

ALASKA LEGISLATURE COMMITTEE FILES 1900-1900 00/Z

4111 SJUD SB 377 (FILE 1)

991

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Physicians and Surgeons Professional Liability

Exhibit "B" |

Exhibit C
Loss and Loss Expense
Payout Patterns

<u>Year</u>	<u>Cumulative Annual Payout</u>	<u>Incremental Annual Payout</u>	<u>Present Value*</u>
1	.061	.061	.059
2	.275	.214	.187
3	.496	.221	.175
4	.668	.172	.124
5	.786	.118	.076
6	.869	.083	.049
7	.910	.041	.022
8	.952	.042	.020
9	.976	.024	.011
10	1.000	.024	.009
		1.000	.732

* Discounted claims payments at 10.5% pre-tax.

EXHIBIT "C"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 Professional Liability Rate Level Review - Occurrence Coverage

Total Limits Rat Level Indication -- \$000's

(1) Calendar/ Accident Year	(2) E. P. at Current Rate Level (Exh. 3)	(3) Ultimate Incurred Loss & ALAE (Exh. 2)	(4) Trend Factor to 7/1/86 at 11% ^{9%}	(5) Losses Trended to 7/1/86 (3)x(4)	(6) Loss Ratio at Current Rate Level (5)/(2)
1979	33,395	24,688	1.826	51,255	1.535
1980	35,732	25,235	1.677	47,200	1.321
1981	33,872	25,904	1.539	43,649	1.289
1982	28,984	25,414	1.412	38,580	1.331
1983	18,203	18,854	1.245	25,785	1.417
	150,185			206,470	1.375
				187,816	1.249

Annual Trend Factor: 11.0%
(Exhibit 4)

- | | | |
|---|-------|-------|
| a) Five year loss ratio at current rate level: | 1.249 | 1.375 |
| b) Discount for investment income at 5.0%: (10%) | .570 | 0.745 |
| c) Discounted loss and ALAE ratio (a) x (b): | .712 | 1.024 |
| d) Provision for Unallocated LAE (Exhibit 6) | 1.05 | 1.050 |
| e) Discounted loss and LAE ratio (c) x (d): | .748 | 1.075 |
| f) Permissible discounted loss and LAE ratio: (Exhibit 6) | .835 | 0.835 |
| g) Indicated rate level increase (e) / (f): | -10.5 | 1.288 |
| h) Selected rate level increase | — | 1.290 |

-1.4%

INVESTMENT
INCOME AND
TREND CHANGE

ONLY
INVESTMENT
INCOME
CHANGE.

Exhibit "D"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 RATE LEVEL REVIEW - PROFESSIONAL LIABILITY - OCCURRENCE COVERAGE

TREND IN TOTAL LIMITS LOSS RATIOS AT CURRENT RATES

(\$000'S)

(1) Calendar/ Accident Year	(2) Earned Premium at Current Rate Level	(3) Ultimate Incurred Loss and ALAE	(4) Loss Ratio at Current Rates	(5) Linear Fit	(6) Exponential Fit
1979	33,395	24,688	.739	.672	.683
1980	35,732	25,235	.706	.748	.747
1981	33,872	25,904	.765	.825	.816
1982	28,984	25,414	.877	.901	.893
1983	18,203	18,854	1.036	.978	.976

Average Annual Trend:

+ 7.8%

+ 9.3%

r :

.899

.906

- (2) Exhibit 3
- (3) Exhibit 2
- (4) (3) / (2)

ISO COUNTRYWIDE TREND (Exh. 4A): 16%

Selected Trend Factor: 11%

relevant

Use 9.0%

EXHIBIT "E"

INSURANCE SERVICES OFFICE

EXHIBIT 4A

COUNTRYWIDE*

Professional Liability Insurance
Calculation of Annual Trend Factor
Based on Basic Limits Loss Ratios at Present Rates

PHYSICIANS, SURGEONS AND DENTISTS

Basic Limits

Average Loss Ratio at
Present Rates

(1) Policy Year Ending	(2) \$100,000 Basic Limits Incurred Losses*	(3) Premium At Present Rates	(4) (2)÷(3) Actual	(5) Exponential Curve of Best Fit
12/31/75	\$167,810,058	\$615,020,250	.273	.232
12/31/76	139,176,608	524,225,850	.265	.271
12/31/77+	181,630,098	638,830,853	.284	.316
12/31/78+	251,848,210	700,894,098	.359	.369
12/31/79+	280,590,219	717,382,127	.391	.430
12/31/80+	332,612,672	705,726,416	.474	.502
12/31/81+	426,038,352	684,461,050	.622	.585
12/31/82+	497,532,513	666,499,516	.746	.683

Average Annual Loss Ratio at Present Rates Trend.....16.6%

* Excluding Texas and Massachusetts

• Losses include allocated loss adjustment expense and are developed to an ultimate settlement basis.

+ Includes Claims Made Data.

Selected Annual Trend16.0%

TS-PR-84-11

12/20/84

Exhibit
"F"

MEDICAL MUTUAL LIABILITY INSURANCE SOCIETY OF MARYLAND

1985 PROFESSIONAL LIABILITY RATE LEVEL REVIEW

Effect of Proposed Classification Changes

<u>Specialty</u>	<u>Description</u>	<u>Distribution Of Total Limits Premium</u>	<u>Present Relativity</u>	<u>Proposed Relativity</u>
80240	Forensic Medicine	0.0 %	.75	.65
80232	Hypnosis	0.0	.75	.65
80248	Nutrition	0.0	.75	.65
80263	Ophthalmology-No Surgery	0.2	.75	.65
80235	Physiatry and Physical Medicine	0.2	.75	.65
80249	Psychiatry	0.3	1.00	.65
80250	Psychoanalysis	0.0	1.00	.65
80251	Psychosomatic Medicine	0.0	1.00	.65
80266	Pathology-No Surgery	0.5	1.00	.65
80261	Neurology-No Surgery	0.8	1.00	1.20
80253	Radiology-Diagnostic-No Surgery	0.5	1.20	1.80
80280	Radiology-Diagnostic-Minor Surgery	0.1	2.10	2.80
80145	Surgery-Urology	3.0	3.00	3.60
80155	Surgery-Plastic-Otorhinolaryngology	1.5	6.00	5.00
80156	Surgery-Plastic-N.O.C.	2.5	6.00	5.00
80141	Surgery-Cardiac	0.0	5.00	6.50
80150	Surgery-Cardiovascular	0.0	6.00	6.50
80153	Surgery-Obstetrics/Gynecology	8.0	9.00	12.00
80168	Surgery-Obstetrics	0.1	9.00	12.00

All Other

82.3
100.0%

Effect: +2.8%

Current Average Relativity: 2.15

Projected Average Relativity: 2.21

LANDSMAN & LASTER

1503 21ST STREET, N.W.
WASHINGTON, D.C. 20036

(202) 331-0800

JOHN L. LASTER
RON M. LANDSMAN

August 14, 1985

Hon. Rick Rule
Acting Assistant Attorney General
Antitrust Division
United States Department of Justice
Tenth and Constitution Avenues, N.W.
Washington, D.C. 20530

Dear Mr. Rule:

I am writing on behalf of the National Insurance Consumer Organization to bring to your attention evidence of concerted anticompetitive conduct within the property casualty insurance industry that is not exempt under the McCarran-Ferguson Act.

The industry is now going through one of its periodic capacity scares. As in previous incidents, the public suffers severe and economically debilitating dislocations. After a period of glut, when premiums drop to a fraction of their prior fixed-price levels, underwriting tightens like a vise and important major manufacturing and service industries find themselves unable to purchase insurance protection at any price from any company.

To be sure, much of this pattern may reflect nothing more than the operation of the business cycle in an industry not under reasonable and effective regulatory oversight at the national level. The extremely aggressive price competition in commercial property/casualty lines in the late 1970s, and perhaps the subsequent price increases as well, appears to reflect such market forces. Some of the industry's responses may also reflect the mindless herd instinct which so distinctively marks the insurance industry. This is perhaps to be expected in an industry with a long history of price-fixing and other cooperative anticompetitive arrangements under state regulation that from the consumers' perspective ranges from lax to impotent, but so be it.

But the response of the industry to recent developments in their customer industries -- and the statements of industry leaders explaining their conduct -- suggest that something more is occurring.

Spokesmen for the reinsurance industry have told state regulators that they plan to withdraw en masse if they -- the regulators -- do not approve new insurance policy forms jointly developed by the reinsurers and the industry price-fixing agency (Insurance Services Office, Inc.). These new policy forms severely

Mr. Rick Rule
August 14, 1985
Page Two

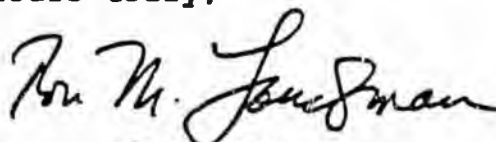
narrow the protection provided to the insurers' commercial customers, changes about which they are, to say the least, extremely unhappy. See Attachment A. Along the same lines, a well-known insurance company executive has justified the mass departure of insurers from medical, toxic waste, and directors' and officers' liability lines by "the social good" in "let[ting] the pressures build in the courts and the state legislatures" to change laws respecting their customers' -- and the insurers' -- liability. See Attachment B.

There is, finally, irrational market conduct that goes beyond even this industry's herd instinct. They have withdrawn from lines for risks with experience ranging from good to excellent and which even the insurers admit could and should be written. See Attachment C.

Boycotts to force action by state and federal officials, be they judges, legislators, or regulators, are illegal. The McCarran-Ferguson Act specifically does not exempt boycotts from federal antitrust enforcement. In St. Paul Fire and Marine Insurance Co. v. Barry, 438 U.S. 531 (1978), the Supreme Court held that the term boycott was broadly applicable to joint action to deny coverage to customers. Nor is there protection to be had under any of the familiar non-statutory exemptions. The Noerr-Pennington doctrine does not exempt "an express or implied agreement ... that the participants will jointly give up their trade freedom, or help one another to take away the trade freedom of others through ... boycotts" Eastern Railroad Presidents Conference v. Noerr Motor Freight, Inc., 365 U.S. 127, 136 (1961). And Parker v. Brown, 317 U.S. 341 (1943), does not exempt joint product-fixing absent state statutes authorizing such joint action. The debates on the McCarran-Ferguson Act reflect absolutely no consideration of agreements respecting products, and the state laws enacted in response to it by and large do not adopt such joint action as state policy. Southern Motor Carriers Rate Conference v. United States, --- U.S. ---, 53 U.S.L.W. 4422 (March 27, 1985).

Property/casualty insurance industry conduct, as explained by industry leaders themselves, may be but a prelude to a larger campaign to force major industries, from the chemical and drug manufacturers to physicians and others, to bend to the interests and will of insurers. If their means include non-exempt joint anticompetitive action, however, then you may hold the key to important public protection. I urge you to investigate to ascertain whether the federal antitrust laws are being violated.

Yours truly,



Ron M. Landsman
Counsel, National Insurance
Consumer Organization

RML/kd

Appendix A

JCC 6/18/85

Insurers Told: Exit Some Lines

By JAMES NOLAN
Journal of Commerce Staff

WOODBRIDGE, N.J. — The insurance industry should quit covering doctors, chemical manufacturers and corporate officers and directors. And the sooner the industry quits such lines of business, the sooner it will free itself from its bondage to a court system "that has run amok."

This was the message delivered to a meeting of actuaries here Monday by John J. Byrne, chairman and chief executive officer of Geico Corp., the Washington-based personal lines insurance company.

Mr. Byrne said that the single thread running through such lines of business for underwriters was that they have fallen under the sway of the courts.

"There will be no problem with insuring homeowners or autos in the coming years," he said. "But anyone who puts his private capital behind lines such as malpractice is putting himself in the hands of a rany judge or jury out in California. To my mind, he is absolutely stupid."

Mr. Byrne's comments came in the midst of a discussion at a meeting of the Casualty Actuaries of New York about what kinds of insurance products might be available in the future.

The touchstone for the discussion was a presentation by the Insurance Services Office Inc., an industry-rating and data-gathering service. The ISO estimates that in the next few

'Anyone who puts his private capital behind lines such as malpractice is putting himself in the hands of a rany judge or jury out in California.'

years the insurance industry will suffer a \$82 billion shortfall in capacity. This means that corporate America will not be able to buy all the insurance it needs because insurers ability to cover them will fall short by that amount.

Mr. Byrne said the industry was responding to these losses in precisely the right way by refusing to cover lines of business that are hostage to court interpretation. "It will be best for the social good to let society know that the problem is not one for the insurance industry but for society as a whole. It is right for the industry to withdraw and let the pressures for reform build in the courts and the state legislatures," Mr. Byrne said.

He said he saw little hope for reform in such things as the federal program for Superfund, a toxic waste cleanup measure. He said the vast amount of money thus far spent by Superfund was to "educate lawyers on how to refine their suits brought on the part of plaintiffs against industry."

"Anybody who leaves his private

capital where the courts can grab it has not done the right thing for his owners," Mr. Byrne said.

On a related score, Thomas A. Greene, president of his reinsurance brokerage firm in New York, said that still more pressure would be brought to bear on the American property and casualty industry by underwriters at Lloyd's of London. Mr. Greene said that beginning in 1986, Lloyd's syndicates would "simply not write reinsurance for the American casualty industry, especially in the lines mentioned by Mr. Byrne." He said further that reinsurance underwriters would virtually dictate to the ISO about a proposed commercial general liability form. He said the domestic reinsurance industry will not write treaties unless the industry adopts the new CGL form.

As to the stability of the insurance companies suffering through this trying period, at least one of the actuaries said that current measures of company solvency used by the National Association of Insurance Commissioners were less than adequate.

Kevin M. Ryan of the National Council of Compensation Insurance urged the actuaries to model industry solvency judgments on a study done by the Aetna Life & Casualty Co. a few years ago.

Aetna studied the financial data of companies that had actually failed and the resultant ratios were absolutely realistic, Mr. Ryan said.

(1)

EPA Chief Deems It Necessary To Keep Toxic Liability Powers

JOC
7/21/85

By LEAH R. YOUNG

Journal of Commerce Staff

WASHINGTON -- The Environmental Protection Agency must have the authority allowing it a wide choice of whom to sue for cleaning toxic waste sites, Administrator M. Thomas said.

While acknowledging that the model for all kinds of environmental insurance is drying up, Mr. Thomas insisted in an interview that EPA cannot give up the "strict, joint and several liability" powers that courts have given it.

The insurance industry has been arguing that it cannot insure and collect premiums from individual companies when a court can require one or a few companies to pay all costs of cleaning up a site.

That is especially true, insurers argue when many of the policies being interpreted by state courts never were intended to pay for hazardous waste cleanup.

But Mr. Thomas pointed out that the industry is responsible for getting such sites cleaned up while ensuring to the extent possible that the polluter, not the federal government, bears the costs.

The insurance industry would like to provide liability so that its clients are held responsible only for the cost of damage, but the EPA finds that in most Superfund waste clean-up substances are mixed and the costs are poor.

When the EPA tried to apportion

responsibility — an approach that is surfacing again among some congressmen at the behest of the insurance industry — it became "just as controversial among the private parties as utilization of joint and several liability," Mr. Thomas said.

The EPA tried to base responsibility on the volume of waste, he said, but the companies fell into long debates over whose waste was more toxic.

However, as adamant as he is that strict, joint and several liability must be part of any Superfund program, Mr. Thomas opposes attempts by House Energy and Commerce Subcommittee Chairman James Florio, D-N.J., to write it into the pending Superfund bill.

"We don't think it should be specifically mandated," Mr. Thomas said. "Trying to get language in the statute has the potential of opening up the whole issue again to litigation."

But Rep. Florio argues that while he is "heartened" by the district court rulings to date, "this principle could be gutted by a specific district court or by the Justice Department."

He wants to make sure that industry cannot convince the administration to abandon this unwritten interpretation.

Rep. Florio lost a battle in his subcommittee on the issue to a group headed by Energy and Commerce Committee Chairman John Dingell, D-Mich.

In spite of the setback, Rep. Florio has vowed to continue his fight on the issue, and for other provisions the subcommittee rejected, in the full committee and on the House floor.

His rejection in subcommittee is no reason for rejoicing by the insurance industry. Many who opposed Rep. Florio support the views of Mr. Thomas.

Rep. Jim Slattery, D-Kan., explained that injecting joint and several liability into the legislation could lead to a situation in which the provision was either stricken or filibustered in the Senate.

That would create legislative history that might convince state courts that such liability is not part of Superfund.

While Mr. Thomas is determined to keep joint and several liability in spite of evidence of growing insurance problems, Mr. Thomas does not have any recommendations to alleviate the burden on the insurance industry.

He pointed out that a lot of the problems are not related just to Superfund, but rather to the general economic situation in the property-casualty insurance industry.

He noted that the European reinsurance market is drying up for environmental policies. There has been poor experience with asbestos, and a general desire to "establish a less risky base of insurance."

Under such circumstances, he said, he has been unable to win from the insurance industry any assurances that particular steps taken on the federal level will result in a return to the environment market.

Instead, insurance industry spokesmen will only say that if some steps are not taken "there is a chance we won't get back in the market," Mr. Thomas said.

It is possible that there is a need for federal involvement in the environmental liability field, but the debate has not reached the point where he thinks he can draw any conclu-

In the meantime, EPA recognizes that many hazardous waste sites being licensed under the Resource Conservation and Recovery Act may not prove financial responsibility on Nov. 8 as required.

Without insurance, some facilities may use their own net worth, Mr. Thomas said, but others may just be forced out of business.

Fewer facilities will require companies that are generating wastes to modify their procedures to incinerate or otherwise minimize waste that until now was cheaper to send to land disposal facilities.

It is too soon to analyze the impact of this scenario, he said, in light of the congressional decision to encourage companies to move away from land disposal.

The only thing he is at all sure of now is that solving the problems of insuring hazardous waste facilities would not solve the entire insurance dilemma.

The House subcommittee did vote against one provision that disturbed the insurance industry. Congressmen rejected an amendment to permit citizens to sue private parties if they perceived a dangerous situation being ignored by the Environmental Protection Agency.

Only one Florio amendment was attached to the Superfund bill that goes to the full Commerce Committee.

That provision requests that the House Ways and Means Committee revise as part of the taxing scheme an import fee to reduce the share of general federal revenues envisioned in the bill from \$250 million to \$110 million.

The idea is to tax imported feedstock derivatives equally with domestic feedstock components in order not to give an advantage to foreign derivatives.

Mr. Thomas said the administration still opposes new Superfund taxes.

In Day-Care Crisis Cited

Official Criticizes Insurance Firms

By Sandra Sugawara
Washington Post Staff Writer

Maryland Insurance Commissioner Edward J. Muhl said yesterday that "hysteria" had caused insurance companies to discontinue coverage of day-care centers and that Maryland officials had blocked an attempt by one California firm to cancel 242 day-care policies.

Muhl also said that state officials were studying a wide variety of options, including the creation of a mutual liability insurance fund in Maryland similar to the one created in 1974 by the General Assembly to help physicians hit by an insurance malpractice crisis.

Muhl testified yesterday before the House Select Committee on Children, Youth and Families, which is holding hearings on the nationwide insurance crisis in the day-care industry. Muhl, who appeared on behalf of the National Association of Insurance Commissioners, criticized insurance companies for wholesale cancellation of day-care policies, saying the insurance industry was overreacting to news accounts of sexual abuse and court suits involving some day-care centers.

Muhl said a California insurance carrier canceled policies at 242 Maryland day-care centers before they were to expire. He said he recently ordered that firm to revoke the midterm cancellations, although he said the company does not have to renew the policies.

Muhl said he was sympathetic to the plight of the insurance industry, which had its worst year ever in 1984. He said the Association of Insurance Commissioners expects the industry to sell \$67 billion less in insurance this year than last year.

Muhl said he has signed 20 notices of insolvency for Maryland insurance firms this year. Those firms have gone out of business or must stop writing policies because of financial problems.

Insurance industry executives testified yesterday that the industry was in a slump and urged Congress to allow the industry to voluntarily



EDWARD J. MUHL

... testifies before House committee

gress would be forced to get involved if the insurance industry failed to take immediate action to prevent the closing of thousands of day-care centers.

Insurance industry representatives have said the financial slump was caused by excessively low rates that companies charged during the late 1970s, when they were trying to increase business. They tried to make up the losses through investments, but were hurt by falling interest rates, according to Marvis A. Walter, senior vice president of Insurance Services Offices Inc., which compiles statistics and rate information for the industry.

Because of the financial problems, insurance firms began dropping high-risk industries, and they place the blame on the high awards given in liability cases.

The potential for multimillion-dollar judgments exists even though no such award has yet been paid in a child-abuse case, said Frank Neuhauser Jr., vice president of AIG Risk Management Inc., an insurance group based in New York. "Many of us believe we are living under a tort system that is completely out of control."

But J. Robert Hunter, former head of the Federal Insurance Administration during the Ford and Carter administrations, said that the insurance industry is using the courts "as a scapegoat."

"It's a self-inflicted problem, and to take it out on day-care centers is wrong," said Hunter.

Mike Causey is on vacation. The Federal Diary will resume when he returns.

(3)

Appendix B

JOC 6/18/85

10A

INSUR

Insurers Told: Exit Some Lines

By JAMES NOLAN

Journal of Commerce Staff

WOODBIDGE, N.J. — The insurance industry should quit covering doctors, chemical manufacturers and corporate officers and directors. And the sooner the industry quits such lines of business, the sooner it will free itself from its bondage to a court system "that has run amok."

This was the message delivered to a meeting of actuaries here Monday by John J. Byrne, chairman and chief executive officer of Geico Corp., the Washington-based personal lines insurance company.

Mr. Byrne said that the single thread running through such lines of business for underwriters was that they have fallen under the sway of the courts.

"There will be no problem with insuring homeowners or autos in the coming years," he said. "But anyone who puts his private capital behind lines such as malpractice is putting himself in the hands of a zany judge or jury out in California. To my mind, he is absolutely stupid."

Mr. Byrne's comments came in the midst of a discussion at a meeting of the Casualty Actuaries of New York about what kinds of insurance products might be available in the future.

The touchstone for the discussion was a presentation by the Insurance Services Office Inc., an industry-rating and data-gathering service. The ISO estimates that in the next few

'Anyone who puts his private capital behind lines such as malpractice is putting himself in the hands of a zany judge or jury out in California.'

years the insurance industry will suffer a \$62 billion shortfall in capacity. This means that corporate America will not be able to buy all the insurance it needs because insurers ability to cover them will fall short by that amount.

