. They are petitioning Congress for product liability tort law changes and the states for changes in other tort systems.

Some property/casualty officials have made statements in the public record that; "It is right for the industry to withdraw and let the pressures for reform build in the courts and in the state legislatures." (Journal of Commerce, 6/18/85) Reinsurance, a critical aspect of maintaining available and affordable insurance rates may not be available from overseas because syndicates would "simply not write reinsurance for the American casualty industry" in 1986. A representative of that overseas market was recently reported to have said that if a new policy form is not adopted by state regulators, reinsurance wouldn't be provided to American liability underwriters.

Wall Street knows what is going on. This chart shows that the property/casualty stocks have soared to record highs more than doubling the Dow Jones Industrial Average rise in 1985. 6/ Wall Street expects state regulators to allow excessive rate increases; Wall Street is right!

Insurers blame this crisis on the courts and the tort law and say the only way to fix it is to take away as many victims' rights as possible. They can point to such statistics as these:

Of 23 insurers riting liability insurar for day care centers in Maryland last year, 15 have left the market. Of the remaining 13, six will not write any new business. The last 7, those who will write new business, all have excluded child abuse from their policies. The Maryland Commissioner of Insurance has termed the pull out "hysteria" since no data supports it. 7/

Insurers will say this points to the need for tort reform, 8/ while admitting that data don't justify the action. 9/ I believe it shows joint action intend to create an atmosphere where rates can be put too high and legislators will be intimidated into action designed to take away victims' rights. Further, at the top of the cycle a few years ago, the now-dreaded liability insurance prices were being slashed wildly and even being sold after the insured event happened, such as in the case of the MGM Grand Hotel fire where liability coverage was written months after the fire. 10/ If tort reform was so desperately needed in 1974 and 1975, why not in 1981? Why again today? The crisis is within the insurance industry, not in the courts.

Now, insurance premiums represent 11.1% of the disposable income in this country. 11/ It is the fourth leading purchase Americans make (behind food, housing and federal income taxes, although we expect it to pass federal taxes this year).

In 1944, the Supreme Court found that insurance was interstate commerce and, thus, subject to anti-trust and other federal statutes. In 1945, under heavy insurer pressure, Congress passed the McCarran-Ferguson Act which uniquely exempts insurance from the federal anti-trust laws (except should intimidation, coercion or boycott occur). Congress delegated the authority to regulate insurance to the states with no standards for regulatory excellence and no ongoing congressional oversight. Indeed, the FTC cannot even study insurance under current law 12/ unless Congress specifically authorizes it in advance. (Their power was revoked because they had the audacity to point out that whole life insurance was not a wise purchase for most Americans. The fact that the FTC was right did not alter their fate.)

The immensely important McCarran-Ferguson Act was adopted by Congress without benefit of a hearing. The legislative history makes it clear that President Roosevelt wanted only a short, two or three-year moritorium after which anti-trust laws would fully apply. 13/ That is, in fact, what both houses of Congress adopted but their language was somewhat different, requiring a conference. Mysteriously, the conference committee reported back a bill that continues in effect today.

Every independent study of insurance concludes that the states have failed mysteriously in their attempts to regulate this giant industry. 14/

The states have allowed this crisis to happen. Had they been equipped to keep prices to statutory standards (all states require that the rates be "not excessive, not inadequate, not unfairly discriminatory") we would not be in the mess we are in today with clearly excessive prices going into effect routinely around the nation and unfair cancellations rampant.

What Should We Do?

(1) We call today upon Congress to review the McCarran-Ferguson Act to determine if it is working to protect America. The quality of state regulation is documented to be inadequate; the insolvency funds are a "Maryland S&L Crisis Waiting to Happen." Congress should act now.

(2) NICO also believes that the approach enacted at a previous bottom, 1968/9 is worthy of consideration by the Congress: The Urban Property Protection and Reinsurance Act of 1968 was a response to the unavailability of insurance in the inner cities in the wake of the riot situation of the late 60's. 15/

To be sure, the predicate for the withdrawal of riot insurance was strong, given the very serious situation extant in the country at the time. But the finding of the President's Panel on the Insurance Crisis is just as valid for the day care provider community today as it was for the inner city communities of the late 60's: "Communities without insurance are communities without hope." 16/ Providers will have to shut down, possibly forcing spouses to decide among themselves which one will have to stop working, or the latchkey situation will be exacerbated, or other undesirable results will be forced on parents. Some families may even have to give up a home for loss of the second income, situations not unlike the loss of mortgage following loss of insurance in inner city areas plagued by riot almost two decades ago.

The federal government agreed to reinsure (insure the insurance companies — a sort of lay-off bookie arrangement) the insurers against the specified peril of riot and civil commotion in return for a reinsurance premium and a commitment to participate in a pool to make sure insurance is available to all residents whose homes met reasonable standards of insurability.

The federal government made $125 million writing this reinsurance!

The cities were saved from the sure death that no insurance brings in twentieth century America!

The program worked well.

I think that a program of stand-by authority should be prepared to take care of the day care and nurse-midwives current problem (and, perhaps some of the others). The authority should be granted to cover future crises as well, to stabilize the insurance profit cycle's harsh symptoms.

When a line of insurance became severely distressed, representatives of those purchasers could appeal to the agency given authority to reinsure. The agency would make a finding as to the extent and cause of the dislocation. If a distressed situation is certified, then the agency could offer reinsurance to insurers who would agree to make a market in the line. Following meetings with the insurers, the agency head would determine what the cause of distress was and would offer only to reinsure that cause (e.g., only reinsure the peril of child abuse for day care liability if that is the finding). Insurers would pay a reinsurance premium designed to be self-sufficient.

Insurers, the administrator of the program and representatives of the distressed industry would meet to set standards for insurability under which those who qualify are assured of an insurance market.

Studies will be undertaken to determine if other longer range action (risk management, tort reform, etc.) is also needed to resolve underlying problems.

Funding for this program would come from reinsurance premiums. I also envision a small surcharge, perhaps one-quarter of one percent of premiums written by all p/c insurers, to back up the program. This is in case premiums are insufficient over a short period or if it is determined by Congress that some short term subsidy is required to stabilize a distressed line sometime in the future.

The one-quarter of one percent surcharge would cost only 81 cents on the average private passenger car premium but would yield over $300 million this year. Over a ten year cycle, with a 10% growth in premiums and a 10% interest rate, $7 billion would flow into the Treasury. I would envision these funds being used in the general revenue area, but carefully accounted for to be available to the agency head when needed.

(3) Finally, NICO has today asked the Department of Justice to review the evidence to see if a conspiracy to boycott insureds has occurred in Day Care insurance and other lines, the intent of which is to intimidate state regulation into granting excessive rate increases and to intimidate state and federal legislators into passing unjustified tort law modifications which will maximize insurer profit levels.

Such boycotts and intimidations are not exempt from federal review under the provisions of the McCarran-Ferguson Act.

Conclusion

America deserves a better deal on its insurance. The federal government cannot sit idly by and let the insurance industry hold day care providers hostage in a large game beyond the providers' control. The terrorist tactics of insurers every 10 years at cycle bottom must be dealt with in a systematic way that adds the stability to our economy that insurance is meant to deliver. It is time the Congress began to look at the delegation it made to the states in 1945 to see if we are, as a nation, getting the most we can out of that twelve percent of our disposable income we pay into insurance premiums. A good place to start is solving the day care crisis that exists only in the minds of a few underwriters on John Street in New York City.

FOOTNOTES

1/ CPI data on "auto insurance", Bureau of Labor Statistics.

2/ Source of data: Citybank Economics and Insurance Services Office.

3/ For a discussion of risk in the property/casualty insurance business, see Investment Income and Profitability in Property/Casualty Insurance Ratemaking, J.R. Hunter and J.W. Wilson, 1983, Chapter 5.

4/ Hearing on December 3, 1975, Subcommittee on Health of the Committee on Labor and Public Welfare, US Senate. Among the interesting data supplied by ISO at that hearing were exhibits that showed that the average claim cost ISO used for ratemaking significantly exceeded the limit of liability, clearly ratemaking that had run amok. That led to this exchange:

Sen. Laxalt: Is malpractice always a loser as far as carriers are concerned?

Mr. Hunter: If they charge these rates, they could not help but win. (Page 141.)

In John Guinther's book, The Malpractitioners, Anchor Press, 1978, Guinther cites this exchange at page 169 in a chapter entitled "They Could Not Help But Win." In the following chapter, called "They Won," Guinther reviewed the later experience.

Final Report, Prodı : Liability Task Force. ɛport on Product Liability Ratemaking, Product Liability and Accident Compensation Task Force, US Department of Commerce, 1980. At page ix the Report states that "overly subjective ratemaking practices were one of the principal causes of the product liability insurance problem."

5/ St. Louis Post Dispatch, Section B, P.3, 4/14/84.

6/ Source of data: Best's Property/Casualty Stock Index, A.M. Best and Company, Oldwick, NJ.

7/ "The day care facilities have been caught up in this availability crunch and are being deemed higher risk, not necessarily based on a claims experience but due more to an insurance hysteria . . ." Testimony of Edward J. Muhl, Insurance Commissioner of the State of Maryland, before the House Select Committee on Children, Youth and Families, July 30, 1985.

8/ "Any permanent solution (of the day care insurance crisis) will require significant changes in the tort system." Testimony of Frank Neuhauser, Vice-President and Actuary for AIG (a leading insurer of day care centers) before the House Select Committee on Children, Youth and Families, July 30, 1985.

9/ "The countrywide experience for those companies reporting premium and loss data to the Insurance Services Office . . . appears to conform with the current loss experience for the majority of commercial insurance lines . . . (these data) do not suggest that insurers should abandon the market." Testimony of James L. Kimble, Senior Counsel, American Insurance Association, before the House Select Committee on Children, Youth and Families, July 30, 1985. The testimony was also endorsed by the Alliance of American Insurers.

10/ See, for instance, the National Underwriter, 11/20/81, page 1, where it says:

> A large commercial umbrella (liability) risk came up for renewal and was rated at $105,000, about the same as the previous year. But the insured was not satisfied. Aware of the aggressive rate competition in the commercial lines market today, he decided to shop around. He approached a second agent, who submitted the very same risk to a different company, which offered to write it for just $20,000.
> But the insured was still not happy. He continued shopping and eventually the original company, which originally wanted $105,000 came back and took the business for $5,000. That's right, $5,000. (Emphasis added.)

