

ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 86/Z

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However, the obvious cyclical factors in the industry tended to obscure a basic phenomenon which had been impacting on the liability insurance system for decades, namely the mushrooming growth in litigation in the U.S., and the associated problem of expanding concepts of liability.

Certain critics of the industry contend that the problems in the availability and affordability of commercial liability insurance are totally due to the competitive nature of the industry and are unrelated to developments in the tort system. The following pages provide brief responses to this and related challenges to the industry.

CHARGE: There is not a tort litigation explosion in this country.

There is a crisis in the civil justice system in America. It is not manufactured by the insurance industry.

* Awards are growing at an alarming rate.

In 1984, there were 401 awards of a million dollars or more in the U.S., up from 372 in 1983. In 1962, in a less litigious era, there was only one award over a million dollars.

The average size of verdicts for three common injuries -- cervical strain, knee injuries and vertebrae fractures -- and for wrongful death of adult males, increased at an average rate of 14.3% between 1974 and 1984, more than double the rate of inflation.

* Cases filed have grown at a spectacular rate.

In federal courts, product liability suits jumped 600% in ten years, from 1,579 in 1974 to 10,745 in 1984.

In state courts, the growth in filings has been at least four times as fast as the increase in population.

* We produce lawyers in this country at a faster rate than we produce babies. The annual rate of growth in the number of lawyers is six times the growth rate in population. Between 1970 and 1980, the number of lawyers in the U.S. increased 68%, while the overall population increased only 11%.

* In the insurance industry our loss data show what's happening. From 1965 to 1985, losses (dollars to be paid out in claims) in commercial liability insurance increased 2,046%, while inflation was up only 242%.

In 1984, losses in commercial liability insurance increased 25%, and in 1985 losses increased 43%.

* The civil justice system is grossly expensive. For example, in Los Angeles a typical trial costs the taxpayers \$11,000.

* The system sometimes delivers meager justice. In asbestos cases, claimants receive only 37 cents of every dollar. The other 63 cents go to pay for litigation costs, according to a recent Rand study.

* The most eminent jurists in the United States believe there's a crisis.

In the words of Chief Justice Burger, the process of going to trial is "not only stressful and frustrating, but expensive and frequently unrewarding for litigants." Other critics of the system include Derek Bok, president of Harvard University and former dean of the Harvard Law School, as well as former Attorneys-General William Smith and Griffin Bell.

Last, but by no means least, is the opinion of the American public. Surveys conducted by the Gallup Organization and Cambridge Reports, Inc. show that the public is fed up with the system.

-- People complain about the excessive delays and outrageous costs of the system.

-- People favor reforms. They favor arbitration as an alternative to going to court.

-- People favor limitations on pain and suffering awards. They favor limits on contingency fees.

Why are people fed up with the system? Because they recognize that what's happening in our society is wrong.

-- In N.J. the Supreme Court ruled that you can't throw a party in your home and serve drinks without running the risk of being sued if someone is injured by an intoxicated guest.

-- Doctors, in addition to taking courses in healing people, are taking courses in how to avoid being sued. According to the AMA, \$17.5 billion is spent in this country on defensive medicine - that's for unproductive tests designed to avoid lawsuits.

-- The threat of lawsuits is discouraging the manufacture of vaccines designed to prevent illnesses.

-- Directors of publicly-held companies are resigning because of the rise in lawsuits.

In sum, this is a basic issue of consumer and human rights. The trial lawyers naturally want the insurance industry to be around, because this is the deep pocket that funds them. But who pays for all this?

The answer is well known. Consumers - the general public - pay through higher insurance premiums. In sum, the insurance industry's current high rates are the symptom not the disease.

The pendulum has swung too far to one side -- we have too many lawyers, too many lawsuits and too many changes in legal doctrine.

Specific Nader-Hunter Challenges:

CHARGE:

The insurance industry is exempted from federal anti-trust law. (The implication being that insurance companies act as an OPEC-like monopoly to gouge consumers).

The insurance industry is not exempted from federal antitrust law. The McCarran-Ferguson Act of 1945 provides that regulation of the insurance industry should occur at the state level. However, federal anti-trust laws apply under McCarran-Ferguson if state regulation is deemed to be ineffective and the Sherman Act always applies in cases of boycott, coercion or intimidation. Federal agencies have exercised regulatory powers. The Department of Justice, for example, has successfully challenged acquisitions in the insurance industry which were viewed as discouraging competition.

(U.S. vs. Chicago Title and Trust Co., et al., 242F. Supp.56, N.D., Ill. 1965.)

CHARGE:

The insurance industry reports only underwriting losses. The industry states that in the ten years 1976 to 1985 insurance companies lost \$81.3 billion. Insurers neglect to mention their investment income over the same period of \$119.8 billion. So overall they made \$38.5 billion.

-- The industry reports data including investment income. I.I.I. reports such data to the trade and general public every quarter. Key sources of data, I.I.I. Fact Book, and Best's Aggregates and Averages, prominently display data on investment income.

-- While \$38.5 billion sounds like a lot of money, it amounts to an average of \$3.85 billion per year. Premiums over this period averaged \$96.8 billion so that profit margin on premiums was only about 4¢ -- 4 cents on the dollar, a profit margin below the rate achieved by most U.S. corporations. For the ten years 1975 through 1984, the rate of return on net worth in the industry averaged 10.9%, 2.3% points below the 13.2% rate of return for U.S. industry.

CHARGE:

The insurance industry pays little in taxes.

Adding up federal, state and local taxes, the industry pays about the same as the average for U.S. manufacturers.

The property/casualty industry pays relatively low federal taxes because much of its income is from tax-exempt state and local bonds.

CHARGE:

The increase in insurance rates is causing an inflationary jolt to the U.S. economy.

The property/casualty insurance industry makes up only 3.6% of the U.S. economy. A 21% increase (as occurred in 1985) in insurance premiums would not even change the inflation rate by a single percentage point.

Insurance rates have been a deflationary force over the past few years. Between 1978 and 1984, the consumer price index increased 59.2%. Premiums increased only 44.6% over the same period.

CHARGE:

The insurance industry won't tell us what we want to know. I have been asking for data, line by line, state by state showing data as follows:

<u>Column 1</u>	<u>Premiums paid</u>
<u>Column 2</u>	<u>Losses paid</u>
<u>Column 3</u>	<u>Investment income</u>

These data are available by line and by state.

Close to 2,000 insurance companies representing over 97% of insurance premiums report data on premiums, losses and expenses, by line, by state, every year.

They report this information in a document called the "Annual Statement", which is over 60 pages long, and contains details on premiums, losses, expenses, investments and taxes.

Insurance companies report on 28 separate lines of insurance. Data on small lines, such as day-care centers or professional liability for accountants, are included in aggregates and are not reported separately in the Annual Statement.

Investment income is not reported by line, as a company manages its investment portfolio as a whole. However, allocations can be made to lines of insurance and are reported on this basis in Best's Aggregates and Averages. (See, Best's Aggregates and Averages, 1985, pages 78 and 79).

CHARGE:

The insurance industry reports fictitious losses. They refer to incurred losses but don't tell us about paid losses.

Close to 90% of incurred losses are paid losses. Incurred losses represent losses paid, plus dollars set aside to cover losses to be

paid in future years. In many areas of insurance, such as medical malpractice, there is a time difference between when an accident occurs and when a claim is paid. The time difference can be quite long. In liability cases, the process of gathering evidence and court delays can result in a difference of many years between the time an accident occurs and the suit is finally resolved.

CHARGE:

Lloyd's holds the U.S. insurance industry in a vice-like grip. Lloyd's operates without any regulation and is dictating to the United States changes in our civil justice system.

It is estimated that Lloyd's writes only 15% of the reinsurance (insurance for insurance companies) in the U.S., so it can hardly be viewed as controlling the U.S. market. Lloyd's has lost a lot of money in liability insurance in the U.S. Its latest results show that while only 12% of its worldwide premiums were in liability insurance, this line was the source of 100% of its financial losses.

Like any responsible company, Lloyd's began withdrawing from areas where it was losing money, and stated the conditions under which it believes it can write business on a profitable basis.

Lloyd's is an accredited reinsurer throughout the U.S., an eligible excess or surplus line insurer in all jurisdictions as well as a licensed insurer in Illinois, Kentucky and the U.S. Virgin Islands. In addition, a number of federal agencies have also recognized Lloyd's insurance. Each year, Lloyd's files audited

financial statements with the U.S. Treasury Department, many State Insurance Departments and the National Association of Insurance Commissioners.

CHARGE:

Insurance companies say they are losing money, yet their stocks were up over 50% last year.

Every analyst of the industry forecast the property/casualty insurance industry would recover. The stock market practically always rises when it is generally believed that a depressed industry is on the road to recovery.

In general, the stock market is a poor indicator of the financial health of an industry. In 1977, the property/casualty stock index fell 4%. The following year, the industry recorded one of its most profitable years in history, with an 18.1% return on net worth.

CHARGE:

What is needed is a federal insurance office to review the industry and to set standards for state regulators.

What is being proposed is some kind of dual regulatory system. These systems don't work very well, as we know from the banking industry.

The banking industry has a dual system of federal and state regulation. Yet, the failure rate of banks is far higher than that of

the insurance companies. In addition, despite federal regulation and a federal insurance system, bank failures in recent years have cost taxpayers billions of dollars. One bank, Continental Illinois, received a commitment of \$4.5 billion from the federal government to stave off bankruptcy. Failures in the insurance industry do not cost taxpayers, as they are covered by state guaranty funds which are collected from the insurance industry itself.

CHARGE:

What is needed is a federal reinsurance program. Reinsurance is largely concentrated among foreign firms. This would free U.S. business from foreign tyranny just as the goal of energy independence was designed to free U.S. citizens of pressures exerted by oil-producing nations.

A federal reinsurance program could cost the taxpayers of this country billions of dollars. Under a general federal reinsurance program, insurance companies could lay off all their bad risks on the federal government while maintaining only the profitable risks. This also would mean that the losses now being suffered by reinsurers in U.S. markets would be borne by the Federal government, rather than by the private sector.

The foreign tyranny assertion is baseless. About 75% of the reinsurance market is in the U.S. The main advantage of keeping U.S. reinsurance markets open to foreign companies is that the supply is expanded. This means that more insurance capacity is available to

U.S. firms and at a cheaper rate than if reinsurance were restricted to the U.S. companies alone.

Also, pursuing a protectionist policy in insurance markets would have the same negative repercussions of protectionism as in any other industry. Other nations would retaliate, not only against U.S. insurance companies operating abroad, but also against other U.S. exporting industries, such as aircraft manufacturing and agriculture.

In general, the reinsurance industry represents less than 10% of primary premiums. (I.I.I. Reinsurance Monograph, page 60). About 75% of this market is with U.S. companies, and 25% with foreign re-insurers. (I.I.I. Reinsurance Monograph, page 42).

CHARGE:

Thirty-eight states have laws that protect insurance agents by denying groups the right to form their own cooperative insurance coverage.

There are very few restrictions on the formation of groups to purchase insurance or to self-insure. In fact, it is estimated that 25% of commercial lines insurance is in the self-insurance area. Group insurance policies, such as those purchased by employers for their workers or unions for their membership, are allowed in all states. The laws in question deal only with the formation of "fictitious" groups, that is a group of people, who have no formal

relationship with one another. The prohibition on "fictitious" groups is designed to protect consumers who cannot join such "fictitious" groups from paying more for an insurance policy.

CHARGE:

State regulation of insurance is so weak as to be almost non-existent. Only half the states have actuaries on their staff.

The major states have full staffs of qualified actuaries. Small states without actuaries regularly hire actuaries on a contractual basis and consult with experts in other state insurance departments when they have an actuarial problem. In addition, the NAIC publishes actuarial guidelines in its field examiner's handbook and has set up an actuarial task force to deal with problems common to all states. Moreover, insurance companies often are examined by regulators from several states who pool information on companies.



February 18, 1986

NADER'S CHARGE ABOUT ONTARIO TERMED INACCURATE AND MISLEADING

At a press conference in Washington, D.C., on Feb. 10, Ralph Nader reported that Ontario, Canada, is experiencing high premiums and a shortage of insurance coverage despite having laws which have many of the tort reform measures being proposed in the United States. Representatives for the National Insurance Consumer Organization said that Ontario already has a cap on compensation for pain and suffering, restrictions on punitive damages, prohibitions on injured parties specifying the amount of the award they are seeking, restrictions on attorneys' contingency fees, few jury trials, and penalties for frivolous suits.

This represents another misleading charge from Nader/Hunter. Here are the facts:

* On a per capita basis, commercial liability insurance premiums are much lower in Canada than in the U.S. In 1985, liability premiums (excluding auto) averaged \$18 (C\$25) per capita in Canada, compared with \$60 per capita in the U.S. The different legal system in Canada is the most likely factor explaining this wide divergence in the cost of insurance.

* There are problems in commercial liability insurance in Canada, but they are not as severe as in the U.S.

* The problems in commercial liability insurance in Ontario, Canada reflect:

1. The impact of recent statutes, which increase the incentives to litigate.
2. An erosion of traditional common law disincentives to sue.
3. The impact of the worldwide contraction in liability insurance capacity.

Commercial liability premiums in Canada are expected to show an increase of 15% for 1985, contrasted with a 72% increase in the U.S.