Mr. Byrne said the industry was responding to these issues in precisely the right way by refusing to cover lines of business that are hostage to court interpretations. "It will be best for the social good to let society know that the problem is not one for the insurance industry but for society as a whole. It is right for the industry to withdraw and let the pressures for reform build in the courts and in the state legislatures," Mr. Byrne said.

He said he saw little hope for reform in such things as the federal program for Superfund, a toxic waste cleanup measure. He said the vast amount of money thus far spent by Superfund was to "educate lawyers on how to refine their suits brought on the part of plaintiffs against industry."

"Anybody who leaves his private

capital where the courts can grab it has not done the right thing for his owners," Mr. Byrne said.

On a related score, Thomas A. Greene, president of his reinsurance brokerage firm in New York, said that still more pressure would be brought to bear on the American property and casualty industry by underwriters at Lloyd's of London. Mr. Greene said that beginning in 1986, Lloyd's syndicates would "simply not write reinsurance for the American casualty industry, especially in the lines mentioned by Mr. Byrne." He said further that reinsurance underwriters would virtually dictate to the ISO about a proposed commercial general liability form. He said the domestic reinsurance industry will not write treaties unless the industry adopts the new CGL form.

As to the stability of the insurance companies suffering through this trying period, at least one of the actuaries said that current measures of company solvency used by the National Association of Insurance Commissioners were less than adequate.

Kevin M. Ryan of the National Council of Compensation Insurance urged the actuaries to model industry solvency judgments on a study done by the Aetna Life & Casualty Co. a few years ago.

Aetna studied the financial data of companies that had actually failed and the resultant ratios were absolutely realistic, Mr. Ryan said.

(1)

Insurers Urge Adoption Of New Policy

By JAMES NOLAN

Journal of Commerce Staff

CHICAGO — The very fate of the American liability insurance industry hangs on state regulatory approval of new liability insurance forms.

An array of insurance industry spokesmen argued this position in public hearings Thursday before a panel of insurance regulators from 18 states.

The industry representatives predicted further that American business and industry in all likelihood would go unprotected by insurance against liability claims on their assets unless the regulators approve a proposed uniform commercial general liability form for use by Jan. 1, 1986.

The hearings were organized by Illinois, New York and Texas insurance commissioners after a meeting of the National Association of Insurance Commissioners in Kansas City in June.

The commissioners at that time said they felt they wanted to hear from the industry in a single presentation, rather than taking testimony on a state-by-state basis as is usually the case when insurers seek approval for a new policy form.

Illinois Insurance Director John E. Washburn, chairman of the regulator panel, grouped supporters of the new policy in the morning and afternoon session.

Opponents, such as the Risk and Insurance Management Society, the voice of corporate insurance buyers,

were to present their case later in the day and continue this morning.

Speaking in support of the new policy John C. Morrison, a senior vice president at Cigna Corp., said the use of the new commercial general liability policy drafted by the

Insurance Services Office, an industry policy-making group, "will help to forestall a very serious threat to the financial solvency of some members of our industry."

"Without approval of the new ISO program, there will likely be an unacceptable number of insurer insolvencies — and this problem could have disastrous consequences for the general public."

The ISO in a statement said the industry's existing "occurrence" policy would be replaced by a "claims-made" version.

An occurrence policy covers the insured for injury and property damage that happen during the policy contract year.

The claims-made policy covers the insured only if a claim is made for the damage during the year the policy is in force.

Christopher C. Mansfield, vice president and general counsel, Liberty Mutual Insurance Co. said that "unless we act positively, our industry may not be able to provide the risk shifting and loss distribution capacity which our customers require and society demands."

Fred R. Maroon, ISO executive vice president and chief operating officer, said, "There has been a complete breakdown in confidence on the part of risk takers: confidence in the predictability of loss, the efficacy of the underwriting process and the ability of insurers to control their own financial destinies."

Supporters of the new policy were united in placing the major share of the blame for the crisis on the judiciary system.

Industry officials say almost with one voice that it is the courts redefinition of policy contract language that has led to awards in pollution liability, product liability and medical malpractice that are bankrupting liability underwriters.

Gerald Wakefield, chief executive, North American reinsurance division of C.T. Bowring & Co., presented the views of Lloyd's of London reinsurers, vigorous supporters of the new policy.

Mr. Wakefield conceded that Lloyd's cannot dictate to American regulators on policy approval, but he wryly said that if the new form is not approved, Lloyd's will not reinsure American liability underwriters.

"Worldwide reinsurance capacity at this juncture is so short that further erosion could cause a fundamental change in the fabric of the U.S. insurance industry's mode of operation." He concluded: "ISO's proposed new claims-made form certainly goes a long way toward the retention of such reinsurance market support which currently looks so tenuous."

The industry spokesmen returned to the hearing table later in the day for questioning by the insurance commissioners.

Vs. Occurrence

Journal of Commerce Staff

CHICAGO — The casualty insurance industry and its biggest customers, corporate America, are having problems with words.

Three words in particular.

The words occurrence and claims made refer to that most important facet of the insurance business, the payment of claims and the question of who will make the payment.

To put it as simply as is possible, no small thing in a sea of policy language complexity, when you buy an occurrence insurance policy, your claim is good for damages you sustained in the period for which you paid the premium, usually one year.

You may not discover the damage until years later, but still your claim is valid and the underwriter who sold you that occurrence policy must pay the claim.

If you bought a claims made policy, your claim is good only if you file the claim during the period in which the policy contract is in force.

So if you are a doctor or make your living by making anything from cookie tins to insect spray, you most assuredly want that occurrence coverage. Who knows what you did 10 years ago to lay yourself open to a claim?

Now we get to the sticky part.

It is the occurrence policy and the way law courts are defining the words therein that is bleeding the casualty industry white, industry leaders say.

The insurance industry, therefore, wants to sell only claims made coverage beginning in January 1986.

In the process, the coverage afforded by the occurrence policy as it is understood by the corporations who buy it would be no more.

Understandly, then, the Risk and Insurance Management Society, the voice of insurance buyers for America's corporations, is, to a

Liability

JAMES NOLAN

of Commerce Staff

Major state insurers were openly skeptical about the property industry's plans to use a special general liability form.

convened by the Illinois Department, regulators in New York, Texas, Connecticut and Illinois said time and time again the insurance industry is reducing the amount of coverage corporations are getting in January.

Regulators argued representatives during intense questioning of the new policy was much more than corporate insurance. A dozen industry representatives countered with arguments that the new policy form was an essential policy for the survival of

of the industry's case. Delegates from the Insurance Office, an industry policy-making body, endorsed the new policy

industry arguments ran the gamut from casualty underwriters suffering catastrophic losses in the last year.

London delegate who was easily for the meeting endorsed the U.S. industry's plan to adopt the new form's reinsurance market. He outlined backing American insurers forthwith. Such a move would severely limit the U.S. industry's ability to buy reinsurance. He cited the major disaster of a supertanker sinking, a well disaster and the problems associated with the gas leak catastrophe. More than 2,000 and in thousands more less

Lloyd's has had a substantial position for generations in supporting American primary underwriters with reinsurance for product liability, pollution and environmental impairment coverages, directors and officers liability and medical and other professional malpractice coverages.

The industry forum was organized by commissioners from Illinois, Texas and New York. They were joined by commissioners and staff regulators from 14 other states after they found they were reacting in a piecemeal fashion to pleas from the industry, state by state, for permission to adopt the new system.

Although the commissioners protested that they were open minded about the issues, their questioning showed mounting skepticism.

For example, Peter Gilles, Connecticut commissioner, said that traditionally the industry position on a new policy filing has been that policy contract language is virtually cast in bronze and should not be changed.

"The purpose of this whole exercise is to avoid litigation. But aren't we going to just march lock step into court on this issue?" Mr. Gilles said.

"When the industry does not want us to approve something in a policy form the argument is made that if you change it, we will have to go and litigate. And you know what this means in the courts, so for God's sake, don't do that to us.

"Now you are asking us to approve a form which is going to make some very dramatic changes in a whole host of areas. How do you avoid the courts?" Mr. Gilles said.

Richard Savage of the ISO said that the danger of litigation was lessened because the new contracts were worded most carefully.

To put the kindest face possible on the matter, the response drew laughter from the regulator's table.

Later, Fred R. Maroon, ISO executive vice president, conceded that the possibility of new litigation had been much on the mind of those who shaped the new form. But, he added, the property/casualty industry has no other course if it is to survive.

At another point, Gerald H.C. Wakefield, chief executive, North American reinsurance division of C.T. Bowling at Lloyd's of London, employed an extended anecdote to explain the genesis of a legal liability principal.

He said that a British court had ruled in the days of Queen Victoria that if a householder was foolish enough to keep a tiger in the back garden, the householder was liable for damages the tiger did when he got out.

At a later moment in the proceedings, Mr. Wakefield sought permission to address the panel on a point.

"Fine," said James P. Corcoran, New York Insurance superintendent, "but, please, no lions and tigers."

Outright hostility to the new policy forms was repeated at the meeting by a delegation from the Risk and Insurance Management Society, an organization of some 3,000 corporate insurance buyers.

William Blick Jr. of the Allen Group, a New York auto parts maker, and spokesman for the society, said the group stood fast on the position it took in public hearings before the New York Insurance Department in May.

The society then accused the ISO of "an abuse of the antitrust exemption granted to insurers by the McCarran Ferguson Act," and that the new policy had been fashioned "with little or no concern as to the impact these changes will have on the insured or potential claimants."

000
4/21/85

**STATEMENT
OF THE
AMERICAN
INSURANCE
ASSOCIATION**

**BEFORE THE
HOUSE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES
CONCERNING
CHILD CARE AND INSURANCE
JULY 30, 1985**



The American Insurance Association is a national trade organization of casualty insurers.

The American Insurance Association (AIA) is a trade association which represents 172 property and casualty insurance companies. The member companies of the Association provide a majority of the commercial line insurance coverages written throughout the United States. Some of AIA's members provide general liability coverage to professional day care centers. Liability insurance is provided to some family day care homes through the application of the "business pursuits" endorsement which removes the business exclusion from the homeowner's policy.

Professional day care centers and family day care homes are currently experiencing a liability insurance availability and affordability problem. To the extent that state law mandates the acquisition of general liability insurance coverage as a prerequisite for doing business, the availability/affordability situation is exacerbated. Current insurance market conditions for professional day care centers suggest a market in transition rather than chaos. The countrywide experience for those companies reporting premium and loss data to the Insurance Services Office, Inc. (ISO) for advisory ratemaking purposes for day nurseries appears to conform with the current loss experience for the majority of commercial insurance lines. If expense factors are built into the loss and loss adjustment data for day care nurseries provided by ISO, the combined ratio approaches the aggregate general liability combined ratio of 152. Although these losses clearly indicate the need for increased rates, they do not suggest that insurers should abandon the market.

Insurance availability and affordability problems are not confined to the day care industry. Societal litigiousness and our legal system's movement

Appendix C (Con't)

"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. The Commissioner went on to point out these statistics for Maryland, remarkable action by many companies given the lack of statistical justification for such a move:

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.

8611 Peck Avenue #4
Anchorage, AK 99504
907/333-9074

April 3, 1986

Senator Pat Rodey
Chair, Senate Judiciary
Pouch V
Juneau, AK 99811

Re: Tort Reform Legislation

Dear Senator Rodey:

I am writing to indicate my dismay over the proposed tort reform legislation now pending in the legislature.

It is my belief that although the current liability insurance crisis is a serious problem, it is too complex a problem to be resolved by passing the ill-advised tort reform package as it presently exists. The crisis, although exacerbated by the clogged civil court system, is a problem manufactured by the insurance industry because of their fiscal mismanagement. The truth is that the insurance companies are looking for a quick fix for investment losses caused by declining interest rates on their fiscal mistakes.

I believe it would be a travesty of justice to abridge the individual's right to personal redress through the court system. I say this as a "victim" in a products liability suit. I am one of the thousands of women who was injured through use of the Dalkon Shield intrauterine device. I was rendered sterile by that dangerous, untested device and am unable to ever have children. It is the single greatest loss of my life--the pain and disappointment I have experienced over this loss will be with me until the day I die. To this day, I have yet to be compensated, in any way, for the damages I have suffered, which include approximately \$13,000.00 in medical expenses. It now appears that I may well never receive any remuneration for my loss, since A.H. Robins has filed bankruptcy.

April 3, 1986

Page 2

Attorney's contingency fees are constantly brought up in the tort reform argument. I personally do not feel that a 1/3 fee is outrageous for an attorney to take when you consider that an attorney takes a risk in taking any case; there is certainly no guarantee that he will receive any award, let alone an amount to cover the billable hours he or she has in the case. People claim to be outraged that an attorney can collect his 1/3 fee from a sizable settlement or jury verdict, but I think those people should remember a few things regarding a large verdict:

1. That multi-million dollar verdicts generally come in cases of very severe injuries; e.g., an accident resulting in quadriplegia or injuries of an equally debilitating magnitude;
2. That many large verdicts are appealed by the loser and can be reduced by a higher court or are reduced by settlement between counsel during the appeal process;
3. That comparative negligence statutes exist in many states and thereby limit the percentage a plaintiff might recover; and
4. That an attorney puts in hundreds of hours in pretrial discovery and other legal procedures and, therefore, if he was billing at an hourly rate, the bill could well come to a comparable amount.

In addition, most attorneys advance costs to the client in contingency fee cases and these can easily run into several thousand dollars when expert witnesses and medical experts must be consulted for testimony.

Speaking from personal experience, I am quite happy to pay my attorney 1/3 of any settlement I may receive because he is the person who made the recovery possible in the first place by going out on a limb in accepting my case and proceeding to file suit.

Punitive damages are another bone of contention in the tort reform proposals. It is my belief that punitive damages are rarely awarded and then only in cases of extreme abuse of the court system by the negligent party or its insurer.

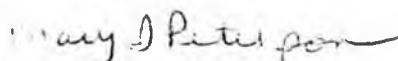
April 3, 1986
Page 3

Perhaps you can explain to me how it is that most of the 50 states dreamed up such severe tort reform proposals, all within the last year. I believe it is the result of a well-orchestrated lobbying effort by the insurance industry, aided and abetted by one of the country's most powerful professional lobbies--physicians. It has long been acknowledged that medical doctors have suffered under the malpractice surge and, prodded by the insurance industry, they have been quite an effective lobby for tort reform. The insurance industry is not regulated by the government, is not subject to anti-trust laws and is the third largest industry in the United States. They have assets of \$319 billion and are adept at using the media for their own purposes.

In consideration of the above, I hope you will vote not to abridge the victim's right to recovery when he has been wronged by the negligence of an individual, corporation or other entity.

Thank you for taking the time to read this letter and to consider my opinion.

Sincerely,



Mary I. Peterson

file 01-07 HA

J. W. WILSON & ASSOCIATES, INC.

ECONOMIC COUNSEL

THIRD FLOOR • WATERGATE OFFICE BUILDING
2600 VIRGINIA AVENUE, N.W. • WASHINGTON, D.C. 20037
(202) 333-7442

ELIZABETH A. BALABAN
THOMAS C. BORZILLERI
NANCY B. BRIGHT
ALLEN G. BUCKALEW
GEORGE L. DONKIN
JAMES H. DRZEMIECKI
CHARLES E. JOHNSON
C. DAVID KIRBY
ERIC J. OLSON
CAROLINE M. SMITH
JOHN W. WILSON

UTILITY REGULATION
ANTI-TRUST ECONOMICS
TELECOMMUNICATIONS STUDIES
NATURAL GAS
TRANSPORTATION
INSURANCE RATES
REF:

March 7, 1986

RECEIVED
Department of Law

Honorable Harold M. Brown
Attorney General of Alaska
Pouch K
State Capitol
Juneau, Alaska 99811

MAR 11 1986
AM 7 8 9 10 11 12 1 2 3 4 5 6 PM

Dear Mr. Brown:

Dramatic insurance rate hikes and reduced coverage for many types of liability insurance in Alaska are disrupting key social sectors and creating crisis conditions in critical economic areas. Municipalities, school districts, medical and other professionals, nonprofit organizations, and even major industries are facing massive premium increases, insurance coverage restrictions, and, in some cases, non-renewals or cancellations. These insurance problems, in turn, are forcing curtailed public services, higher costs, and even closings for some important civic and business organizations.

The insurance industry blames our legal tort system for this situation. Law suits and rising damage verdicts, the insurance companies say, are forcing them to raise rates and limit coverages. But the actual evidence that insurance companies have presented is slim. In fact, the liability insurance claims data which are publicly available do not appear to support the insurance industry's crisis mentality. To be sure, some insurance companies have posted substantial underwriting losses during the past several years, due largely to their own rate cutting in a few highly competitive commercial insurance markets. But, those losses were generally not in the crisis liability lines, and they were substantially offset by equally large investment income profits (i.e., insurance companies operate like banks -- collecting premiums from policyholders in advance and investing these funds until they are ultimately "withdrawn" through the payment of claims).

Letter to Attorney General Brown
March 7, 1986
Page 2

Many insureds and public officials have responded to the insurance industry's arguments by questioning their reasoning and motives. Why should liability insurance premiums triple and coverages be cut in half for municipalities that have had no claims? Why do municipalities, churches, school districts and day care centers suddenly look like asbestos plants to insurance companies that have, up to now, profited from writing these coverages? Are key social areas being singled out by insurance companies to "soften up" public and regulatory resistance to insurance rate increases for all lines of coverage? Are insurers using their recent short-term profit reductions to promote statutory changes which would limit citizens' rights to compensation and thereby increase long-term insurance company profits? Are the special federal antitrust exemptions which permit insurance companies to operate collusively undermining effective independent competition in the insurance industry? Why is our legal tort system, which has played an increasingly key role in policing harmful actions by individuals and organizations now being singled out as the cause of the insurance crisis absent any conclusive supporting evidence?

Clearly, there is an insurance crisis. Any municipality, civic or professional organization, or business enterprise that has faced insurance renewals in the last year can attest to that. The cause, and therefore an appropriate response to the problem, is the only question. The importance of accurately identifying the cause of the insurance crisis and devising an appropriate solution can hardly be overstated. The insurance industry's hasty proposal to dismantle our legal tort system, which has evolved over the past two centuries to protect victims rights and shield the public from harmful products and actions, should be examined closely. If, as some have argued, a major cause of the crisis is actually traceable to the insurance industry's own cost excesses, rate increase strategies and antitrust exemptions, an entirely different solution is warranted.

Letter to Attorney General Brown
March 7, 1986
Page 3

That is the point of this letter -- to encourage the undertaking of a careful, independent, factual study of the causes and potential solutions to the mounting liability insurance crises in Alaska. J.W. Wilson & Associates, Inc., in cooperation with the National Insurance Consumer Organization (NICO), has actively researched issues in the insurance industry in recent years. Recommendations that we developed for the National Association of Insurance Commissioners (NAIC) on the importance of insurance company investment income in rate-making were adopted by the NAIC and are now generally recognized in many states. We have also been actively involved (as advisors and consultants to state governments) in numerous insurance rate cases. In that capacity, we have gained detailed insights on insurance industry operations, costs, and rate increase strategies. We have undertaken research projects for State Insurance Departments and legislative committees dealing with insurance matters -- including, in recent months, examinations of the causes of and solutions to the liability insurance crisis.

Because of the knowledge that we have gained in these and related areas in recent years, we believe that the analysis that should be completed as a foundation for legislative or administrative action to resolve the liability insurance crisis in Alaska can be accomplished within several months and at a relatively modest cost, with appropriate legislative or administrative support in order to obtain necessary data and information from insurance companies.

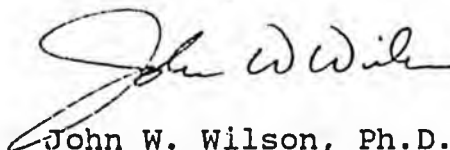
In our opinion, the essential independent study that must be completed in order to devise an effective and publicly responsible solution to the liability insurance crisis involves two major focusses. First, a detailed and thorough examination of insurance company closed claims by line in Alaska should be completed. From such a closed claim study we will be able to identify: (a) the extent to which the legal system has or has not been the cause of dramatic liability insurance premium increases and coverage reductions in crisis lines in Alaska, (b) how victims are faring under the present system, and (c) what the various specific reform proposals

Letter to Attorney General Brown
March 7, 1986
Page 4

will actually accomplish. Second, a thorough examination should be made of insurance company financial operations, expenditures and profitability. This analysis will enable us to determine: (a) the extent to which dramatic liability insurance rate increases and coverage limitations in Alaska are or are not cost-justified, (b) what alternatives exist to limiting coverage and raising rates, and (c) the legislative and/or regulatory actions which may be undertaken to resolve the State's liability insurance crisis.

We would welcome the opportunity to discuss undertaking a project of this type in Alaska. We will, of course, be glad to supply examples of our past research and references from public officials who are familiar with our work in other states. Please call either of us at your convenience if you are interested in pursuing such a study.

Sincerely,



John W. Wilson, Ph.D., President
J.W. Wilson & Associates, Inc.
202-333-7442



J. Robert Hunter, FCAS, MAAA, President
National Insurance Consumer Organization
703-549-8050

ALASKA ACADEMY OF TRIAL LAWYERS

1015 W. 7th Ave.

Anchorage, AK 99501

FOR IMMEDIATE RELEASE

APRIL 4th, 1986

FOR MORE INFORMATION CALL:

AMES LUCE, 276-1191

ELEVEN STATE LEGISLATURES ADJOURN '86 SESSION

REJECTING TORT CHANGES

Eleven states throughout the nation have rejected so called tort reform as a way of addressing the national insurance crisis. All eleven states have adjourned their business for the year.

"Legislators from these states have realized that changing the tort system will severely reduce their constituents' legal rights without a corresponding reduction in insurance rates," said Ames Luce, a local attorney and member of the Alaska Academy of Trial Lawyers. "Tort 'reform' does not mean lower rates, and insurance companies are refusing to make promises to that effect."

Six of the eleven states ended the session with no action on insurance issues. Both houses of the Georgia legislature had passed comprehensive tort change bills, but refused to compromise on a final version when the state's insurance industry, which spearheaded the tort effort, refused to guarantee that a rate

- more -

rollback would follow passage. Virginia empaneled an Interim Committee to study the issue.

Minnesota, Washington, and Idaho passed strict insurance reporting legislation requiring insurance companies to report on profits, investment income, reserves, and loss expenses for in-state operations for each type of insurance offered. Alaska requires each company to submit minimal information concerning its state operations.

West Virginia approved a \$1,000,000 limit on pain and suffering in medical malpractice cases, but rejected an array of proposals. Likewise, Iowa simply passed a bill prohibiting frivolous lawsuits.

"Legislators in these states have seen the insurance industry campaign for what it is--a citizens rights reduction package," said Luce.