11/

Item	1984 Amount Spent in Billions a/	Column (1) -- 1984 Disposable Income of $2,578.1 Billion a/
Food	444.3	17.2%
Housing	397.8	15.4
Personal Income Taxes	302.6	11.7
INSURANCE b/	287.1	11.1

a/ Source: US Department of Commerce, Bureau of Economic Analysis.
b/ Source: Bests Management Reports, December 31, 1984, page 1.
Life Insurance Fact Book, page 56.
Blue Cross Association, Telephone call of 1/25/85.

12/ The law was euphemistically entitled the "FTC Improvements Act of 1979."

13/ See Statement of Honorable Claude Pepper before the Subcommittee on Monopolies and Commercial Law on the Insurance Industry's Antitrust Exemption, April 11, 1984; found at page 5 of the Subcommittee's report, Competition in the Insurance Industry.

14/ See, for instance, Issues and Needed Improvements in State Regulation of the Insurance Business, General Accounting Office, 1979; Invisible Bankers, Andrew Tobias, Linden Press, 1982; The Life Insurance Game, Ronald Kessler, Holt, Rinehart and Winston, 1985; "Protection for Sale: The Insurance Industry," NBC-TV News, 1981; Risk, Reality and Reason, the Conference of Insurance Legislators, September, 1983.

One of the tests of state preparedness to deal with a crisis in availability and pricing of liability insurance is actuarial staff. Of the 52 states (including DC and Puerto Rico) NICO surveyed, we find that 26 have actuaries. So one-half of the states have no actuaries at all.
There are 62 actuaries employed by the states, of the 7,682 actuaries in the nation. It is well known in the industry that those best suited to deal with matters pertaining to liability insurance are those who have passed the examinations enabeling them to be "Fellows" in the Casualty Actuarial Society. State regulation has only 8 such persons. They are employed by only 5 states [Connecticut (1), Massachusetts (1), Michigan (1), New Jersey (1) and New York (4).]
Aetna Life and Casualty Insurance Company alone employs 126 actuaries. Travelers has 100.

Source of data: American Academy of Actuaries 1985 Yearbook and Directory of Members by Business Affiliation.

15/ Public Law 90-448, 82 Stat. 476; 12 U.S.C. 1749bbb, 42 U.S.C. 4011.

16/ Meeting the Insurance Crisis of Our Cities, A report of the President's National Advisory Panel on Insurance in Riot-Affected Areas, January, 1968, p. 1.

NATIONAL INSURANCE
CONSUMER ORGANIZATION

5 Rocky Mt. States Lose Liability Cover

6/27/85

The Colonial Press Insurance Co. has "nonrenewed" a liability insurance policy for the entire state of Colorado.

Unless the state can come up with ... coverage by Sept. 15, ...

"We've been ... the three thousand ... companies in ... country, only ... them are willing ... government entiti..."

Midwives Facing Loss of Insur...

7/13/85

By CAROL LAWSON

Birthing Centers Face Shortage of Cover

7/1/85

Insurance Premiums Sink Fishing Fleet

7/5/85

Transit Systems Fa... Liability Shortage

7/12/85

The loss ratio for pub... transportation systems has remained constant, yet members are experiencing premium increases from 300 percent to 1,000 percent.

Fireworks Makers Face Loss of Insurance

7/2/85

NEW YORK — A Fourth of July without its evening of "ooo — booo — ahh" is unthinkable.

But the way things are in the casualty insurance industry, the Fourth next year might very well be quiet, indeed.

Day Care Insurance Imperiled

Policies Canceled, House Hearing To...

Rate hikes, capacity crunch seen with July 1 renewals

7/15/85

THE 1985 INSURANCE CRISIS

WHAT'S GOING ON HERE?

Auto Insurer To Discontinu... Service in D.C.

7/10/85

About 18,000 customers, most of them high-risk drivers ...

Risky Business

Liability Insurance Is Difficult to Find Now For Directors, Officers

7/10/85

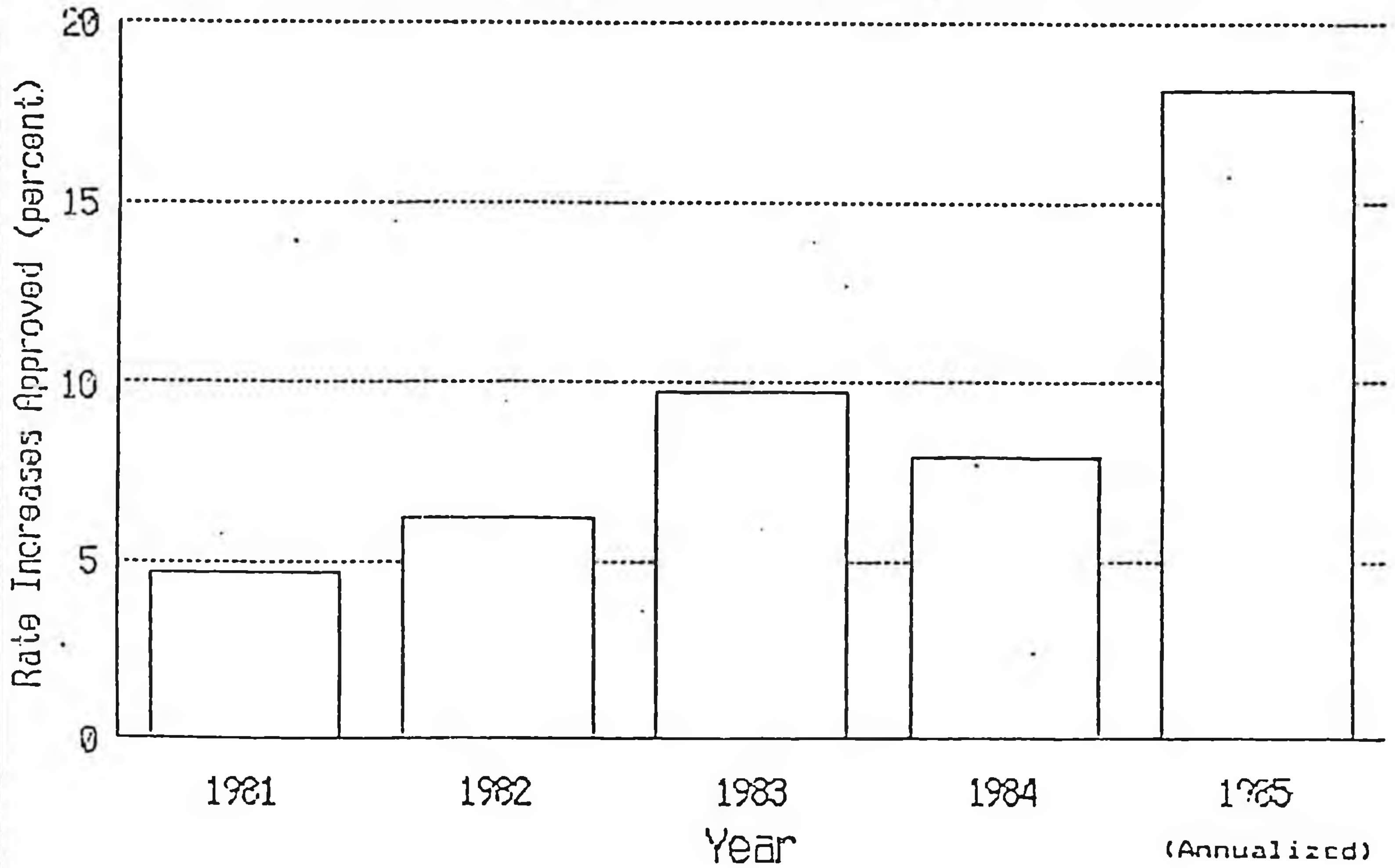
Suits by Shareholders Cause Premiums to Skyrocket

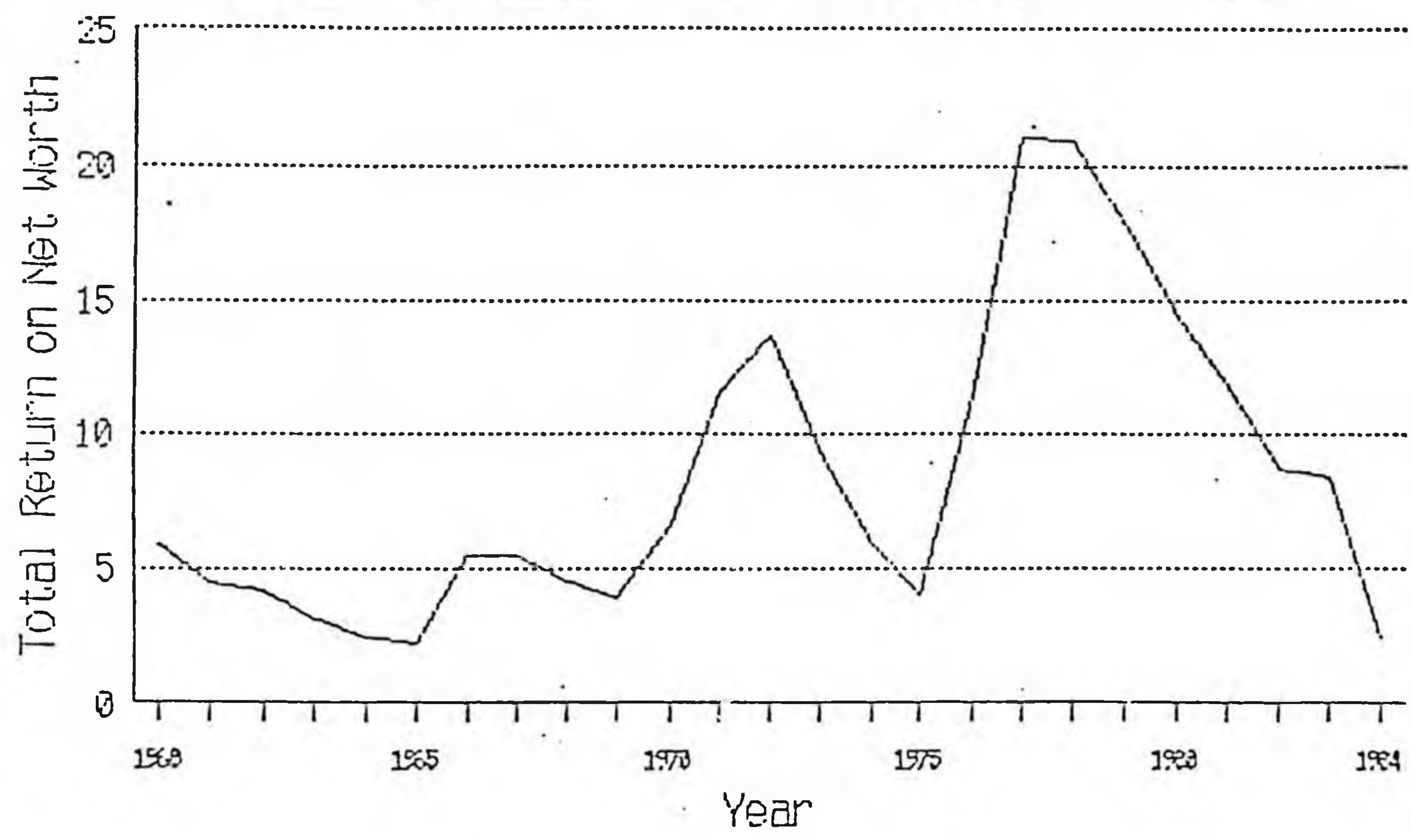
The worst is yet to come, reinsurers, brokers predict

By DOUGLAS McLEOD

7/5/85

AUTO INSURANCE RATE INCREASES IN THE USA




THE "CYCLE" AND CONSUMER ABUSE
Total Return on Net Worth
0
5
10
15
20
25
1960
1965
1970
1975
1980
1984
Year

CITIZENS COALITION ON TORT REFORM, INC.

