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IN THE SENATE

BY THE LABOR AND  
COMMERCE COMMITTEE

CS FOR SENATE BILL NO. 404 (L&C)  
IN THE LEGISLATURE OF THE STATE OF ALASKA  
FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to insurance; and providing for an effective date."

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

\* Section 1. AS 21.36.190(d) is amended to read:

(d) This section does not apply to workers' compensation insurance when issued to an association of employers formed for purposes other than the purchase of insurance and that

(1) has a constitution and bylaws; the requirement of this paragraph does not apply to municipalities, school districts, and regional educational attendance areas;

(2) incorporates a safety program;

(3) as a group has preferred characteristics over similar risks written on an individual basis; and

(4) has filed and received approval from the director for the rating program to be applied to the group.

\* Sec. 2. AS 21.36.190 is amended by adding a new subsection to read:

(e) The provisions of (a) and (b) of this section do not apply to coverage purchased through a joint insurance arrangement formed under AS 21.76.

\* Sec. 3. AS 21.36.210(a) is amended to read:

(a) An insurer may not exercise its right to cancel a policy of personal [AN] automobile insurance [POLICY] except for the following reasons:

1 (2) the driver's license or motor vehicle registration of  
2 either the named insured or of an operator who resides in the same  
3 household as the named insured or who customarily operates a motor  
4 vehicle insured under the policy has been under suspension or revoca-  
5 tion during the policy period or, if the policy is a renewal, during  
6 its policy period or the 180 days immediately preceding its effective  
7 date.

8 \* Sec. 4. AS 21.36.210(d) is amended to read:

9 (d) This section does not apply to

10 (1) the failure to renew a policy, except as to coverage in  
11 force for less than 12 months;

12 (2) a policy that has been in effect less than 60 days at  
13 the time notice of cancellation is mailed or delivered by the insurer,  
14 unless it is a renewal policy;

15 (3) a policy issued under an automobile assigned risk plan  
16 or automobile insurance plan;

17 (4) a policy insuring more than four motor vehicles;

18 (5) a policy covering the operation of a garage; automobile  
19 sales agency, repair shop, or service station; or public parking  
20 place;

21 (6) a policy providing insurance only on an excess basis;

22 (7) any other contract providing insurance to the named  
23 insured, even though the contract may incidentally provide insurance  
24 with respect to motor vehicles.

25 \* Sec. 5. AS 21.36.210(f) is amended to read:

26 (f) An [NOTWITHSTANDING (e) OF THIS SECTION, AN] insurer may not  
27 exercise its right to cancel a policy of personal insurance other than  
28 personal automobile insurance, except for the following reasons [THE  
29 TYPE DESCRIBED IN (a) OF THIS SECTION]

1 CONDITIONS OR CIRCUMSTANCES ARISES]:

2 (1) nonpayment of premiums, including nonpayment of addi-  
3 tional premiums, calculated in accordance with the current rating  
4 manual of the insurer, justified by a physical change in the insured  
5 property or a change in its occupancy or use;

6 (2) conviction of the insured of a crime having as one of  
7 its necessary elements an act increasing a hazard insured against;

8 (3) discovery of fraud or material misrepresentation made  
9 by the insured or a representative of the insured in obtaining the  
10 insurance or by the insured in pursuing a claim under the policy;

11 (4) discovery of a grossly negligent act or omission by the  
12 insured that substantially increases the hazards insured against; or

13 (5) physical changes in the insured property that result in  
14 the property becoming uninsurable.

15 \* Sec. 6. AS 21.36.220 is amended to read:

16 Sec. 21.36.220. NOTICE OF CANCELLATION. An insurer may not  
17 exercise its right to cancel a personal insurance policy unless a  
18 written notice of cancellation is mailed or delivered to the named  
19 insured, at the address shown in the policy, at least 20 days before  
20 the effective date of cancellation. However, if [, EXCEPT THAT WHEN]  
21 cancellation is for nonpayment of premium, the notice shall be mailed  
22 or delivered to the named insured at the address shown in the policy  
23 at least 10 days before the effective date of cancellation, and must  
24 [SHALL] include or be accompanied by a statement of the reason for the  
25 cancellation. [THIS SECTION DOES NOT APPLY TO THE FAILURE TO RENEW A  
26 POLICY, EXCEPT AS TO COVERAGE IN FORCE FOR LESS THAN 12 MONTHS.]

27 \* Sec. 7. AS 21.36.220 is amended by adding a new subsection to read:

28 (b) An insurer may not exercise its right to cancel a policy of  
29 business or commercial insurance unless

1 cancellation is mailed or delivered to the named insured, at the  
2 address shown in the policy and to the agent or broker of record, at  
3 least 60 days before the effective date of cancellation. However, if  
4 cancellation is for nonpayment of premium, the notice shall be mailed  
5 or delivered to the named insured at the address shown in the policy  
6 and to the agent or broker of record at least 10 days before the  
7 effective date of cancellation, and must include or be accompanied by  
8 a statement of the reason for the cancellation.