There are, however, some problems of availability of commercial liability insurance in Ontario. This province is known to be litigious. Specific statutory provisions have increased the number and size of claims in Ontario Province:

- a. The Family Law Reform Act of Ontario Province (1978). This law extended the number of persons who could sue. For example, under this law a person with only passing acquaintance with another relative (say a cousin or nephew) can sue for loss of companionship.

- b. The province of Ontario passed a prejudgment interest act, which adds interest to awards from the date of filing.

Also, judicial procedures in Ontario have tended to increase awards beyond expectations. For example, courts in Ontario have tended to add to the award enough money to cover the taxes on interest earned from the award in future years.

In addition, Canada is affected by the worldwide shortage of liability insurance, caused mainly by severe losses by reinsurers in the U.S. market.

The Province of Ontario did not enact a series of tort reforms as might be inferred from the Nader charges. The reforms mentioned are features of the common law system and are not statutory law. Since they are part of common law, they are subject to change by judicial decision and, in fact, there has been erosion in these areas in recent years.

The following reviews the elements of the legal system in Ontario, Canada, that are highlighted in the Nader charge:

1. Cap on compensation for pain and suffering. In the early 1970s, Canadian courts established through case law a cap of C\$100,000 on pain and suffering awards. The cap has since been eroded and the figure now is C\$180,000. (Since the cap is set by case law, it can be changed by case law.)
2. Restrictions on punitive damages. These restrictions also are set by case law and have been in place for many years. The restrictions in Canada are in general tougher than those used by U.S. courts.
3. Prohibition on injured parties specifying the amount they are seeking. This prohibition holds that a jury cannot be directly informed or led by evidence to know the amount of damages sought by a plaintiff. This rule is a common law rule and has been in place for decades.
4. Restriction on attorneys' contingency fees. In Ontario, attorneys' fees are set by the Law Society. Contingency fees are prohibited. This system has been in place for decades.
5. Few jury trials. Traditionally, Canada uses juries infrequently in civil cases.
6. Penalties for frivolous suits. Defendants who win suits can collect legal fees and other costs from plaintiffs. This system has been in place for decades.

Sean Mooney, Ph.D., CPCU
I.I.I. Senior Vice President and Economist

CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison.."

TO: ALL LEGISLATORS

FROM: CITIZENS' COALITION FOR TORT REFORM

SUBJECT: ENCLOSED DATA FOR YOUR USE AND REVIEW

Thanks,

Al Tamagni, Sr.
Chairman

On Saturday February 1, 1986, the Fort Richardson Flying Club's flight operations were suspended due to the inability of the Department of the Army to negotiate the renewal of the excess liability policy with the previous carrier. The suspension also affects the Fort Wainwright Flying Club. The remaining Army Flying Clubs are not affected.

The Alaska Flying Clubs do approximately 25% of the total flying of all Army flying clubs. There are currently 289 members of which 74 are Active Duty Military, 50 Reserves, and 57 Retired Military. Dues are assessed at \$15.00/month.

The Army is requesting a maximum liability of \$250,000 per seat and \$5,000,000 per occurrence, with a \$100,000 deductible. The deductible is self-insured by the Army's established rate for hull and liability to \$100,000.

The majority of Anchorage area flight schools are currently carrying \$100,000 per seat liability and \$500,000 per occurrence. The Army's established limits may not be affordable for the flying club to continue operations.

The impact on the Fort Richardson Flying Club is wide ranging as outlined below:

1) Financial - The club's annual operating budget exceeds \$500,000 per year. The eleven (11) member staff has an annual payroll of approximately \$136,000. The maintenance on the airplanes is accomplished by a contracted mechanic at a cost of \$25-30,000 per year.

2) Contracted personnel:

- a. Thirteen (13) Flight Instructors - per hour basis.
- b. Eighteen (18) lease back airplane owners - per hour basis.

3) Alaska State Student Loan (ASSL) Program - Currently approximately 35 students are utilizing the ASSL Program with approximately \$85,000 on account at the flying club. ASSL funds are required to be placed on account at the flying club. The state requires 25 hours of instruction per three month period or 8.3 hours per month. An extended down time can put many students in non-compliance with state requirements for maintaining full-time status.

4) Veterans - The Flying Club is approved for the training of Veterans for flight training. There are currently twelve (12) members using veterans assistance for flight training.

5) Current students - there are approximately 107 current students enrolled in the flying club - includes ASSL students. In CY1985 there were 91 students who obtained pilot ratings.

As a Veteran utilizing the flying club for flight training, I have been unable to train since 1 February 1986. In the event of a permanent closure, I would be forced to transfer schools and run the risk of losing my benefits for flight training as the maximum allowed break in training is six months.

I feel the Army should do the following:

- 1) That the Department Army (ACIF) Army Central Insurance Fund set obtainable and affordable liability limits.
- 2) That the Army Central Insurance Fund self-insure the flying clubs until an acceptable commercial policy is obtainable, and if that is not possible, then the ACIF establish a reasonable rate for the liability deemed necessary to maintain the airplanes.

SIGNED _____ DATE _____

CLUB MEMBER (FT. RICHARDSON FLYING CLUB)

ADDRESS:

PHONE # (H) _____ (W) _____

Is It Us?

The following is a condensed transcript of an interview conducted by the AIA with Victor O. Schinnerer & Company management, including J. Sprigg Duvall, president; Paul Genecki, senior vice president, and Thomas H. Porterfield, vice president.

AIA, Both DPIC and Victor O. Schinnerer (VOSCO) had agreed to meet with us today but we were advised yesterday that DPIC had decided that they could not make the meeting. And so we are with VOSCO people only. But in this current market, they provide coverage for at least half the insured architects.

Is there any good news for architects about insurance?

DUVALL: We did a study some time ago that indicated that the losses we paid in dollars represented only six one hundredths of 1 percent of the construction values put in place by the architects and engineers against whom those claims were made. That's an incredibly high performance: a very low error rate. The problem is, in those rare instances—and six one-hundredths of 1 percent means a rare instance—it's very costly.

AIA: Looking at that small percentage, what can architects learn from those claims?

DUVALL: If you look at the period '80 to '84, the frequency of claims against architects did not increase all that much. It went from 43 per 100 insureds in 1980 to 44.4 in 1984. So it's not the frequency of claims; it's the severity of them that is the problem.

AIA: Of the claims that go to trial, do architects win more or lose more?

GENECKI: They win two-thirds of all the claims that go to court.

DUVALL: But I'm afraid in most of the cases we settled out of court, there really was a basis for a finding of fault against the architect. In the minds of our defense lawyers and probably the courts, architects defend themselves, because they had to give their permission to settle the cases.

AIA: What kinds of people were the claimants?

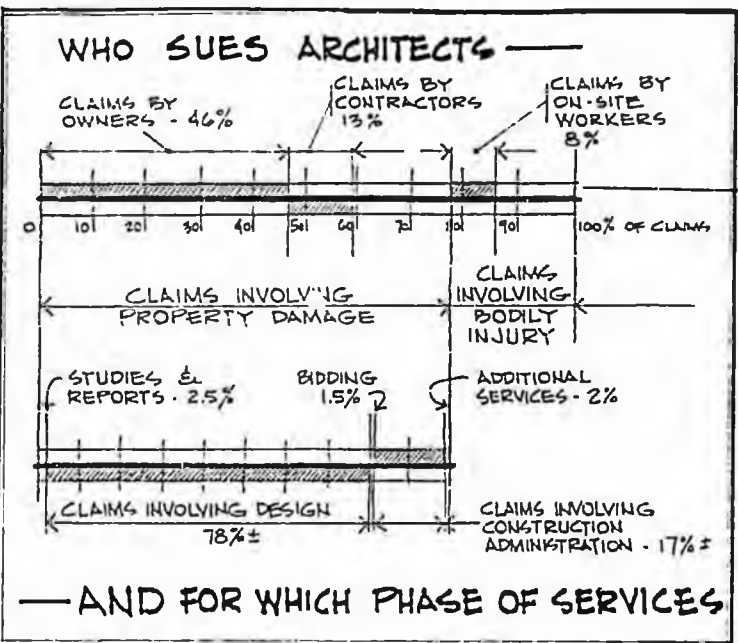
DUVALL: The most recent study we did involved 802 claims on architectural projects, and in 372 of those, the claimant was the owner.

AIA: So these were claims that might have been prevented contractually?

DUVALL: Not in every case, because I suspect some number of these claims by owners were actually third-party actions when the owners had been sued by the contractors. The second largest category is bodily injury claims by the public.

AIA: Is there any way architects can use these data to protect themselves?

DUVALL: As a starting point, architects should use the standard AIA documents. Also, if I were an architect, I would be very



careful about the financial integrity of my client. I'd be very careful about the degree to which he had been involved in previous construction and how that had turned out.

AIA: What else do the claims data say?

DUVALL: I think the claims data would disabuse a lot of architects about what they think the problems are. I know in the past, there was a feeling that bodily injury and death was a major element. The fact of the matter is, although 22 percent of the claims involve bodily injury and death, only 15 percent of the loss dollars are spent on those claims. If we could eliminate that 15 percent, we would avoid probably one year's rate increase.

AIA: Then pain and suffering would not be architects' issues?

DUVALL: Not major issues, no.

AIA: Is it true that half of the 22 percent of the bodily injury claims involve on-site workers?

GENECKI: Yes. They're the biggest single group we can identify.

AIA: So if we could convince state legislatures to include us under the workers' compensation umbrella, we could put an end to 50 percent of the bodily injury claims.

At the same time, architects feel that the judicial system is a lottery and that there's no predictable fairness to it all. Do the claims data bear out that sentiment?

DUVALL: Well, we've paid when we thought we would win; we've won when we thought we would lose. But I think, overall, we've probably paid when we should have and won when we should have.

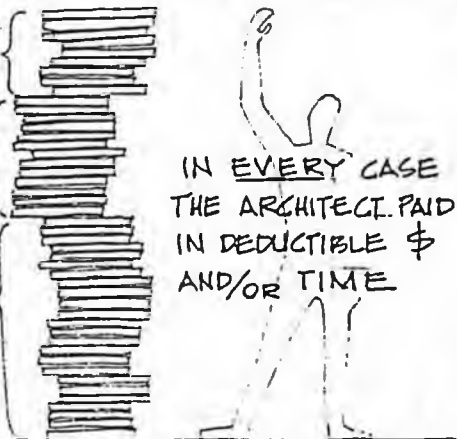
PORTERFIELD: We don't believe the legal system is out to get design professionals.

DUVALL: I think it's more a case that buildings are very complicated. To me, a modern building is very much like a ship, and there are virtually no ships that are perfectly designed, and there are virtually no buildings that are perfectly designed. Buildings, like ships, need shakedown cruises. There's going to be a list of things that need correction. The problem is that where years ago owners looked to architects to pay only for the major corrections, now they're looking to them to pay for more and more.

AIA: What's an architect to do, then, given that mentality?

OF THE 44 CLAIMS PER 100 INSURED, VOSCO REPORTS:

- IN 9 CASES THE INSURANCE PAID THE PLAINTIFF
- IN 13 CASES THEY PAID LEGAL DEFENSE ONLY, AND
- 22 CASES WERE SETTLED WITH NO PAYMENT BY THE INSURANCE COMPANY.



DUVALL: In the short term, if I were an architect, I would be collecting my insurance premium as a direct reimbursement. As a reimbursable expense, it would be provided in the contract that the owner is going to pay to the architect a percentage of each billing, which will be a line item for insurance. And if my insurance costs are \$220 per \$100 of billings and I've billed the client for \$10,000, I'm going to charge him \$220 and show it as an item.

Now, the argument is that'll encourage claims, but when you've reached the point where claims are running at 44-plus per hundred insureds, there's not much more claims encouragement you can give. That is a frightening frequency of claims.

AIA: What else could an architect do?

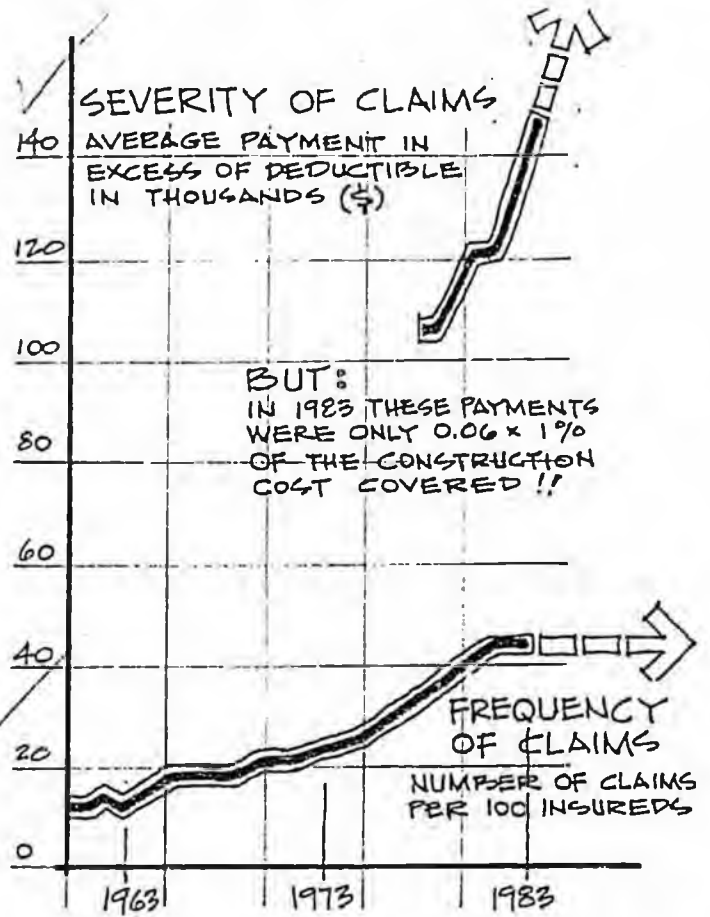
GENECKI: He could build into his contract that, after some period of operation of the structure, the owner will, on a fee basis, have the architect come back and make a detailed analysis, a walk-through of the structure, to see if maybe there are some maintenance items that the owner is not particularly aware of. Or the architect finds out that the building is being used a little differently from the way he was told originally and adjustments need to be made.