One of the gravest problems facing individuals, governments and businesses in Alaska today is the dramatic rise in liability premiums. At the present time the problem is compounded by a variety of factors. While insurance premiums are being increased, many insurance companies are pulling back from servicing policies in Alaska. The risks, especially in the Bush, are too great. Legislative remedies are needed. Following is a summary of proposals from the CITIZENS COALITION ON TORT REFORM INC.

1. CAP NON-ECONOMIC AWARDS

Non-economic awards compensate a victim for pain and suffering, loss of consortium and other intangible losses. A cap will establish consistency and result in predictable insurance programs. We suggest a maximum award of $250,000.

A recent United States Supreme Court decision allowed California to impose a limit of $250,000.

Bollio v Elliot AK

2. MANDATE STRUCTURED SETTLEMENTS

Structured settlements provide future payments to the victim equal to the total award. The future payments are consistent with the victim's loss.

3. DISCLOSE COLLATERAL INCOME SOURCES

Juries currently are not allowed to know when a victim has insurance coverage and has already been compensated. Accordingly that coverage is ignored in jury awards.

4. SET A SLIDING SCALE OF ATTORNEY'S CONTINGENT FEES

A sliding scale will increase the proportion to the victim as the amount of the award increases. Current practice allows an attorney a set percentage irrespective of the amount of the award.

The California sliding scale has been upheld as constitutional.

5. MODIFY JOINT AND SEVERAL LIABILITY

Several liability will apportion responsibility in accordance with degree of fault. Under current practice of Joint and Several liability, anyone at fault may be subject to the total liability.

6. REQUIRE ITEMIZATION OF ALL JURY AWARDS

The jury should make its award for damages with specific amounts. Damages will be itemized so as to reflect the monetary distribution among economic losses, non-economic loss, future losses, past expenses and other losses as applicable.

Similar legislation has been adopted by the State of Illinois in May of 1985.

7. ABOLISH RULE 82

This eliminates an additional expense. Current practice allows juries to make an award for damages which includes attorney's fees. Under Rule 82, the court can add up to 10% of the award for attorney's fees. (An attorney can claim and receive up to 10% of the settlement even if the case does not go to court.)

8. MODIFY PREJUDGEMENT INTEREST

Interest should accrue from the time of award or first offer of settlement. Current practice allows for interest to accrue from time of occurance. This will eliminate an unreasonable expense. How about time of filing?

9. REVISE WRONGFUL DEATH STATUTE

A cap on wrongful death awards where there are no legal dependents will eliminate unreasonable expenses. The maximum benefit payable for wrongful death, in instances of no surviving dependents, should be limited to $25,000.

Similar legislation exists in Montana.

10. PUNITIVE DAMAGES

Awards for punitive damages should accrue to the benefit of society as a whole, ie., the State of Alaska. ??

11. Statute of Limitations

The current statutes of limitation should be modified to insure that they are applicable to a reasonable time certain. Recent interpretations open the individual to liability to an indefinite time future. The result is total unpredictability and unlimited exposure is an uninsurable risk.

12. REQUIRE AN AFFIDAVIT OF MERIT

As a condition of filing a complaint, the plantiff's attorney; must certify there is reasonable and meritorious cause of filing the action. The plantiff's attorney must certify that he has consulted and reviewed the facts with a competent authority and has determined there is reasobnable and meritorious cause for filing the action.

Similar action has been adopted by the State of Illinois in May of 1985.

13. SPECIAL DAMAGES IN COUNTERCLAIMS

Eliminate the requirement to show special damages. This will require the plantiff's attorney to be held to the same standard of care principles required of other professionals.

14. EXPERT WITNESSES

Strict guidelines must be established for expert witness standards including current experience, substantial portion of his or her time currently involved in the practice and demonstration of a knowledge of the state of the art. Currently there are some expert witnesses whose sole practice is being an expert witness.

15. UNTRUE ALLEGATIONS

Legislation is needed to permit award of attorney's fees and payment of reasonable expenses from parties making untrue allegations without reasonable cause.

Currently there is no prohibition to plantiffs making allegations which are untrue. Similar legislation has been adopted by the State of Illinois in May of 1985.

16. MANDATORY ARBITRATION

Contracts shall provide for mandatory arbitration. The law should provide for judicial review of the arbitration hearings. In the event the mandatory arbitration is substantially upheld, the party requesting the judicial review shall assume all costs and fees related to the appeal.

OTHER SIGNIFICANT ISSUES

Provision for early dismissal of uninvolved parties by filing an Affidavit of Non-Involvement.

Require release of records prior to the institution of a suit.

Mandate advance notice of at least 60 days prior to the cancellation of insurance and provide for a timely return of unearned premiums.

Require disclosure of settlement information to licensing authority.

Provide reasonable immunity in anti-trust suits, except in the instance of malice and provide penalities for frivolous suits.

Make provision for review of professional activities by professional society.

Require all disciplinary actions by any professional group duly consistituted to be reported to licensing authority.

Limit application of strict liability.

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TESTIMONY OF

J. ROBERT HUNTER
PRESIDENT
NATIONAL INSURANCE CONSUMER ORGANIZATION

BEFORE THE
ALASKA LEGISLATIVE CONFERENCE

THE LIABILITY CRISIS IN INSURANCE

ANCHORAGE, ALASKA
DECEMBER 6, 1985

121 N. Payne Street
Alexandria, Virginia 22314
(703) 549-8050

OVERVIEW

We are here today to discuss a mounting crisis among small businesses and across America, a crisis which involves every man, woman and child: the nation is losing its liability insurance. Day care centers are losing their insurance and are being forced to close, perhaps driving second breadwinners out of work or creating new latchkey children. Nurse-midwives are losing their insurance and the lower cost birthing centers are shutting down. Doctors are marching on state capitals because insurance is unavailable or costs have skyrocketed. Cities, transit authorities, even whole states are losing their liability insurance. One of the leading auto insurers in the District of Columbia has pulled out. The list goes on and on.

And prices have skyrocketed. For example, the cost of insuring an automobile in America has gone up at a 9.1% rate for the first 6 months of 1985, exceeding the rate of change for all of 1984. 1/ The annualized rate of change is 18.2%, a record dollar change.

What is going on here? Are these practices of insurers justified?

The answer is "NO!" What we are witnessing is a manufactured crisis intended to bloat insurer profits and reduce victims' rights.

Property-Casualty insurance has a cyclical profitability, as Chart Number 1 shows. 2/ In 1984, if you accept the insurer's whopping reserve increases as valid (quite a large leap of faith), they earned about a 3% rate of return on net worth (equity). That is too low. 3/ It would indicate that their premiums were about 5% short. If their premiums had been 5% higher, they would have earned a rate of return on net worth of about 13%, more than enough for an industry of the low to average riskiness of Property/Casualty insurance. 4/

A five percent premium shortfall is not a crisis. Yet we see all of the cancellations and mammoth price increases such as:

- A 70% increase for OB/GYNs in Maryland (totally unjustified -- per analysis, attached as Exhibit I).

- 300% to 900% increases in lawyer and architect malpractice insurance premiums around the country.

- Increases of 200% to 500% for the day care centers who can get insurance. Many can't.

- 300% to 1000% increases for public transit authorities.

- One Northeastern state's liability insurance was $100,000 for $100 million of coverage last year. This year it's $400,000 for $3 million in coverage. Last year, it cost $1.00 per $1000 of coverage; this year it is $1.00 for $7.50 of cover.

The list goes on and on, but the statistics don't justify any of this!

What is going on?

THE LAST CYCLE BOTTOM - 1974/5

If you look again at the first chart you will see that 1984 was a typical "bottom-of-the-cycle" year. The last time it happened was in the mid-1970's when I served as Federal Insurance Administrator in the Ford Administration. At that time, the country observed the precise phenomena we see today. As a Washington Post editorial of November 3, 1976 put it:

> It is becoming increasingly apparent that liability insurance -- or the lack of it -- is becoming a national problem. . . . The rates charged those in professions other than medicine, most notably architects, are rising rapidly. Local governments are finding that it is increasingly difficult or expensive to buy insurance covering their police departments. And because of the price now placed on it, many small companies are dropping the product liability insurance they thought they needed. . . .
>
> It is no doubt true that the increasing number and size of judgments against police departments for false arrest or mistreatment of prisoners have had some salutory effects on police behavior. Similarly, malpractice suits have provided an incentive for more careful medical care, and product liability suits have forced manufacturers to produce better and safer products. But there must be some limit to all this, and we suspect it has been passed. The real beneficiaries of this litigation explosion have been the lawyers. . . . There has to be a better way of compensating those to whom reparations are due than the clumsy and expensive mechanisms that exist today. The legal ingenuity that created the present problem is going to have to be used to solve it. Otherwise, the whole system of liability insurance and of personal liability for wrongdoing is going to collapse of its own weight.

After insurers abandoned the medical and product manufacturer lines, the federal government reviewed the situation. I was fortunate to be part of the interagency working groups that found that there were no justifications for the insurer actions. 5/ We concluded that the insurers had just panicked from lack of data.