The Alaska Academy of Trial Lawyers is a statewide organization of personal injury and criminal defense attorneys. The Academy provides education and training for its members.

--END--

The Alaska Society of Professional Engineers



Address Reply To:

Vincent S. Haneman, Jr.
Dean, School of Engineering
539 Duckering Building
University of Alaska
Fairbanks, Alaska 99775

March 4, 1986

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

Dear Senator Rodey:

The liability crisis and its impact upon the fabric of Alaskan life has become a major concern for everyone. It has hit full force across the United States at about the same time and is the subject of extensive study.

As president of the Alaska Society of Professional Engineers, I am involved in both the national effort and the Alaskan consideration. The impact upon Alaskan design professionals is far worse than on the country as a whole.

Insurance is either not available or is available with such restrictions that it is placing Alaskan firms at a disadvantage as compared to outside firms. The cost of premiums, when partial coverage is available, is extremely high. There are many reasons. An obvious one is the financial position of the insurance companies. Less obvious is the lack of predictability of awards, sizes of awards, and the cause or extent of liability.

The growing expectation of the average person to "make out" in litigation on liability; to "make out" far in excess of actual damages on cost to "restore to whole" is at the root of this problem.

The Alaska Society of Professional Engineers has joined the Citizens Coalition for Tort Reform. A strong thread throughout all the business ventures having trouble is that of establishing predictability for insurance. The Coalition has defined a primary set of areas which would reestablish some basis of logic and therefore assist in liability coverage. These items, in spite of comments from the bar, will not reduce recovery legitimately due the injured party for actual damages or limit the resources to "make whole".

The findings of the NSPE Liability Task Force and the NSPE/PEPP Professional Liability Committee are attached in the form of the NSPE White paper "The Liability Crisis". We feel this paper documents most of the items and, in turn, House Bill 532.

We, the Alaskan engineers, hope that you will support HB 532. If we can provide any information, please call.

Sincerely,

A handwritten signature in cursive script, appearing to read "V. Haneman".

Vincent S. Haneman, Jr.
President, ASPE
Dean, School of Engineering, UAF

VSH/nas:300
Enclosure



a National Society of Professional Engineers

WHITE PAPER

THE LIABILITY CRISIS

published by the
Professional Engineers in Private Practice
and the
Legislative and Government Affairs Committee

This report was prepared by Milton F. Lunch, NSPE General Counsel, and reviewed for concept by the NSPE Liability Task Force and the NSPE/PEPP Professional Liability Committee. It is published for NSPE by the Professional Engineers in Private Practice, a semi-autonomous Practice Division of NSPE, and the NSPE Legislative and Government Affairs Committee.

Appreciation is expressed to Paul L. Genecki, Senior Vice President, Victor O. Schinnerer & Company, Inc., administrators of the NSPE/PEPP-endorsed liability insurance program, for reviewing the text and providing the insurance data.

It is intended that this report will serve as a basis for further cooperative programs with other professional societies and trade associations through the work of the Committee on the Liability Crisis of the Interprofessional Council on Environmental Design composed of The American Institute of Architects, American Society of Landscape Architects, American Society of Consulting Planners, American Society of Civil Engineers, American Institute of Certified Planners, American Consulting Engineers Council, and the National Society of Professional Engineers.

THE LIABILITY CRISIS

INTRODUCTION

At midnight on September 11, 1985 the town of Sykesville, Maryland (population 2200) went out of business.

At that hour the town's liability insurance expired and the town had been unable to find any replacement policy. The elected and appointed town officials resigned their positions and terminated all town services to the town's citizens. Their stated reason was the fear that they might be held individually liable for claims arising from the activities of the town or the services rendered by the town, ranging from street repair, water supply maintenance, enforcement of police laws, traffic control, and the host of other day-to-day functions which residents of towns and citizens routinely expect and hardly think about.

The Sykesville case is not unique or even special any longer. The loss of liability insurance because it is no longer available, or because the premiums are out of reach, has now extended to all elements of society. Child care centers are closing, school boards must close down schools with asbestos installed years ago, midwives are leaving the field, hospitals increasingly raise patient charges to cover ever-increasing premiums.

These concerns are not new to the professions. Engineers, architects, medical doctors, accountants, and now even lawyers (who are often blamed for the crisis) are feeling the pinch in terms of loss of coverage or substantial premium increases.

The purpose of this special report is not to assess blame, or to present solutions, as such. Rather, it is intended that it will be beneficial to members of NSPE, and others, to understand the background of how this all came about, what is the current situation in particular aspects of the problem, and what actions are underway or contemplated to deal with the many and varied issues which form the total crisis.

The emphasis of this report will naturally be on the implications of the problem for engineers, but not confined to those in private practice or any other single segment of the profession. Likewise, it discusses the relationship of the concerns of engineers with those of the other professions, but recognizing that there are major differences between the professions in light of their different forms of practice and liability exposure.

The liability crisis is not confined to the professions. It sweeps across virtually all elements of society. For some ten years the manufacturing industry has attempted to enact a federal law establishing a uniform standard for product liability. Despite extensive efforts and substantial financing the effort has not been successful. In addition to the arguments

about the substance of the proposal which is intended to lessen the liability exposure for product cases, there has been strong opposition to the idea of "federalizing" what has always been a state function. Currently, a revised proposal to establish a voluntary "no fault" system for product liability has emerged, but there is no indication that Congress will move in that direction at this time. The justification for a national standard in product cases is that products are often produced in several states and are sold nationally in interstate commerce. That is not the case, however, with professional design and related services, which are almost always located within a particular state.

Engineering employees are sometimes concerned with the possibility of being named as defendants on an individual basis. While this is a rare occurrence, it is possible, particularly for those employed in industry, government, contracting or education, among others. Even those in consulting firms which do not carry professional liability insurance may be vulnerable. Employees in firms with such insurance policies are covered under the policy along with the firm, but there may be liability exposure for employees who leave the firm and go into non-consulting employment.

NSPE has attempted to provide for this potential exposure by a separate insurance program (jointly with ASCE) for individual employees. However, this undertaking did not generate enough support to justify its continuation from an insurance viewpoint. An effort to develop a new program for individual employees is continuing, but in the present state of the insurance industry there is no immediate prospect of success.

It is hoped that by this exploration of the problem, faced realistically from practical, economic, legal and ethical viewpoints, the engineering profession, working in concert with the other professions, may be able to play a constructive role in seeking remedies to a familiar, but now worsening situation; one which is heavily invested with an overriding public concern of health, safety and economic well-being of all citizens.

This report is presented in two basic parts. Part I is intended to deal with the current or immediate problems and to outline pending proposals to deal with practical approaches. These aspects of the problem reflect mainly the concerns of engineers in private practice and the efforts of the Professional Liability Committee of the Professional Engineers in Private Practice Section of NSPE. The Professional Liability Committee has worked extensively in recent months to monitor these fast-breaking developments, in-

cluding meetings with the insurance administrators and underwriters to press for the best possible language to limit the new policy exclusions discussed under the section on policy coverage.

Part II relates more to the long-term problems which are at the heart of the crisis, but which will require a much more detailed exploration of causes and possible remedies. This

aspect, which in general is referred to as "tort reform", will require many years of effort if fundamental changes in our legal system are to be achieved. Of equal, if not more, importance will be a better public understanding of the nature of a legal system which in many respects has gone berserk in evaluating and balancing the rights of plaintiffs and defendants in injury cases.

THE LIABILITY CRISIS

PART I—The Immediate Crisis

The most evident change in the worsening liability picture has been the very high increases in premiums charged to practicing engineers in recent years.

For twenty-eight years NSPE and the American Institute of Architects have endorsed a professional liability insurance program underwritten by Continental Casualty Company, and administered by Victor O. Schinnerer & Co., Inc. It has been a fully collaborative program during all of those years, with regular review of development since its inception by committees of the two societies, and with full disclosure of all pertinent statistics as the basis for premium development.

In recent years the premium rate increases resulting from increased claims have averaged:

1981	17%
1982	9%
1983	9%
1984	15%
1985	35%

Historically, average premiums have been approximately 2-3 percent of gross billings of consulting firms. With the projected increases for the current policy period it is expected that they will average approximately 4-5 percent.

It should be emphasized that average rate increases or percentage of billings do not mean that each policyholder received or will receive the same increase. Premiums reflect a host of factors—size of the firm in terms of billings, type of practice, geographical location and loss experience. Thus, a firm with a substantial growth in billings may well have an increase above the average. Because firms which specialize in structural engineering have experienced the worst loss records in recent years their premium currently is in the highest range. Those firms which practice entirely, or mainly, in the field of structural engineering, and which have not heretofore been insured under the CNA program are finding it most difficult to find any source of liability insurance.

Another significant development in the worsening liability insurance picture is a trend toward higher deductibles required of the insured firms. This obviously means that in the event of a loss covered by insurance the firm will have to dig deeper into its own pocket to cover the first element of the loss.

All of this, compounded by the withdrawal or reduction in the availability of reinsurance, has resulted in a substantial lessening of insurance underwriters for A/E professional liability insurance. Only a few years ago there were some ten or a dozen insurance companies offering A/E liability insurance. Today there are only a handful or fewer insurance companies willing to offer such policies.

It would be erroneous, however, to conclude that the crisis is an insurance crisis. The state of the insurance market is basically a reflection and result of the liability crisis.

The reasons for insurance underwriters dropping out of the market are complex, but clear. The main reason, of course, is the heavy losses sustained by these companies in recent years. According to recent reports, the casualty insurance industry, overall, has lost \$3.7 billion in the past year. In the A/E program alone, CNA, the largest of the remaining underwriters, reported an underwriting loss of \$113,000,000 on the first \$1,000,000 limit of liability between 1978-1983 with an accelerating loss trend. It has been observed by insurance authorities that insurance companies are not mainly interested in premium income; they look for their profit from cash flow—from investment of the premium income. This formula worked well during the years when interest rates were in the 20 percent, or better, range. The underwriters were then content to absorb the underwriting loss and make up for it from the investment income. In this regard it is worth noting that invested premium income generates income for a long period of time before claims are resolved and indemnity payments made. Now, however, with interest rates at a much reduced level the cash flow-investment formula fails to produce a sufficient return to compensate for the increased costs of claims handling, indemnity payments and overhead.

As an indication of the deteriorating A/E liability picture from the insurance underwriter's standpoint, in 1983 (the latest available complete statistics) claims frequency remained fairly steady at 44 claims per 100 firms per year. Paid claims frequency (claims in which there was an indemnity payment) was 9.5 per 100 firms. But, severity measured in terms of average indemnity payment was reported at \$148,000, representing an increase since 1978 of approximately \$40,000 per claim. Also, during the same time frame, average claims expenses have more than doubled on a per claim basis.

Policy Coverage

As serious as the premium increases have been, in some respects it is not the most serious concern. The firms required to pay these higher insurance costs must of course, pass them along to clients as part of the firm's overhead. It has been suggested in that connection that in billing a client the A/E may choose to add a line item to the bill to represent the liability insurance part of the bill. Thus, if a firm is paying 3 percent of its billings for liability insurance it would add 3 percent of the basic bill to the client. This is a dubious tactic, however, on several grounds. First, the line item for insurance would represent double billing if the same 3 percent were in the overhead part of the firm's charge to the client. Second, it may well be questioned whether it is wise in any event to spell out to clients the extent of the A/E's insurance, thereby perhaps giving the client the false idea that it may as well file a claim for some imagined deficiency in the plans and specifications "because the insurance company will pay it."

From its inception, the A/E insurance policy has included certain exclusions, such as certain types of more hazardous projects, guarantees by the A/E, nuclear facilities, etc. In the face of the emergence of pollution-related claims and enormous claims related to asbestos, the insurance industry as a whole has opted to now exclude those two categories from liability insurance coverage. Those two exclusions, to be written into every new policy and renewal policies read as follows:

Pollution

We will not defend or pay under this policy for "claim" and "claim expense" resulting from "professional services" performed by you and arising out of:

1. The actual, alleged or threatened discharge, dispersal, release or escape of "pollutants"; or
2. Any governmental or regulatory directive or request that "you" or anyone acting under your direction or control test for, monitor, clean up, remove contain, treat, detoxify or neutralize "pollutants".

This exclusion does not apply to "claim" or "claim expense" resulting from "professional services" performed by you in the design and construction of treatment facilities for:

- a. domestic sewage including those receiving industrial waste but only if such industrial waste is pretreated in accordance with applicable governmental or regulatory standards,
- b. potable water and
- c. "storm water".

ADDITIONAL DEFINITIONS

"Pollutants" means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste. Waste includes materials to be recycled, reconditioned or reclaimed.

"Storm water" means from rain, hail, snow or sleet.

It is noted that the exceptions to the basic exclusion were initially developed by extensive discussions between the NSPE/PEPP Professional Liability Committee and representatives of CNA and the Schinnerer firm. That initial language, later revised for a clearer understanding that the exclusions would not apply to "traditional" engineering activities, such as water supply facilities, drainage, wastewater facilities, street, roads and highways, municipal incinerators, power plants and domestic and non-manufacturing facilities, was not accepted by CNA, which had meanwhile filed the language quoted above with the state insurance authorities.

As the language now stands it does not meet the concerns of engineers in private practice, but there is an indication that the more extensive and explicit language will be considered for subsequent policies. The present language is, hopefully, only a first step in better defining the extent of the exclusion, but it will take more time to learn how the exclusion will be applied through a case-by-case experience. As explained by the CNA comment in transmitting the exclusion language to policyholders, the intent is to remove from coverage claims which rest upon damage from pollution, as defined, but to continue to cover the remedial costs in the project when it is deemed that the A/E had been negligent in the design of the particular part of the facility which failed.

Asbestos

To "claim" or "claim expense" alleged to or actually arising out of:

1. specification of a product, material or process containing asbestos
2. failure to detect the existence or proportion of asbestos in a product, material or process
3. the performance or failure to perform "professional services" in the abatement, replacement or removal of a product, material or process containing asbestos

whether by you or on your behalf.

Indemnification

Faced with a choice of taking on a project which may entail pollution or asbestos exposures, or declining the project because of the uninsurable risks, the engineer has little choice but to seek protection through an indemnification clause. For that purpose the PEPP committee has developed two indemnification clauses as follows:

Hazardous Waste—For services involving or relating to hazardous waste elements of this agreement, it is further agreed that the OWNER shall indemnify and hold harmless ENGINEER and their consultants, agents and employees from and against all claims, damages, losses and expenses, direct and indirect, or consequential damages, including but not limited to fees and charges of attorneys and court and arbitration costs, arising out of or resulting from the performance of the work by ENGINEER, or claims against ENGINEER arising from the work of others, related to hazardous waste.

The above indemnification provision extends to claims against ENGINEER which arise out of, are related to, or are based upon, the dispersal, discharge, escape, release or saturation of smoke, vapors, soot, fumes, acids, alkalis, toxic chemicals, liquids, gases or any other material, irritant, contaminant or pollutant in or into the atmosphere, or on, onto, upon, in or into the surface or subsurface (a) soil, (b) water or water-courses, (c) objects, or (d) any tangible or intangible matter, whether sudden or not.

Asbestos—For services involving or relating to the removal or encapsulation of asbestos as part of this agreement, it is further agreed that the OWNER shall indemnify and hold harmless ENGINEER and their consultants, agents and employees from and against all claims, damages, losses and expenses, direct and indirect, or consequential damages, including but not limited to fees and charges of attorneys and court and arbitration costs, arising out of or resulting from the performance of the work by ENGINEER, or claims against ENGINEER arising from the work of others, related to asbestos activities.

Already the question has been raised as to what action the engineer should take if a particular project does not indicate the likelihood of either a pollution or asbestos concern, but during the course of the work such a potential problem develops. It would be impractical in such an instance for the engineer to unilaterally terminate services. To do so, in fact, might well generate a claim for breach of contract. One suggestion to deal with this kind of potential problem is to add a clause in the owner-engineer agreement and in supplementary general conditions to the effect that when and if such conditions are observed the engineer or

the contractor, as the case may be, shall cease all work related to the pollution or asbestos conditions and notify the owner of the circumstances. The owner will then be obligated to determine what course of action is to be taken, such as bringing in experts for advice on how to deal with the condition.

Toxic and Hazardous Waste—As this report was being prepared Congress was in the midst of deliberations on an extension and expansion of the federal Superfund program. This federal program designed to bring about the cleanup of toxic and hazardous waste sites around the country is expected to involve the expenditure of somewhere between \$5 and \$10 billion over the next five years. The key players in this national program will obviously be engineers and contractors. Yet neither will be able to play their role in such an undertaking without any protection from claims alleging damage as a result of cleanup operations in a highly sensitive area, and particularly as such claims may entail class action suits of enormous magnitude.

Fortunately, Congress appears to be receptive to the problem and is moving toward an indemnification program whereby the federal government will "hold harmless" engineers and contractors (referred to as "response action contractors") in the pending legislation.

The Senate has already passed its Superfund bill, which authorizes EPA to hold harmless and indemnify response action contractors " . . . against such claims to the extent not covered by available insurance and to the extent that any such damages awarded do not arise out of the gross negligence, recklessness, or intentional misconduct of the contracting or subcontracting party, so long as such indemnification is in the public interest."

Likewise, three House committees have adopted similar language in their bills, which are now being merged into one bill for House action. As explained by the report of the House Judiciary Committee:

"At present, insurance availability for response action contractors is diminishing, limits of coverage are being reduced, and premium rates are increasing by more than 50-200 percent. Insurance industry sources estimate that only 10 percent of contractors' market needs are currently being met by insurers, and that by January, 1986, no insurance will be available. The present lack of insurance is already causing a reduction in the number of qualified contractors willing to participate in Superfund cleanups. As insurance becomes increasingly unobtainable over the next year, the availability of qualified contractors could diminish to the point of being acute, and the Superfund cleanup program could come to an abrupt halt."

Assuming final congressional approval of the Superfund bill, a remaining question will be the extent to which the EPA indemnification will apply. The House Judiciary Committee report recognizes that EPA may provide "appropriate limits", to represent amounts equivalent to, but not in excess of, adequate insurance coverage, and to include deductibles. The report also refers to payment by response action contractors of a premium for the indemnification coverage and to offer it only as a supplement to available insurance, if available insurance is not adequate. Thus, following enactment of the indemnification provision it will be necessary for engineers and contractors to engage in detailed discussions with EPA to define the basis upon which indemnification will be provided.

Final congressional action of an indemnification approach will open the way for similar legislative action at the state level to cover projects which are state-financed outside of the federal program. Some efforts have been initiated at the state level along similar lines, but it will take concerted action by the state societies to press for more vigorous action during the 1986 legislative sessions. The federal approach should serve as a model to spur state action.

Private cleanup operations will likewise call for an insistence upon indemnification provisions in the engineer-owner contract.

Other Approaches

Various other ideas have been advanced as possible means of dealing with the liability conditions which confront the design professions.

These include, for example, a firm establishing a separate corporation to handle the pollution and asbestos kinds of projects. The idea would be for the separate company to be alone liable for claims in those areas. This entails several important considerations. First, from a legal standpoint, for this approach to work it must be clearly established that the separate firm is truly independent of the parent company. This means separate stockholders, separate officers and personnel, and separate financial arrangements. Otherwise it may well be argued that the separate company is no more than a "shield" to avoid liability, much as the cases in which a husband-owner transfers his assets to his wife to protect himself from liability. The courts will most likely, in such cases, apply the legal doctrine of "piercing the corporate veil."

A second important consideration is whether, even if a company is created as a truly separate entity, prospective clients will be willing to enter into contracts with a firm which presumably would have limited assets and no liability insurance.

From time to time, some engineers have chosen to "go bare" on the theory that in the absence of liability insurance they may be less likely targets for liability suits. There is some theoretical basis for this philosophy in today's climate of plaintiffs' attorneys looking for the "deep pocket". Again, it is a question of the extent to which the engineer is a gambler and is willing to take the chance that his personal assets will be subject to claim. It may be contended that this approach might work if the assets of the firm alone are at risk, and not those of the individual officer or shareholder. However, in the case of professional services it is more likely than not that those who are in responsible charge of plans and specifications which are found to be negligent will be held personally liable. For that reason the present professional liability policy covers the individuals in the firm, as well as the firm itself.

This idea is closely akin to what is called "self-insurance" a term which actually means no insurance. True, a firm may set aside part of its revenue each year into a separate fund for liability claims only, but under present tax law such set-aside funds are after tax dollars. If a firm is lucky enough to not have serious liability claims for enough years to build the self-insurance fund to a substantial amount it may be a workable scheme, but how much is enough to pay potential losses is purely speculative.

Part II of this report will deal with the broader aspects of the liability crisis, including protective legislation against injured construction worker claims, joint and several liability laws, punitive damages, restrictions on contingent fees, frivolous suit claims, pre-trial panel requirements, statutes of limitation, a new "unified risk" insurance concept, and the need for long-range tort reform.

THE LIABILITY CRISIS

PART II—Remedial Actions

The commonly used phrase in discussion of what actions might be taken to help resolve the liability crisis is "tort reform". That refers broadly to the idea that much of the problem arises from laws and judicial procedures which tend to impose ever-higher responsibilities and costs upon defendants in liability cases. Another common reference to this situation is the use of the "deep pocket" in determining who should be held liable for damages in a given situation. It is said that whereas the lawyer representing a plaintiff traditionally would first ask, "who is at fault", now will first ask "who has the money?"

An equally important perception is the attitude of the general public in being excessively lenient in dealing with the claims of persons claiming the right of recovery for damages sustained in a given situation, with much less concern for whether a particular defendant was at fault. This is a reflection of the same "deep pocket" philosophy alluded to above, but here it is even more significant because it is the members of the general public who make up the juries. Since 1970 there have been approximately 220 verdicts of more than \$1 million in injury cases. Even though many of these were later reduced by the courts as excessive, those kinds of numbers attract headlines and further implant the idea of tremendous awards in cases in which the sympathy of the jury is with the injured plaintiff.

The more difficult problem in trying to cope with these kinds of developments is that remedial action may be taken to bring about a fairer and more equitable system designed to protect the rights of those with a proper claim, while at the same time limiting the current atmosphere which drives juries to grant ever-higher awards on responsible defendants, and, even worse, drives a finding of liability when not justified.

This Part of the paper, therefore, deals with various and sundry current proposals and developments designed to achieve some degree of reform in the justice system. It should be emphasized that many of these items as discussed below flow from medical malpractice cases, and to a substantial degree are less relevant to cases involving design professionals. The reason for the distinction is that in medical malpractice situations there is virtually always a claim involving death or injury. In the design professions, however, approximately 80 percent of the cases involve property damage, broadly defined. Only about 20 percent of design professions cases relate to personal injury or death, and most of those occur in connection with accidents during the construction process.