AIA: By the same token, could you say, given the fact that roofs are the primary cause of claims, that the architect should go back and watch the supervision of the placement of the roof on building? On the one hand, architects could increase their initial liability because they would be physically on the roof observing the entire installation; on the other hand, they might decrease liability because finally roofs would be put on correctly. Do you have any feelings about that at all—which argument is the stronger of the two?

GENECKI: We'd rather see them out there.

DUVALL: The presence of a knowledgeable person has got to create some deterrent to the roofing subcontractor from cutting corners, if nothing else.

GENECKI: Surely if the roof does fail, then the courts, the



owner and everybody else are going to expect the professional would have been more involved.

AIA: But they expect it anyway.

DUVALL: Yes, I'm not sympathetic to these theories of "let's not do that because by doing it there is more liability."

AIA: You'd probably say charge more and be present.

DUVALL: Charge more and do it. Be there—with knowledgeable people. Just a body there isn't going to do it.

Here we're touching on another subject that is near and dear to me, and that is, I don't think architects charge enough, and I don't think architects pay their consultants enough, and I think a lot of these things happen because there isn't sufficient talent, sufficient staff available, competent staff to get done what needs to be done to avoid having these problems. I think the fees are remarkably low.

GENECKI: Sticking with roofing, we don't have the empirical evidence yet, but it's my guess that 50 percent of all of the claims involving roofing also involved the substitution of material or a system different from that in the original drawings and specs.

AIA: That gets us back to the 78 percent of the cases that are property damage. You say 46 percent of those are initiated by the owner. Is it possible that those claims could be defeated, so to speak, by having better owner-architect relations or having better owner-architect contracts?

GENECKI: Yes, especially if you include relations.

DUVALL: It used to be that nobody wanted to talk to the owner about the possibility that disputes could arise. At 44 claims per 100 insured we're well past it. If at the outset of a project, an architect has frankly discussed with the owner the problem and the need for some form of contingency fund, I think it can be controlled much better than it is being now.

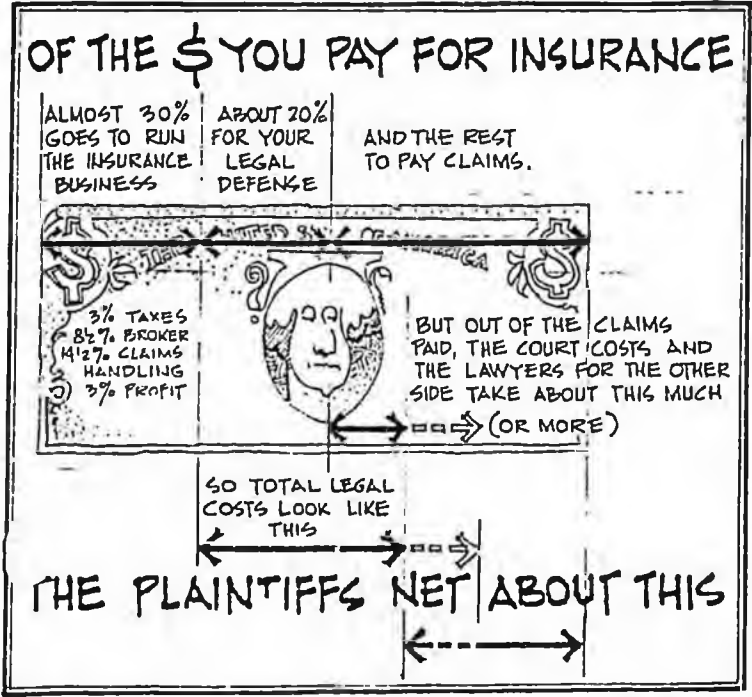
AIA: Are there any kinds of owners who need special handling, special education?

DUVALL: Well, you have the committee owners. And that generally involves churches, hospitals and schools.

GENECKI: And local government.

DUVALL: Churches have always bothered me because they represent a disproportionate amount of loss and they have all the elements that have got to lead to problems. They have a limited budget; they always want far more than they can afford; it's a committee of amateurs. Probably most serious of all, they have a

Continued on page six





Resolution 86-4

A RESOLUTION SUPPORTING THE CITIZEN'S COALITION FOR TORT REFORM REGARDING
INSURANCE PREMIUMS.

WHEREAS, the City of Houston has had its budget reserve seriously diminished by the unanticipated increase of 16% in its annual insurance premium; and,

WHEREAS, other Alaska communities, businesses, school districts, and private citizens are similarly suffering because of the need for legislative redress of the problems peculiar to the Alaska insurance industry; and

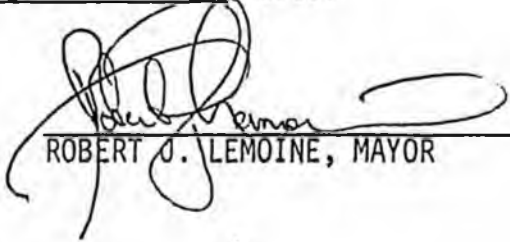
WHEREAS, Alaska has a limited availability of liability insurance programs and has experienced a dramatic rise in liability premiums; and

WHEREAS, legislative remedies are needed to restore predictability and affordability to liability insurance programs; and

WHEREAS, the Citizens' Coalition for Tort Reform has identified those areas needing legislative remedy, and have proposed solutions;

NOW, THEREFORE, BE IT RESOLVED by the COUNCIL OF THE CITY OF HOUSTON, ALASKA, that it supports the efforts of the Citizens' Coalition for Tort Reform to achieve legislative remedies, and urges the Alaska Legislature to make these reforms a priority of the 2nd session of the 14th legislature.

PASSED AND APPROVED THIS 13th DAY OF FEBRUARY, 1986.


ROBERT J. LEMOINE, MAYOR

ATTEST:


ELSIE M. O'BRYAN, CITY CLERK



D.J.'s ALASKA RENTALS INC.

Formerly Andrews Alaska Rentals & Sales
405 BONIFACE PARKWAY • ANCHORAGE, ALASKA 99504-1099
(907) 337-2552

DON REDMOND, President

December 18, 1985

Citizens Coalition for Tort Reform
738 H Street
Anchorage AK 99501

To Whom It May Concern:

D.J.'s Alaska Rentals, Inc., a tool and equipment rental agency, submits the following information that reflects typical positions of many professionals and businesses in Alaska and nationwide concerning increases in liability insurance costs:

From December 31, 1984 through December 31, 1985 our General Liability costs for \$1,500,00.00 in coverage was \$23,763.00. Annual cost per \$1000.00 was \$15.84.

From December 31, 1985 through December 31, 1986 General Liability quoted cost for ONLY \$300,000.00 in coverage is \$30,737.20. Annual cost per \$1000.00 is \$102.44, which is 6.47 times the 1985 cost!

THERE HAVE BEEN NO CLAIMS FILED!

Sincerely


Don Redmond, President



CITIZENS COALITION FOR TORT REFORM, inc.

"voices raised in unison.."

MEMORANDUM

TO: ALL LEGISLATORS
FROM: CITIZENS COALITION FOR TORT REFORM
SUBJECT: ENCLOSURE

Enclosed please find a copy of the testimony submitted by Dennis DeWitt of the Health Association of Alaska, dated February 17, 1986 to the Labor and Commerce Committee. Attached to this testimony, you will find the McMilliman and Robertson, Inc. report from the state of New York and you will also find the information from the state of California which indicates that tort reform does, can and will work.

Also enclosed you will find a letter to Mr. Richard E. Wagner from an attorney in Fairbanks regarding Rule 82.

As you have probably already been informed by the House Labor and Commerce Committee (this information was forwarded to Sid Billingsly the committee aide); that virtually all homeowners and automobile policy holders in the State of Alaska are being assessed an additional surcharge ranging in the amount of \$3.00 to \$45.00 per year to pay attorney fees under Rule 82. There are an estimated 300,000 to 400,000 homeowners in Alaska and approximately 300,000 to 400,000 automobile insurance policy holders.

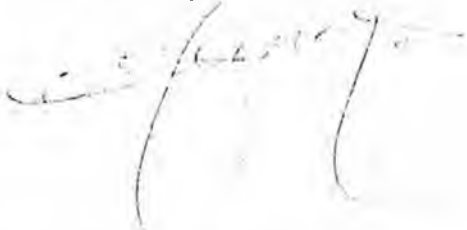
As you can well calculate, there is anywhere from approximately 2 to 6 million dollars that are being collected and paid out in attorneys fees simply because of Rule 82, which is obsolete due to the fact there is no need for the rule and Alaska is the only State with such a rule remaining.

Additionally, as you will see, the new Federal Insurance Administrator has a position as to how really effective the riot insurance was that was established by Mr. Hunter.

Also enclosed are the remarks made to the joint House and Senate Labor and Commerce committee by David J. Frazier, Chairman of the Board of MICA.

This is for your information and hopefully will be useful in determining the facts of tort reform.

Sincerely,



health
association
of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

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Soldotna

Physician Member of
the Board
Morris Horning, M.D.
Anchorage

President
Dennis DeWitt
Juneau

Testimony Before the
LABOR AND COMMERCE COMMITTEE
February 17, 1986

Mr. Chairman and members of the Labor and Commerce Committee. I am Dennis L. DeWitt, President of the Health Association of Alaska. The Health Association of Alaska represents 31 hospitals and nursing homes in Alaska. I appreciate the opportunity to testify before you on the issue of liability insurance and tort reform.

You are no strangers to the crisis facing Alaskans today. Our membership shares the problems of accessibility and affordability just the same as every other segment of society today. We are concerned with both parts of the problem and urge you to adopt a bill such as HB 532, as we believe that it will help us address both parts of the crisis.

We believe that the study by Milliman & Robertson, Inc., Consulting Actuaries demonstrates that tort reform will have a beneficial impact on the liability crisis. The study, which is attached, shows that there is a potential savings of 28% by passing legislation requiring periodic payments, collateral source offset, limitations on non-economic damages, and contingency fee limitations.

In California tort reform was passed in 1975. A summary is attached. It took 10 years and five court suits to get it validated by the California State Supreme Court. Anticipating court challenges following the enactment of the reform, and pending definitive appellate court determinations (the first issued in July of 1984), many many trial court judges were not willing to apply the reforms, and defense attorneys did not seek authorized protections. Nonetheless, observers detected an impact at the settlement stage of court action, as well as significant psychological impact in prompting physicians to form their own insurance carriers.

FORMERLY

alaska
state
hospital
association

Testimony by Dennis L. DeWitt
February 17, 1986
Page three

We hear a great deal about protecting the consumer. I suggest that it is the consumer that will benefit from tort reform. The cost of malpractice insurance is reflected in prices to the public. The more significant issue is the level of coverage.

South Peninsula is limited to \$500,000 of insurance. Thus if you or I were injured and permanently disabled as a result of an accident that occurred while we were there for treatment our recovery would be limited to \$500,000 and the keys to the hospital. That translates to about \$15,000 for the next 38 years for salary replacement for Mr. Navarre plus the right to effectively manage his new enterprise, the South Peninsula Hospital. We simply do not believe that this situation is in the best interest of the consumer.

We believe that the Rand study, the actuarial studies, and the history of California tort reform indicate that tort reform does solve the availability and affordability issues in terms of liability insurance. We also believe that the reforms found in HB 532 are reasonable and will, if adopted, contribute significantly to the solution.

I would be pleased to respond to any questions.

Testimony by Dennis L. DeWitt
February 17, 1986
Page 2

Moreover, data now available indicate a slower rate of increase in the average plaintive verdict award and the cost of physicians' malpractice insurance premiums. Recent information shows that in 1984 the average jury award for a medical malpractice case in California was \$396,662, compared to the national average of \$974,858. (To place this in context, it should be noted that the average plaintiff award in California for all personal injury suits combined is slightly higher than the national average.) Although the national experience is rising malpractice awards, 333% since 1975, the upward trend in California for the same period is markedly slower, showing an increase of only 150%.

Similarly, physicians' malpractice premiums in California in 1974 had an average increase of only 16% compared to the national average increase of 32% for all physicians.

Hospitals and nursing homes in Alaska are facing increasing premiums and decreasing limits of coverage. MICA informed its insured that the 1986 premium would double and the coverage would be limited to \$500,000 per exposure and \$1 million in the aggregate per year. For facilities that is a decrease from \$10 million in 1985.