But look at what happened; their profits skyrocketed to all time record levels. Insurers learned that the state regulators would, during the panic, give away the store in rate increases. Insurers also learned that state legislators would act to reduce victims' rights in the wake of the panic (over half the states did so 6/). The fact that insurers achieved much of their 1975 legislative agenda and now are back for a bigger bite from the apple is very significant. Now, medical professionals want caps on overall and non-economic damages and municipal governments (and especially insurers!) are seeking elimination of joint and severable libility and punitive damage awards. Where will this raid on victims' rights end?

They are applying the lessons they learned in the mid-1970's very well today -- to day care centers, to nurse-midwives, to doctors, to product manufacturers, and so on. They are petitioning Congress for product liability and medical malpractice tort law changes and the states for changes in other tort systems.

THE HEAT IS ON

Some property/casualty officials have made statements on the public record that; "It is right for the industry to withdraw and let the pressures for reform build in the courts and in the state legislatures." 7/ Reinsurance, a critical aspect of maintaining available and affordable insurance rates may not be available from overseas because syndicates would "simply not write reinsurance for the American casualty industry" in 1986. A representative of that overseas market (Lloyd's of London) was recently reported to have said that if a new policy form is not adopted by state regulators, reinsurance wouldn't be provided to American liability underwriters. When I recently testified before the Maryland Governor's Special Medical Malpractice Committee, a medical malpractice insurance company executive told the committee that higher rates for ob/gyns in Maryland were put into their filing because the reinsurer required it, not because the rates were actuarily justifiable (which they weren't).

Wall Street knows what is going on. Chart Number 2 shows that the property/casualty stocks have soared to record highs more than doubling the Dow Jones Industrial Average rise for 1985. Through November 20, 1985, the Best's Property/Casualty Stock Index was up by 44% compared with a 20% Dow Jones increase.8/ Wall Street expects state

regulators to allow excessive rate increases; Wall Street is right! At the end of the first six months of 1985, the surplus of insurers has skyrocketed by $8 billion, over the year earlier figure, a growth of 13.4%. 9/

Insurers blame this crisis on the courts and the tort law and say the only way to fix it is to take away as many victims' rights as possible. They can point to such statistics as these:

> Of 28 insurers writing liability insurance for day care centers in Maryland last year, 15 have left the market. Of the remaining 13, six will not write any new business. The last 7, those who will write new business, all have excluded child abuse from their policies. The Maryland Commissioner of Insurance has termed the pull out "hysteria" since no data supports it. 10/

Insurers will say this points to the need for tort reform, 11/ while admitting that data don't justify the pull out. 12/ In New Jersey, at a hearing where ISO requested the new claims made form, the ISO could not say how many million dollar CGL type claims there were in recent years, nor what percentage of claims paid were in suit last year. Iowa Insurance Commissioner and NAIC president, Bruce Foudree says that "regulators cannot trust annual statements and quarterly financial data. We [regulators] will therefore need to get tougher and spend more time looking over companies' shoulders. We cannot tolerate falsification or deception on annual statements." 13/

I do not believe that there is a tort crisis across the nation, I believe we are witnessing joint action by insurers intended to create an atmosphere where rates can be put too high and legislators will be intimidated into action designed to take away victims' rights and to allow wrongdoers to go unpunished. It was no accident that A.H. Robbins tried to piggyback onto federal tort "reform" to be excused from its misdeeds.

At the top of the cycle a few years ago, the now-dreaded liability insurance policy rates were being slashed wildly and even being sold after the insured event happened, such as in the case of the MGM Grand Hotel fire where liability coverage was written months after the fire. 14/ Chart #3, labeled the "National Insurance Strike," shows the effect of rate cutting during 1981 and 1982 upon the profit levels of insurers. As you can see, the insurers cut about $1.5 billion in premiums over this interval and the resulting impact upon insurers profits was vastly significant---they plummeted. Chart #4 shows the profit levels insurers would have enjoyed had insurers not cut their premiums, but only maintained them at 1981 levels. Chart #4 shows great disparity between actual profits and those able to have been

realized had insurers simply held the line on premiums. Obviously, if premiums were increased at the same level as, say, the Consumer Price Index, insurer profits could have been even higher than the levels indicated in Chart #4. The national problem of insurer profits is clearly and convincingly self-inflicted.

If tort reform was so desperately needed in 1974 and 1975, why not in 1981? Why again today? The crisis is within the insurance industry, not in the courts.

When insurance trade association representatives talk to legislators, they point their fingers at the tort system for all their financial ills. But, amongst themselves, insurance association representatives and insurance company executives are more honest and admit their culpability for the current capacity crunch. A recent report put out by the Insurance Services Office (ISO) and the National Association of Independent Insurers (NAII) concluded that:

> The property/casualty industry must accept the major responsibility for its current financial condition. But, the brutal price war of the last six years is over. The industry has finally realized that a business cannot indefinitely price its product below cost and expect to survive. 15/

Now, we are asked to take the insurance industry's word that there is a tort problem and that limits on pain and suffering or on overall damages must be imposed so that rates will go down. All the evidence so far indicates that such caps have no effect on rates whatsoever.

Virginia has had limits on medical malpratice damages for years, but I was still called to testify before the legislature this year about insurance problems. Pennsylvania enacted one of the most restrictive immunity acts on record for its political subdivisions in 1978. 16/ Yet, despite those limits, Pennsylvania has another "crisis" in municipal liability insurance. A recent national study of the impact of "reforms" after the last crisis showed that caps on pain and suffering in medical malpractice cases have had no statistically measurable impact upon premium increases. 17/

I have done a lot of work in North and South Carolina as a consultant to the state governments. I am convinced that the degree of litigeousness in the Carolinas is low, significantly below that of other states where I work, for example. Such actuarial calculations as the loss development and the ratio paid to incurred losses, which I use for investment income purposes, make it crystal clear that, if there is a tort problem in this nation, it has not manifested itself in these states.

Yet, South Carolina has had to issue emergency regulations requiring no mid-term cancellations and 30-day notice of non-renewal price increases. If the crisis were truly tort based, South Carolina would not have to undertake such action. The fact that South Carolina insureds are feeling the same "hit" as the other states is stong evidence that the law is not causing the crisis, but rather that it is a creation of insurers.

In plain English, what the insurers propose in so-called "tort reform" hasn't worked and won't work. The evidence points overwhelmingly to a substantial insurance problem, both in the regulation and management of the property/casualty industry.

Insurance premiums represent 11.1% of the disposable income in this country. 18/ Insurance is the fourth leading purchase Americans make (behind food, housing and federal income taxes, although we expect it to pass federal taxes this year). Insurance rates have grown at an 18% rate for the first six months of 1985. If we are to see any relief, specific steps will have to be taken at both the state and federal level to end this insurance company misbehavior.

ALASKA'S EXPERIENCE

As great as things have been over the last cycle for the property/casualty insurers nationally, it is greater in Alaska. Over the last cycle, the operating income of insurers in Alaska was more than double that of the nation as a whole. Think of it, the profits in the nation were excessive, leading to a stock market performance of about four times the Dow Jones, yet Alaska's profit was twice the nation's; three times in private passenger auto insurance.

Perhaps you should look into your Insurance Division instead of into the tort law. In the 1981 Private Passenger Auto and Homeowner's Insurance, A Statistical Analysis published by the Division of Insurance, there was a discussion of the fact that Alaska had the lowest loss ratio in the country, indicating the highest profits for insurers, the least competition and the least efficiency. The Analysis said:

> The fact that Alaska ***enjoyed*** this position ***for the past three years*** is indicative of a ***healthy trend, one we hope to see continue . . . .***" (Emphasis added.)

How's that for consumer protection?

THE MCCARRAN-FERGUSON ACT

In 1944, the Supreme Court of the United States found that insurance was interstate commerce and, thus, subject to anti-trust and other federal statutes. In 1945, under heavy insurer pressure, Congress passed the McCarran-Ferguson Act which uniquely exempts insurance from the federal anti-trust laws (except should intimidation, coercion or boycott occur). Congress delegated the authority to regulate insurance to the states with no standards for regulatory excellence and no ongoing congressional oversight. Indeed, the Federal Trade Commission (FTC) cannot even study insurance under current law 19/ unless Congress specifically authorizes it in advance. (FTC's power was revoked because they had the audacity to point out that whole life insurance was not a wise purchase for most Americans. The fact that the FTC was right did not alter their fate.)

The immensely important McCarran-Ferguson Act was adopted by that earlier Congress without benefit of a hearing. The legislative history makes it clear that President Roosevelt wanted only a short, two or three-year moritorium after which anti-trust laws would fully apply. 20/ That is, in fact, what both houses of Congress adopted but their language was somewhat different, requiring a conference. Mysteriously, the conference committee reported back a bill that continues in effect today; an infinite moritorium.

Every independent study of insurance concludes that the states have failed miserably in their attempts to regulate this giant industry. 21/ The states have allowed this crisis to happen. Had regulators had the political will and been properly equipped to keep prices to statutory standards (all states require that the rates be "not excessive, not inadequate, not unfairly discriminatory") we would not be in the mess we are in today with clearly excessive prices going into effect routinely around the nation and unfair mid-term cancellations, coverage and price changes rampant.

WHAT SHOULD CONGRESS DO?

(1) NICO has called upon the Judiciary Committees of the US Senate and House to review the McCarran-Ferguson Act to determine if it is working to protect America. The quality of state regulation is documented to be inadequate; the insolvency funds are a "Maryland S&L Crisis Waiting to Happen." I do not call for the elimination of state regulation here as some insurers recently have. I believe that federal standards for state regulation, coupled with federal oversight on a continuing basis, are needed. Further, the federal government should take over the insolvency funds, making them an FDIC-type operation.

(2) NICO also believes that the approach enacted at a previous bottom, 1968/9 is worthy of consideration by Congress: The Urban Property Protection and Reinsurance Act of 1968 was a response to the unavailability of insurance in the inner cities in the wake of the riot situation of the late 60's.22/

To be sure, the predicate for the withdrawal of riot insurance was strong, given the very serious situation extant in the country at the time. But the finding of the President's Panel on the Insurance Crisis is just as valid for the day care provider community today and others losing coverage as it was for the inner city communities of the late 60's when the panel found that; "Communities without insurance are communities without hope." 23/

In the riot insurance crisis, the federal government agreed to reinsure (insure the insurance transactons of the insurance companies -- a sort of lay-off bookie arrangement) the insurers against the specified peril of riot and civil commotion in return for a reinsurance premium and a commitment to participate in a pool to make sure insurance is available to all residents whose homes met reasonable standards of insurability.

The federal government made $125 million writing this reinsurance!