Worker Compensation Laws

Turning, then, to the construction accident situations, a move has started in two states (Oklahoma and Kansas) which gives promise of alleviating a problem in which the design professional is unfairly a victim of claims for accidents completely outside the responsibility of the engineer. In a typical case, an unshored trench (in violation of safety laws) collapses and a construction workman is killed. The widow is entitled to the benefits provided under the state workers compensation law, which are generally relatively low. This exonerates the contractor-employer from any further liability. The widow in this case then files suit against the design engineer, alleging that in some fashion the collapse was caused by the negligence of the design firm in failing to properly monitor the construction as part of its services during the construction phase. Even if the defendant engineering firm is ultimately found to not be responsible, substantial legal costs are involved and to a large extent, if not totally, are paid by the firm out of its deductible under the liability insurance policy.

To deal with this kind of "no-win" problem, Oklahoma first enacted an amendment to its workers compensation law which provides that in such instances the design professional stands in the same shoes as those of the contractor; the firm is equally not subject to suit for damages over and above the amount paid under the worker compensation law system. The only exception is if it is determined that the collapse was due to the negligence of the engineer. While this exception may open the door to the filing of a suit in the kind of example stated above it should be relatively simple to quickly prove that the engineer under his contract had nothing to do with the trench. In that connection, it is exceedingly important that the engineer's contract with the owner, plus provisions in the general conditions, make it clear that the engineer during the construction phase is not responsible for contractor's means, methods and techniques.

A copy of the Oklahoma law is reproduced in Appendix A.

Frivolous Suits

Probably every engineer who has been sued has reacted that the suit was unjustified, groundless and without merit—a frivolous suit. While it is often true that the engineer is brought into a dispute between other parties on a "shotgun" basis, it does not follow that the engineer is a vic-

tim of a truly frivolous suit. A frivolous suit does not result because a party wins the case on the merits, or is dismissed prior to trial. While there are various definitions of what constitutes a frivolous suit, the most common characteristics are that the party alleging the suit was frivolous must first be dismissed from the case or win on the merits. But that is not enough. It must also be shown that the allegations were totally without merit, a showing of bad faith or other improper motives on the part of the plaintiff.

The leading case to illustrate the difficulty of maintaining a frivolous suit (sometimes called a counter suit) involving design professionals is *Bird v. Rothman*, 627 P.2d 1097 (Ariz. 1981). In that case an architect had designed a race track in 1963. In 1976 he was sued by a woman who was injured at the track when the grandstand glass was shattered by a rock. In 1977 the architects were dismissed from the case. In 1978 he sued the woman's attorney on the ground the attorney had been negligent in failing to investigate the facts and the law before bringing the case. In finding against the architect, the court noted that a balance must be struck between freedom of access to the court and discouraging unmeritorious litigation; that the courts must be open to litigating parties without fear of subsequent prosecution for calling upon the court to decide a contested issue; that an ulterior purpose alone cannot constitute abuse of legal process, concluding:

"In summary, despite appellant's arguments that negligence suits, such as the underlying suit in this action, against architects and engineers have a significant impact on malpractice liability insurance rates and serve to impugn the reputation of conscientious professionals, we are persuaded that in the absence of proof of malicious prosecution on the part of the injured party or his attorney, the interest of freedom of access to the courts compels the conclusions we have reached."

A number of the state societies have tried over the years to enact frivolous suit statutes to define the circumstances in which a successful defendant might recover his legal costs in defending an unmeritorious case. In fact, however, most states have such provisions by law or by court rules, even though the wording varies considerably. For those still pursuing this type of legislation attention is called to the wording in Rule 11 of the federal rules of civil procedure, as amended in 1983, requiring that all pleadings and motions on behalf of a party shall be signed by the attorney of record, and further providing that:

"The signature of an attorney or party constitutes a certificate by him that he has read the pleading, motion, or other paper; that to the best of his

knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact and is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation. If a pleading, motion, or other paper is not signed, it shall be stricken unless it is signed promptly after the omission is called to the attention of the pleader or movant. If a pleading, motion, or other paper is signed in violation of this rule, the court, upon motion or upon its own initiative, shall impose upon the person who signed it, a represented party, or both, an appropriate sanction, which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee."

(As amended Apr. 28, 1983, eff. Aug. 1, 1983).

While a rule of this type, or a statute along similar lines, is proper and desirable, based upon a review of the cases over the years it is not likely that a design professional who was involved to any degree in either the design or construction phase of the project will be held entitled to the benefits of a countersuit through a frivolous suit action except upon a showing of a malicious purpose on the part of the plaintiff, or a reckless failure of the plaintiff's attorney to make even a minimal investigation of the facts before naming the design professional as a defendant.

Pre-Trial Panels

A development of potential significance in recent years has been the enactment of laws to require that in malpractice cases the party bringing the action first submit it to a panel of those with ostensible experience in the area of practice involved for a hearing and subsequent rendering of an opinion on the merits of the case.

These kinds of statutes vary considerably in detail, ranging from the composition of the panel members, procedural hearing requirements, compensation for the panel members, and, most importantly, the extent to which the panel opinion is admissible in any subsequent court proceedings.

The theory behind this kind of procedure is that if the pros and cons of the case are presented to an unbiased but knowledgeable panel of persons with some degree of expertise in the subject matter the resulting opinion may bring about a result which is acceptable to either or both parties, and thus avoid full-scale litigation. In every such instance, however, the panel opinion is not binding on either party and either may then take the case to court in the normal manner.

Most of the experience in this type of operation has been in the medical field. A number of pertinent questions have resulted from that experience. First, in several states the courts have ruled that a requirement that the case be first submitted to the panel is unconstitutional because it has a "chilling" effect on the plaintiff. That is, the plaintiff is required to go through what may amount to two full-scale proceedings, involving repetition of witnesses, attorney fees and time spent in prosecuting the case. This objection is compounded when the statute allows the panel finding to be submitted to a jury in a subsequent trial because it may unduly influence the jury's judgment of the case. In other states, however, the courts have upheld the mandatory panel procedure in medical malpractice cases on the ground that such a procedure is designed to deal with the "medical crisis" in the state.

To what extent the constitutional issue will be resolved when the concept is applied to non-medical cases remains to be seen. To date only one state—Hawaii—has enacted a similar requirement for design professionals. The first Hawaii statute was enacted in 1981 and was subsequently determined to be lacking in several major respects, following which it was amended in 1985. The full statute is included as Appendix B.

The essential features of the Hawaii law are:

1. The panel is composed of a chairperson who is familiar with tort claims settlement processes, one attorney experienced in trial practice and one design professional appointed from a list submitted by the registration board.

2. The claimant and the design professional defendant must each deposit \$450 with the director of regulatory agencies.

3. The panel is required to hear the case within 30 days after the date for filing a response, and no persons other than the parties, witnesses, consultants and attorneys may be present except with the permission of the chairperson.

4. The panel hearing is informal, but witnesses and consultants may be questioned by the panel members and legal counsel. The panel may subpoena witnesses and documents.

5. Following completion of the hearing, the panel shall file a written advisory opinion with the director of regulatory agencies, who shall mail copies to all parties in the case and the professional liability insurance carrier. The panel opinion is to decide the issue of liability and the amount of damages, if any, stipulating which part of the damages are for economic loss and non-economic loss, but the panel may not recommend punitive damages.

6. The claimant may institute litigation based upon the claim only after a party to the panel hearing rejects the decision of the panel. The opinion of the panel on the issue of liability or damages may not be admitted in evidence in any subsequent trial.

7. The section requiring cooperation on the part of all parties to the case also provides that the costs of the action may be assessed against a professional liability insurance carrier or a party for failure to cooperate, even though the insurance company is not a party to the proceeding.

8. The 1985 amendment added a section permitting a judge to avoid the panel procedure if the judge determines that the subject matter in dispute is unsuitable for the panel procedure.

9. The 1985 amendment also added a section calling upon the attorney for the claimant to obtain a qualified person's opinion that there is merit to the claim, but this requirement may be avoided if the attorney is not able to obtain such consultation from qualified persons.

It is too early since the 1985 amendments to determine to what degree the Hawaii procedure may be helpful in resolving disputes. Design professionals in Hawaii have reported a lack of success under the 1981 law, and more recent reports indicate divided opinion as to whether the amended law has been useful to date.

Dispute Resolution

The federal and state courts are literally drowning in the volume of civil cases filed each year. As reported in a recent special study of the Defense Research Institute, there were approximately 240,000 cases filed in 1984 in the federal courts alone, and there are now 10 million civil cases filed in all courts annually. That number suggests the reason for the lengthy delay in bringing a case to trial and judgment, often running into many years. It is only because a vast majority of these cases are ultimately dropped or settled that the judicial system works at all.

Meanwhile, there is renewed interest in finding means to resolve disputes short of formal trials, both in the interest of time and cost. In Hamlet's famous soliloquy he noted, among other of life's problems, "the law's delay", and as far back as 1759 Edmund Burke observed that, "The contending parties find themselves more effectively ruined by the delay than they could have been by the injustice of any decision." Warren Burger, Chief Justice of the United States, has led the way in calling for alternative dispute resolution techniques, observing:

"We must remember that when a dispute arises there are options. I was trained with that generation of lawyers taught that the best service a lawyer could render a client was to keep the client out of court. The adversary litigation process is expensive and time-consuming; and it often leaves a trail of stress and frustration. Other alternatives represent a way to avoid litigation, yet they largely go unused."

Arbitration

The best known system of alternative dispute resolution is arbitration: a procedure which is particularly pertinent to disputes involving design professional and construction cases.

Arbitration of disputes has existed since time immemorial, going back to the story of King Solomon's resolution of a dispute between two women who claimed parentage of a baby. And it has long been used in commercial cases. But in 1966 the design professions undertook to establish a special set of rules and procedure for construction disputes under the aegis of the American Arbitration Association. NSPE and some dozen other societies now support and participate in the oversight of a special set of Construction Industry Arbitration Rules, administered by AAA through its 26 regional offices. The Rules and explanatory material about the program may be obtained from AAA, 140 West 51st Street, New York, NY 10020.

While there is little doubt that arbitration is faster and less expensive than full-blown litigation, there are some in the design professions and among their lawyers who find it unacceptable for a variety of reasons. There has been some confusion about the nature of arbitration by reference to it as "mandatory" arbitration. It is mandatory in the sense that if the parties agree by contract to arbitrate disputes which may arise either party may invoke the arbitration provisions. The resulting decision of the arbitrators is then binding and enforceable in the court. But the parties may likewise agree to not include an arbitration provision in their agreement, and in that case it is simply not an option for dispute settlement. Some critics favor a clause which says that the parties may agree to arbitrate when a dispute arises, but realistically the chances of the parties at that point agreeing to anything are almost nil, such as the procedure to select the arbitrators, the rules to be observed, payment of costs, and a host of other details spelled out in the AAA Rules.

Among the objections offered by opponents of arbitration are that it is an informal procedure; the rules of evidence do not apply, the decision is not subject to appeal to the courts on the merits of the dispute, there is no provision for discovery of information by the parties prior to the hearing, and that, according to some, arbitrators tend to "split the difference" in the decision. The other side of the coin, of course, in response to these arguments is that the lack of legal formalities is one of the factors that makes arbitration more expeditious and less expensive, that without the arbitration decision being final and binding the procedure would be fruitless if a party could retry the case in court at double expense. One of the advantages of arbitration is that it is private, whereas a court trial is public.

One of the strongest arguments for arbitration rather than a jury trial is that the arbitrators are selected on the basis

of their technical expertise in dealing with often-complex cases in a construction setting. Under the AAA procedures, the parties have the choice of reviewing a list of suggested arbitrators and striking those not desired to the point that the arbitrators are then named from the lists acceptable to both parties. It is vitally important in cases involving technical issues that the arbitrators have an adequate technical background to fully understand the issues. Members of juries, on the other hand, and judges, for that matter, are most unlikely to have that kind of knowledge and expertise.

To deal as objectively as possible with these arguments and counter-arguments, NSPE and the other participating societies in the Engineers' Joint Contract Documents Committee have included an arbitration clause in the owner-engineer agreement and in the general conditions on a separate page which may be removed without affecting the rest of the document, thus leaving it to the parties to decide in advance which way they prefer to go in handling potential disputes. Also, the arbitration clause in the owner-engineer agreement is limited to claims and counterclaims not in excess of \$200,000. This figure, however, based on AAA statistics, represents some 80 percent of all claims involving design professionals. Another important aspect of the arbitration clause is a stipulation that it may not be used to join the design professional not a party to the agreement; that is, in a dispute between an owner and contractor, or contractor and subcontractor, the engineer may not be required to participate in or be bound by the arbitration result without prior consent.

Mediation

An emerging form of alternative dispute resolution is the use of mediation. This is a process, sometimes confused with arbitration, which attempts to have the parties agree to bring in a neutral third party to act as a "go between", to try to encourage and induce the parties to reach a voluntary settlement. A mediator has no authority to render a binding decision. It has been suggested that in advance of the start of a project the parties agree to name a mediator in the event disputes arise. While this has not been tried to any degree in the construction area, it is somewhat questionable whether the formal anticipation of disputes might not, in fact, generate disputes which otherwise might be settled by the parties themselves.

Another aspect of this development has been the suggestion that two functions be combined; that is, an arrangement in which the mediator first attempts to induce the parties to reach a voluntary settlement, and if that effort fails to convert his status to that of an arbitrator, with authority to render a binding decision. That concept is flawed by the fact that because the two functions are so different in concept and procedure the same person cannot serve both purposes. A primary function of a mediator is to solicit from both

parties separately and confidentially their "bottom line" positions on each aspect of the dispute. If the parties know that such confidential information may be used against their interests if the mediator becomes an arbitrator the system itself will obviously fail.

The AAA has adopted "Construction Industry Mediation Rules" under the auspices of the Construction Industry Advisory Committee, including a contract clause for mediation. But this clause is not enforceable if either party refuses to mediate in good faith, in which case the clause becomes inoperative and the procedure turns to arbitration if the parties have also inserted the arbitration clause in their agreement.

Limitation of Liability

Another controversial idea in trying to deal with liability costs has been to write into the owner-engineer agreement a provision to the effect that the liability of the engineer will be limited to a stipulated amount or the amount of the engineer's fee, whichever is more. Although some engineers have indicated the acceptance of this idea by owners, it raises several difficult problems.

As noted in the Commentary accompanying the standard documents prepared by the Engineers' Joint Contract Documents Committee:

"The Committee also feels strongly that it is undesirable and quite unprofessional to try by standard society-endorsed contract forms to relieve Engineers from liability for improperly performing those duties and responsibilities which their expertise and professional training qualifies them to perform and which, because of their being licensed to practice, they have a duty to the public to perform. In fact, such contractual endeavor may well provide no more than illusory legal protection since courts and juries are not likely to accept wholesale efforts to avoid professional responsibilities."

To date there have not been definitive court decisions applying to specific limitation of liability clauses for design services, but in several cases involving professional services the courts have held such clauses to be in violation of public policy. In some instances the courts have upheld limitation of liability clauses for commercial transactions, provided that the parties were of relatively equal bargaining strength. But in other instances where it has been determined that the contract was a "contract of adhesion", meaning it was prepared on a "take it or leave it" basis, the courts have ruled such a provision invalid.

Another facet for consideration is the reaction of clients when presented with a provision which, in effect, asks the

client to share in paying the damages resulting from the negligence of the engineer. Some engineers have reported an adverse reaction to the point of endangering their retention for the job.

Unified Risk Insurance

Approximately one-third of professional liability insurance dollars go to the payment of litigation, including investigations, expert witnesses and appeals.

Suppose it were possible to find a way to eliminate most of the litigation cost? A novel and intriguing idea to accomplish that goal has been advanced and is under study by a joint committee of the professional societies. The idea, which has a long way to go before it will be known if it is feasible, is called "unified risk insurance". In brief, it contemplates that there would be one insurance policy covering the entire risk of the parties involved in the project—owner, design professional, prime contractor, subcontractors, and perhaps material suppliers. The owner would pay the entire premium on the justification that in the long run the owner pays all the costs through fees and construction bids which must reflect the cost of insurance.

Under this approach as a liability issue arose there would not be an attempt, as now, to decide which party was at fault. The single insurance fund would pay the cost of remedial action. It has been compared to home fire insurance. If there is a fire it does not matter from an insurance standpoint whether it was caused by smoking in bed, bad electrical wiring, lightning, or any other cause. The insurance pays the cost of restoring the property to its original state. In a word, it is a form of "no fault" insurance.

There are some obvious questions and limitations. It could not cover non-property claims between the parties, such as a contractor claim for an extra because another party had delayed his performance. That kind of claim would have to be resolved by arbitration or litigation. It could conceivably cover claims by injured third persons, but those kinds of claims could involve litigation to determine if the injury was caused by any of the covered parties, and, if so, the amount of damages.

The idea basically is to have three related insurance policies—one for property damage in the project (the walls crack, there is roof leakage, the HVAC system does not work, and a host of other typical property claims). A second policy would cover third-party claims of the type noted above. And a third policy would extend the coverage to an undefined period of years following completion of the project. One of the many unresolved issues at this point is whether and to what extent there would be deductibles for the various parties, and how they would be allocated.

The insurance consultant retained by the societies to develop the idea has noted that in today's insurance market it would be most difficult to launch such a revolutionary

approach, and it is likely that the insurance industry would require, at best, some form of "stop loss" fund to protect the insurance underwriters; an in-house or captive insurance fund raised by the participating societies.

The current status is that the idea is being explored in depth with representatives of the insurance industry, owners, contractors, subcontractors, and others. Realistically, it will be several years before there is any definitive conclusion as to the merits and feasibility of such an approach to reduction of liability insurance costs.

Statute of Limitations

A more immediate remedial provision is the enactment of statutes of limitation, more correctly identified as statutes of repose. These kinds of state laws, which exist in more than half of the states today, provide that after a stated period of time following substantial completion of the project (usually 6-8 years) a person claiming injury as a result of faulty design or related services is barred from maintaining an action against the design professional. Appendix C lists the states with such statutes and the applicable time period.

In some states, as noted, the courts have held these statutes to be unconstitutional in that they deprive an injured party of his "day in court", although in each such state law it is provided that the bar to suit does not apply to the owner or person in possession of the property. That party is more justifiably accountable for a failure which occurred long after the project was designed and built by virtue of inadequate maintenance of the facility.

The existing statutes of repose vary in detail and should be read in entirety to determine the starting period for the time cut-off, the parties covered by the law and the interpretation of the law by the courts.

Contingent Fees

An area of tort reform drawing considerable attention as the overall liability situation has worsened is the use (or abuse) of contingent fees by lawyers. It is alleged that this system of allowing lawyers to collect substantial fees as a percentage of awards to injured persons generates claims, and there is little doubt that this is true. As a result, several states have now moved to put a limit on contingent fees on a reduced sliding scale. A recent New York law, for example, stipulates that contingent fees will be limited to 30 percent of the first \$250,000 recovered, 25 percent of the next \$250,000, 20 percent of the next \$500,000, 15 percent of the next \$250,000, and 10 percent of any amount over \$1,250,000.

The contingent fee system relates almost exclusively to injury or death claims, and is therefore of less importance to design professionals than to those in the medical field.

However, as previously noted, a limitation schedule of the New York type will be helpful to some extent to engineers in the 20 percent of cases involving bodily injury or death.

A related aspect of this point is the suggestion that one of the major deterrents to unjustified suits would be to adopt the so-called "English Rule" in which the losing party is required to pay the legal costs of the prevailing party. The "American System", to the contrary, has always called upon the parties to pay their own legal costs no matter the outcome. The American Rule has been eroded to a considerable extent in recent years in special types of litigation, such as violation of civil rights, environmental cases, and others in which the legislature has determined that there are special considerations justifying a form of "penalty" on those who violate basic rights of others. But in the design field, and in commercial cases generally, the American Rule still holds.

The "other side of the coin" in considering a change to the English Rule, however, is that it cuts both ways. If the design professional is held to have been negligent he would have to pay the legal costs of the plaintiff.

Punitive Damages

Engineers and other design professionals have rarely been subjected to punitive damages, i.e., sometimes called "smart damages", meaning that the offending party has acted in such a grievous manner that he should feel the sting of his dereliction by having to pay a penalty on top of actual damages. This has become a major concern in injury and death cases, often resulting in enormous awards far exceeding actual economic loss, i.e. loss of wages, medical costs, loss of use of property, etc. The Defense Trial Lawyers' Task Force on Litigation Cost Containment has proposed that punitive damages be eliminated entirely, or at least severely restricted in light of its abuse in recent years.

Richard K. Willard, Assistant Attorney General, Civil Division, Department of Justice, has observed:

"Another remarkable development in tort actions between private parties is that awards of punitive damages have increased dramatically. Punitive damages were originally intended to punish particularly egregious or malicious conduct. Such damages may have a place in a system bottomed on fault. One would therefore expect that as the tort system moved away from fault, punitive damage awards would become rarer. Instead, the incidence and size of punitive awards seem to be increasing.

If this trend toward massive increases in punitive and noneconomic damages continues, its impact on the economy of this nation is likely to be devastating."

Pain and Suffering

A closely related aspect of the drive for tort reform is huge awards for pain and suffering. This has reached the point of bringing about corrective legislative action in some states. The most notable action along this line was the enactment in California of a flat \$250,000 maximum limitation in medical malpractice actions for "non-economic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement, and other non-pecuniary damage."

The statute was promptly challenged on constitutional grounds, but was upheld by the California Supreme Court. *Fein v. Permanente Medical Group*, 695 P. 2d 665 (1985). An appeal was taken to the U.S. Supreme Court, which dismissed the appeal "for want of a substantial federal question," without written opinion. That type of rejection by the Supreme Court is a decision on the merits, suggesting that a number of other states may well follow the California precedent now that the Supreme Court has found no constitutional objection at the federal level. However, the issue is far from being finally resolved. Justice Byron White, the lone dissenting member of the Supreme Court, opined that the Court should have taken the case for full review because other state courts have rejected similar limits. Justice White predicted, in effect, that the issue will eventually be back before the Supreme Court as more states enact similar limitations.

The issue more directly impacts the medical profession, but is nevertheless significant for the design professions if the trend for a larger share of design cases to involve bodily injury or death continues.

Joint and Several Liability

If a case involves several defendants, which is not unusual in construction industry operations, and if judgment is rendered against all the defendants the state law may make each defendant fully liable for the total judgment, even if a particular defendant was only negligent to a small degree. Thus, the doctrine of joint and several liability, poses serious dangers to design professionals caught up in a multi-defendant case. Suppose that the engineer was only 5 percent negligent, and the contractor, subcontractor, owner, or other liable parties are no longer in business, or have been adjudged bankrupt, or have inadequate assets to pay their share. The engineer in that situation is liable for the entire award.