I would like to share three specific examples with you. At South Peninsula Hospital in Homer which is insured by MICA, the 1985 premium was \$35,232 with \$10 million exposure, the 1986 premium was \$69,236 with a per occurrence limit of \$500,000 and aggregate of \$1 million. Kodiak Island Hospital is insured with a captive group through the Lutheran Hospital and Home Society of Fargo North Dakota(LIHS). They have the advantage of a large homogeneous group with a broad base. They are self insured as a group for the first \$20 million. Their 1984 rates were \$9,174, 1985 rates were \$23,254, and 1986 rates of \$47,000. The coverage has changed in that in 1984 the Society self insured the first \$ 2.25 million but now must self insure the first \$25 million. Central Peninsula Hospital in Soldotna also with the LIHS has had premium increases from \$14,894 in 1984 to \$135,000 in 1986.

MILLIMAN & ROBERTSON, INC.
CONSULTING ACTUARIES

TWO PENNSYLVANIA PLAZA NEW YORK, N. Y. 10001

812/278-7100

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September 11, 1985

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

Dear Mr. Johnson:

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

APPROACH

The objectives of this project were as follows:

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

Our approach to achieving this objective included the following steps:

1. Estimate the medical professional liability premium (including self-insured costs) in the United States in 1984.
2. Estimate a range of potential savings for each of the four tort reforms in the Bill separately and combined. The bill language we evaluated is included in Appendix A.

Testimony by Dennis L. DeWitt
February 17, 1986
Page three

We hear a great deal about protecting the consumer. I suggest that it is the consumer that will benefit from tort reform. The cost of malpractice insurance is reflected in prices to the public. The more significant issue is the level of coverage.

South Peninsula is limited to \$500,000 of insurance. Thus if you or I were injured and permanently disabled as a result of an accident that occurred while we were there for treatment our recovery would be limited to \$500,000 and the keys to the hospital. That translates to about \$13,000 for the next 38 years for salary replacement for Mr. Navarre plus the right to effectively manage his new enterprise, the South Peninsula Hospital. We simply do not believe that this situation is in the best interest of the consumer.

We believe that the Rand study, the actuarial studies, and the history of California tort reform indicate that tort reform does solve the availability and affordability issues in terms of liability insurance. We also believe that the reforms found in HB 532 are reasonable and will, if adopted, contribute significantly to the solution.

I would be pleased to respond to any questions.

Mr. Kirk Johnson
September 11, 1985
Page 2

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

SUMMARY OF CONCLUSIONS

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

Estimated Premium

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

Table 1

Estimated Medical Professional Liability Premium Costs in the United States

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

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

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

Potential Initial Savings

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

Table 2

Potential Initial Savings from Reform Bill

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

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

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

1. To realize the potential savings it is necessary that law impact claim settlements to the same extent as court awarded claims, even though the statutory language only applies specifically to court awards. In the extreme case, if the law had no effect on settlements the value of the savings when applied only to court awards would be approximately 5%.
2. The savings will vary from state to state based on considerations which are discussed in Appendix C. Application of models to a range of state situations implies that the range of savings within which the experience of most states is likely to fall would be 23% to 33%.
3. The potential initial savings might not be fully reflected in cost reductions immediately after passage of a state law. Insurers and JUA's might be reluctant to decrease rates by the full amount of potential savings until the effectiveness of the law could be tested. PCF's generally charge premiums based on expected claim payments. For several years after passage of state law claim payments will reflect the prior law, and PCF charges will not be immediately affected. Self-insurance costs may be subject to considerations like those of insurers if the self-insurance program is fully funded or like those of PCF if the self-insurance program is not fully funded.

Mr. Kirk Johnson
September 11, 1985
Page 4

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

Impact on Trends

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

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

LIMITATIONS ON RESULTS

The following limitations should be considered in utilizing these results:

1. The projected potential savings rely on models which depend critically on the judgments which are applied. We believe the judgments are reasonable. Other reasonable judgments could result in significantly different results.
2. The actual savings which might result from passage of these tort reforms will depend on factors such as plaintiff behavior, attorney behavior and court interpretations which cannot be predicted in advance. Actual results may therefore differ significantly on these projections.
3. There are a number of studies underway (the GAO study for example) which are gathering statistical and non-statistical information. If such information were currently available it could significantly affect our judgments and conclusions. As part of this project we are not responsible for updating this report to reflect information which becomes available after the report is issued.

Mr. Kirk Johnson
September 11, 1985
Page 5

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

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

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

Sincerely,

Allan Kaufman

Allan Kaufman, F.C.A.S.

AK/dmk

STATE
ISSUES
FORUM

444 North Capitol Street, N.W.
Suite 500
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202/638-1100

CALIFORNIA

Contact: Gene Marsh
916/442-5532

Development of Legislation: Medical Injury Compensation Reform Act of 1975

- o California Assembly's Select Committee on Medical Malpractice formed in 1973; Preliminary Report issued in 1974 after public hearings and review of recommendations of both the State Attorney General and HEW's Report of the Secretary's Commission on Medical Malpractice;
- o January 1975: two major medical malpractice insurance carriers in Southern California stop writing coverage for physicians; a third carrier in Northern California threatens to cease unless a premium rate hike of 384% is allowed;
- o Northern California physicians request Insurance Commissioner's permission to form a physician-owned insurance company;
- o On approval of the 384% insurance premium rate increase in Northern California, many Northern California physicians withdraw from practice: virtually all surgery was discontinued at various hospitals in the San Francisco Bay Area;
- o Governor calls special legislative session to consider malpractice reform; Northern California physicians return to work.

Legislative Purpose of the Medical Injury Compensation Reform Act of 1975 (MICRA):

(1) to reduce the incidence and severity of medical malpractice injuries by strengthening governmental oversight of the education, licensing and discipline of physicians and health care providers;

(2) to curtail unwarranted insurance premium increases by authorizing alternative insurance coverage programs and by establishing new procedures to review substantial rate increases; and

(3) to reduce the costs and increase the efficiency of medical malpractice litigation by revising a number of legal rules applicable to such litigation (American Bank & Trust Co. v. Community Hospital of Los Gatos-Saratoga, 36 Cal.3d 359, 363-64, 1984).

Enacted Legislation

The California Hospital Association supported MICRA provisions that:

- o permitted the defendant to introduce evidence of collateral source recovery by the plaintiff and the plaintiff to introduce evidence of the amount paid to secure such benefits;
- o established a \$250,000 limit on noneconomic damages, e.g., awards for pain and suffering;
- o limited attorney contingency fees: 40% of the first \$50,000; 33 1/3% of the next \$50,000; 25% of the next \$100,000; and 10% of any amount exceeding \$200,000;
- o mandated periodic payments for awards in excess of \$50,000;
- o changed the statute of limitations for minors from one year after reaching majority to three years from the date of the alleged wrongful act;
- o required 90-day notice to defendant of intent to sue;
- o permitted arbitration agreements between physicians and patients;
- o restructured the Board of Medical Quality Assurance (formerly the Board of Medical Examiners) and strengthened its disciplinary abilities; and
- o required health facilities to report certain disciplinary sanctions taken against staff members.

** Legislation enacted in 1978 requires any malpractice complaint filed to be accompanied by a certificate of merit verifying that a physician of the appropriate specialty has examined the situation and found cause for a medical malpractice action. Originally a temporary measure due to expire in January 1984, the law was extended to January 1987 in the 1983 legislative session.

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—
CHARLES J. CLASBY
OF COUNSEL

February 11, 1986

(HAND DELIVERED)

Mr. Richard E. Wagner
Alaska 100 Insurance, Inc.
Pouch 1872
Fairbanks, AK 99707

RECEIVED FEB 11 1986

Dear Rick:

This will confirm my discussion with you a few days past, wherein I expressed to you my opinion that the automatic assessment of attorney's fees in favor of the "successful party" in litigation, as required by Alaska Civil Rule 82, should be abolished.

As you know, I represent a great number of plaintiffs in personal injury actions, and I also represent a number of insurance companies in defending such actions. I have a varied trial practice and am involved in numerous cases requiring litigation which do not involve personal injury, e.g., real property, contracts, mining, property damage, etc.

It is my opinion that the "attraction" or "spectre" (depending on your point of view) of Alaska Civil Rule 82 many times diverts the attention of the parties from the merits of the dispute. Further, it is my opinion that it is the "little guy" who is more detrimentally affected by Alaska Civil Rule 82 than any other party to litigation. For instance, many times plaintiffs will settle their claims (and again I am talking about all kinds of claims, not only personal injury) for much less than the claims merit, because they cannot economically undergo the risk of losing the case, and at the same time, having a judgment entered against them for significant sums of money in favor of the successful party pursuant to Alaska Civil Rule 82. By the same token, I am aware of cases where plaintiffs' claims are kept alive and are pursued when they would ordinarily be settled, except that a plaintiff is looking for an additional award of attorney's fees pursuant to Alaska Civil Rule 82. The concomitant of this position involves an insurance company who has written a policy for comparatively low limits (\$25,000.00 for

RICE, HOPPNER, BROWN & BRUNNER

Mr. Richard E. Wagner
February 11, 1986
Page 2

auto liability) and the claimant is offered settlement of the policy limits, plus Rule 82 based on the amount of the policy limits, but the plaintiff elects to pursue the case to judgment, even though the defendant himself may be personally without significant assets with which to satisfy a judgment. The reason for pursuing the case to judgment is that an award of attorney's fees pursuant to Alaska Civil Rule 82 will be based upon the total amount of the judgment, not the amount of the policy limits that are available. Therefore, in many cases, if the matter is taken to judgment it is possible for a claimant to wind up with more money pursuant to an award of attorney's fees than he or she would otherwise get from the policy limits themselves.

The abolishment of Alaska Civil Rule 82 would not abolish the court's power to grant an award of attorney's fees in appropriate cases. Before the enactment of Alaska Civil Rule 82, the court always had the inherent power to grant a successful party an award of attorney's fees in an appropriate case, such as where the court was to find that the claim being brought, or the defense being raised, was frivolous. Abolishing Alaska Civil Rule 82 would not abolish the inherent power of the court to award attorney's fees in such a case.

Therefore, at least from the viewpoint of this trial lawyer, I believe that it would be in the best interests of the people of the State of Alaska to have Alaska Civil Rule 82 abolished.

Very truly yours,

RICE, HOPPNER, BROWN & BRUNNER



Lloyd I. Hoppner

LIH/mcb



January 27, 1985

INTERVIEW: FEDERAL INSURANCE ADMINISTRATOR JEFFREY S. BRAGG

Q: The reinsurance market for commercial liability is tight and getting tighter. There are some who propose that the federal government should serve some role in expanding the capacity of the reinsurance market. How do you feel about that?

A: That proposal is extremely premature. It would be totally inappropriate for the federal government to take any role in commercial liability -- or any other line of insurance for that matter -- when there is a short-term availability problem. If we have learned only one thing over the years, it is that the insurance industry is cyclical and, from time to time, we are faced with availability problems. We have seen these availability problems are short-lived, and premature involvement by the federal government is just not productive. I would caution the Congress and others who call for a government solution to these kinds of problems not to get involved at this time, not to take the bait. Allow free enterprise a chance to self-correct. Only if that correction doesn't take place would you want to see the government become involved in an availability issue.

For example, the riot reinsurance program was created over the objections of many people in the industry, including many of the reinsurers. There was a market for federal riot reinsurance for a period of time, but that market all but dried up during the last four years, and we were able to terminate the program. To create programs which later prove to be unnecessary is a tremendous burden on the industry and on government. That is why I think it is premature to consider a government role in these areas. Had the government waited in the area of the riot reinsurance program and in the crime insurance program, Congress would have discovered there was no need to get involved.

Flood insurance obviously is a different situation. We knew for years that there was not a market available in the private sector. One never developed in the first place. So there is a case for a National Flood Insurance Program (NFIP).

Q: What, in your view, is the federal government's role in the insurance marketplace?

A: The federal government does not have a role in regulating insurance. I think the federal government does have a role in administering the NFIP, and perhaps some other lines of business which, like the NFIP, simply can't be handled by the private sector. I tend to view what the government should be doing in the insurance marketplace very, very narrowly.

I think a case could be made, for example, for some federal role in the area of earthquake insurance. But beyond floods and earthquakes, I am not persuaded that the government needs to be involved in any other area.

Q: Are you suggesting that, other than natural disasters, there is little place for the federal government in insurance?

A: That is basically right. The reason is because the federal government would probably have to pay disaster assistance claims in the event of a major earthquake, and does make disaster assistance payments after major flooding in this country. And so insurance provides a benefit to the government as an alternative to disaster assistance and at the same time provides a higher level of compensation to victims of a major catastrophe like a flood or an earthquake.

Q: Your agency currently administers the Federal Crime Insurance Program (FCIP) and yet you leave that off of the list of insurance programs that the government ought to be in.

A: We have tried to eliminate the FCIP for the past four years now. The majority of the policies and claims are in one state, and the program just does not address problems of federal proportions. It was a mistake, I think, to ever create the FCIP. Getting it off the books has been a major personal goal as well as a goal of the Administration.

Q: What is the current status of the crime insurance program?