The cities were saved from the sure death that being uninsured brings in twentieth century America!

I think that a program of stand-by authority should be prepared to take care of the day care and nurse-midwives current problem (and, perhaps, some of the others). The authority should be granted to cover future crises as well, to stabilize the insurance profit cycle's harsh symptoms. I have provided a copy of a draft bill to establish such a program to your staff.

Insurers, the administrator of the program and representatives of the distressed industry would meet to set standards for insurability under which those who qualify are assured of an insurance market.

Studies will be undertaken to determine if other longer range actions (risk management, insurance reform, etc.) are also needed to resolve underlying problems.

Funding for this program would come from reinsurance premiums. I also envision a small surcharge, perhaps one-quarter of one percent of premiums written by all property/casualty insurers, to back up the program. This is in case premiums are insufficient over a short period or if it is determined by Congress that some short term subsidy is

required to stabilize a distressed line sometime in the future.

(3) NICO has asked the Department of Justice to review the evidence to see if a conspiracy to boycott insureds has occurred in day care insurance and other lines, the intent of which is to intimidate state regulation into granting excessive rate increases and to intimidate state and federal legislators into passing unjustified tort law modifications which will maximize insurer profit levels. 24/ Such boycotts and intimidations are not exempt from federal review under the provisions of the McCarran-Ferguson Act. NICO has called upon the Congress to monitor activity upon this important request, which has prompted a preliminary investigation by the FTC.

(4) NICO has called upon the Congress to require federal licensing of alien insurers that are not licensed and meaningfully regulated by any state in this nation but who insure or reinsure here. If Lloyd's of London will use its economic clout to dictate our nation's policy forms, (it is Lloyd's which is pushing the claims made form down the throats of the primary carriers; it is Lloyd's which is forcing the defense costs inside the limit of liability) we think they should be subject to review by some authority here.

5) NICO proposes that the Congress modify the Product Liability Risk Retention Act of 1981 25/ to allow small businesses as defined by the Small Business Administration at 13 CFR 121 to form risk retention groups along the lines already authorized under the statute. Targeted assistance through the proposed reinsurance program can assist those small business insureds who are too few to form risk retention groups in a given state.

WHAT SHOULD STATES DO?

States must concentrate their major efforts on insurance reform and not tort "reforms."

1) States should encourage the federal government to seek a more pro-active role in the regulation of the insurance business. It is a sign of strength, not weakness, to ask for help when it is truly needed, and states surely need help in this area today.

2) The US General Accounting Office noted that the most critical deficiency in the regulation of insurance by the states was in the shortage of proper staff for adequate regulation. 26/ The GAO pointed out that this was a function of money and increased resources for targeted staff development for actuaries, accountants and lawyers will improve the quality and extent of state regulation of the

insurance business. Regulators need to develop staff in the critical areas outlined and must be given sufficient resources to do so.

3) State law must require disclosure of loss data on a line-by-line basis which would give regulators much better ability to discern whether rates are excessive, inadequate or unfairly discriminatory. Line-by-line reporting will allow for adjustments between personal and commercial lines. Companies' annual statements should be expanded to require detailed reporting of all general liability subline data, by subline.

4) To the maximum feasible extent, insurance rates must be made based upon experience. The failures of the regulators and the insurers to provide proper safety incentives lies chiefly in their unwillingness to rate commercial risks based upon individual experience. Admittedly some risks are hard to rate experentially, but over time the necessary data base can be developed to properly rate individuals and unusual risks. Experience rating will allow proper market messages to be sent to unsafe risks and reduce the costs for good risks currently paying to allow the continued operations of bad risks. No where is this more critically needed than in medical malpractice rates.

5) Tough conflict-of-interest statutes must be enacted in the states to prevent continuation of the "revolving door" found by the USGAO where 50% of regulators came from the industry and 50% went to it after being a regulator. 27/ An "arms length" relationship between regulators and the regulated industry must be established.

6) Insurance regulators need better data verification techniques either through conducting their own, more frequent audits or using outside auditors. Recent charges by the NAIC president that data has been falsified strikes at the core of state regulation of insurance. If we cannot trust the annual statements, then state regulation of insurance is a fraud and a sham.

7) Insurers must be required to fully disclose to regulators the total rates of return earned, including on investment income, so that full blown rate of return rate regulation can be utilized. The NAIC endorsed this approach at its June 1984 meeting. Texas, the first state to fully use the method in setting auto rates earlier this year, saw a 10 percent reduction in premiums required. This action saved Texas consumers $250 million over the proposed rates.

8) State Commissioners must be empowered by the legislatures to meaningfully regulate excess, surplus lines carriers and reinsurers, at least to the extent that the federal goverment does not. Abuses, such as withholding cover by these

carriers, have contributed significantly to the current capacity crunch.

9) States need to establish their own reinsurance programs modeled after NICO's federal proposal. A state reinsurance program with a risk management component requirement can bring meaningful safety considerations into insurance markets. Establishing models for risk management as a requirement for reinsurance through the state would provide a general market incentive and would ease availability and decrease risks faced by consumers and their primary carriers.

10) States need to examine their anti-group and anti-rebate statutes to see if they serve any public purpose. If these laws adversely impact upon availability and affordability of cover, then they should be scrapped.

11) State regulators should conduct financial, market conduct and trade practice examinations on a regular basis for all licensed insurers in states. Increased monitoring of insurer's practices and finances can only benefit consumers by curbing rating and other market abuses, as well as insolvencies.

12) Regulators must resist attempts by industry advocates to force proposed claims made forms, which include defense costs inside the limit of liability, upon consumers.

The proposed, and constantly modified, ISO claims made form means less coverage, more exclusions and less competition for insureds.

There is less coverage because of the timing of coverage involved in the policy and the proposed inclusion of defense costs inside the limit makes coverage illusory. If a buyer has a million dollar claim against it and a million dollars are spent by the insurer defending the suit from which the loss accrued, there is nothing to pay for the loss but the assets of the insured. That's not coverage, its an insurance defense lawyer income security plan! The proposed pollution exclusion is simply a refusal to write this risk until the tort law is changed to suit the industry. It is fascinating to note that ISO does not discount the claims made policy rate a whit for excluding "high cost" pollution coverage. ISO cannot have it both ways; either polluton cover costs a lot and the exlusion should cause a dramatic drop in price, or it costs little (nothing according to ISO) and the coverage should be contained within the policy. Consumers face captivity because of the exhorbitant levels of premium for extended tail coverage that can go as high as 200 percent of the last year's premium. The higher the tail coverage cost, the less likely you are to seek more competitive rates at another company.

Claims made poses a particular problem for the unsophisticated purchaser. Believing that they are getting the same coverage for less, many insureds will immediately purchase the new policy and suffer unanticipated losses. I think that if states adopt any form of the new claims made policy form that it should not be allowed to be sold to small business consumers at all. ISO admits that its "problems" are with only five percent of its larger accounts. It would be inappropriate for regulators to broadly restrict cover based upon scarce, potentially false, and small samples of data. In the alternative, if it can be shown that some small business consumers (again, as defined in 13 CFR 121) would be able to benefit from the new policy form, then that form should be made available to such consumers but only after a reasonable occurrence policy quote is given and a full and complete disclosure of the differences of cover is made by the seller. Disclosure forms could be promulgated by the regulators with input from consumers and the industry.

In any event, states should not approve this moving target, constantly amended form until the industry has had time enough to educate the agents and the consumer. Even if the latest amendments are the last, which I doubt, the form should not become effective before July 1, 1986 at the earliest.

13) States must allow greater consumer representation before the regulatory bodies. All too often the only parties to rate cases are the regulators and the insurer. States must give greater funding to or create Offices of Public Advocate to statutorily intervene in insurance rate cases. The New Jersey experience can serve as a good model, there the costs of intervention are billed back to the filing party and this causes minimal growth in appropriations expenditures while maximizing consumer protection from abusive insurance rates. A related program could be authorized by the federal government or the states to allow consumers to organize their own Citizen's Insurance Board to intervene on their own behalf as a complement to the efforts of the Public Advocates.

CONCLUSION

America deserves a better deal on its insurance. The federal and state governments cannot sit idly by and let the insurance industry hold day care providers, nurse-midwives, and others, hostage in a large game beyond the providers' control. The terrorist tactics of insurers every 10 years at cycle bottom must be dealt with in a systematic way that adds the stability to our economy that insurance is meant to deliver. Periodic price gouging must be stopped. It is time for the states, as well as the federal government, to act responsibly in the area of insurance regulation and take appropriate remedial action now.

FOOTNOTES

1/ CPI data on "auto insurance", Bureau of Labor Statistics.

2/ Source of data: Citibank Economics and Insurance Services Office.

3/ The ISO admits that the p/c industry had a positive return on net worth last year, conceding the point that the industry did not lose money last year. But, ISO's Mavis Walters disputes the level of that return, saying it was only two percent on net worth. Even at that level, the premium shortfall for last year was only 5.5 percent or so. (See, Statement of Mavis Walters, Senior Vice President, Insurance Services Office,Inc., before the House Energy and Commerce Subcommittee on Commerce, Transportation and Tourism hearings on the Liability Insurance Crisis of 1985, p.16 (Sept. 19, 1985)).

4/ For a discussion of risk in the property/casualty insurance business, see Investment Income and Profitability in Property/Casualty Insurance Ratemaking, J.R. Hunter and J.W. Wilson, 1983, Chapter 5.

5/ Hearing on December 3, 1975, Subcommittee on Health of the Committee on Labor and Public Welfare, US Senate. Among the interesting data supplied by ISO at that hearing were exhibits that showed that the average claim cost ISO used for ratemaking significantly exceeded the limit of liability, clearly ratemaking that had run amok. That led to this exchange:

Sen. Laxalt: Is malpractice always a loser as far as carriers are concerned?

Mr. Hunter: If they charge these rates, they could not help but win. (Page 141.)

In John Guinther's book, The Malpractitioners (Anchor Press, 1978), Guinther cites this exchange at page 169 in a chapter entitled "They Could Not Help But Win." In the following chapter, called "They Won," Guinther reviewed the later experience.

Final Report, Product Liability Task Force. Report on Product Liability Ratemaking, Product Liability and Accident Compensation Task Force, US Department of Commerce, 1980. At page ix the Report states that "overly subjective ratemaking practices were one of the principal causes of the product liability insurance problem."

6/ St. Louis Post Dispatch, Section B, P.3, 4/14/84. (See also, Sloan, infra, at note 17).

7/ Journal of Commerce, "Insurers Told: Exit Some Lines," p.8A, (June 18, 1985).