Various tort reform groups are now pushing for a change in the state laws to eliminate the joint and several doctrine and require that each defendant pay its fair share to the degree it contributed to the damage. The alternative to joint and several, or course, is the doctrine of comparative negligence. This means, of course, that in a particular situa-

tion the plaintiff may not collect the full award if one or more of the co-defendants is "judgment proof", but that is a risk that the plaintiff should share in bringing the action in the first place. The obverse argument to the effect that no matter the plaintiff must be "made whole" at the expense of another, even if unfairly, reflects what is perhaps the most basic cause of all of the liability crisis—that we want to live in a risk-free society. But the real issue is not whether we can achieve the impossible of a "risk-free" society, rather how to most fairly allocate those risks.

Structured Settlements

Another area of tort reform much to be desired is a requirement for structured settlements in the case of very large awards. Again, this pertains mainly to injury and death awards. If the award is required to be paid in one lump sum it amounts to much more than the amount of the award in that the large amount is invested and over a period of years may amount to twice or more the original amount. This kind of case arises mainly when an injured person needs a substantial sum each year for an indefinite period to pay for housing, food, nursing care, special equipment, etc. Under a structured settlement arrangement the amount of the award is not changed, but is payable over the years, which means that the liable defendant may put a considerably lesser sum in some form of trust or escrow account to provide the required amount each year, probably adjusted for inflation.

The arrangement is much like the case in which the winner of a state lottery wins a million dollars. In fact, the winner does not receive a lump sum of one million dollars. Rather, he more likely receives \$50,000 a year for 20 years, and the state deposits whatever lesser amount is required in a special account to provide that amount out of principal and interest.

Collateral Source Rules

When a judgment is made in favor of an injured plaintiff the jury is required to then ascertain the amount of damages and the amount to be awarded. But the jury is not advised of the amounts which may be received by the plaintiff from other sources, such as worker compensation benefits, private insurance, employer payments, and the like. Thus, the jury is left in the dark in calculating the amount of damages to be awarded in terms of offsetting benefits related to the injury. This so-called "collateral source rule", which prohibits the defendant from offering evidence of other benefits, serves to give the plaintiff additional benefits over and above those determined by the jury.

The basic concept of money damages for one injured by the negligence of another is to reach a result which is said to "make the plaintiff whole", that is, to compensate the in-

jured party for "out-of-pocket" losses (leaving aside here the issue of punitive damages, discussed above).

Several of the state liability reform studies have accordingly recommended that the collateral source rule should be repealed so that a more equitable result will occur for both parties, thereby reducing the impact of liability awards and related insurance costs without penalizing the plaintiff.

In-House Controls

Although it has been said and written *ad nauseam*, the single best thing an engineer can do to limit, if not avoid, liability claims is to exercise tight control over in-house operations, use legally and technically sound documents, monitor on-site functions of assigned personnel during the construction phase, and, in general, approach every project with one eye on the liability potential.

Among the tools available for general guidance and assistance are the NSPE/PEPP "Architect-Engineer Quality Control Manual", (NSPE Pub. No. 1957), the NSPE/PEPP "Office Policy Handbook", (NSPE Pub. No. 1967), and a 60-minute video seminar entitled "Professional Liability".

Also, as previously mentioned, the Engineers' Joint Contract Documents Committee has over the years developed a set of documents which attempt to provide contract terms which are fair to the engineer, the owner and the contractor. (Appendix D).

There are numerous other sources of information from other societies, private publishers and public agencies which may be helpful. It is recognized that an engineer cannot spend all his time on a project with the only emphasis on liability exposure, but to a reasonable degree the extent to which the liability possibilities are kept in mind and in balance with technical and managerial functions the engineer will be well served.

The Coalition Approach

Part of this special report deals with action items engineering and related societies can tackle on their own, but hopefully with the support of other interested groups. A larger part of the problem areas, particularly those identified as tort reform, will require involvement in broader coalitions of other professions and public groups, such as organizations of municipalities and private concerns hard hit by the liability crisis.

A number and variety of tort reform coalitions are developing around the country. Some of these have been authorized by state legislation, others by action of the governor. The private groups range from manufacturers concerned with product liability, to state chambers of commerce, and to attorney groups, both from the standpoint of defense attorneys and trial lawyers who are the natural opponents of

tort reform. NSPE has organized a liability task force to monitor developments at the national level and to cooperate with state groups. It behooves each state society to ascertain the status of these developments in the state, and to participate to the extent possible with such coalitions or separate reform groups in order that the views of the engineering profession are expressed as the campaign for tort reform progresses. It is particularly important that the state societies make early contact with state-sponsored liability study groups and seek appointment of at least one engineer in such bodies.

In the final analysis, every group involved in the reform movement has agreed that the greatest success can be achieved only if the general public is made aware of the issues and the need for corrective action. This is happening already to a considerable extent as child care clinics close, municipalities "go out of business", for lack of insurance or face enormous tax increases to pay the higher premiums, as obstetricians cease practice, as hospital rates soar, and so on down the line. As the general public is made aware of the problem, and particularly comes to understand that the ultimate losers are those who pay the taxes and the increased cost of products and services, the opportunity for improvement in the legal justice system will emerge.

In this connection, a potentially significant development has occurred at the federal level with the announcement by Attorney General Edwin Meese of the appointment of an interagency Tort Policy Working Group. This federal group, under the direction of Assistant Attorney General Richard K. Willard, head of the Civil Division, who has spoken out strongly on the need for tort reform, will consider a broad range of policy issues that relate to the current crisis of the tort system.

The federal interagency group is intended to recommend legislative, regulatory and litigative proposals at the federal level. Although the major scene of action in tort reform must occur at the state level, the eventual report of the federal group will not only serve to present specific proposals, but, more importantly, will be a key factor in bringing to the attention of the public the need for action.

AN ACT RELATING TO WORKERS' COMPENSATION; AMENDING 85 O.S. 1981, SECTION 12, AS AMENDED BY SECTION 1, CHAPTER 37, O.S.L. 1982 (85 O.S. SUPP. 1983, SECTION 12); PROVIDING PROCEDURES RELATING TO EXCLUSIVE LIABILITY, EXCEPTIONS, COURT ACTIONS, AND IMMUNITY INCLUDING PERSONS TO WHICH LIMITED LIABILITY APPLIES TO.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. AMENDATORY 85 O.S. 1981, Section 12, as amended by Section 1, Chapter 37, O.S.L. 1982 (85 O.S. Supp. 1983, Section 12) is amended to read as follows:

Section 12. The liability prescribed in Section 11 of this title shall be exclusive and in place of all other liability of the employer and any of his employees, any architect, professional engineer, or land surveyor retained to perform professional services on a construction project, at common law or otherwise, for such injury, loss of services, or death to the employee, or the spouse, personal representative, parents, or dependents of the employee, or any other person. If an employer has failed to secure the payment of compensation for his injured employee, as provided for in this title, an injured employee, or his legal representatives if death results from the injury, may maintain an action in the courts for damages on account of such injury, and in such action the defendant may not plead or prove as a defense that the injury was caused by the negligence of a fellow servant, or that the employee assumed the risk of his employment, or that the injury was due to the contributory negligence of the employee; provided:

(i) The immunity created by the provisions of this section shall not extend to action by an employee, or the spouse, personal representative, parents, or dependents of the employee, or any other person against another employer, or its employees, on the same job as the injured or deceased worker where such other employer does not stand in the position of an intermediate or principal employer to the immediate employer of the injured or deceased worker;

(ii) The immunity created by the provisions of this section shall not extend to action against another employer, or its employees, on the same job as the injured or deceased worker even though such other employer may be considered as standing in the position of a special master of a loaned servant where such special master neither is the immediate employer of the injured or deceased worker nor stands in the position of an intermediate or principal employer to the immediate employer of the injured or deceased worker; and

(iii) This provision shall not be construed to abrogate the loaned servant doctrine in any respect other than that described in paragraph (ii) of this section. This section shall not be construed to relieve the employer from any other penalty provided for in this title for failure to secure the payment of compensation provided for in this title.

(iv) For the purpose of extending the immunity of this section, any architect, professional engineer, or land surveyor shall be deemed an intermediate or principal employer for services performed at or on the site of a construction project, but this immunity shall not extend to the negligent preparation of design plans and specifications.

**RELATING TO DESIGN PROFESSIONAL
CONCILIATION PANEL.**

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

SECTION 1. Chapter 672, Hawaii Revised Statutes, is amended by adding two new sections to read as follows:

“§-672 Determination of unsuitability. Any party or any person served with notice of a claim may file a motion with circuit court in the judicial circuit in which the claim arose for a determination that the subject matter of the dispute is unsuitable for review by a panel under this chapter; provided that no such application may be filed within ten days of the date on which the claim is scheduled to be heard by a panel or after such a hearing has taken place.

In determining whether the subject matter of a dispute is unsuitable for disposition pursuant to this chapter, a court may consider:

(1) The magnitude of the potential award, or any issue of broad public concern raised by the subject matter underlying the dispute;

(2) Problems referred to the court where court regulated discovery is necessary;

(3) The fact that the matter in dispute is a reasonable or necessary issue to be resolved in pending litigation and involves other matters not covered by or related to this chapter;

(4) The fact that the design professional's involvement in the matter is distinctly secondary in importance to the involvement of parties not covered by this chapter;

(5) The potential for unreasonable delays in reaching any resolution of the matter by its referral to a panel pursuant to this chapter; or

(6) The fact that there are too many parties or issues involved to be effectively handled by the informal processes of this chapter.

Any such application to the circuit court shall be made and heard in a summary manner and in accordance with procedures for the making and hearing of motions.

§672- Certificate of consultation. (a) any claim filed under this chapter shall be accompanied by a certificate which declares one of the following:

(1) That the attorney has reviewed the facts of the case, that the attorney has consulted with at least one design professional who is licensed to practice and practices

in this State or any other state, or who teaches at an accredited college or university and is licensed to practice in this State or any other state, in the same discipline as the design professional against whom the claim is made and who the attorney reasonably believes is knowledgeable in the relevant issues involved in the particular action, and that the attorney has concluded on the basis of such review and consultation that there is a reasonable and meritorious cause for the filing of the claim. The persons consulted may not be a party to the case;

(2) That the attorney was unable to obtain the consultation required by paragraph (1) because a statute of limitations would impair the action and that the certificate required by paragraph (1) could not be obtained before the impairment of the action. If a certificate is required pursuant to this paragraph, the certificate required by paragraph (1) shall be filed within thirty days after filing the claim; or

(3) That the attorney was unable to obtain the consultation required by paragraph (1) because the attorney has made three separate good faith attempts with three separate design professionals to obtain such consultation and none of those contacted would agree to such a consultation.

(b) Where an attorney intends to rely solely on a failure to inform of the consequences of a procedure, this section shall be inapplicable. The attorney shall certify upon filing of the claim that the attorney is relying solely on the failure to inform of the consequences of a procedure and for that reason is not filing a certificate as required by this section.

(c) For the purposes of this section, the attorney shall not be required to disclose the names of design professionals consulted to fulfill the requirements of subsection (a).

(d) Unless a certificate is filed pursuant to subsection (a) or (b), the claim shall not be received for filing by the department.”

SECTION 2. Section 672-1, Hawaii Revised Statutes, is amended to read as follows:

“§672-1 Definitions. For the purposes of this chapter: “Design professional” means a professional engineer, architect, surveyor or landscape architect.

“Entities employing design professionals” means professional corporations or other business structures under which design professionals may practice and does not include non-design professional entities.”

SECTION 3. Section 672-2, Hawaii Revised Statutes, is amended to read as follows:

“§672-2 Actions against architects, professional engineers, surveyors, and landscape architects. In any action for damages arising out of the alleged professional negligence of actions performed in the professional practice of a person holding a license as a professional engineer, architect, surveyor, or landscape architect under chapter 464, before the time of filing the complaint, the aggrieved person shall file a claim with the design professional conciliation panel.

SECTION 4. Section 672-3, Hawaii Revised Statutes, is amended to read as follows:

“§672-3 Design professional conciliation panel; composition, selection, compensation. (a) There are established conciliation panels which shall review and render findings and advisory opinions on the issues of liability and damages in tort claims against professional architects, engineers, surveyors, and landscape architects.

(b) A design professional conciliation panel, hereafter called “the panel”, shall be formed for each claim filed pursuant to section 672-4 and after each panel renders its decision or the claim is otherwise disposed of it shall be disbanded. Each design professional conciliation panel shall consist of one chairperson selected from among persons who are familiar with and experienced in the tort claims settlement process, one attorney licensed to practice in the courts of the State and experienced in trial practice, and one architect, engineer, surveyor, or landscape architect licensed to practice under chapter 464. The chairperson shall be appointed by the chief justice of the supreme court of Hawaii. The attorney shall be appointed by the chairperson from a list of not less than thirty-five attorneys experienced in trial practice submitted annually by the supreme court. The architect, engineer, surveyor, or landscape architect shall be appointed by the chairperson from a list of not less than thirty-five design professionals submitted annually by the board of registration of professional engineers, architects, surveyors, and landscape architects.

The chairperson shall preside at the meetings of the panel. The chairperson and all panel members shall be compensated at the rate of \$300 per claim handled which will become payable when the decision of the panel is submitted and shall be paid allowances for travel and living expense which may be incurred as a result of the performance of their duties and they shall be paid by the department of commerce and consumer affairs from funds collected from the claimant and defendant, to be shared equally. The claimant

shall deposit \$450 with the department upon the filing of the claim and the failure to do so shall result in the claim being rejected for filing. The design professional shall deposit \$450 with the department within twenty days of being served with the claim and the failure to do so shall result in termination of proceedings under this chapter allowing the claimant to proceed in accordance with section 672-8. If the claim is withdrawn, determined to be unsuitable for proceedings under this chapter, or otherwise terminated without participation by a panel, the department shall return all moneys collected to the respective parties.

The office and meeting space, secretarial and clerical assistance, office equipment and office supplies for the board shall be furnished by the department of commerce and consumer affairs.

The board of registration shall prepare a list of architects, engineers, surveyors, and landscape architects along with their respective specialties who shall then be considered consultants to the panel in their respective fields. Panel members may consult with other legal, technical, and insurance specialists. Any consultant called by the panel to appear before the panel shall be paid an allowance for travel and living expenses which may be incurred as a result of such person's appearance before the panel. Such costs shall be paid by the department of commerce and consumer affairs.”

SECTION 5. Section 672-4, Hawaii Revised Statutes, is amended by amending subsection (a) to read as follows:

“(a) Any person or his representative claiming that a tort has been committed by the design professional or entities employing such design professionals shall file a claim with the department of commerce and consumer affairs before a suit based on the claim may be commenced in any court of the State. All claims shall be submitted to the department of commerce and consumer affairs in writing on forms provided by the department. If the claim is presented orally, the department of commerce and consumer affairs shall reduce the claim to writing. The claimant shall set forth facts upon which the claim is or may be based and shall include the names of all parties against whom the claim is or may be made who are known to the claimant. Within five business days thereafter, the panel shall give notice of the claim, by certified mail, to all architects, engineers, surveyors, or landscape architects and others who are or may be parties to the claim and shall furnish copies of written claims to such persons. Such notice shall set forth a date, not more than twen-

ty days after mailing the notice, within which any design professional against whom a claim is made may file a written response to the claim, and a date and time, not less than five days following the date for filing a response, for a hearing of the panel. Such notice shall describe the nature and purpose of the panel's proceedings and shall designate the place of the hearing. The times originally set forth in the notice may be changed by the chairman, on due notice to all parties, for good cause; provided that a party requesting the rescheduling of the hearing within seven days of the scheduled date shall be required in the sole discretion of the panel chairperson to additionally compensate the panel in an amount equal to the fee panel members receive pursuant to section 672-3."

SECTION 6. Section 672-5, Hawaii Revised Statutes, is amended to read as follows:

"§672-5 Design professional conciliation panel hearing; fact-finding; evidence; voluntary settlement. Every claim of a tort shall be heard by the design professional conciliation panel within thirty days after the date for filing a response. No persons other than the panel, witnesses, and consultants called by the panel, and the persons listed in section 672-6 shall be present except with the permission of the chairperson. The panel may, in its discretion, conduct an inquiry of a party, witness, or consultant without the presence of any or all parties.

The hearing shall be informal. The panel may require a stenographic record of all or part of its proceedings for the use of the panel, but such record shall not be made available to the parties. The panel may receive any oral or documentary evidence. Questioning of parties, witnesses, and consultants may be conducted by the panel, and the panel may, in its discretion, permit any party, or any counsel for a party to question other parties, witnesses or consultants. The panel may designate who, among the parties, shall have the burden of going forward with the evidence with respect to such issues as it may consider, and unless otherwise designated by the panel, when the design professional's records have been provided to the claimant for the claimant's proper review, such burden shall initially rest with the claimant at the commencement of the hearing.

The panel shall have the power to require by subpoena the appearance and testimony of witnesses and the production of documentary evidence. When such subpoena power is utilized, notice shall be given to all parties. The

testimony of witnesses may be taken either orally before the panel or by deposition. In cases of refusal to obey a subpoena issued by the panel, the panel may invoke the aid of any circuit court in the State, which may issue an order requiring compliance with the subpoena. Failure to obey such order may be punished by the court as a contempt thereof. Any member of the panel may sign subpoenas, administer oaths and affirmations, examine witnesses, and receive evidence. Notwithstanding such powers, the panel shall attempt to secure the voluntary appearance, testimony, and cooperation of parties, witnesses, and consultants without coercion.

At the hearing of the panel and in arriving at its opinion the panel shall consider, but not be limited to, statements or testimony of witnesses, construction documents, inspection reports, calculations, and other records kept in the usual course of the practice of the design professional without the necessity for other identification or authentication, statements of fact or opinion on a subject contained in a published treatise, periodical, book or pamphlet, or statements of experts without the necessity of the experts appearing at the hearing. The panel may upon the application of any party or upon its own decision appoint as a consultant, an impartial and qualified architect, engineer, surveyor, or landscape architect or other professional person or expert to testify before the panel or to conduct any necessary professional or expert examination of the claimant of relevant evidentiary matter and to report to or testify as a witness thereto. Such a consultant shall not be compensated or reimbursed except for travel and living expenses which may be incurred as a result of such person's appearance before the panel. Such expenses shall be paid by the department of commerce and consumer affairs to be paid as provided in Section 672-3. Discovery by the parties shall not be allowed.

During the hearing and at any time prior to the rendition of an advisory decision pursuant to section 672-7, the panel may encourage the parties to settle or otherwise dispose of the case voluntarily."

SECTION 7. Section 672-10, Hawaii Revised Statutes, is amended to read as follows:

"§672-10 Statute of limitations tolled. The filing of the claim with the design professional conciliation panel shall toll any applicable statute of limitations, and any such statute of limitations shall remain tolled until sixty days after the date

the decision of the panel is mailed or delivered to the parties; provided that in no case shall the applicable statute of limitations be tolled for more than twelve months. If a decision by the design professional conciliation panel is not reached within twelve months, the statute of limitations shall resume running and the party filing the claim may commence a suit based on the claim in any appropriate court of this State. The panel shall notify in writing all parties of this provision."

SECTION 8. Section 672-11, Hawaii Revised Statutes, is amended to read as follows:

"§672-11 Duty to cooperate; assessment of costs and fees. It shall be the duty of every person who files a claim with the design professional conciliation panel, every architect, engineer, surveyor, or landscape architect against whom such claim is made, to cooperate with the design professional conciliation panel for the purpose of achieving a prompt, fair, and just disposition or settlement of such claim, provided that such cooperation shall not prejudice the substantive rights of said persons.

After trial of such claim or after settlement of such claim after suit has been filed, any party may apply to the court in which the suit was brought to have the costs of the action assessed against any party or any insurance carrier or any other person providing professional liability insurance to a party design professional or both, for failure to cooperate with the design professional conciliation panel. The court may award such costs, or a portion thereof, including attorney's fees, witness fees, including those of expert witnesses, costs of discovery and transcribing depositions, and court costs to the party applying therefor.

On application of the director of commerce and consumer affairs, the court may award as a civil penalty against any party or any insurance carrier or other person providing professional liability insurance to a party design professional, or all or any combination of such persons, all or a portion of the costs and expenses of the design professional conciliation panel attributable to a claim involving such persons, if the court finds that such person or persons failed to cooperate with the design professional conciliation panel. Such penalty shall be payable to the general fund.

In determining whether any person has failed to cooperate in good faith, the court shall consider, but is not limited to, the following:

- (1) The attendance of the persons at the hearing of the design professional conciliation panel;
- (2) The extent to which representatives of the parties and counsel representing parties came to panel hearings with knowledge of the claims and defenses and authority to negotiate a settlement or other disposition of the claim;
- (3) The testimony of members of the panel as to the facts of the person's participation in the panel hearing;
- (4) The extent of the person's cooperation in providing the panel with documents and testimony called for by the panel; and
- (5) The reasons advanced by the person so charged for not fully cooperating or negotiating."

SECTION 9. Section 672-14, Hawaii Revised Statutes, is amended to read as follows:

"§672-14 Retroactive application. This chapter shall apply to any claim arising prior to June 22, 1981 if a suit based on the claim has not been filed in a court of competent jurisdiction prior to that date."