A: The program has now been extended another three months (until March 1986), basically because Congress can't agree whether it wants to continue the program for a longer period. More and more pressure is being placed on reducing deficits, and over the long period, I am convinced the program is going to die. The Congress, everybody wants the flood insurance program to be continued, and the reason the flood program is only extended for brief periods of time is because it is being held hostage by those who want to see the crime insurance program continued. Eventually, we will see that the flood insurance program will have a long-term extension and the crime insurance program will be phased out.

Q: It must be difficult to administer a program when you have a month-to-month lease.

A: Yes, it is. And we have incurred almost \$100,000 in costs simply sending notice to our insureds that the crime insurance program is going to be terminated, allowing them to cancel and rewrite, which we don't want to encourage them to do. The false starts we keep getting from the Congress are expensive.

Q. At the same time that Congress passed the Gramm-Rudman legislation to eliminate deficits, it limited increases in flood

insurance premiums to no more than 5%. How does one reconcile the goal of a balanced budget with limitations on needed premium growth?

A: There is a conflict between those goals. There is some question about whether claims payments under the flood insurance program, or the crime insurance program for that matter, would fall under the Gramm-Rudman Act. But notwithstanding that, we are facing the situation in which many members of Congress support rate increases and other members of Congress oppose any rate increases. We have to settle for compromises. We are going to implement a 5% increase during this fiscal year because Congress said that was all we could implement. And we will be going ahead next fiscal year with a rate increase. Our goal is still to make the NFIP self-supporting.

Q: Implicit in the way the National Flood Insurance Program was constructed is a set of incentives to discourage building or rebuilding in certain flood-prone areas. Has there been a noticeable impact? Can we look back now and see actual movement away from construction in the floodplain?

A: We can clearly see that aspect of the program has had a positive impact in terms of reducing losses. I don't think anybody could quantify that, but you can go into any community in the country that participated in the flood insurance program and you can see where the regulations implemented to enforce those restrictions have had a positive impact.

One area where the floodplain management aspect of the program was not as successful was caused by the fact that until 1981 we didn't support floodplain management adequately by having the insurance rates reflect what happened when somebody did build at a lower elevation or built in an area of higher risk. Until we brought the rates more in line with the risk, we were not supporting the floodplain management aspects of the program as well as we could and should have been doing.

Q: Is the flood insurance program reaching everybody that it should?

A: No. We estimated we are only reaching about 25% of our at-risk population. The program evened out in the late '70s at just short of 2 million policies, which is where we are today.

One of the major purposes of the Write Your Own program was to harness the marketing and distribution elements of the private sector so we could reach a much higher percentage of the at-risk, uninsured property owners. Happily, I can report 27-30% of the business sold now by the Write Your Own companies is brand new business, so our early results indicate the Write Your Own program is doing precisely what we intended it to do; to reach many of those people who heretofore had not purchased our product and to make it available to them.

Q: But even with many insurers involved in the Write Your Own program, three-quarters of the potential market still is not participating.

A: That is exactly right. I don't think we should anticipate reaching all 8 million of the potential insureds, because obviously as the program increases its penetration we are going to get less and less high-risk population. But one of the other significant things in this Write Your Own program is that now as we expand our policy base, we are by and large getting a better quality risk. We have now the very worst of the risk, so as we improve our penetration we gain a better spread of risk and that, we are certain, is going to have a positive impact on our goal of self-sufficiency.

Q: You spoke of two major natural disasters, floods and earthquakes. We have a flood insurance program. Is there a federal earthquake program in the offing?

A: In an article in I.I.I.'s Insurance Review (November/December 1984), I encouraged the industry to bring proposals to the table which could deal effectively with the earthquake insurance problem. Many segments of the insurance industry have brought together specific proposals to deal with that problem. Yet, I am a little concerned that there does not seem to be a consensus developed in the industry regarding which of the proposals should move forward. I have to compliment the industry for at least working to generate proposals and treating the issue seriously, but unless we present Congress with an industry consensus, there will be little chance of enacting any insurance solution to the problem.

Q: Is there a willingness on the part of Congress and the Administration to entertain these proposals?

A: I haven't presented a specific earthquake insurance program to the Administration. I believe the right proposal could be sold to the Administration, particularly when it is contrasted with what might be the result if we had to make massive disaster assistance payments in lieu of an insurance program. Administratively at least, an earthquake insurance program would have to pay for itself or I don't think the Administration would entertain it.

You could make a case that if a catastrophe should happen, in the short run, there could be federal dollars available to supplement insurance payments. But I think we should strive for a program which calls on the government only as a last resort, after insurance payments have been exhausted and after the industry has made as significant a financial and administrative contribution as it is capable of making. Then I think the government could be persuaded to take up the remaining burden.

Marc Rosenberg, I.I.I. Vice President-Federal Affairs

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M E M O R A N D U M

DATE: FEBRUARY 24, 1986

SUBJECT: TORT REFORM - HOUSE BILL #532 &
SENATE BILL #377

Remarks made by David J. Frazier before a
joint House and Senate Committee Chaired by
Mike Navarre in Anchorage

My name is David J. Frazier and I am presently serving as the Chairman of the Board of Governors of the Medical Indemnity Corporation of Alaska. I was appointed to the Board by two Governors during the last ten years. Most recently I was reappointed to the Board by Governor Sheffield in 1985.

The reason we are here today is to discuss tort reform in the State of Alaska. MICA is back after operating under legislative mandate for ten years. Our enabling legislation was enacted by Legislature in 1976. We find ourselves caught in a struggle between time and a legal system that does not promote the best interests of Alaskans.

You will recall that the Medical Indemnity Corporation of Alaska is a non-profit insurance company that provides hospital and physician medical malpractice liability. We feel that MICA has done its best to full-fill its role as a public organization.

We have an excellent Board made up of nine (9) Alaskans appointed by the Governor. Currently our board consists of;

1. The Hospital Administrator from Nome
2. Physician representatives from throughout the State:
 - a. An Internist from Fairbanks
 - b. A Surgeon from Anchorage
 - c. A General Practitioner from Anchorage
 - d. A Radiologist from Juneau
3. Our public members include:
 - a. A banker from Juneau
 - b. A risk manager from Anchorage
4. The board also has two insurance industry representatives including:
 - a. A workers' compensation expert
 - b. Myself who specializes in employer-medical community relations.

The Medical Indemnity Corporation has hired the best claims personnel available in Alaska. Our office manager and director has twenty-five years experience in claims containment procedures. His claims manager is an RN with 15 years experience working with the medical community and is highly regarded among the physicians and hospitals. Our staff is sought after to meet with our insureds to provide educational training and information regarding insurance programs provided by the Medical Indemnity Corporation of Alaska.

MICA has a comprehensive risk management program that is now over six years old. We have held risk management meetings in every hospital throughout the State of Alaska. We have held risk management seminars inviting every physician in every community in Alaska. These seminars emphasize medical records keeping, advanced training, patient consent, risk avoidance, and what happens if the insured is sued. In addition we have a video tape library system that is available to physicians and hospital employees who are not able to attend our seminars.

We have retained one of the most renowned physician, risk consultants in the United States. He is in such high demand by other physician liability companies throughout the lower 48, that we are very fortunate to have Dr. Brittan visit and discuss liability concerns with our insureds on a regular basis.

The Medical Indemnity Corporation retains as its actuary an individual who works exclusive with physician-hospital liability companies throughout the United States. Our actuary continually monitors MICA's claims experience. He compares it with U. S. standards and calculates rates that are in conformance with enabling legislation mandated in 1976. These rates are fair, adequate and not excessive. They realistically reflect the claims situation in the State of Alaska.

Every step of our ten year experience has been followed closely by the Division of Insurance. Often the Director has personally monitored our committee and board sessions. The Director has reviewed and approved every rate and policy filling since inception. The operation of the Medical Indemnity Corporation is closely followed by the Division of Insurance on behalf of the Legislature and the administration.

I believe that the Medical Indemnity Corporation of Alaska has done all the right things and has full-filled its mandate to the public to the best of its ability.

Why then are we back again telling you this story? I believe that it is because the legislature did only part of its job in 1976 and still has a portion to complete or the liability claims crisis will continue here.

I believe we are back to tell you that even though we did everything right, MICA's claims experience is no different than the rest of the hospital-physician companies in the United States. To offset expenses this year our average rate increase to provide \$500,000 policies was 90%. To increase a physician's policy to \$1,000,000 an additional premium charge of 40% is required.

We continue to spend most of our revenue on legal expenses. It is not uncommon for us to spend the first \$100,000 before the aggrieved patient gets one (1) cent.

The system is just not efficient. It doesn't work like your Aetna or Blue Cross coverage. Nor does it operate like our excellent workers' compensation system. Whereas these programs return 90 cents on the dollar, we are lucky to get 40 cents on the dollar to the aggrieved. There is something wrong with a system like that. We are doing more dancing with the legal system than we do good for Alaskans, whom we are supposed to serve.

Back in 1975 and 1976 the Governor's Commission on Insurance Reform made a number of recommendations to the legislature and senate regarding revision in tort law. This legislature has before it two bills that embody most of those recommendations. You have an opportunity to complete that job by now enacting the provision Senate Bill #377 and House Bill #532. These are good bills, they protect the interest of the majority of the people and they are politically positive in nature.

Non-enactment protects the status quo, special interest groups, economic windfalls for plaintiff trial attorneys and the eventual restriction of medical services to the general public. If the Senate and House do not act on these bills I predict the following will happen:

1. Within 24 months MICA will be the only insurance company underwriting physician and hospital medical liability policies.
2. The Medical Indemnity Exchange Company of California and other companies who are now operating in Alaska will have completely pulled out.
3. MICA'S premiums will again double, policy limits will not exceed \$500,000 and our reinsurers will discontinue support.

Reinsurer support is contingent on predictability. Insurance companies and their reinsurers cannot tolerate total unpredictability. The number and especially the amount of claims will continue to be unpredictable if tort legislation is not enacted. Adequate premiums cannot be projected if this situation continues.

4. MICA will be pressured to underwrite all medical practitioners and hospital is who apply. If that happens our inability to accept or reject applications will have an adverse effect on claims experience.
5. MICA will have no alternative but to solicit the State for more funds. If you fail to enact, MICA will be back to the State within 36 months for a sum of up to \$10 million dollars.

It is my belief that if you do enact the proposed legislation there is a good chance that you will have acted in time. Enactment insures uninterrupted and continuous health services to all Alaskans. I hope you feel as I do that good health care is more important than enriching a few who take advantage of our preferential legal procedures.

Thank you for taking into consideration the concerns of the Medical Indemnity Corporation of Alaska.

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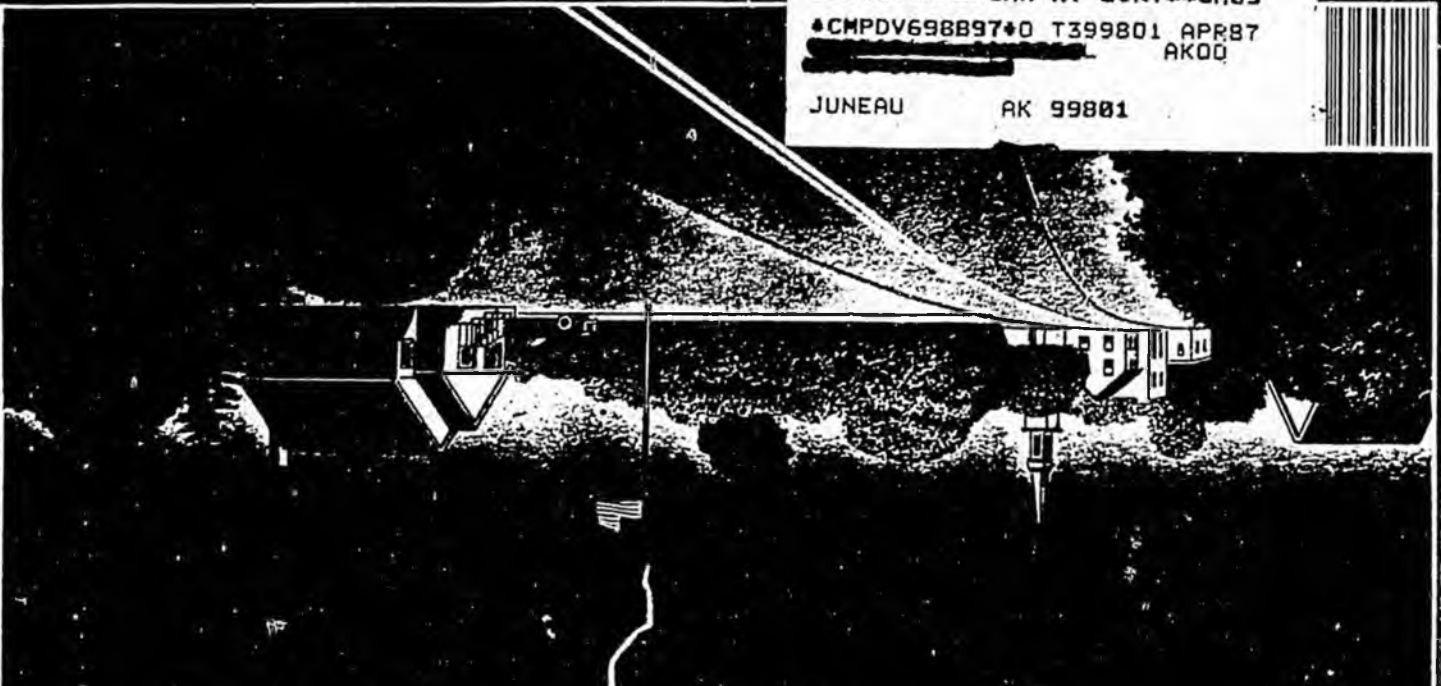
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Sorry, America,
Your Insurance
Has Been
Canceled

TIME

MARCH 24, 1986

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from
SENATOR
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COVER STORY

Sorry, Your Policy Is Canceled

Those who have been sued for malpractice or negligence, as is happening to lawyers more and more, he would have to pay any court-ordered damages out of his own pocket. "There is no market that will sell me liability insurance," says Spence. "I am going bare, and it is a frightening prospect."