8/ Source of data: Best's Property/Casualty Stock Ind x, A.M. Best and Company, Oldwick, NJ. December 31, 1984 index = 416.30; November 20, 1985 index = 600.06. Dow Jones Industrial Average December 31, 1984 = 1211.57; November 20, 1985 = 1441.37.

9/ According to the Insurance Information Institute's Executive Letter of August 26, 1985, Policyholder surplus grew from $58.2 billion as of 6/30/84 to $66.0 billion as of 6/30/85.

10/ "The day care facilities have been caught up in this availability crunch and are being deemed higher risk, not necessarily based on a claims experience but due more to an insurance hysteria . . ." Testimony of Edward J. Muhl, Insurance Commissioner of the State of Maryland, before the House Select Committee on Children, Youth and Families, July 30, 1985.

11/ "Any permanent solution (of the day care insurance crisis) will require significant changes in the tort system." Testimony of Frank Neuhauser, Vice-President and Actuary for AIG (a leading insurer of day care centers) before the House Select Committee on Children, Youth and Families, July 30, 1985.

12/ "The countrywide experience for those companies reporting premium and loss data to the Insurance Services Office . . . appears to conform with the current loss experience for the majority of commercial insurance lines . (these data) do not suggest that insurers should abandon the market." Testimony of James L. Kimble, Senior Counsel, American Insurance Association, before the House Select Committee on Children, Youth and Families, July 30, 1985. The testimony was also endorsed by the Alliance of American Insurers.

13/ Journal of Commerce, "Tougher Insurance Rules Loom," p.1A, (Oct. 10, 1985).

14/ See, for instance, the National Underwriter, 11/20/81, page 1, where it says:

> A large commercial umbrella (liability) risk came up for renewal and was rated at $105,000, about the same as the previous year. But the insured was not satisfied. Aware of the aggressive rate competition in the commercial lines market today, he decided to shop around. He approached a second agent, who submitted the very same risk to a different company, which offered to write it for just $20,000.

But the insured was still not happy. He continued shopping and eventually the original company, which originally wanted $105,000 came back and took the business for $5,000. That's right, $5,000. (Emphasis added.)

15/ NAII and ISO, "1985: A Critical Year," p.30 (Spring 1985). This quote has been curiously lacking in any reference made to this document by insurers in previous testimonies. (See, Walters, supra.)

16/ Pennsylvania Political Subdivision Tort Claims Act, (42 Pa. CSA 8541 et. seq.)

17/ Sloan, Frank A., "State Responses to the Malpractice Insurance 'Crisis' of the 1970s: An Empirical Analysis," 9 Journal of Health Politics, Policy and Law, 629 (Winter 1985).

18/

Item	1984 Amount Spent in Billions a/	Column (1) - 1984 Disposable Income of $2,578.1 Billion a/
Food	444.3	17.2%
Housing	397.8	15.4
Personal Income Taxes	302.6	11.7
INSURANCE b/	287.1	11.1

a/ Source: US Department of Commerce, Bureau of Economic Analysis.
b/ Source: Bests Management Reports, December 31, 1984, page 1.
Life Insurance Fact Book, page 56.
Blue Cross Association, Telephone call of 1/25/85.

19/ The law was euphemistically entitled the "FTC Improvements Act of 1979."

20/ See Statement of the Honorable Claude Pepper before the Subcommittee on Monopolies and Commercial Law on the Insurance Industry's Antitrust Exemption, April 11, 1984; found at page 5 of the Subcommittee's report, Competition in the Insurance Industry (Serial No. 127).

21/ See, for instance, Issues and Needed Improvements in State Regulation of the Insurance Business, General Accounting Office (Oct. 9, 1979) (hereinafter, GAO Issues); The Invisible Bankers, Andrew Tobias (Linden Press, 1982); The Life Insurance Game, Ronald Kessler (Holt, Rinehart and Winston, 1985);"Protection for Sale: The Insurance Industry," NBC-TV News (1981); Risk, Reality and Reason, the Conference of Insurance Legislators (September 1983).
One of the tests of state preparedness to deal with a crisis in availability and pricing of liability insurance is actuarial staff. Of the 52 states (including DC and Puerto

Rico) NICO surveyed, we find that 26 have actuaries. So one-half of the states have no actuaries at all.
There are 62 actuaries employed by the states, of the 7,682 actuaries in the nation. It is well known in the industry that those best suited to deal with matters pertaining to liability insurance are those who have passed the examinations enabeling them to be "Fellows" in the Casualty Actuarial Society. State regulation has only 8 such persons. They are employed by only 5 states [Connecticut (1), Massachusetts (1), Michigan (1), New Jersey (1) and New York (4).]
Aetna Life and Casualty Insurance Company alone employs 126 actuaries. Travelers has 100.

Source of Data: American Academy of Actuaries 1985 Yearbook and Directory of Members by Business Affiliation.

22/ Public Law 90-448, 82 Stat. 476; 12 U.S.C. 1749bbb, 42 U.S.C. 4011.

23/ Meeting the Insurance Crisis of Our Cities, A report of the President's National Advisory Panel on Insurance in Riot-Affected Areas, January, 1968, p. 1.

24/ See Exhibit II for a copy of the letter to the Justice Department.

25/ 15 USC 3901 et. seq. and 1983 amendments.

26/ GAO Issues, p.35.