Statutes of Limitation for the Design Professionals
 (Note—**boldface** indicates a statute subsequently held unconstitutional)

STATE	DATE ADOPTED	NUMBER OF YEARS AFTER SUBSTANTIAL COMPLETION OR OCCUPANCY
Alabama	1969	Seven (Latent Defects) Four (Patent Defects)
Alaska	1967	Six
Arizona	—	No statute
Arkansas	1967	Five (Property Damage) Four (Personal Injury)
California	1971	Ten (Latent Defects) Four (Patent Defects)
Colorado	1979	Ten
Connecticut	1969	Seven
Delaware	1974	Six
District of Columbia	1972	Ten
Florida	1980	Fifteen (Latent Defects) Four (Patent Defects)
Georgia	1968	Eight
Hawaii	1974	Six
Idaho	1965	Six
Illinois	1982	Twelve
Indiana	1967	Ten
Iowa	—	No Statute
Kansas	1963	Ten (Latent Defects) Two (Patent Defects)
Kentucky	1966	Five
Louisiana	1964	Ten
Maine	1975	Ten
Maryland	1979	Ten
Massachusetts	1968	Six
Michigan	1967	Six
Minnesota	1980	Fifteen
Mississippi	1966	Ten
Missouri	1976	Ten
Montana	1971	Ten

Nebraska	1972	Ten
Nevada	1965	Six
New Hampshire	1965	Six
New Jersey	1967	Ten
New Mexico	1967	Ten
New York	1963	Three
North Carolina	1963	Six
North Dakota	1967	Ten
Ohio	1963	Ten
Oklahoma	1978	Ten
Oregon	1971	Ten
Pennsylvania	1965	Twelve
Rhode Island	1975	Ten
South Carolina	1970	Ten
South Dakota	1966	Ten
Tennessee	1965	Four
Texas	1975	Ten
Utah	1967	Seven
Vermont	1959	Six
Virginia	1964	Five
Washington	1967	Six
West Virginia	1983	Ten
Wisconsin	1976	Six
Wyoming	1973	Ten

ORDER FORM

TO: NSPE PEPP
P.O. Box 35023
Washington, D.C. 20013

Send to the undersigned the indicated quantity of Contract Documents — Check enclosed in the amount of \$ _____

NSPE

Publication No.	Title	Quantity	Price
1910-1	Standard Form of Agreement between Owner and Engineer for Professional Services (1984 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-1-A	Suggested Listing of Duties, Responsibilities and Limitations of Authority of Resident Project Representative (1983 ed.)	_____	\$1.00 10 or more 50c ea.
1910-2	Standard Form of Letter Agreement between Owner and Engineer for Professional Services (1985 ed.)	_____	\$1.00 10 or more 50c ea.
1910-8	Standard General Conditions of the Construction Contract (1983 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-8-A-1	Standard Form of Agreement between Owner and Contractor on the Basis of a Stipulated Price (1983 ed.)	_____	\$1.00 10 or more 50c ea.
1910-8-A-2	Standard Form of Agreement between Owner and Contractor on the Basis of Cost-Plus (1983 ed.)	_____	\$1.00 10 or more 50c ea.
1910-8-B	Change Order (1983 ed.) — Pads of 25	_____	\$2.00 per pad
1910-8-D	Certificate of Substantial Completion (1983 ed.) Pads of 25	_____	\$2.00 per pad
1910-8-E	Application for Payment (1983 ed.) — Pads of 25	_____	\$2.00 per pad
1910-8-F	Work Directive Change (1983 ed.) — Pads of 25	_____	\$2.00 per pad
1910-9	Commentary on Agreements for Engineering Services and Contract Documents by John R. Clark, Esq. (1981 ed.)	_____	\$10.00 No bulk rate
1910-9-A	Commentary on 1983 Editions of Construction Related Documents by John R. Clark, Esq. (1983 ed.)	_____	\$5.00 No bulk rate
1910-9-B	An Update to Indicate Important Changes in EJCDC Standard Agreements for Engineering Services (1984 ed.)	_____	\$5.00 No bulk rate
1910-9-C	Focus on Shop Drawings by John R. Clark, Esq. (1985 ed.)	_____	\$15.00 No bulk rate
1910-10	Standard Form of Agreement between Engineer and Architect for Professional Services (1985 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-11	Cross Reference between EJCDC Standard General Conditions of the Construction Contract (1910-8, 1983 ed.) and AIA General Conditions of the Contract for Construction (No. A201, Aug. 1976 ed.) (1984 ed.)	_____	\$1.00 No bulk rate
1910-12	Guide to the Preparation of Instructions to Bidders (1983 ed.)	_____	\$1.00 10 or more 50c ea.
1910-13	Standard Form of Agreement between Engineer and Associate Engineer for Professional Services (1985 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-14	Standard Form of Agreement between Engineer and Consultant for Professional Services (1985 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-15	Standard Form of Agreement between Owner and Project Manager for Professional Services (1977 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-16	Uniform Location of Subject Matter (1981 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-17	Guide to the Preparation of Supplementary Conditions (1983 ed.)	_____	\$5.00 No bulk rate
1910-18	Suggested Bid Form and Commentary for Use (1983 ed.)	_____	\$1.00 10 or more 50c ea.
1910-19	Standard Form of Agreement between Owner and Engineer for Study and Report Professional Services (1985 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-20	Engineer's Letter to Owner Requesting Instructions re Bonds and Insurance During Construction (1985 ed.)	_____	\$1.00 10 or more 50c ea.
1910-21	Owner's Instructions to Engineer re Bonds and Insurance During Construction (1983 ed.)	_____	\$1.00 10 or more 50c ea.
1910-22	Notice of Award (1983 ed.) — Pads of 25	_____	\$2.00 per pad
1910-23	Notice to Proceed (1983 ed.) — Pads of 25	_____	\$2.00 per pad
1910-24	Contract Documents Bibliography (1984 ed.)	_____	\$1.00 No bulk rate
1910-25	Commentary on AIA C141 Standard Form of Agreement between Architect and Engineer, June 1979 (1981 ed.)	_____	\$3.00 No bulk rate
1910-26-A	Standard Form of Procurement Agreement between Owner and Contractor (1981 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-26-B	Procurement General Conditions (1981 ed.)	_____	\$3.00 10 or more \$1.50 ea.
1910-26-C	Guide to the Preparation of Procurement Supplementary Conditions (1981 ed.)	_____	\$3.00 10 or more \$1.50 ea.
1910-26-D	Instructions to Bidders for Procurement Contracts (1981 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-26-E	Commentary on Procurement Documents by John R. Clark, Esq. (1981 ed.)	_____	\$2.00 10 or more \$1.00 ea.
1910-28-A	Construction Performance Bond (1984 ed.) — Pads of 25	_____	\$2.00 per pad
1910-28-B	Construction Payment Bond (1984 ed.) — Pads of 25	_____	\$2.00 per pad
	Complete set of documents (does not include full pads; single document copies only)	_____	\$80.00
	Binder; 3-ring	_____	\$10.00
	Complete set of documents with binder	_____	\$90.00

NAME _____

ADDRESS _____

CITY _____

STATE _____

ZIP _____

All prices are net for members & non-members. Virginia residents add 4% sales tax. Tel. (703) 684-2800

December 1985

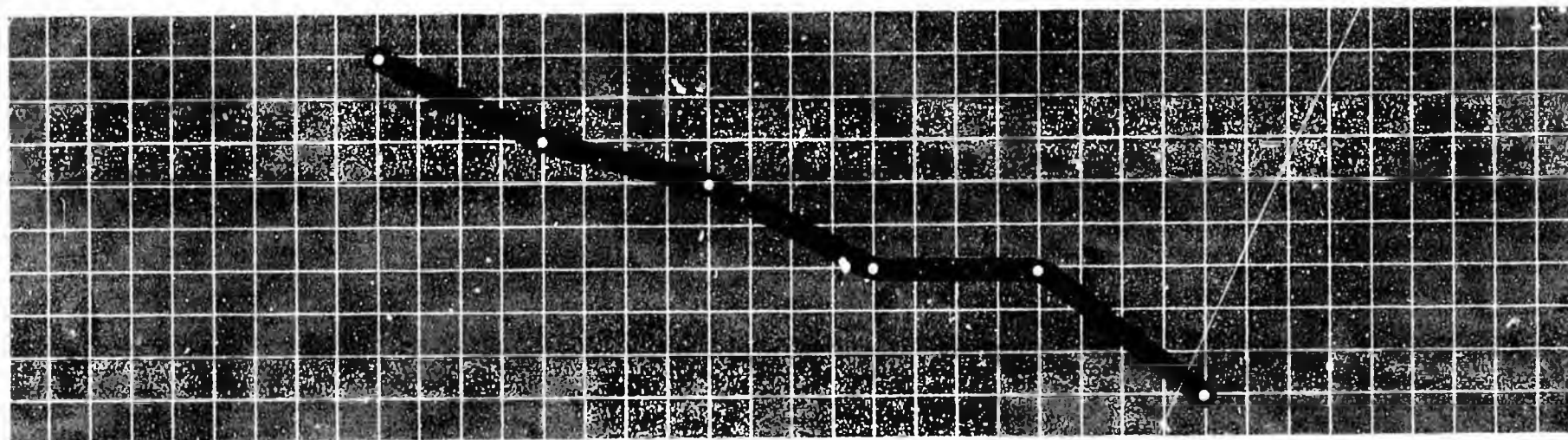


National Society of Professional Engineers
1420 King Street
Alexandria, Virginia 22314

NSPE Publication Number 1975
December, 1985

INSURER PROFITABILITY— THE FACTS

A commentary on the
financial condition of the property/casualty
insurance industry



Insurance Services Office, Inc.
February 1986

Insurance Services Office, Inc. (ISO) is a non-profit corporation that makes available advisory rating, statistical, actuarial, policy form and related services to any U.S. property/casualty insurer.

INSURER PROFITABILITY— THE FACTS

A commentary on the
financial condition of the property/casualty
insurance industry

**Insurance Services Office, Inc.
February 1986**

PURPOSE

Given the current condition of the property/casualty insurance marketplace—with affordability and availability problems affecting many commercial insurance consumers—several critics have charged that the current large liability premium increases are unnecessary, that the industry's financial condition is improperly stated, and that its accounting procedures are misleading. In this analysis, Insurance Services Office, Inc. provides a fact-based review of the property/casualty insurance industry by (1) presenting a broad perspective of the industry's current financial condition, and (2) responding to factual errors and irrelevant data intended to substantiate the critics' charges, as well as providing a meaningful context for the numbers.

NOTE: Actual year-end 1985 results for the property/casualty insurance industry will not be compiled until late March 1986. Industrywide year-end figures cited by various analysts and critics in January 1986 were estimated results based largely on financial data through the first

nine months. In this analysis, ISO references the financial statistics most often cited by critics—those estimates published by A.M. Best Company. This report is being issued prior to the release of year-end 1985 results in order to promptly provide comprehensive information.

The source of all historical financial data through 1984 is A.M. Best Company, with exceptions as noted. Nine-month 1985 financial data come from the A.M. Best Company or ISO compilations.

TABLE OF CONTENTS

PURPOSE/3

TABLE OF CHARTS/6

EXECUTIVE SUMMARY/7

OVERVIEW OF THE FINANCIAL CONDITION OF THE PROPERTY/CASUALTY INSURANCE INDUSTRY/11

- 1984 was the worst year to date for the property/casualty insurance industry./12
 - Year-end 1985 results will show no significant improvement over 1984, despite substantial premium increases./13
 - The companies that insure our nation's businesses have been particularly hard hit./14
 - Reinsurers have experienced large financial losses./14
 - Recent insurance industry financial results would have been worse without unprecedented realized capital gains and tax credits./15
 - Premiums will have to increase faster than claim costs in order to achieve positive operating income in future years./16
-

MAJOR CHARGES RAISED BY INDUSTRY CRITICS/17

ACCUSATION: The industry's accounting procedures regularly misrepresent its true financial condition. The profitability "crisis" is manufactured.

- CHARGES
- The industry deliberately misstates loss reserves to produce a profitability "crisis," just as it did for medical malpractice 10 years ago./19
 - Policyholder dividends are not a business expense, but a voluntary distribution of profits./20
 - Insurers publicize operating income, rather than net after-tax income, in order to show losses./21
 - The industry's return on net worth would have been 13% in 1984 if premiums had been only 5% higher. And the industry's rate of return for 1985 would be 13%, if you exclude policyholder dividends and unusually high hurricane losses./23

ACCUSATION: Price increases are excessive. Losses are not the problem.

- CHARGES
- The industry needed to increase premiums only 12-15% in 1985 to achieve a 13-15% return in 1986. Given the estimated 20% premium increase in 1985, no additional price increases are needed in 1986./25
 - Premium increases are so dramatic today solely because of prior inadequate prices. Losses are not the problem./25
 - 1985's 71% increase in general liability premium was excessive. If insurers had not slashed liability rates a few years ago, they would have earned handsome profits./28
 - Since, for medical malpractice, paid losses are less than investment income, this line can be treated on a "pay as you go" basis./29

ACCUSATION: Insurers are making substantial profits and paying no taxes. There's nothing fundamentally wrong with industry profitability. This is just a typical cyclical downturn.

- CHARGES
- Property/casualty insurer stock prices rose by 50% in 1985, hardly indicative of a troubled industry./31
 - The industry made \$75 billion over the last 10 years and paid no taxes./31
 - This is a typical cycle for the industry, and it will recover quickly./33

ACCUSATION: Insurance is too expensive.

- CHARGES
- The total insurance bill in the U.S. rose to more than \$300 billion in 1985 /38
 - Property/casualty premiums rose by \$24.6 billion in 1985—an increase of \$105 per person./39

APPENDIX

- Discussion of Reinsurance/41
- Coopers & Lybrand Opinion/42

TABLE OF CHARTS

TITLE/PAGE NUMBER	TITLE/PAGE NUMBER
A Return on Net Worth: Property/Casualty Industry vs. The Fortune 500 (%)/ 8	17 Loss Growth and Premium Growth vs. GNP (%): General Liability & Medical Malpractice Combined/ 26
B Loss Growth and Premium Growth vs. GNP (%): Commercial Liability/ 8	18 General Liability & Medical Malpractice Losses vs. GNP—1979–84 (Annual % Change)/ 27
1 Return on Net Worth: Property/Casualty Industry vs. The Fortune 500 (%)/ 13	19 Product Liability Lawsuits (Thousands)/ 27
2 Investment Income vs. Underwriting Loss (\$ Billions)/ 13	20 Million-Dollar Verdicts/ 28
3 Return on Net Worth: Personal vs. Commercial Insurers (%)/ 14	21 Average Expenditures per Tried Asbestos Claim/ 28
4 Return on Net Worth: Reinsurers vs. Total Property/Casualty Industry (%)/ 14	22 General Liability Premium Growth vs. Loss Growth (%)/ 29
5 Realized Capital Gains (% of Net Worth)/ 15	23 Medical Malpractice Insurers' Paid Loss & Loss Adjustment Expense vs. Investment Gain (\$ Millions)/ 30
6 Calendar Year 1976 Loss Reserves (\$ Billions)/ 20	24 1976 Medical Malpractice Claims: Percent of Ultimate Losses Paid/ 30
7 General Liability Incurred Loss Development—1976 (\$ Billions)/ 20	25 Return on Net Worth: Property/Casualty Insurers vs. Other Industries (%)/ 32
8 Medical Malpractice Incurred Loss Development—1976 (\$ Billions)/ 21	26 A Typical Cycle?: Underwriting Losses (\$ Billions)/ 34
9 Calendar Year 1979 Liability Loss Reserves (\$ Billions)/ 21	27 A Typical Cycle?: Operating Losses (\$ Billions)/ 34
10 Who Paid Policyholder Dividends in 1984?/ 22	28 A Typical Cycle?: Combined Ratios/ 34
11 Realized Capital Gains and Net Income After Taxes (\$ Billions)/ 22	29 A Typical Cycle?: Insolvencies Covered by State Guaranty Funds/ 34
12 Catastrophe Losses (% of Earned Premium)/ 24	30 A.M. Best's A + Rating Reductions/ 35
13 Realized Capital Gains (% of Assets)/ 24	31 Industry Reinsurance Recoverable (% of Surplus)/ 36
14 Loss Growth and Premium Growth vs. GNP (%): All Lines/ 26	32 Reinsurers' Reinsurance Recoverable (% of Surplus)/ 36
15 Loss Growth and Premium Growth vs. GNP (%): Commercial Lines/ 26	33 Combined Ratios: Reinsurers vs. Total Property/Casualty Industry/ 36
16 Loss Growth and Premium Growth vs. GNP (%): Commercial Liability/ 26	34 Combined Ratios: Personal Lines vs. Commercial Lines/ 36

EXECUTIVE SUMMARY

A financially sound U.S. property/casualty insurance industry provides a vital service in the form of needed security to individuals and corporations.

The cost of insurance affects almost every aspect of American life. Consequently, the economic integrity of this industry, as well as the availability and affordability of insurance, are critical to society.

In the past year, differences have emerged between the property/casualty insurance industry and its critics over the true financial condition of the industry and the need for large commercial liability premium increases. This has occurred despite the fact that quarterly and annual reports of the industry's financial results, as well as several special studies, have documented the weakened state of the industry and its current low profitability.

Critics have taken the industry's published financial information and distorted it to assert that, rather than being in financial peril, property/casualty insurers are actually engaged in price gouging and are hiding current profits. These charges are misleading, unsubstantiated and false.

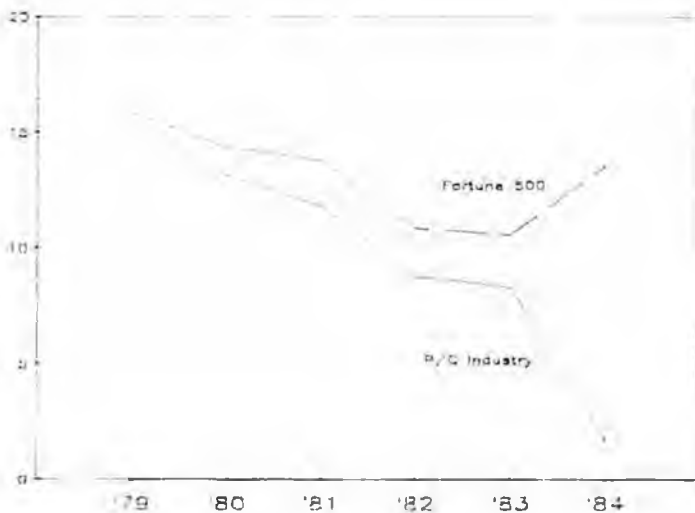
This analysis reviews the current financial state of the industry and refutes, on a point-by-point basis, the critics' charges.

All facts point to the inevitable conclusion that 1984 was the worst year to date for the property/casualty insurance industry. The weakened condition of the industry is highlighted by:

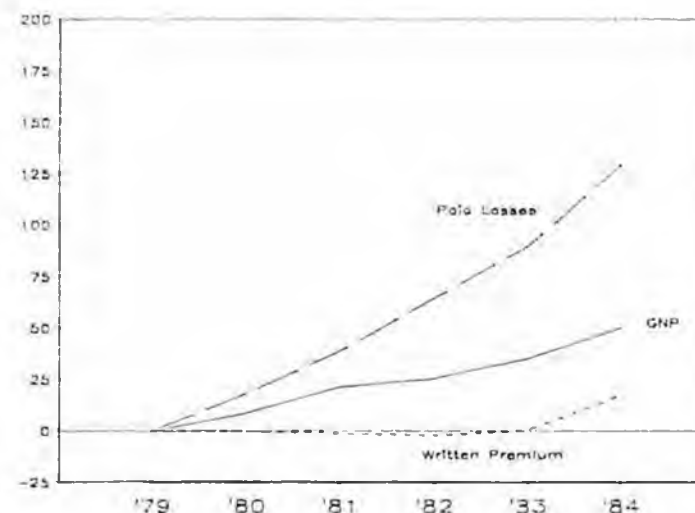
- a return on net worth of less than 2% and an operating loss of nearly \$4 billion, both record low levels;
- a record number of insurer insolvencies;
- a record number of insurers placed on a "watch list," based on tests of financial strength developed by the National Association of Insurance Commissioners; and
- a wholesale downgrading of insurer ratings by A.M. Best Company.

During the 1980's, the return on net worth for the property/casualty industry moved increasingly below the average rate for the Fortune 500 companies. (See chart A.) And results for the first nine months of 1985 indicate no major improvement in profitability. The annualized return on net worth was 4%, and operating losses as of nine months were at record levels. Rather than producing large profits for insurers, the 1985 premium increases have slowed the dramatic downside and possibly signalled the beginning of the long road back to adequate levels of profitability. The number of insurer insolvencies in 1985 has already matched the all-time record, set in 1975, with the books for 1985 insolvencies not yet closed.

Critics have made charges about the industry's financial condition that fall under four

**A**

Return on Net Worth: Property/Casualty Industry vs. The Fortune 500 (%)

**B**

Loss Growth and Premium Growth vs. GNP (%): Commercial Liability

broad accusations. The following paragraphs summarize these charges and ISO's responses.

- **The industry's accounting procedures regularly misrepresent its true financial condition. The profitability "crisis" is manufactured.**

This analysis notes that the industry's accounting procedures are in accordance with those promulgated by the Financial Accounting Standards Board (FASB) and state regulatory authorities. The analysis refutes the charges that the industry's lack of profitability is due to creative accounting, that loss reserves are overstated whenever the industry chooses to create a crisis, and that policyholder dividends and capital gains are improperly treated.

- **Price increases are excessive. Losses are not the problem.**

This analysis shows that the recent, substantial commercial liability price increases are necessary. The explosive growth in claim payments, in combination with depressed premiums, continues to create an urgent need for large premium increases in the commercial lines. These premium increases will not recoup lost profits; rather, they have begun the process of bringing current premiums in line with current losses. Losses are a serious problem, since loss growth substantially outpaced growth in GNP. (See chart B.)

The underlying causes of loss growth are not discussed in detail in this strictly financial analysis. But it is clear that the property/casualty insurance marketplace's difficulties—low insurer profitability and the impact of premium increases on policyholders—have now led to a significant public debate regarding the nature of liability in our society.