9 \* Sec. 8. AS 21.36 is amended by adding a new section to read:

10 Sec. 21.36.235. RETURN OF PREMIUM UPON CANCELLATION. If an  
11 insurer cancels a policy under AS 21.36.220(b), it shall return any  
12 unearned premium to the agent or broker of record or directly to the  
13 insured or premium finance company, if applicable, by the effective  
14 date of cancellation, except that if cancellation is for nonpayment of  
15 premium, any unearned premium shall be returned within 30 days after  
16 the notice of cancellation is given. If the unearned premium is  
17 returned by the insurer to a person other than the insured, that  
18 person shall promptly return the unearned premium to the insured  
19 unless otherwise provided by agreement between the person and the  
20 insured.

21 \* Sec. 9. AS 21.36.240 is amended to read:

22 Sec. 21.36.240. FAILURE TO RENEW. An insurer may not fail to  
23 renew a personal insurance policy in force for less than 12 months.  
24 An insurer may not fail to renew a policy [IN FORCE FOR 12 MONTHS OR  
25 MORE] unless a written notice of nonrenewal is mailed or delivered to  
26 the named insured, at the address shown in the policy, at least 20  
27 days for a personal insurance policy, and at least 60 days for a  
28 business or commercial insurance policy, before the expiration date of  
29 the policy [,] or of the anniversary date of a policy with

1 term longer than one year or with no fixed expiration date. This  
2 section does not apply

3 (1) if the insurer has in good faith manifested in any way  
4 its willingness to renew;

5 (2) in case of nonpayment of premium for the expiring  
6 policy; or

7 (3) if the insured fails to pay the premium as required by  
8 the insurer for renewal.

9 \* Sec. 10. AS 21.36.250 is amended to read:

10 Sec. 21.36.250. NOTICE OF ELIGIBILITY. When a policy of automo-  
11 bile liability insurance is cancelled, other than for nonpayment of  
12 premium, or is not renewed in accordance with [FOR FAILURE TO RENEW A  
13 POLICY OF AUTOMOBILE LIABILITY INSURANCE TO WHICH] AS 21.36.240 [AP-  
14 PLIES], the insurer shall notify the named insured of possible eligi-  
15 bility for automobile insurance through the automobile assigned risk  
16 plan, or automobile insurance plan. The notification must [SHALL]  
17 accompany or be included in the notice of cancellation or nonrenewal  
18 required by AS 21.36.220 [AS 21.36.230] and 21.36.240.

19 \* Sec. 11. AS 21.36.310 is amended to read:

20 Sec. 21.36.310. DEFINITIONS. In AS 21.36.210 - 21.36.310

21 (1) "business or commercial insurance" means insurance  
22 other than personal insurance, life insurance, disability insurance,  
23 title insurance, or an annuity contract;

24 (2) "nonpayment of premium" means failure of the named  
25 insured to discharge when due any obligations of the named insured in  
26 connection with the payment of premium on a policy, or any installment  
27 of the premium, whether the premium is payable directly to the insurer  
28 or its agent or indirectly under any premium finance plan or extension  
29 of credit;

1                   (3) "personal automobile insurance" means insurance not  
2 related to business or commercial activities, covering [(2) "POLICY"  
3 MEANS AN INSURANCE POLICY COVERING THE RISKS AND EXPOSURES LISTED IN  
4 AS 21.36.210(e) OR AN AUTOMOBILE POLICY THAT INCLUDES] automobile  
5 liability [COVERAGE], uninsured or underinsured motorists [MOTORIST  
6 COVERAGE], automobile medical payments [COVERAGE], or automobile  
7 physical damage [COVERAGE], that is delivered or issued for delivery  
8 in this state, [INSURING AS THE NAMED INSURED, ONE INDIVIDUAL OR HUS-  
9 BAND AND WIFE RESIDENT OF THE SAME HOUSEHOLD,] and under which the  
10 insured vehicles are of the following types only:

11                   (A) a motor vehicle of the private passenger or sta-  
12 tion wagon type that is not used as a public or livery convey-  
13 ance, nor rented to others, or

14                   (B) any other four-wheel motor vehicle with a load  
15 capacity of 1,500 pounds or less that is not used in the occupa-  
16 tion, profession, or business of the insured, nor used as a  
17 public or livery conveyance, nor rented to others;

18                   (4) "personal insurance" does not include an annuity con-  
19 tract or a policy of life insurance, disability insurance, or title  
20 insurance; the term means personal automobile insurance, or insurance  
21 covering