Nation

TIME/MARCH 24, 1986

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

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

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

Century Cartage Co., a small truck line out of Atlanta, is still in business only because the Georgia Public Service Commission approved an "emergency" 5%

rate increase for its customers. But that boost came nowhere near meeting the cost of liability-insurance premiums that doubled to \$48,000 last year and then leaped to \$114,000 at the start of 1986.

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

Spence, a Miami lawyer, is the kind of attorney insurers often blame for their troubles. He has won and earned a healthy slice of several multimillion-dollar awards for clients who suffered personal injuries. But if Spence should be

sued for malpractice or negligence, as is happening to lawyers more and more, he would have to pay any court-ordered damages out of his own pocket. "There is no market that will sell me liability insurance," says Spence. "I am going bare, and it is a frightening prospect."

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

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

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

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

Consumer groups point to the insurance companies. When interest rates were high, they say, insurers wrote policies with little concern about how they would make good if claims went up and returns on their investments went down. Insurers point to the legal system. Juries, they say, have been handing out punitive damage awards that resemble lottery jackpots.

Lawyers point to the negligence of Big Business. It can be redressed, they say, only if individuals have a right to present their cases to a jury. Businessmen point to changing attitudes. The individualistic notion of taking risks and accepting responsibility, they say, has been replaced by a sue-everyone-in-sight reaction to any accident. What makes the problem such a nightmare is that, to some extent, all of the finger pointers have a point.

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

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

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

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

Risky business, life.
Always has been.
But is it
more so these days?
Must be. The horror
stories go on and
on and on . . .

Lacrossed Up

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



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

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

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

The situation is studded with an endless variety of similar horror stories (see



Manufacturers massing to urge product-liability reform on Capitol Hill
"There are going to be people who are dumb and stupid."

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

Among professionals, malpractice in-

rosurgeon in Long Island, N.Y., about \$83,000.

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

Strung Out

When New York City's Roosevelt Island was opened for residential development nearly eleven years ago, part of its allure was a tramway that would soon connect the community to midtown Manhattan in six scenic minutes.

That lifeline was cut last month when the tram's liability premium soared from \$800,000 to nearly \$9 million a year. Operators shut down the system, forcing some 5,250 islanders to spend up to an hour commuting on buses and subways.

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



Bad Trip

For sponsor PROpeace, the anti-nuclear Great Peace March between Los Angeles and Washington turned out to be a movable flop, beset by celebrity no-shows, cold weather and a lack of funds that last week

caused the project's collapse. One major headache was the inability to obtain a \$5 million liability policy required by some municipalities along the marchers' route. Because they lacked such coverage, 900 or so PROpeaceniks were denied the use of a schoolyard in Claremont, Calif., where they had planned to camp their third night on the road.

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



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

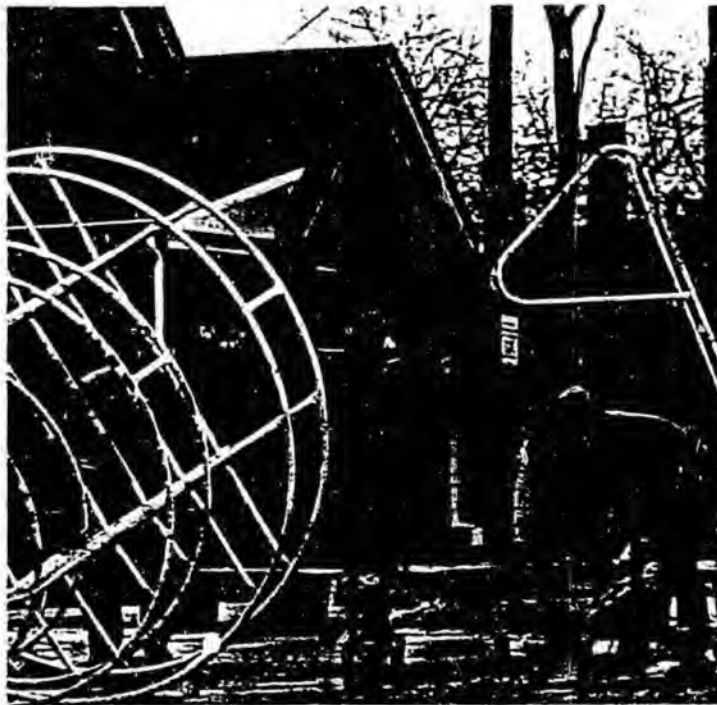
Rising premiums are forcing up prices on a variety of services too. Ski-lift tickets are jumping by \$2 or \$3 at many resorts. Through last year Kennestone Hospital in Marietta, Ga., insured itself for the first \$1 million of any claims that might be made and paid a premium of \$70,000 for additional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

Day-care centers, which have become an essential part of American life in an era of two-career families, are a striking example of how the insurance crunch may soon affect the lives of many unwary citizens. Operators fume that allegations of child abuse at a handful of centers have spooked insurers into indiscriminately

canceling liability policies or demanding giant premiums. Mission Insurance Group, the chief provider of coverage for day-care centers, abruptly pulled out of the business last year. The handful of insurers that will still write day-care policies insist either on specifically excluding claims for damages arising from sexual abuse or setting up rules for strict supervision, such as unannounced visits by special investigators. Says Suzanne Grace, associate director of the Georgia Day Care Association: "The insurers are telling us, 'We don't care what your record is.' This business has the perceived risk of killing an insurance company."

buck, and they seem to have little concern for the overall societal effects of what they are doing."

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



Workers dismantling playground equipment on Chicago's Northwest Side
Says the insurer: "Park districts are a terrible risk for any carrier."

City Halt

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

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



Overboard

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

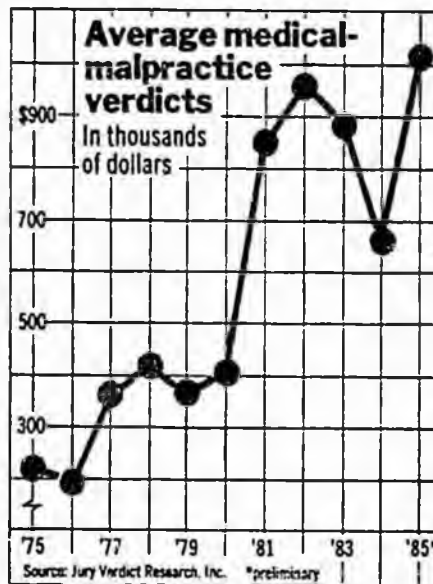
Vice President Lowell Robinson could not recruit more than two new directors. Says he: "It's getting very difficult to find qualified people." The number of lawsuits filed against directors of U.S. corporations, by some estimates, has climbed by more than 150% since 1974.



Nation

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

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



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

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

► According to one frequently cited tale, a body builder competing in a footrace with a refrigerator strapped to his back

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

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

Birth Pangs

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

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



Crying Shame

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

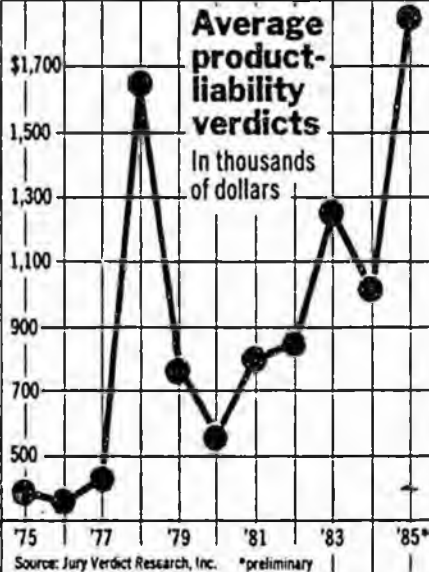
Co-Director Judy Silverman (left in photo) charges that underwriters are unduly skittish about day care because of a few widely publicized child-abuse cases. But even she is worried: "We try to be very careful," she says, "but I am uneasy. If a case of abuse came up and we were sued, my co-director and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



Nation

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

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



pensated for injuries, even that severe, sustained while committing a theft.

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

Equally significant is the growing size of punitive damages, which supposedly serve the same purpose as a don't-ever-do-anything-like-that-again fine of the defendant. Juries sometimes find that a person's actual damages amounted to

only a few thousand dollars, yet decide that the corporation at fault should also pay punitive damages in the millions. In one startling case, now awaiting decision by the U.S. Supreme Court, an Alabama couple sued Aetna Life & Casualty Co., claiming that it had wrongfully refused to pay \$1,650 of the wife's hospital bill. A jury awarded them punitive damages of \$3.5 million, or 2.121 times the size of the disputed bill.

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

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

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

Truck Stop

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

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



TAYLOR—ALBERT STAR

Sawed Off

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

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



JIMMY MCGO

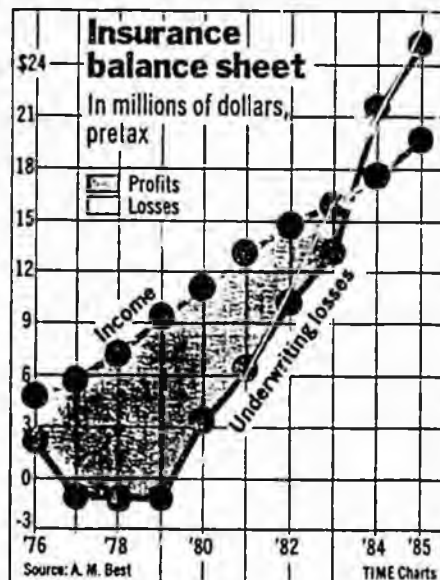
Nation

ble, all three agreed to a settlement paying her \$80,000.

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

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

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



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

Unwilling to risk paying the damages

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

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

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

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

Stiff Drinks

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



Hung Up

When a late-winter storm dumped nearly 100 in. of snow on California's Sierra Nevada range near Lake Tahoe in March 1982, operators of the Alpine Meadows ski area closed down their 13 lifts and warned guests



not to venture onto the slopes. When an avalanche struck, however, it did not bury the ski trails but the parking lot and a ski-patrol building, killing seven people. The families of three victims sued Alpine Meadows for \$10 million in damages.

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

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

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

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

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

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

The National Insurance Consumer Organization maintains that the true figure was \$5 billion. Given that, the industry's critics argue, the premium increases now being posted go far beyond what is justified. Sneers Gerry Spence, a famed Wyoming trial lawyer (no relation to Mi-



In the Pool

Many Americans have experienced the insurance crisis only at second hand in the form of rising prices for goods and services ranging from ski lift tickets to medical care. When insuring their homes and cars, most consumers for once have largely escaped the cost crunch. Liability coverage for drivers and homeowners has risen an average of only 7½% annually since 1980, about the same as inflation. Says Sean Mooney, chief economist for the industry-supported Insurance Information Institute, "Personal liability premiums haven't taken a quantum leap, and I don't expect them to."

Behind this stability is a basic principle of underwriting: the larger the pool of premium payers, the less the shared risk. Out of 131 million U.S. car owners, 90% carry at least some liability protection, creating a kitty of \$49 billion in 1985 against \$40 billion in claims. Similarly, 55 million U.S. homeowners paid \$15 billion in premiums last year to offset \$1.6 billion in claims. This huge pool of consumers also makes risk much more predictable—and therefore rates lower—than for narrower lines of insurance. Automobile-accident law is relatively well established, leaving juries with few opportunities to award damages wildly out of line from similar cases.

Personal liability insurers can still be jarred by novel rulings. In 1984 the New Jersey Supreme Court held that homeowners, like saloon keepers, are responsible for accidents caused by intoxicated guests. So far, the ruling has had no effect on insurance rates, though companies warn that further widening of homeowner liability could eventually increase premiums.

Nor do all consumers feel that personal liability risks are being shared equitably. Eight California plaintiffs have filed suit to curb in overruled the state's 1984 mandatory automobile insurance law, claiming that policy writers charge excessive rates to residents of high-risk neighborhoods, usually in inner cities, even if applicants have spotless driving histories. While the case is pending, California authorities have stopped enforcing the mandatory coverage. Another suit filed in the state of California would have

ami's J.B. Spence): "What the insurance companies have done is to reverse the business so that the public at large insures the insurance companies." Consumerists often point to the judgment of Wall Street, hardly a Naderite stronghold. Stock traders bid up the price of property-casualty insurance shares an average of about 50% last year, in the apparent belief that the industry at minimum is on its way back to solid profitability.