- **Insurers are making substantial profits and paying no taxes. There's nothing fundamentally wrong with industry profitability. This is just a typical cyclical downturn.**

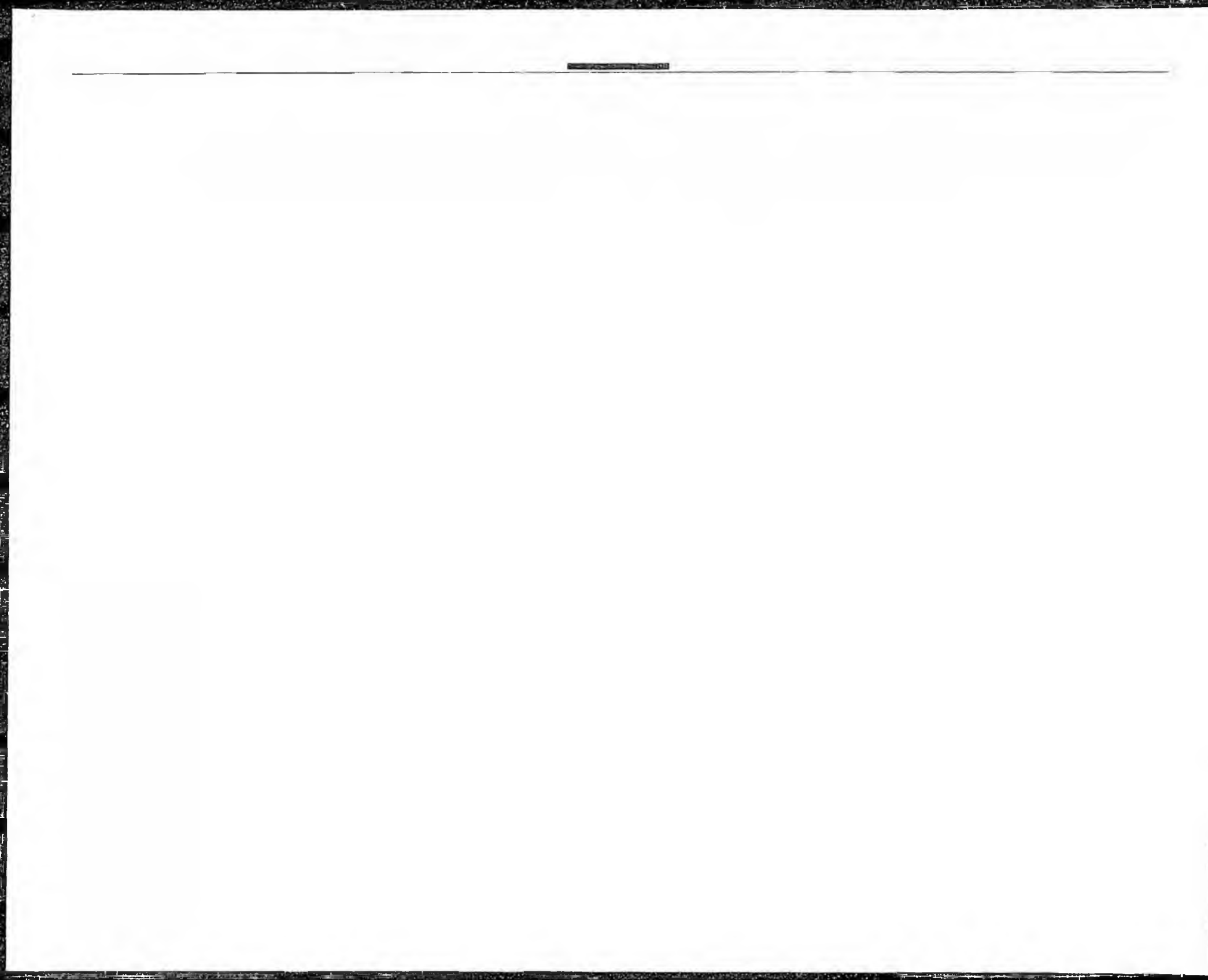
This analysis demonstrates that long-term profitability has been poor, with insurers' return on net worth below the average of the Fortune 500 companies in eight of the last 10 years. The last two years have been particularly poor, even for a low point in the cycle. This is not a typical cycle. It is both longer in duration and deeper in magnitude than any previous cycle in the property/casualty insurance industry's history. With regard to taxes, the analysis indicates that the industry is in compliance with federal law.

- **Insurance is too expensive.**

This charge is both misleading and emotionally charged. First, the critics include life, accident and health insurance premiums with those for property/casualty insurance, thereby increasing the figures in their charges. Second, losses have increased dramatically, and the premiums to pay for them must rise as well.

Conclusion

The property/casualty insurance industry's rate of return must improve, and insurers must achieve profits consistent with the risks they assume. Higher returns are needed for the industry to retain its capital base and attract new funds. Such stability and expansion are crucial if insurers are to have the capacity to provide needed insurance in the coming years.



OVERVIEW OF THE FINANCIAL CONDITION OF THE PROPERTY/CASUALTY INSURANCE INDUSTRY

In the past year, differences have emerged between the property/casualty insurance industry and its critics over the true financial condition of the industry. The insurance industry claims that it is experiencing unprecedented losses, while its critics claim that the industry is really profitable. This section will provide the facts.

A critical measure of financial results is the return on net worth, which is commonly used by investors for inter-industry performance comparisons. Responsible analysis of any industry must also look beyond that measure and evaluate the components of economic income. How does the property/casualty industry make its money? What impact do state and federal regulations have on insurance accounting procedures? What are the components of net income after taxes? Which of those components are inextricably tied to the underwriting operations of insurers? Which are subject to fortuitous events?

This section examines the elements that are critical to any analysis of insurer profitability. The following conclusions emerge:

- 1984 was the worst year to date for the property/casualty insurance industry.
- Year-end 1985 results will show no

significant improvement over 1984, despite substantial premium increases.

- The companies that insure our nation's businesses have been particularly hard hit.
- Reinsurers have experienced large financial losses.
- Recent insurance industry financial results would have been worse without unprecedented realized capital gains and tax credits.
- Premiums will have to increase faster than claim costs in order to achieve positive operating income in future years.

The key support for each of these conclusions is as follows:

1984 was the worst year to date for the property/casualty insurance industry.

The industrywide return on net worth¹ was

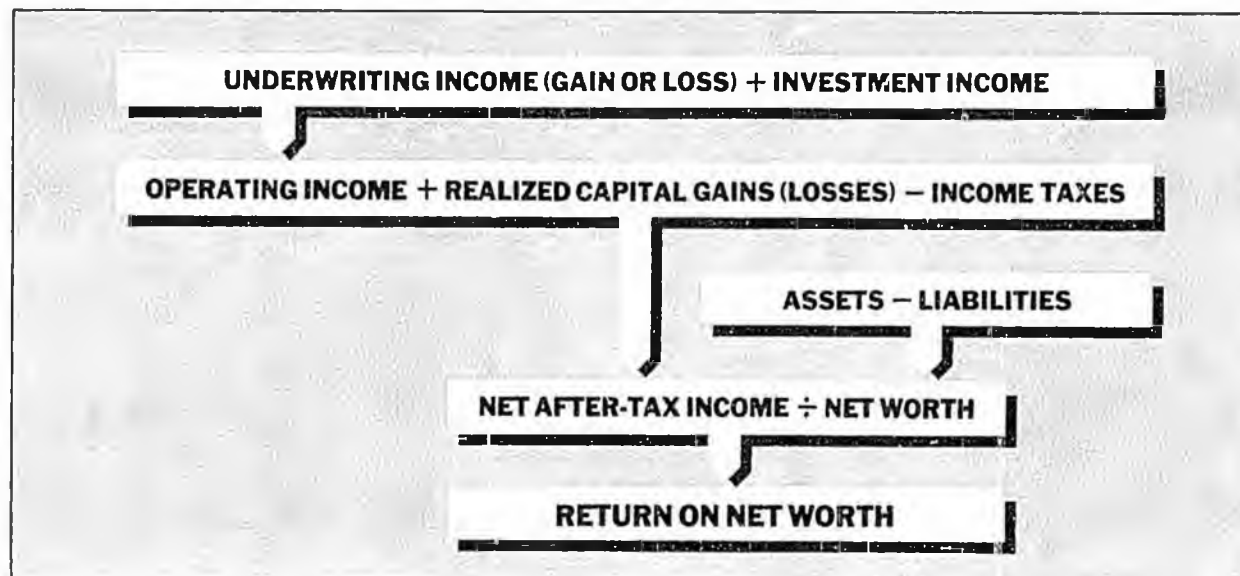
below 2% in 1984, with total earnings of \$1.3 billion. The Fortune 500 companies' median return was 13.6% in 1984, averaged 13.2% over the last ten years, and has never fallen below 10% over that span. During the 1980's, the return on net worth for the property/casualty industry has moved increasingly below the average rate for the Fortune 500. (See chart 1.)

Some insurers reported returns higher than the industry average in 1984, while others had

¹Return on net worth is net income after taxes divided by total net worth. In this report, both income and net worth figures have been calculated to be consistent with generally accepted accounting principles (GAAP) as set forth by the Financial Accounting Standards Board (FASB). GAAP-adjusted figures for both income and net worth are larger than corresponding statutory figures, which are based on more conservative measurements. For example, in 1984, statutory surplus was \$64 billion compared with GAAP-adjusted net worth of \$75 billion; statutory net income was \$0.8 billion compared with GAAP-adjusted net income of \$1.3 billion.

THE MAJOR COMPONENTS OF INSURER PROFITABILITY

Operating income comprises underwriting income and investment income. It is a component of net after-tax income. The other major components are realized capital gains (losses) and income taxes. An insurer's net worth consists of assets minus liabilities.



lower earnings. Many companies actually lost money overall. In fact, 330 of the nation's 867 insurer groups, representing 40% of industry premiums, recorded negative returns. Eighty-four insurers lost more than one-quarter of their surplus during 1984.

The most important component of insurers' net income after taxes is operating income—the sum of underwriting income and investment income. It represents profit or loss from insurance operations. Other components of net income after taxes include realized capital gains and federal income taxes. The diagram on page 12 illustrates the relationships among the major components of insurer profitability.

Underwriting income (the difference between premiums earned and the sum of losses on claims, expenses and policyholder dividends) has actually been *underwriting loss* beginning in 1979. Each subsequent year brought ever-growing underwriting losses—reaching a staggering \$21.5 billion in 1984.

In all but two years of its history, the industry's *investment income* (the interest and dividends received on investments) was enough to offset underwriting losses. (See chart 2.) The first time investment income did not exceed underwriting losses was in 1975, when investment income fell short of the underwriting deficit by \$300 million. In 1984, a new record was set, with underwriting losses exceeding investment income by \$3.8 billion. Only unusually large realized capital gains and tax credits allowed the industry's bottom-line earnings to be positive in 1984.

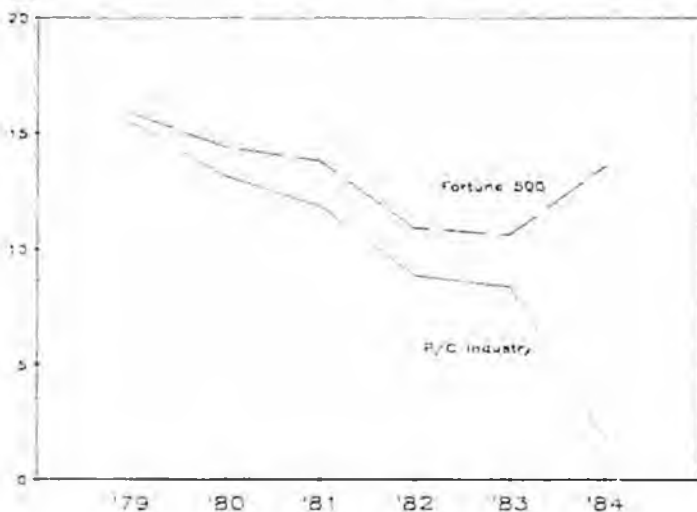
Year-end 1985 results will show no significant improvement over 1984, despite substantial premium increases.

Figures for the first nine months of 1985 showed slight improvement over the comparable period in 1984, but the annualized 4% return on net worth was still far from acceptable by any business standard. It is unlikely that the full-year 1985 returns on net worth will exceed 4%.

The underwriting loss for 1985 will exceed the 1984 record of \$21.5 billion. During the first nine months of 1985 the industry recorded an underwriting loss of \$17.8 billion, compared with a loss of \$15.2 billion for the first nine months of 1984.

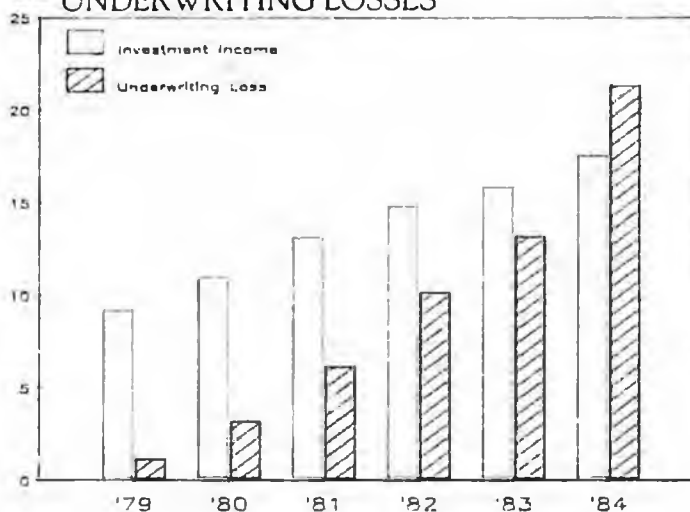
During the first nine months of 1985, investment income fell short of the underwriting loss by \$3.5 billion, compared with a

1 PROPERTY/CASUALTY RETURNS HAVE PLUMMETED



Return on Net Worth: Property/Casualty Industry vs. The Fortune 500 (%) Returns on net worth for the property/casualty industry have consistently lagged behind those for the Fortune 500 companies, plummeting 12 points below the Fortune 500 in 1984.

2 INVESTMENT INCOME NO LONGER OFFSETS UNDERWRITING LOSSES



Investment income vs. Underwriting Loss (\$ Billions) Investment income offset underwriting losses in every year from 1979 to 1983. In 1984, investment income fell short—creating a \$4 billion operating loss. This operating loss will continue at least through 1985.

shortfall of \$2.5 billion for the first nine months of 1984. All available evidence indicates a record operating loss for 1985.

The companies that insure our nation's businesses have been particularly hard hit.

The degree of deterioration in insurers' claim experience has varied greatly by type of insurance. In general, the results for commercial lines (insurance coverages purchased by businesses) have deteriorated more severely.

Since 1979, insurers that concentrated in the personal lines fared better than those that concentrated in the commercial lines. (See chart 3.) While personal lines insurers' profits dropped from 1979 to 1984, their decline was more moderate. The return on net worth for predominantly personal lines insurers fell from over 13% in 1979 to below 8% in 1984.

Insurers that concentrate in commercial lines have experienced a much more dramatic drop in earnings. In 1979, this group achieved a slightly higher return than personal lines insurers, posting a 15% return on net worth. The return declined during the early 1980's, reaching a negative 3% return on net worth in 1984.

Reinsurers have experienced large financial losses.

Insurance companies are in the business of assuming risk, but in many cases the potential claims are too uncertain and too large for any one company to absorb. This is particularly true for liability policies covering government entities and many large corporations, which may require coverage limits of \$50 million or more. In response to the expanding liability coverage needs, reinsurers² (often described as companies that insure insurance companies) have

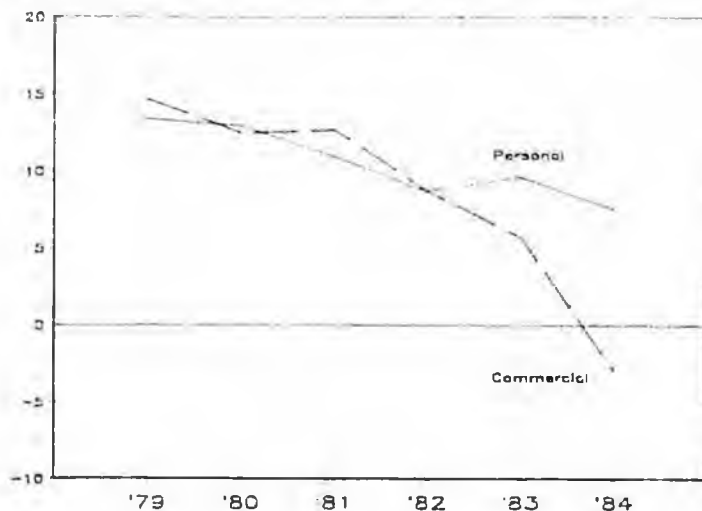
grown to be an important segment of the property/casualty insurance industry and a crucial link in providing many necessary types of insurance coverages.

Reinsurers are often involved in the riskiest coverages. Financial and economic theory dictates that they should therefore be rewarded with larger expected average returns on net worth. In fact, recent returns for reinsurers have been worse than the industry average.

From 1979 through 1983, U.S. reinsurers' returns on net worth were comparable to those of the entire industry. (See chart 4.) In 1984, reinsurers' returns plummeted to a negative 10%, nearly twelve points below the industry

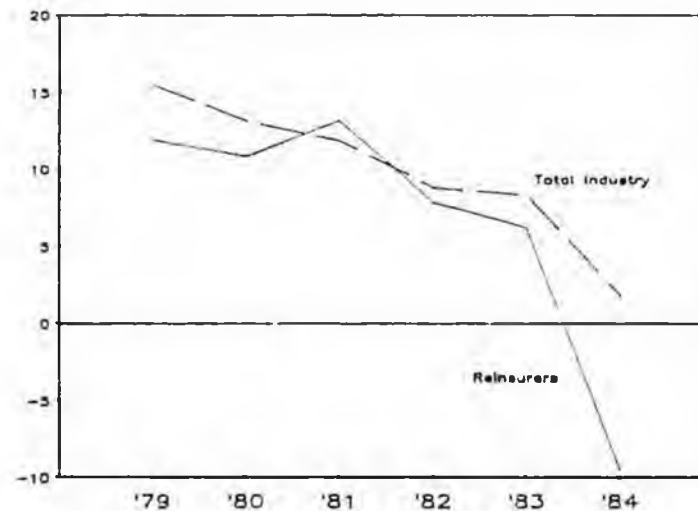
²For a more thorough discussion of reinsurance, see the Appendix.

3 COMMERCIAL INSURERS LOST MONEY IN 1984



Return on Net Worth: Personal vs. Commercial Insurers (%) Commercial lines insurers have experienced a dramatic decline in their returns on net worth over the last four years, dropping to negative 3% in 1984. Personal lines insurers' returns also declined, but less precipitously.

4 REINSURERS LOST MONEY IN 1984



Return on Net Worth: Reinsurers vs. Total Property/Casualty Industry (%) U.S. reinsurers lost money in 1984 — a factor in 1985's commercial lines marketplace.

average. This result was a significant factor in the insurance marketplace disruptions that occurred in 1985. Many reinsurers withdrew partially or totally from writing business; others restructured coverages (adding exclusions or restrictions) and increased prices in an attempt to return to profitability.

Recent insurance industry financial results would have been worse without unprecedented realized capital gains and tax credits.

The major components of net income after taxes are operating income (the sum of underwriting income and investment income), realized capital gains and federal income taxes. Although the industry produced an operating loss of \$3.8 billion in 1984, this loss was offset by other sources of income. These other sources of income are not predictable or regularly recurring

and therefore cannot be depended on to provide similar amounts of additional income in future years.

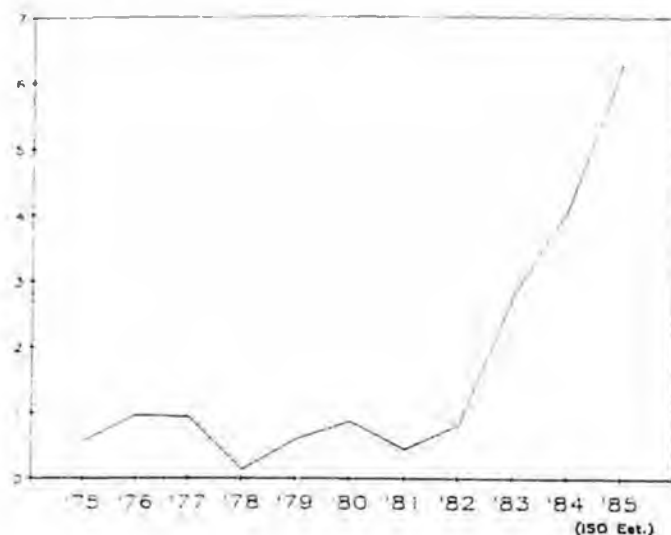
A major source of non-repeatable income for many insurers during the last three years was *realized capital gains*. These gains occur when insurers sell assets that have risen in value since they were purchased. Until very recently, capital gains realized by the property/casualty industry were relatively insignificant compared to net worth. (See chart 5.) From 1975 to 1982, total realized capital gains never exceeded 1% of net worth. In 1983, the ratio grew to 3% and continued upward in 1984 to 4%.

Capital gains may be realized under two sets of circumstances. If the overall stock market performance is relatively flat, offering little if any appreciation in value for shareholders, large

investors with a portfolio of both winners and losers may be able to sell the winners—stocks that increased in value since the time of purchase. These investors will have realized a capital gain. But by keeping the losers, they have incurred an offsetting *unrealized* capital loss, since their portfolio account now consists of stocks with depreciated value. These circumstances generally prevailed in 1984.

Under a second set of circumstances, exemplified by 1985, the stock market rises dramatically. Under those circumstances, investors may be able to realize extraordinary capital gains. But if the existing securities are sold and new ones are purchased, only additional substantial market appreciation will produce

5 REALIZED CAPITAL GAINS AT RECORD LEVELS



Realized Capital Gains (% of Net Worth) Realized capital gains grew to unprecedented levels in 1984 and 1985.

further large capital gains. And the effect of large realized capital gains distorts earnings over a short period of time.

Any quantitative analysis of profitability for a particular year requires an adjustment to reduce the distorting effect of abnormal events. Recording the results of a dramatic but short run stock market rise or the realization of a capital gain that actually accumulated over many years as an element of only the latest year's profit is highly misleading. The effect of abnormal realized capital gains—as well as capital losses or any catastrophes—should, for purposes of analysis, be averaged or smoothed over several years. Certainly, in assessing future years' rates of return, only a "normal" amount of realized capital gains should be assumed.

A second major source of non-repeatable income for insurers in the last few years is tax credits. Tax credits are available to those businesses that have incurred a pre-tax net loss for a given tax year and paid taxes during a prior profitable period. Tax credits may also be used by a company that is a subsidiary of an otherwise profitable parent. During the last two years, nearly \$4 billion in tax credits have been utilized

by the property/casualty industry. Clearly, tax credits at these levels cannot be expected to continue.

In summary, the property/casualty insurance industry benefited from nearly \$5 billion of realized capital gains and tax credits in 1984. Without those extraordinary items, the industry would have incurred a large overall net loss. Over the prior twenty years, the average of total capital gains and federal income taxes was a net of only \$500 million a year. Given their historically small contribution to total profit, realized capital gains and tax credits cannot be relied upon to provide a continuing and consistent bailout for operating losses. If the industry is to maintain a reasonable level of profitability for the long term, profits must come from operating income.

Premiums will have to increase faster than claim costs in order to achieve positive operating income in future years.

Positive operating income—the difference between underwriting loss (after policyholder dividends) and investment income—has been hard to achieve. Although investment income has grown steadily over the last decade to nearly \$18 billion in 1984, its average annual increase since 1980 has been less than \$2 billion, while underwriting losses increased at an average annual rate of over \$4 billion. All available evidence indicates a record operating loss for 1985, despite substantial premium increases. If operating income is to become a source of profits, underwriting losses must be drastically reduced from the 1984 level of more than \$21 billion. For this to happen, premium increases would have to continue to exceed the rate of growth in claim costs.

MAJOR CHARGES RAISED BY INDUSTRY CRITICS

The property/casualty insurance industry has recently been a target of criticism. Critics charge that, by manufacturing a crisis, insurers hope to lobby legislators to implement tort reform. A notion common to many of these criticisms is that the "actual" results reported by insurance companies are not actual at all, because they are based on *estimates* of loss reserves that insurers set aside to cover future loss payments.