27/ Ibid., p.176

CHART #1

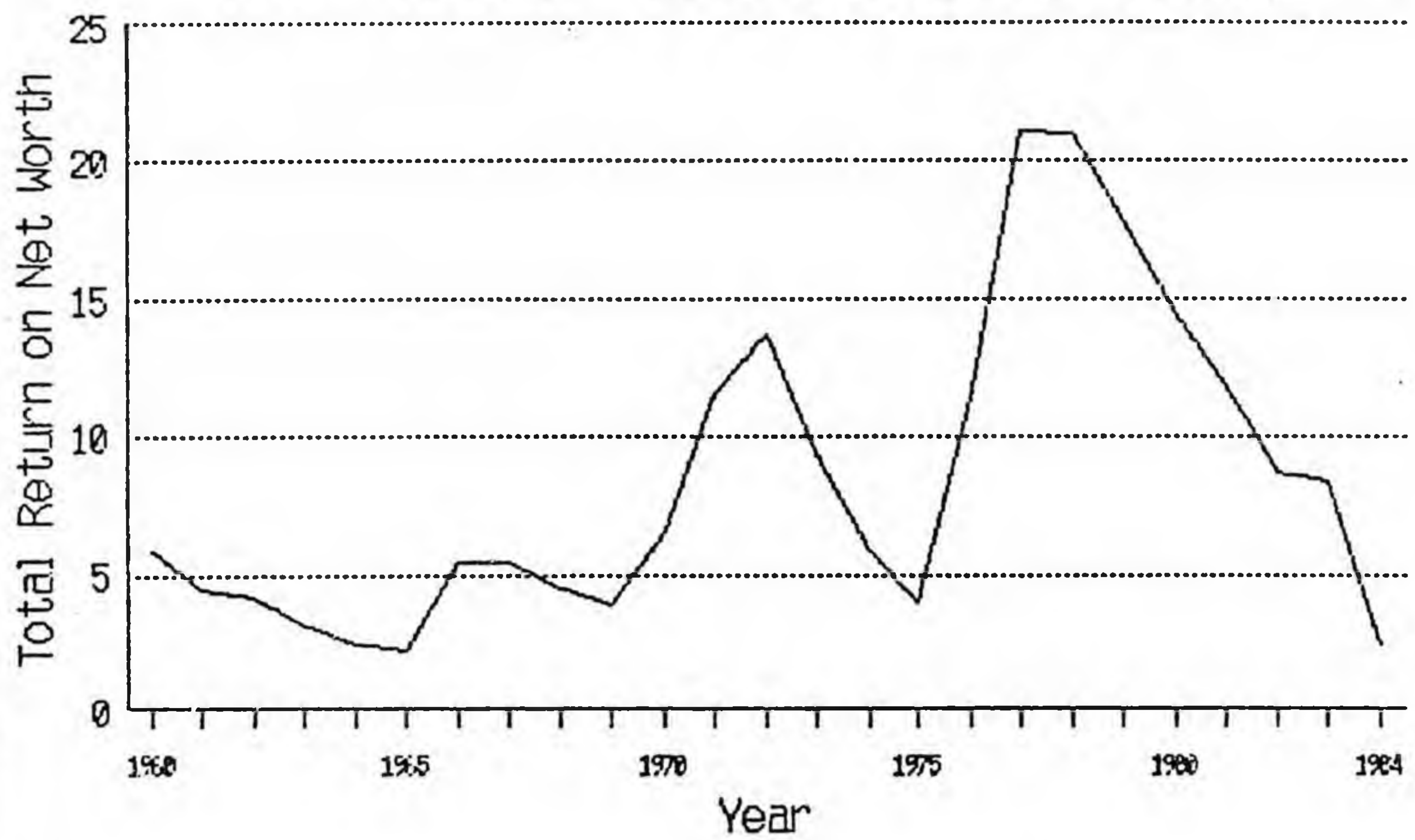


CHART #2

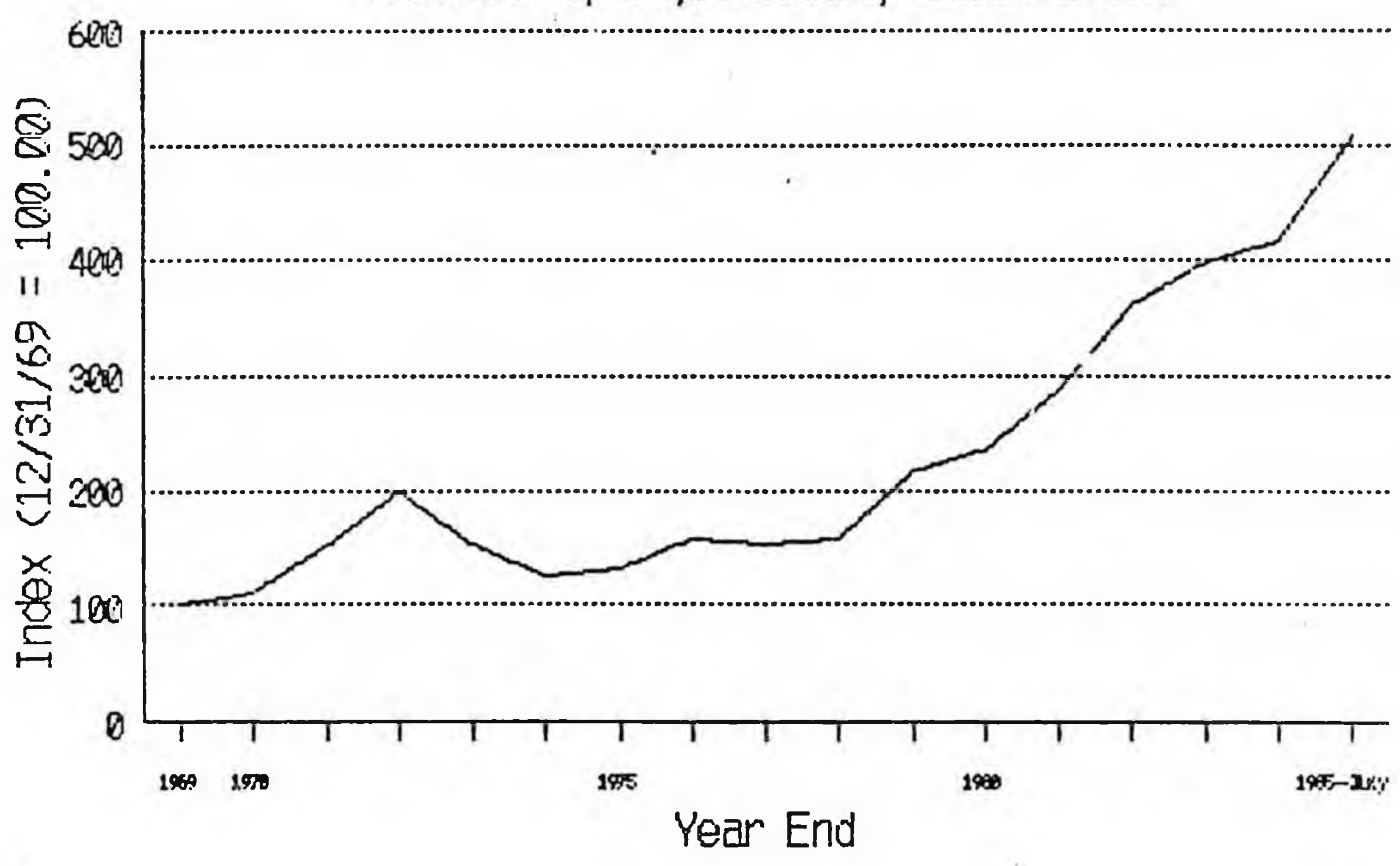
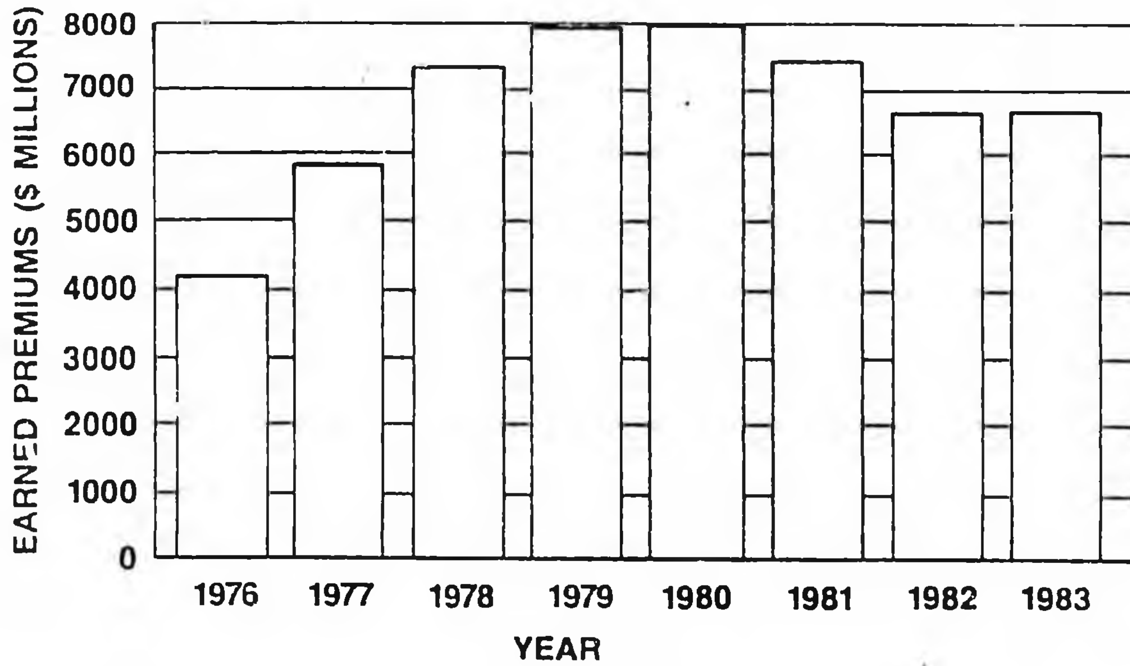


CHART 3

NATIONAL LIABILITY INSURANCE STRIKE



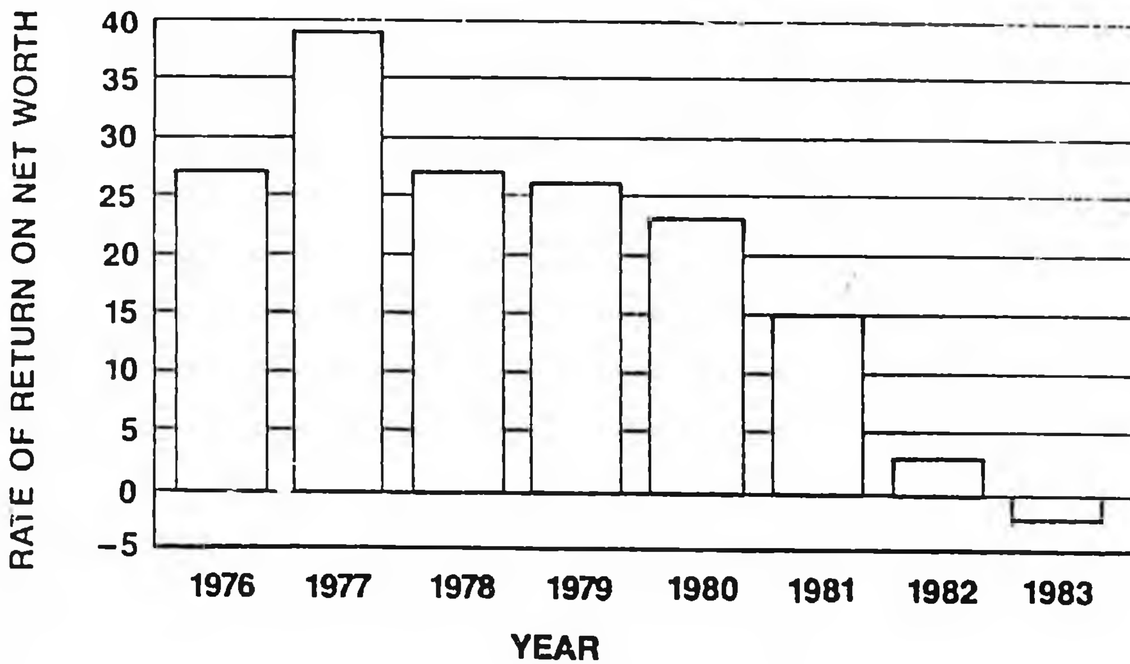
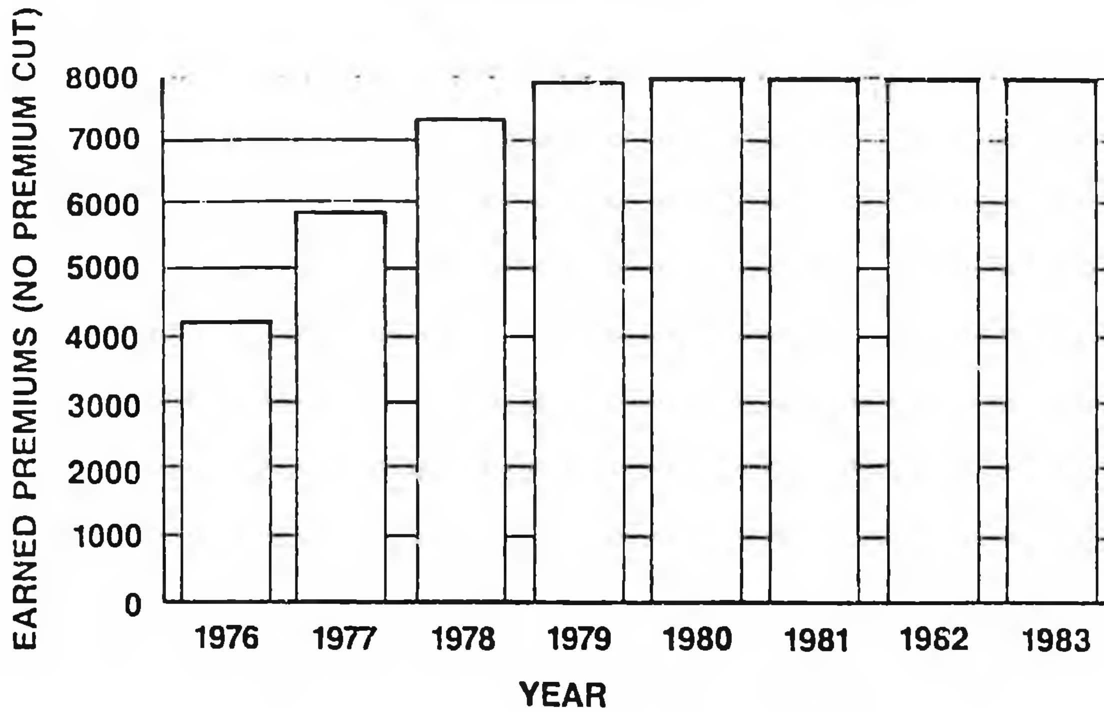
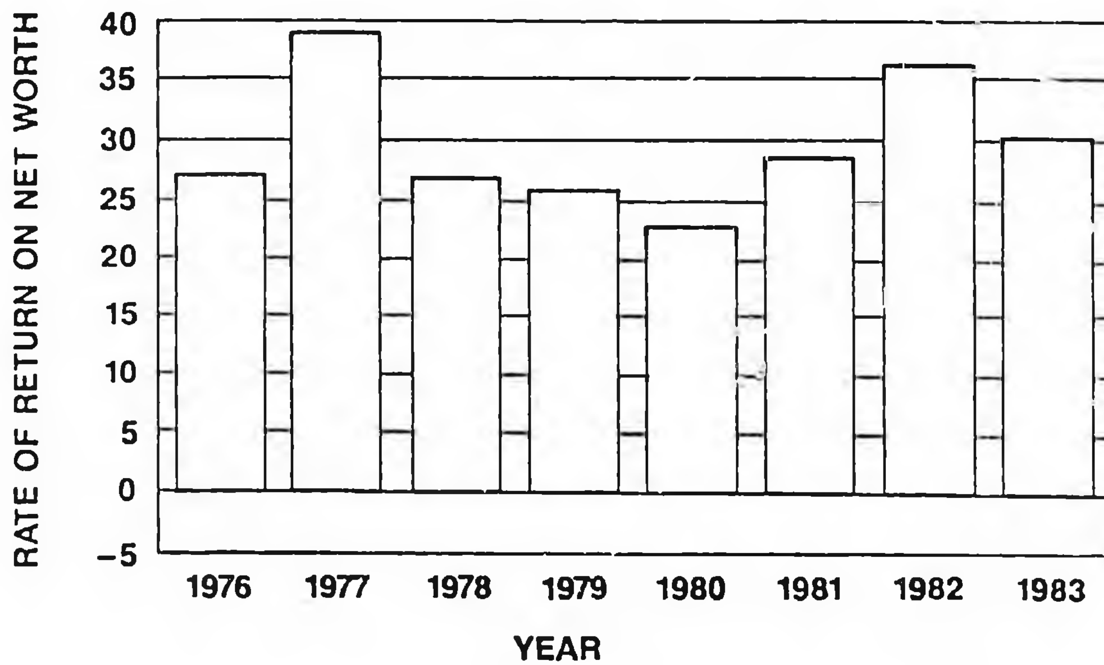