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

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

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

- ▶ Put limits on pain-and-suffering awards and punitive damages. Republican Senator Mitch McConnell of Kentucky has introduced a congressional bill encouraging states to cap pain-and-suffering awards at \$100,000 and to require that punitive damages be paid to a court, as outright fines are, rather than to a plaintiff and his or her attorney.
- ▶ Establish stricter standards for proving who really bears how much of the blame for an accident or injury. Senator John Danforth, a Missouri Republican, is sponsoring a bill that would set uniform federal standards in product-liability cases to replace the present morass of 50 often conflicting state laws; it would require a plaintiff to prove negligence or fault by the manufacturer.
- ▶ Either abolish the doctrine of joint and

Nation

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

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

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

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

Some 600 members of the National Association of Manufacturers descended on Washington last week to lobby for the Danforth bill, which besides setting national standards for product-liability suits would establish a new procedure for speedy out-of-court settlement of claims for economic damages. They first gathered at the Marriott Hotel to swap horror stories and pep talks. Under present legal rules, "you're afraid to try anything, put any new product on the market," cried Gust Headdbloom, president of Michigan's Apex Broach & Machinery Co. Peter J.

Nord, president of Schauer Manufacturing Corp. in Cincinnati, which makes battery-charging machines, drew loud applause by declaring, "There are going to be people who are dumb and stupid and screw up no matter what we do." Ohio Democratic Congressman Thomas Luken showed up to cheer on the manufacturers. Said he: "Probably no recent issue has snowballed so quickly."

After eating paper-bag lunches, the manufacturers boarded buses to Capitol Hill to buttonhole legislators from their home states. So many Michiganders packed into the office of Democratic Sen-



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

In all probability, that seriously overstates the case. Present and former trial lawyers populate state legislatures and

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

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

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

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

Reported by Anne Constable/Washington, B. Russell Leavitt/Atlanta and Michael Riley/Los Angeles

SOME OBSERVATIONS ON THE NEED FOR TORT REFORM

Gustave H. Shubert

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THE INSTITUTE FOR CIVIL JUSTICE

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The Institute for Civil Justice, established within The Rand Corporation in 1979, performs independent, objective policy analysis and research on the American civil justice system. The Institute's principal purpose is to help make the civil justice system more efficient and more equitable by supplying policymakers with the results of empirically based, analytic research.

Rand is a private, nonprofit institution, incorporated in 1948, which engages in nonpartisan research and analysis on problems of national security and the public welfare.

The Institute examines the policies that shape the civil justice system, the behavior of the people who participate in it, the operation of its institutions, and its effects on the nation's social and economic systems. Its work describes and assesses the current civil justice system; analyzes how this system has changed over time and may change in the future; evaluates recent and pending reforms in it; and carries out experiments and demonstrations. The Institute builds on a long tradition of Rand research characterized by an interdisciplinary, empirical approach to public policy issues and rigorous standards of quality, objectivity, and independence.

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PREFACE

This paper is an edited transcript of a speech made by Gustave H. Shubert, Director of The Institute for Civil Justice, to the National Conference of State Legislatures in Denver, Colorado, in January, 1986. An earlier version of the talk was presented to the Public Policy Institute in Albany, New York, November, 1985.

The work described in this paper is part of the research program of The Institute for Civil Justice. The paper draws on studies of civil court congestion and delay, alternative dispute resolution, the public costs of civil litigation, asbestos-related litigation, punitive damages, and medical malpractice. It explores the relevance of policy research to a subject of much current public debate: tort reform.

SOME OBSERVATIONS ON THE NEED FOR TORT REFORM

Gustave H. Shubert

BACKGROUND

I am here to talk about the need for reform in the civil justice system. There has been a lot of discussion this morning about legislative action, about the need for change in the insurance industry, and about the need for changes in business practices. My task is to set the background and describe the need for reform; I leave it to others to deal with potential courses of action.

In considering the problems of the civil justice system, problems with which all of us here today are concerned, I am reminded of my experience with the Air Force in Korea: One night, the lights went out and North Korean and Chinese troops started pouring over the fence of the base. I happened to be on the command net and heard the Base Commander, who had been roused out from the Officers' Club, saying, "Colonel Jones, Colonel Jones, where are you? Where is that base defense plan I asked you to design last month?" That plan, of course, had never been prepared.

I think we are finding ourselves in a similar situation with regard to civil justice today. Plans aside, even the basic, fundamental information necessary to understand the need for reform has not yet been developed.

When we started The Institute for Civil Justice within The Rand Corporation in 1979 (I think most of you will agree that the problems we are talking about were with us in 1979 and before), there was virtually no systematic knowledge of the civil justice system or its operations. There was a feeling of general unease in certain sectors, particularly in the insurance industry, about the absence of information necessary to understand the operations of the system. On the one hand, there were the academics who were outlining rather elegant--but largely data-free--theories of legal behavior. At the other end of the spectrum, there was some information available on the operations of courtrooms--how many

jurors to impanel if one wanted to have three juries per week for so many weeks and so forth--but the entire area between these extremes was devoid of systematic research.

THE WORK OF THE INSTITUTE FOR CIVIL JUSTICE

Our job at Rand and at The Institute for Civil Justice is to try to fill that gap as much as we can to develop an understanding of the relationships between the various factors and the various players that comprise the civil justice system. The ICJ has focused on trying to understand the fairness of the system, the efficiency of the system, and its overall effectiveness. Translating that into researchers' terms:

- We are concerned with the outcomes the system has been producing: Are they consistent with the law? How do they vary as the law evolves? Have they been changing over time? What are some of their potential policy implications?
- We are concerned with the benefits and costs of the system: Who's paying what to whom--both in terms of compensation and in terms of transactions costs? What is the distribution of costs and benefits among various segments of our society?
- We are concerned with the overall effectiveness of the process by which outcomes are reached, costs incurred, and benefits distributed.

Then, knowing as much as we can and trying to accrue knowledge about these key issues as we go along, we disseminate information to those, like yourselves, who are concerned with the need for reform to help you decide what changes are needed and to perceive the ways in which they can be achieved.

I would like to convey to you this morning a few pieces of information about what we have learned in each of these areas--outcomes, costs, and timeliness--and to draw out some of the implications that I see for the important matters you are here to consider.

Research on Outcomes

First, let me deal with the question of outcomes. When we began our work, we found that there had been no data gathered in any systematic way pertaining to the outcomes the system is producing over time. We were confronted with anecdotal information, on the one hand, from people who would argue that the American jury was out of control, awarding more and more money to less and less deserving people all the time. Conversely, we encountered arguments that the American jury is the backbone of the civil justice system; that the jury is responsible and predictable; and, therefore, that the jury should be retained and enhanced as the fundamental basis of our civil justice system. These arguments had one common characteristic: Neither one had a shred of empirical evidence to support it.

So we began to examine what the American jury has been doing for the past 20 years. We found that, in terms of aggregate performance over time in Cook County and in San Francisco (the two areas that we chose for intensive study, developing the first longitudinal data bases regarding civil suits for money damages ever assembled in this country) the *median* jury award has remained essentially constant (in constant dollars) for 20 years. Considering only those cases in which the plaintiff prevailed, the fiftieth percentile award has been flat. In fact, in Cook County the median has actually decreased somewhat, hovering around the level of \$7,900 in 1979 dollars. That doesn't look like much to get excited about. However, when we looked at *average* awards, we found that toward the middle of the period the average award began to take off at an ever-increasing pace. This divergence between the average and median awards was accounted for almost exclusively by the top ten percent of cases. I will come back to the implication I draw from that in just a minute.

In these studies we found a number of other things. For example, in both Cook County and San Francisco, juries systematically inflate awards from between the time of filing and the time an award is made. So we have, in effect, juries awarding implicit prejudgment interest at the prevailing rate of inflation during the interval between filing and award.

Furthermore, we found that the circumstances of an injury affect the compensation awarded--something that I believe is not the intent of the law. The loss of two legs in an automobile accident, for example, is "worth" an average of \$250,000 in compensation. In contrast, the same loss to the same kind of plaintiff, but resulting from a workplace accident, brings an average compensation of \$750,000. Now we are not talking about punitive damages here: We are talking just about compensatory awards.

In another analysis, we examined the relationship between the nature of the litigants and the kinds of compensation that are awarded. We found in Cook County, for example, that blacks win less often, and, when they win, they obtain lower awards.

We also found a relationship (in both Cook and San Francisco Counties) between the apparent wealth of the defendant and the amount of compensation awarded by the jury for serious injuries. (Nothing in this field, it seems, is simple: We found no such "deep pocket" effect for relatively minor injuries.) Some of you probably know this intuitively or anecdotally. But to my knowledge, this is the first time that any attempt has been made to test the so-called "deep pocket" theory systematically and to see whether there is, in fact, any direct association between the size of awards and the characteristics of the plaintiff and defendant.

We are now examining carefully the phenomenon of punitive damages. We are assessing the characteristics of cases in which punitive damages occur and attempting to understand the implications of trends in punitives for the future. We are also attempting to estimate the effects of punitive damages on corporate decisionmaking, corporate behavior and the propensity to settle, as well as the amounts that are agreed upon.

The bottom line that I draw from our studies of the outcomes produced by the civil justice system is that one ought to focus on where the difficulty is. That difficulty seems to us to be primarily in the area of large, complex cases--the cases that are, in effect, new types of litigation for our system--cases involving product liability, professional malpractice of various kinds, suits against government, and

litigation in the area of business and contracts. The vast bulk of civil cases--the small suits (the fender-bender types, if you will)--seem to be proceeding relatively normally as far as verdicts are concerned. And recall that it is true that at the median, awards have remained (in constant dollars) relatively constant over time. It is in the area of the new types of litigation that the problems we have been talking about so far today are occurring, and it is in this area, I believe, they are likely to continue.

Research on Costs

What about costs? The first question we asked was: How do we, as citizens, value the services performed for us by the civil justice system--as expressed by our expenditures of tax dollars? What share of our public resources do we allocate toward supporting this system in the United States? This is, after all, the system dedicated to resolving all of our noncriminal disputes--disputes between individuals, between organizations, and between organizations and individuals.

The ICJ developed a method for assessing the costs of the civil justice system to the public--to you and me as taxpayers. We found that on an annual operating basis, we in the United States at the federal, state, and local levels are devoting about \$2.2 billion per year to operating that system. Now you might say, "That sounds like an awful lot of money to me," or you might say, "When I compare that amount of money with what we put into other public systems in this country, it doesn't look like much--in fact it looks rather small." The point I want to make is that at least we now know where our priorities are, expressed in dollar terms. We are finally in a position to ask and answer meaningfully questions about the significance of changes in public funding and whether increases in funding to improve the quality of that system would strain our overall resources.

With regard to private costs, we began by analyzing private costs of asbestos litigation. This is an important area in and of itself, but also because we believe it is a precursor of future massive toxic torts litigation. I think our results are reasonably well known by now. If you visualize a pipeline into which we put money at one end and see compensation coming out the other, that pipeline starts with a total

expenditure of about \$95,000--the full private-dollar input into the civil justice system for the average case. There is an immediate draw-down of \$35,000, about 37 percent of that initial amount, for defense costs--legal fees and related costs of corporations engaged in litigation. The remaining \$60,000 is paid to the plaintiff. The plaintiff, in turn, spends about \$25,000--about 40 percent--of what he recovers (26 percent of the total) on his legal fees and costs. The plaintiff himself, then, ends up with about \$35,000--37 percent of all the funds expended. So of all the monies spent, the injured parties net just a little more than a third of the total. These results raise two bottom-line questions in the cost area: Is it appropriate to spend nearly twice as much money determining how much should go to whom as is eventually provided in compensation to injured parties; and, would an increase in public resources, including some spent on thought about the problem, help reduce the extraordinary expenses that we are encountering in the private sector in the process of awarding compensation?

Research on Process

That brings me to the area of the overall effectiveness of the process. Here I will focus on the problems of congestion and delay and of the quest for alternatives that will lead to more efficient ways of resolving our disputes. Effectiveness, of course, must be measured in many dimensions, not just in terms of timeliness.

Court congestion and delay are problems that are widely known and discussed. When we began our work on them, we reached for the book entitled *Congestion and Delay: What We Are Doing About It*, and found that it had yet to be written. There was no data base in this country concerning the problem, either at the state or national level, that explained what the problem was, what its dimensions were, and what was being done about it. The ICJ, in effect, began putting that book together, and by providing our findings to officials of the judiciary in all the states and throughout the federal court system, we helped them to better understand their problems and all the different remedies that were being tried, or had been tried, or were being considered, to deal with congestion and delay.

We analyzed the history of congestion and delay in the Los Angeles Superior Court, the largest single trial court in the United States--one in which the mean time to trial is now about 48 months. Although attempts have been made again and again to deal with congestion and delay in the Los Angeles Superior Court, none of these efforts have had lasting effect. (I do not mean to point a finger at this particular court; jurisdictions across the country have attempted to reduce backlogs with little permanent effect on time-to-trial or on caseload.)

We believe the explanation lies in the changing composition of the caseload in the Los Angeles Superior Court--a change which my earlier remarks about the "new litigation" foreshadowed. Since World War II, the Los Angeles Superior Court has evolved from essentially a debt-collection mechanism to an institution primarily concerned with personal injury litigation: handling product liability and medical malpractice suits of increasing scientific and technological complexity; and grappling with the problem of asbestos litigation, of which Los Angeles is a major center. In short, the case mix has gone from one which required considerably less than one judge-day per trial to one which currently calls for more than three judge-days per trial, without consciously recognizing the causes and without adjusting its management mechanisms to accommodate them. The ICJ is now working with the Los Angeles Superior Court to see if together we can discover some answers to that problem--answers that will provide for handling routine cases in a prompt, efficient, and low-cost way; and, at the same time, permit targeting of complex litigation for special channeling and treatment to process those cases expeditiously, fairly, and at less cost to the parties and the public.