Some critics argue that the industry inflates the amount of money it reserves when it wants to show that it is unprofitable and puts less money in reserves when it chooses to show a profit. History does not support these charges. Financial analysts of the business have noted that, in times of low profitability, many insurers set aside less than they should to cover future losses on current or past policies.

The following pages contain 13 specific charges, together with the relevant facts that refute these charges, organized under four major accusations:

- The industry's accounting procedures regularly misrepresent its true financial condition. The profitability "crisis" is manufactured.
- Price increases are excessive. Losses are not the problem.
- Insurers are making substantial profits and paying no taxes. There's nothing fundamentally wrong with industry profitability. This is just a typical cyclical downturn.
- Insurance is too expensive.

ACCUSATION

The industry's accounting procedures regularly misrepresent its true financial condition. The profitability "crisis" is manufactured.

CHARGE: The industry manipulates its financial results by deliberately misstating reserves held to make future loss payments. Industrywide estimates of future loss payments are often overstated, thus producing a "crisis." During the last "crisis," the industry seriously overreserved, particularly in medical malpractice. It has again manufactured this current "crisis" in availability and affordability by overstating reserves.

THE FACTS: These charges have no basis in fact and contradict the consensus opinion of acknowledged financial analysts, who believe that current loss reserves are understated. A published ISO study concluded that year-end 1982 industrywide loss reserves were deficient by more than 10%. Subsequent ISO analyses indicate that no significant strengthening occurred in industry loss reserves through year-end 1984. Furthermore, experience has shown that industry loss reserves were seriously *understated* at the time of the last "crisis" in 1976.

It is true that loss reserves are estimates, made by insurers on a given date, of liabilities for additional loss payments that will ultimately be made for a particular set of claims. State insurance commissioners, charged with overseeing the solvency of insurers, suggest that these liabilities be reported at their full ultimate value for most lines of insurance. Reserves are particularly significant for the liability lines, for which the final payout may not be known for many years, which is why such lines are known as "long-tail" lines.

At the time of the last "crisis"—1976—the reserves set aside at year-end 1976, for all claims incurred to that date, were \$47.1 billion. As of year-end 1984, \$48.6 billion had been paid out on those initial pre-1977 claim reserves. And an additional \$8.0 billion was still held in reserve for the same group of claims—for a total payment of \$56.6 billion rather than the \$47.1 billion originally expected. The nearly \$10 billion difference represents an initial reserve deficiency of 20%. (See chart 6.)

One reason that reserves set in the past for long-tail lines such as general liability have proven to be deficient is that scientific, technological and social changes have revealed new sources of exposure to injury and new theories of legal liability. For example, when general liability loss reserves were established 10 to 20 or more years ago, insurers could not have predicted the huge number of claims related to asbestos, Agent Orange, DES, and other alleged causes of latent injuries under policies already written. At that time, no reserves were set up for future payments of those losses. It is now clear

that the initial general liability reserves will prove to be significantly understated.

This pattern of underreserving can easily be seen in two particularly long-tailed lines, general liability and medical malpractice. In 1976, general liability claim payments already made, plus the reserves carried for future payments on policies written through that year, totaled \$24.0 billion. At year-end 1984, the estimated costs for those same general liability claims had risen to \$28.0 billion, of which \$26.0 billion had already been paid. (See chart 7.) This means that, as of year-end 1984, the original 1976 general liability reserve was already *insufficient* by \$4 billion.

For medical malpractice, the estimate for ultimate claim payments on the policies written through 1976 initially totaled \$1.9 billion. The year-end 1984 estimate for those same medical malpractice losses had risen to \$2.3 billion, of

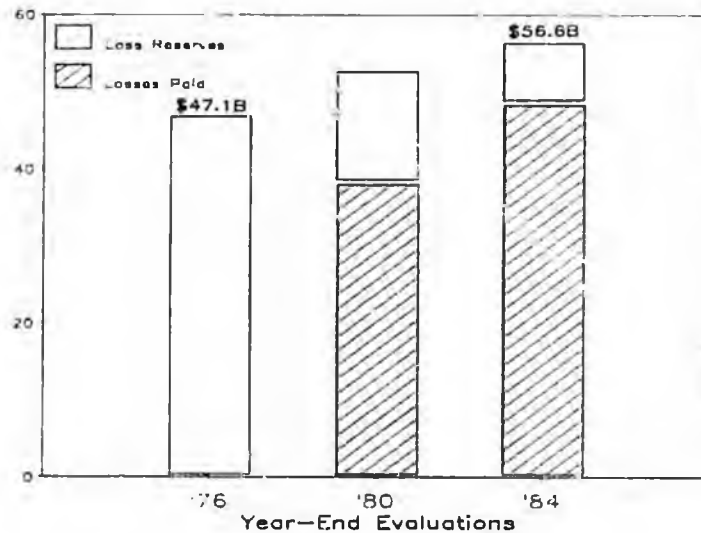
which \$1.9 billion had already been paid. (See chart 8.) This means that, as of year-end 1984, the original 1976 medical malpractice reserve was already *insufficient* by \$400 million.

The 1976 loss reserves were not unique. More recent years show a similar pattern of final losses that are likely to exceed the initial reserves. For example, the 1979 reserve for liability lines was \$65.3 billion at year-end 1979. As of year-end 1984, \$53.8 billion of those reserves had been paid and \$15.7 billion was still held in reserve, for a total of \$69.5 billion—an initial reserve deficiency of more than \$4 billion (6%) as of year-end 1984. (See chart 9.) Given recent historical trends, it is likely that estimated final claim payments—and, therefore, the reserve deficiencies—will grow as later evaluations are made.

CHARGE: Policyholder dividends should not be included with losses in determining underwriting results. Policyholder dividends are not a business expense, but a voluntary choice of profitable companies to distribute some of the profit to policyholders.

THE FACTS: Policyholder dividends, although not “losses”, are price discounts to customers that are legitimate business expenses, deductible from income. This treatment follows that dictated by statutory accounting procedures developed by the National Association of Insurance

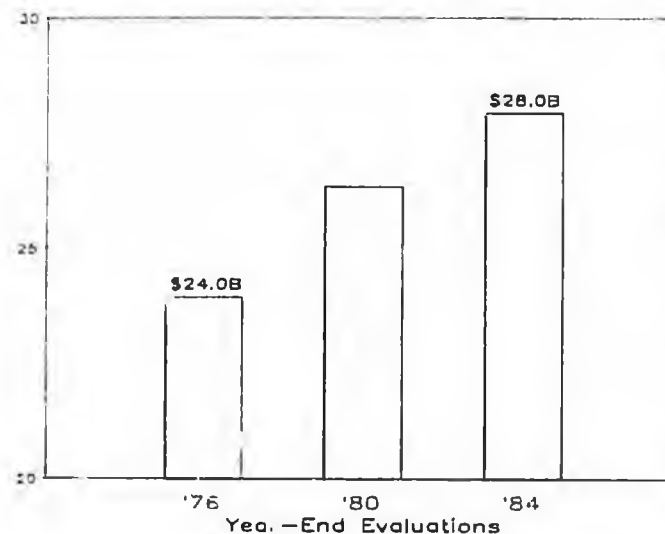
6 1976 INDUSTRY RESERVES FELL SHORT



Calendar Year 1976 Loss Reserves (\$ Billions)

The reserves set aside at year-end 1976 proved to be nearly \$10 billion (20%) short eight years later.

7 1976 GENERAL LIABILITY RESERVES FELL SHORT



General Liability Incurred Loss Development—1976 (\$ Billions) Estimated costs of general liability claims incurred through '84 proved to be \$4 billion too low by year-end 1984.

Commissioners and is consistent with generally accepted accounting principles as articulated by the Financial Accounting Standards Board (FASB). The opinion of the independent accounting firm of Coopers & Lybrand supporting this treatment may be found in the Appendix.

The charge policyholder dividends should not be treated as expenses could just as easily—and just as mistakenly—be applied to any price discount a company offers its customers to encourage the purchase of the company's product or service. And that's what policyholder dividends are: a price discount. When manufacturers offer a \$10 refund on the price of a coffeemaker or a \$500 rebate on the price of a car, they are not distributing profits; rather,

they are incurring an expense that is, in effect, a price cut. As with manufacturers offering price discounts, policyholder dividends are appropriately recognized as an insurer expense that *reduces* profits. Policyholder dividends are not a distribution of profits.

Policyholder dividends are unlike dividends to stockholders. Policyholder dividends represent a portion of gross revenues that a company has designated for return to its policyholders. Many insurer managements pay dividends to policyholders as a competitive tool to retain business. Also, many insurers grant dividends to policyholders whether they are profitable or not, treating the practice as a necessary cost of doing business. (See chart 10.)

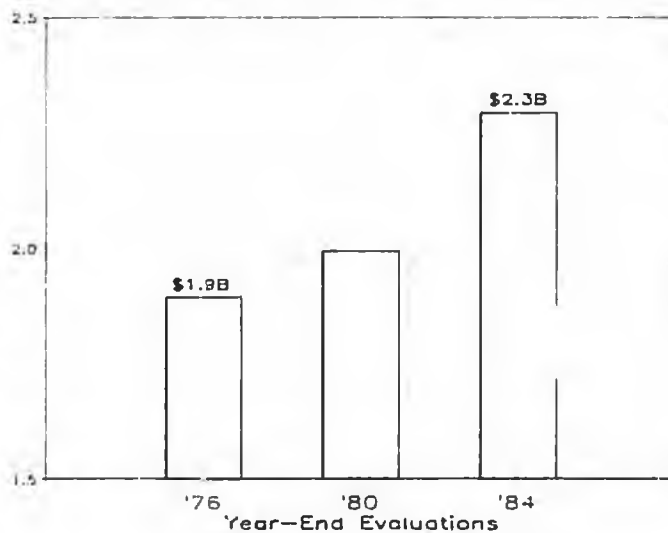
On the other hand, dividends to stockholders of *any* business corporation represent a distribution to its owners of a portion of

current or past earnings, based on each owner's total holdings. Unlike policyholder dividends, stockholder dividends do not offset income. They are charged directly to net worth.

CHARGE: The property/casualty insurance industry defines "income" to exclude certain items, such as realized capital gains. Insurers report operating income, rather than net after-tax income, to show they had losses when they really made money.

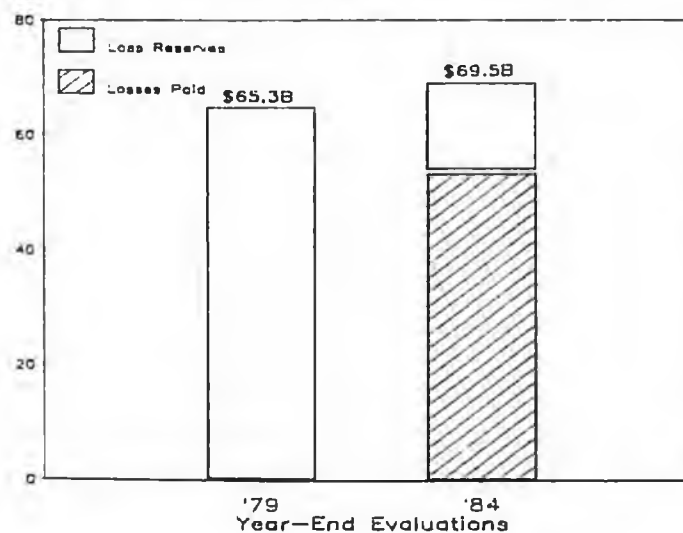
THE FACTS: This charge is false. Every quarter, statistics compiled and released by ISO highlight net after-tax

8 1976 MEDICAL MALPRACTICE RESERVES FELL SHORT



Medical Malpractice Incurred Loss Development — 1976 (\$ Billions)
Estimated costs of medical malpractice claims incurred through 1976 proved to be \$400 million too low by year-end 1984.

9 1979 INDUSTRY RESEPVES FELL SHORT



Calendar Year 1979 Liability Loss Reserves (\$ Billions)
The reserves set aside at year-end 1979 for liability lines were more than \$4 billion (5%) deficient just five years later.

income, which includes realized capital gains, as well as all other components of income.

For example, a widely-distributed November 26, 1985 news release from ISO and the National Association of Independent Insurers began with the following statement:

"The nation's property and casualty insurance industry's consolidated net after-tax income totaled \$1.49 billion for the first nine months of 1985, up 118 percent from the nine-month 1984 net income of \$685 million."

This news release went on to document various components of net after-tax income, including underwriting results, investment results and pre-tax operating income—all important and commonly-used measures of an insurer's business.

Pre-tax operating income is important to financial analysts, since it is free of the unpredictable and erratic swings exhibited by realized capital gains over a short period. While the total return on net worth (represented by net after-tax income, including realized capital gains) is the more proper measure when comparing insurer results with other commercial and industrial enterprises, operating income is a more precise reflection of the company's insurance operations—how well it is doing in its basic business.

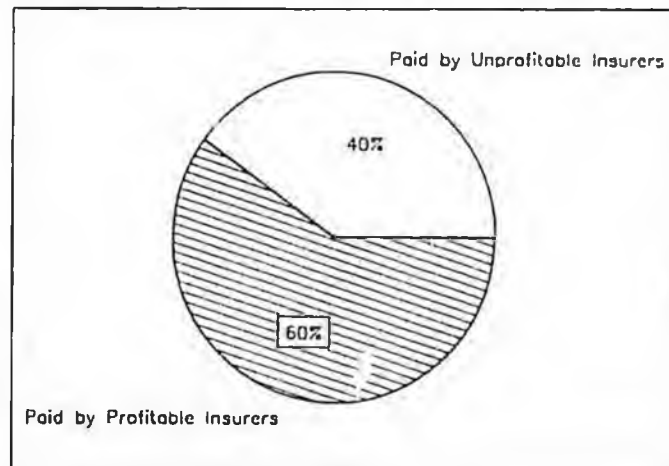
The components of operating income are underwriting income (after policyholder dividends) and investment income (net of investment expenses). While realized capital gains are considered in the determination of taxable income, they are not part of operating income. The opinion of the independent accounting firm of Coopers & Lybrand

supporting this treatment may be found in the Appendix.

Realized capital gains reflect a decision to sell assets. Companies may realize capital gains to offset operating losses and/or to utilize federal income tax credits. Prior to 1983, the industry's realized capital gains were not significant, relative to net income after taxes. But in 1984 and 1985, without unprecedented realized capital gains, net income after taxes for the industry would have been a net loss. (See chart 11.)

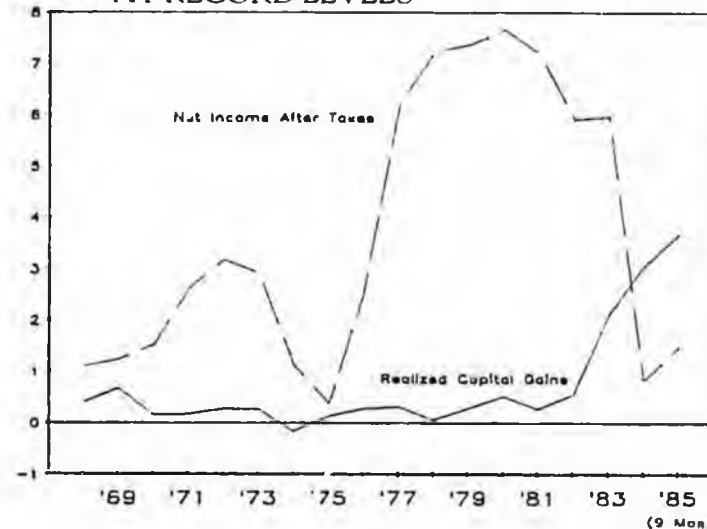
No insurer can guarantee large realized capital gains in a future year. Therefore, operating income has become the common measure for evaluating the success—or lack thereof—of an insurance company's operation.

10 WHO PAID POLICYHOLDER DIVIDENDS IN 1984?



Insurers with a negative return on net worth paid 40% of 1984 policyholder dividends.

11 INSURERS REALIZED CAPITAL GAINS AT RECORD LEVELS



Realized Capital Gains and Net Income After Taxes (\$ Billions) Only the unprecedented levels of gains from the sale of assets allowed the industry to show positive net income after taxes in 1984 and 1985.

CHARGE: In 1984, property/casualty insurers earned about a 3% rate of return on net worth. That is too low. However, if their premium had been 5% higher, they would have earned a rate of return on net worth of about 13%. In 1985, insurers' return on net worth rose to an estimated 7%. If the effects of dividends to policyholders and unusually high hurricane losses in 1985 were removed, the industry's return on net worth in 1985 would have been about 13%, the average for all American industries.

THE FACTS: The 3% return on net worth quoted by critics for 1984 is wrong. More importantly, the conclusion that an additional 5% of premium would add 10 points to that return is also wrong. Similarly, the estimated 7% return on net worth for 1985 is too high. More importantly, the adjustment to the 1985 return, adding 6 points to the estimated value, is inaccurate, inappropriate and misleading.

First, the 3% rate of return quoted by critics for 1984 is wrong. The actual figure is 1.7%. Second, an additional 5% of premium would have added about 6 points to the return on net worth. This 6-point increment is based on the conservative assumption that fixed expenses will not grow at all despite the increased revenues. If one assumes growth in fixed expenses, the additional return is 5 points.

With regard to 1985, although the critics' adjustments are unsupported, it appears that policyholder dividends have been added back into income (incorrectly raising the return by 3 points) and *all* catastrophe losses have been removed (incorrectly adding another 3 points to the return). The proper adjustments to calculate a hypothetical industry rate of return—for a year with normal events—include removing the effect of all unusual events—not only unusual catastrophe losses, but unusual realized capital gains as well. These adjustments would lower the 1985 return on net worth by about 3 points—not raise it by 6 points.

Dividends to policyholders are premium discounts to customers, rather than a distribution of profits to owners. They are properly considered as a legitimate business expense in the determination of the rate of return on net

worth. Removing the effects of policyholder dividends on income is inaccurate. (See page 20.)

Catastrophe losses are defined as events that cause more than \$5 million of insured losses. 1985 was indeed a year of unusually high catastrophe losses, totaling \$2.8 billion or about 2.1% of premium. The average annual catastrophe loss over the last 10 years has been 1.3% of premium. (See chart 12.) To calculate the return on net worth as if 1985 had been a more typical year, an average annual catastrophe loss amount should be substituted for 1985's actual catastrophe losses. Using 1.3% rather than 2.1% to smooth the dollar value of catastrophe losses would raise the return on net worth by approximately 1 point.

But to restate the 1985 return as a more typical year, one should also adjust the component of 1985 insurer profitability that showed the most atypical result—realized capital gains. The average annual realized capital gain over the last 10 years has been 0.51% of assets, while 1985 realized capital gains are estimated to be 5.3

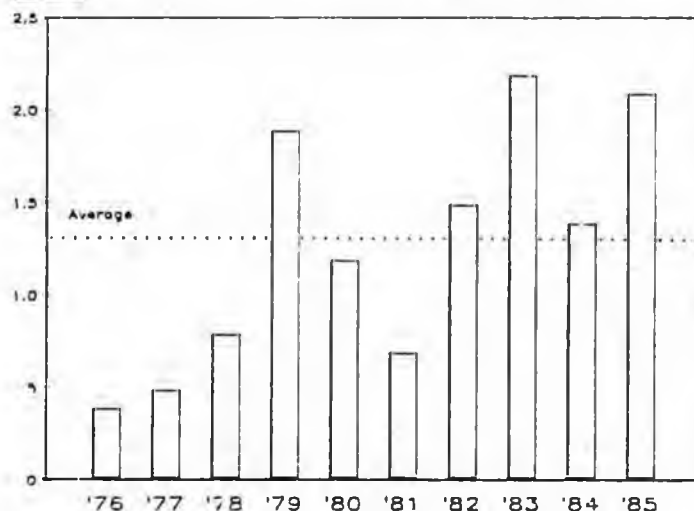
billion or 1.75% of assets—more than three times the 10-year average. (See chart 13.) Substituting the average capital gains for the 1985 amount reduces the return on net worth by 4 points.

Using a long-term average for both catastrophe losses and realized capital gains lowers the return on net worth by approximately 3 points.

Not only do the critics err in how they apply adjustments, but their estimate of a 7% return on net worth for 1985 is too high. This estimate appears to include both unrealized capital gains, as well as an incorrect amount for federal income tax credits as income. Unrealized capital gains are not income and should not be included as such in a calculation of the 1985 return on net worth. The latest estimate of 1985 federal income tax credits is \$1.9 billion, rather than the \$3.5 billion that appears to be included in the estimate of 7%. Correcting both of these errors would lower the return by several additional points.

These errors have been partially recognized by critics who, more recently, quoted a revised return on net worth of 6% for 1985—still an overestimate.

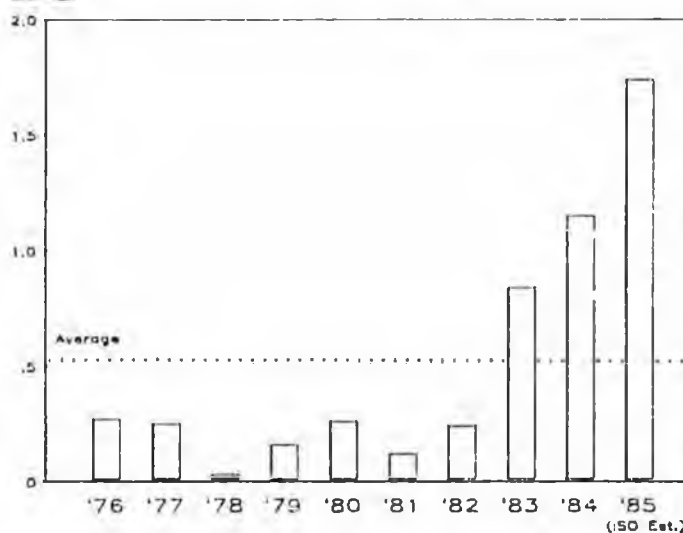
12 CATASTROPHE LOSSES CANNOT BE IGNORED



Catastrophe Losses (% of Earned Premium)

Catastrophe losses have varied over the last 10 years, averaging 1.3% of earned premium. Use of a long-term average for catastrophes is an appropriate adjustment in the calculation of expected return on net worth. Total exclusion of all catastrophe losses in 1985 is wrong in determining 1985 profitability for the property/casualty industry.

13 REALIZED CAPITAL GAINS VARY OVER TIME



Realized Capital Gains (% of Assets)

Realized capital gains have grown in recent years to unprecedented levels. Use of a long-term average of realized capital gains is an appropriate adjustment in the calculation of expected return on net worth. Inclusion of the record levels of realized capital gains in a calculation of the 1985 return is misleading in determining potential profitability.