CHART 4

NATIONAL LIABILITY INSURANCE
STRIKE II





COMMERCIAL LIABILITY INSURANCE PROFITABILITY STATISTICS (1)
Rate of Return on Net Worth (2)

Year	Earned Premiums (Millions of $)	Actual ROR	All American Industry (3)
1976	$4160	27%	13.3%
1977	[illegible]	39	13.5
1978	7334	27	14.3
1979	7943	26	15.9
1980	7969	23	14.4
1981	7416	15	14.0
1982	6627	3	11.0
1983	6671	-2	11.5
Average		19%	13.5%

(1) Source: National Association of Insurance Commissioners Report on Profitability, By Line, By State.

(2) Rate of Return on net worth estimated from the NAIC Reported Insurance Operating Profit on Earned Premiums by converting to net worth by multiplying by a 2:1 Premium/Net Worth Ratio. Investment Income on Surplus is added at an assumed after tax yield as follows: 1976, 5.0%; 1977, 5.5%; 1978, 6.0%; 1979, 6.5%; 1980, 7.0%; 1981, 7.5%; 1982, 8.0%; 1983, 8.5%.

(3) Fortune 500, 1976-1980; Business Week, 1981-1983.

NOTE: Had the insurers not cut premiums after 1980 but held them constant, the Rate of Return on Net Worth would have been:

1981	29%
1982	37%
1983	31%
8-year average	30%

The problem is clearly rate cutting, nothing else!

Analysis of Rate Filing of

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

Filing Date: May 16, 1985   Effective: July 1, 1985

J. ROBERT HUNTER

Fellow, Casualty Actuarial Society
Member, American Academy of Actuaries
President, National Insurance Consumer Organization
Former Federal Insurance Administrator

BACKGROUND

On May 16, 1985, the Medical Mutual Liability Insurance Society of Maryland (MMLIS) filed for an increase in malpractice premiums of +29%. The filing also requested changes in the relativities between classes, the most notable of which was a one-third increase in Class 8 (OB/GYN surgery). The total impact of the overall rate change of +29% and the class relativity change of +33.3% on OB/GYN surgeons was to increase their rates by 66.7%. For the highest rated territory, these doctors had their rates raised from $25,429 to $42,393. This did not please the OB/ GYN community.

WAS THE OVERALL 29% RATE INCREASE JUSTIFIED?

In my opinion, there was no justification for an overall rate increase of 29%. Indeed, I believe that the filing supports a reduction in premiums rather than an increase. Here's why:

- The filing incorrectly assumes that the yield on investments that the MMLIS will earn is 5%, an unrealistically low assumption, and

- The filing incorrectly assumes that inflation in the future will be at double-digit levels.

When proper assumptions are made on just these two items, even accepting other major assumptions (such as their reserves are accurate), a rate reduction of 10.5% is indicated.

HOW SHOULD INVESTMENT INCOME BE FACTORED IN?

To do the job properly, a full blown total return analysis should be undertaken. The National Association of Insurance Commissioners adopted the total return approach at their June, 1984 meeting, and issued a report detailing several approaches. Under a total return approach, all income is analyzed to determine what overall profit the company will make under a given set of rates and a comparison of that potential earning power to the needed margin to attract risk capital is undertaken. It is a sophisticated, highly desirable approach that should be used in Maryland, as the NAIC recommended for all regulated lines.

In that the filing was woefully short of the data needed to undertake total return analysis, I decided to accept, for review purposes, the MMLIS approach to discounting the cash flows (their Exhibit 5, my Exhibit "A", attached). On my exhibit, you will see the MMLIS approach as typed and mine in

handwriting. MMLIS discounted the losses based on a distribution of losses paid by time. Presumably this is based on their Maryland experience, the filing does not identify that.

The average claim takes a bit over 7 years to pay. This means that MMLIS holds the money in reserve for that long before they pay the average claim. Obviously this means that the reserves, which are fully funded today under statutory accounting rules, will produce a significant amount of investment income.

The MMLIS approach assumes that they will earn 5% on their invested reserves. This is obviously too low. MMLIS has earned, according to their 1984 Annual Statement, the following yields on their total assets (including assets not invested or used for business--such as properties) the following:

1982	9.1%
1983	8.9%
1984	9.3%

Other filers recognize that the yield is not so absurdly low. For example, on May 17, 1985 the leading writer of medical malpractice insurance in the country, St. Paul submitted a filing in South Carolina in which it used a 10.5% yield to discount that state's cash flow. (see my Exhibit "B")

I have chosen to use a 10% discount rate, which is reasonable for [illegible] invested assets of MMLIS. That change is shown on Exhibit "A". It results in a discount for investment income of 43% rather than 26% based on the unjustified 5% yield assumption. If that change is carried through to the rate level itself, the rate filing would have been for a <u>reduction</u> in rates of 1.4% rather than an increase of 29%. The calculation of the reduction is found on Exhibit "C", attached.

TREND

MMLIS displayed its own Maryland data for trend on its Exhibit 4, my Exhibit "D". It carefully analyzed the data and concluded that the range of results were between an annual trend of +7.8% based on straight line projection, and +9.3% based on exponential line projection. The data are company specific and Maryland specific andthrough the most recent year, 1983.

For some reason, the filer then displays data for other insurers, for other states, that is old data. (See Exhibit

"E"). This experience is from a period of high inflation and is not relevant, in my opinion to the case at hand. For one thing, the federal government has reported that medical inflation rates in the nation are below 10%, certainly no where near the 16% figure that the irrelevant data produce. These data should not be given weight, in my estimation.

I selected a trend of 9% for the purposes of this review. It gives weight to the fact that the exponential line has a slightly better "fit" to the data and is within the range as calculated by MMLIS, but near the exponential side. I also chose to apply the trend exponentially (this gives a higher answer than using a straight line).

Looking again at Exhibit "C", the use of the amended trend, coupled with the 10% yield assumption produces an indicated rate level reduction of 10.5%

SENSITIVITY ANALYSIS

If we used a yield of only 9% (less than MMLIS earns, even on all assets including cash) and use a trend of 10% (ehich is more than that realized by MMLIS and more than that in the nation today) the indicated rate would be a reduction of 0.9%.

ANALYSIS OF CLASSIFICATION CHANGES

Incredibly, there is absoultely no justification for the changes in the classification differentials employed by MMLIS contained in the filing. The entire "justification" for the change is found on Exhibit "F", attached.

There are other, more minor changes made without a shread of evidence, such as the territorial relativity changes, and the increased limits changes.

BALANCE SHEET

MMLIS is as solid an insurer as there can be. Their 1984 balance sheet shows that the company enjoys a premium/surplus ratio of 1.2 to 1. This company appears to be over-capitalized. If the ratemaking has followed the current filing approach, it is no wonder.

Exhibit "A"

MEDICAL MUTUAL LIABLITY INSURANCE SOCIETY OF MARYLAND

1985 PROFESSIONAL LIABILITY RATE LEVEL REVIEW - OCCURRENCE COVERAGE

PRESENT VALUE OF PAID MEDICAL MALPRACTICE CLAIMS

(OCCURRENCE BASIS)

Time Interval	Cum. Paid	% Paid Losses By Interval	Years of Discount (n)	Vn (5%)	10%	Present Value	
Up to 12 mos.	0.0%	0.0	0.5	.976	.954	-	
24	2.0	2.0	1.5	.929	.867	1.858	1.73
36	7.0	5.0	2.5	.885	.788	4.425	3.94
48	19.0	12.0	3.5	.843	.716	10.116	8.59
60	35.0	16.0	4.5	.803	.651	12.848	10.47
72	53.0	18.0	5.5	.765	.592	13.770	10.65
84	68.0	15.0	6.5	.728	.538	10.920	8.07
96	79.0	11.0	7.5	.694	.489	7.634	5.38
108	87.0	8.0	8.5	.661	.445	5.288	3.55
120	92.0	5.0	9.5	.629	.404	3.145	2.02
132	95.0	3.0	10.5	.599	.368	1.797	1.10
144	97.0	2.0	11.5	.571	.334	1.142	.669
156	99.0	2.0	12.5	.543	.304	1.086	.609
168	100.0	1.0	13.5	.518	.276	.518	.27
			Ave 7.1 yrs			74.547%	57.1

CONCLUSION

This filing is not justified. An overall [illegible] level decrease of 10.5% is needed, not a 29% increase. The class changes which so sharply impact the OB/GYN surgeon group is not justified in the filing, although their may be experience somewhere that supports that change. The filing should have been disapproved. It is particularly abusive to observe a 66.7% increase for OB/GYN surgeons with no justification. On the basis of the filing, the OB/GYN rate should have been decreased by 10.5%. This means that the OB/GYN surgeons in Maryland may be paying about 85% too much.