We have concluded that there are indeed better ways. If one understands the system, if one develops the facts about the system, it is possible to make it work better.

One further illustration: As we began the Institute in 1979, California initiated a mandatory judicial arbitration program in an effort to avoid the conventional and congested litigation track by shunting cases through an alternative dispute resolution mechanism. We evaluated the first year's experience with that program, and I think

there is a very important lesson that flows from that analysis. We found that in the large districts in California, a system designed as an alternative intended to save time and money was costing *more* and taking *longer*--yet no one was aware of these effects. We were able to identify the factors responsible for this counter-intuitive and perverse effect. Our work led to legislation which sought to correct these effects. Now the system is operating more efficiently and at less cost.

The bottom-line message I want to leave with you here is that there are dangers in whatever reforms you seek--dangers of unintended effects that may, indeed, be perverse. I emphasize the need to not only watch what you are doing, but also the equally important need to monitor the results and the impacts of what you have done.

THE NEED FOR REFORM

Is there a need for reform? What do I draw out of our work? It seems to me that:

- When you have radical changes in the types of litigation that you are attempting to handle;
- When the outcomes reflect the consequences of those changes;
- When you see that the *public* costs of settling even routine disputes through jury trials exceed the stakes (the average jury trial in this country costs taxpayers around \$8,000--not including the costs to the parties--and the median verdict in Cook County is around \$7,900. As Chief Justice Burger has been saying for the last couple of years, when you have a system where the process costs more than the stakes, you have a system that is not operating as efficiently as it might.);
- When you find that you have a mean time to trial of five years or more;
- When you find your alternatives are costing more and taking longer;

we must conclude that change may indeed be necessary.

Furthermore, we have a system that appears to prevent actions that everyone in this room would agree are socially desirable. Here I am talking about a system that withholds compensation where compensation is deserved, or provides compensation on an irrational, random, or unfair basis. I am talking about a system which, for example, delays (and even

prevents) through its rules--and some of the derivatives of those rules--the cleanup of toxic waste sites and causes all kinds of perverse behavior.

Let me give you two cross-cutting examples to conclude this discussion about what research has to say about the problem--something about asbestos in the courts and something about medical malpractice.

Example--Asbestos in the Courts

The ICJ has just published a document dealing with asbestos litigation, and I would like to sum up what I think that report says about our civil justice system. At the beginning of the period of asbestos litigation the system had strong, positive aspects. It provided incentives for lawyers to seek compensation for injured parties when the outcomes were very uncertain and the financial rewards of seeking that compensation were far from clear. The system demonstrated its flexibility, its capacity to absorb new knowledge, at least within some limits, and its ability to incorporate this knowledge into the legal process; and it demonstrated that it held at least the promise of deterring behavior which was known to be potentially hazardous and injurious. But as the asbestos litigation system entered its current phase--the "mega-plaintiff/mega-defendant" phase--we are processing thousands of cases, taking thousands or hundreds of thousands of man-years, with expenditures in the billions of dollars, and the weaknesses of the system, I think, have begun to overshadow its strengths.

We have a system in which plaintiffs, who may or may not be injured, have cases filed over which they have essentially no control. We have a system which idealizes individualized justice, but in fact delivers justice by the carload, where the individual is submerged in the batch processing of hundreds, sometimes even thousands, of cases. We have a system in which the incentives to lawyers provided by the rules and by the outgrowths of those rules are often conflicting and transcend the interests of the people they represent. We find that the rules themselves are frequently inappropriate, or at least, inconsistent. States like New York, with a two-year statute of limitations, make it virtually impossible to seek compensation for any long-term disease, such as those associated with asbestos--whereas other

states with much longer statutes do permit recovery. We find that the litigation is virtually endless: Since there are 20 defense firms per case on average, representing 20 defendants, the same issues are litigated 20 times in each case. These cases go on day after day, week after week, month after month on a repetitive basis.

The procedures used in these cases are tailored to trials, trials which almost never take place, as opposed to settlements which eventually do. Dispositions are slow, outcomes are inconsistent. Judges themselves are responding to their own incentive systems, which tell them to avoid handling these dirty, protracted, difficult, and acrimonious cases that are often appealed. No judge has a strong incentive to subject himself to the appeal process. The dispositions, as I mentioned, are not just slow, they are glacial. So to put some flesh on the bones for the need for reform, I think it is fair to say that in this area, outcomes are affected by considerations outside as well as inside the law. One is left with only one question about the need for reform: Will it work?

Example--Medical Malpractice

That brings me to the medical malpractice policy research conducted by The Institute for Civil Justice. Here we sought to determine whether the reforms introduced in response to the medical malpractice situation of the mid-1970s had any effect; and if they did, whether or not they were the intended effects. We can give a qualified "yes" to these questions. On the whole, in those states that took action through their legislatures to dampen medical malpractice activity in contrast to states which did not, suits were less likely to be filed; when they were filed, they were more likely to be dropped; if they were pursued, they were more likely to be settled rather than tried--and settled for a lesser amount.

As we went through the various measures that were legislated, however, we found substantial variation in the effects observed. For example, simply relaxing the collateral source rule, which many had thought would have a profound effect on this litigation, seemed to have no statistically significant effect at all. Here was a reform measure which, like California's initial approach to arbitration, did not have

its intended effects. Mandatory inclusion of payments from collateral sources, on the other hand, did have a significant effect. The lesson from all of this certainly is not, "Don't try for improvement." Rather, the lesson that I draw from this is: Try to estimate in advance as best you can the impact of legislation on costs, outcomes, and process, and build into every reform measure--or every measure for change--the capacity to evaluate the impact of that change; to provide, if you will, for some mid-course correction that will be available if these reforms are not having their intended effect.

CONCLUSION

People with more authority than I--people who are on the firing line--told you earlier this morning that we are in tough times. This is not just a consequence of an "insurance problem," although I believe the current insurance situation is, in part, a high-profile symptom of the maladies of our civil justice system. That symptom may turn out in the long run to be a benefit: (1) if it forces attention to the problem from those who are responsible for policy changes, be they chief executive officers, legislators, the bar, or the judiciary; (2) if it forces us to understand the system and how it operates; and (3) if it enables us to produce constructive changes toward fairer, more efficient, and more effective resolution of our civil disputes and forces us to make rational choices among the options we are confronted with today.

I think underlying all our problems with the civil justice system is the inability of this country to decide whether it wants to have a pure compensatory system or whether it wants to have a fault-based liability system. We can't decide whether everybody should be compensated for every injury no matter what its cause, or whether we want compensation to be limited in a strict way, in a comparative way, or in a contributory way to those who have caused the injury. My personal assessment is that we are experiencing the disadvantages of trying to operate both systems in tandem, the worst of both worlds. We are attempting to compensate everyone within a fault-based system and we are incurring huge social overhead costs by attempting to do so. I believe it is time to focus on that overall choice and to be rational in doing so.

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 H. Kritzer, W.L.F. Felstiner, A. Sarat, D. Trubek
 1986

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

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

Read first time 2/5/86.

1 AN ACT Relating to civil actions; amending RCW 5.60.060,
2 4.22.030, 51.24.060, 4.16.350, 4.24.115, 4.16.160, 4.16.310, and
3 4.16.300; adding a new section to chapter 4.22 RCW; adding new
4 sections to chapter 4.24 RCW; adding new sections to chapter 4.56
5 RCW; adding new sections to chapter 5.40 RCW; adding a new section to
6 chapter 7.70 RCW; adding a new section to chapter 48.19 RCW; adding a
7 new section to chapter 48.22 RCW; creating new sections; repealing
8 RCW 4.56.240; and declaring an emergency.

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

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

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

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

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

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

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

16 PART I

17 ACCELERATED PHYSICIAN-PATIENT PRIVILEGE

18 Sec. 101. Section 294, page 187, Laws of 1954 as last amended by
19 section 1, chapter 56, Laws of 1982 and RCW 5.60.060 are each amended
20 to read as follows:

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

1 court prior to being called as a witness.

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

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

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

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

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

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

32 PART II

33 ATTORNEYS' FEES

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

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

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

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

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

13 (4) The amount involved and the results obtained;

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

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

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

20 (8) Whether the fee is fixed or contingent;

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

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

27 PART III

28 LIMITATION ON NONECONOMIC DAMAGES

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

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

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

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

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

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

11 (d) "Average annual wage" means the average annual wage in the
12 state of Washington as determined under RCW 50.04.355.

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

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

30 PART IV

31 APPORTIONMENT OF DAMAGES

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

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

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

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

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

22 (2) If a defendant is jointly and severally liable under one of
 23 the exceptions listed in subsections (1)(a) or (1)(b) of this
 24 section, such defendant's rights to contribution against another
 25 jointly and severally liable defendant, and the effect of settlement
 26 by either such defendant, shall be determined under RCW 4.22.040,
 27 4.22.050, and 4.22.060.

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

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

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

1 marking.

2 Sec. 402. Section 11, chapter 27, Laws of 1981 and RCW 4.22.030
 3 are each amended to read as follows:

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

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

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

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

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

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

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

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

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

1 beneficiary:

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

9 (f) If the employer or a co-employee are determined under section
10 401 of this 1986 act to be at fault, (c) and (e) of this subsection
11 do not apply and benefits shall be paid by the department and/or
12 self-insurer to or on behalf of the worker or beneficiary as though
13 no recovery had been made from a third person.

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

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

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

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

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

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

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

1 compensation and benefits paid or payable from state funds.

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

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

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

1 subdivision of the state, public corporation, or agency of the state.
 2 a notice and order to withhold and deliver property of any kind if he
 3 or she has reason to believe that there is in the possession of such
 4 person, firm, corporation, municipal corporation, political
 5 subdivision of the state, public corporation, or agency of the state,
 6 property which is due, owing, or belonging to any worker or
 7 beneficiary upon whom a warrant has been served by the department for
 8 payments due to the state fund. The notice and order to withhold and
 9 deliver shall be served by the sheriff of the county or by the
 10 sheriff's deputy, or by any authorized representatives of the
 11 director. Any person, firm, corporation, municipal corporation,
 12 political subdivision of the state, public corporation, or agency of
 13 the state upon whom service has been made shall answer the notice
 14 within twenty days exclusive of the day of service, under oath and in
 15 writing, and shall make true answers to the matters inquired of in
 16 the notice and order to withhold and deliver. In the event there is
 17 in the possession of the party named and served with such notice and
 18 order, any property which may be subject to the claim of the
 19 department, such property shall be delivered forthwith to the
 20 director or the director's authorized representative upon demand. If
 21 the party served and named in the notice and order fails to answer
 22 the notice and order within the time prescribed in this section, the
 23 court may, after the time to answer such order has expired, render
 24 judgment by default against the party named in the notice for the
 25 full amount claimed by the director in the notice together with
 26 costs. In the event that a notice to withhold and deliver is served
 27 upon an employer and the property found to be subject thereto is
 28 wages, the employer may assert in the answer to all exemptions
 29 provided for by chapter 7.33 RCW to which the wage earner may be
 30 entitled.

PART V

LIMITATION OF ACTIONS

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

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

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

6 Sec. 502. Section 1, chapter 80, Laws of 1971 as amended by
 7 section 1, chapter 56, Laws of 1975-'76 2nd ex. sess. and RCW
 8 4.16.350 are each amended to read as follows:

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

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

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

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

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

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

5 For purposes of this section, notwithstanding RCW 4.16.190, the
 6 knowledge of a custodial parent or guardian shall be imputed to a
 7 person under the age of eighteen years. Any action not commenced in
 8 accordance with this section shall be barred(~~(1) PROVIDED, That the~~
 9 ~~limitations in this section shall not apply to persons under a legal~~
 0 ~~disability as defined in RCW 4.16.190)).~~

1 PART VI

2 INDEMNIFICATION AGREEMENTS

3 Sec. 601. Section 2, chapter 46, laws of 1967 ex. sess. and RCW
 4 4.24.115 are each amended to read as follows:

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

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

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

1 the effective date of this 1986 section.

2 PART VII

3 BUILDER LIMITATION

4 Sec. 701. Section 2, chapter 4, laws of 1955 and RCW 4.16.160
 5 are each amended to read as follows:

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

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

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

Sec. 702

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

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

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

PART VIII

PERIODIC PAYMENTS

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

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

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

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

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

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

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

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

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

PART IX

MISCELLANEOUS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 11 (1) The price as it relates to a filed Insurance Services
12 Organization rate;
- 13 (2) The solvency of such mechanisms;
- 14 (3) The effect it has on the admitted market;
- 15 (4) The effect it has on the nonadmitted market;
- 16 (5) The effect or availability on the voluntary market; and
- 17 (6) What effect it has on lines or classes of insurance not
18 designated.

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

23 NEW SECTION. Sec. 910. Except as provided in sections 202 and
24 601 of this act and except for section 904 of this act, this act
25 applies to all actions filed on or after August 1, 1986.

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

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