22                   (A) loss of or damage to real property that is used  
23 predominantly for residential purposes and that does not consist  
24 of more than four dwelling units;

25                   (B) loss of or damage to personal property, including  
26 personal effects, household furniture, fixtures and equipment  
27 located in not more than four dwelling units; or

28                   (C) legal liability of natural persons for loss of,  
29 damage to, or injury to, persons or property if the insurance

1 does not cover liability arising from or in connection with  
2 business or commercial activities;

3 (5) [(3)] "renewal" or "renew" means

4 (A) the issuance and delivery by an insurer of a  
5 policy replacing at the end of the policy period a policy previ-  
6 ously issued and delivered by the same insurer,

7 (B) the issuance and delivery of a certificate or  
8 notice extending the term of a policy beyond its policy period or  
9 term, or

10 (C) the extension of the term of a policy beyond its  
11 policy period or term under a provision for extending the policy  
12 by payment of a continuation premium.

13 \* Sec. 12. AS 21 is amended by adding a new chapter to read:

14 CHAPTER 76. JOINT INSURANCE ARRANGEMENTS.

15 Sec. 21.76.010. AUTHORITY TO ESTABLISH JOINT INSURANCE ARRANGE-  
16 MENTS. (a) Municipalities, school districts, and regional educa-  
17 tional attendance areas may enter into cooperative agreements with  
18 each other for the purpose of establishing, operating, or participat-  
19 ing in joint insurance arrangements through which the participating  
20 members agree to pool contributions and

21 (1) assume risks from losses on a group basis; or

22 (2) purchase coverage on a group basis.

23 (b) A joint insurance arrangement under (a)(1) of this section  
24 may be only for property insurance.

25 (c) A joint insurance arrangement under (a)(2) of this section  
26 may be for any kind of insurance defined by this title except for

27 (1) life, annuity, disability, and title insurance; and

28 (2) surety.

29 (d) A joint insurance arrangement shall be considered an

1 alternative or supplement to any other policy or contract of insurance  
2 authorized or required by law, including insurance under AS 21.75.

3 Sec. 21.76.020. REGULATION BY DIVISION OF INSURANCE. A joint  
4 insurance arrangement may not be considered insurance for the purpose  
5 of any other law of the state and is not subject to regulations of the  
6 director except as expressly provided in this chapter.

7 Sec. 21.76.030. GENERAL PROVISIONS OF COOPERATIVE AGREEMENTS. A  
8 cooperative agreement shall provide for the proper operation of the  
9 joint insurance arrangement, and include provisions for

10 (1) administration of the arrangement by a board of direc-  
11 tors, specifying the number of members of the board and other require-  
12 ments necessary for the proper functioning of the board;

13 (2) appointment of an administrator and other persons as  
14 necessary for the proper functioning of the arrangement;

15 (3) organization of the arrangement, including a roster of  
16 participating members and the names of the members of the board of  
17 directors;

18 (4) procedures to establish and promote an aggressive risk  
19 management and program among the members of the arrangement, including  
20 procedures for identifying and reducing the risks that can be reduced  
21 through implementing better safety technologies and improved work  
22 techniques and procedures;

23 (5) enforcing the collection of contributions or payments  
24 in default from members of the arrangement;

25 (6) the addition of new members to the arrangement or the  
26 withdrawal of members from the arrangement;

27 (7) the method of apportioning costs and disposition of  
28 excess contributions;

29 (8) transmission of financial statements and audit reports

1 of the arrangement to participating members;

2 (9) terminating the arrangement and disposing of its as-  
3 sets; and

4 (10) establishing and administering a joint insurance fund.

5 Sec. 21.76.040. FINANCIAL PROVISIONS OF AGREEMENTS. (a) A  
6 cooperative agreement must include a provision requiring an annual  
7 determination by a casualty actuary who is a member of the American  
8 Academy of Actuaries that procedures for establishing reserves for  
9 losses of the joint insurance arrangement are actuarially sound.

10 (b) A joint insurance arrangement shall be subject to an annual  
11 independent audit. The audit shall be conducted in accordance with  
12 generally accepted auditing standards and must include a review of the  
13 actuarial assumptions used for establishing the reserves under (a) of  
14 this section. The audit report must include certification from a  
15 casualty actuary who is a member of the American Academy of Actuaries  
16 that the actuarial assumptions continue to be sound and the level of  
17 the reserves are adequate.

18 (c) A joint insurance arrangement shall use a method of account-  
19 ing that conforms with generally accepted government accounting prin-  
20 ciples.

21 Sec. 21.76.050. CONTRACTING WITH PRIVATE ADMINISTRATORS. A  
22 cooperative agreement may authorize the board of directors to enter  
23 into contracts for services necessary to perform the functions of a  
24 joint insurance arrangement. The person contracting to perform the  
25 functions must be appropriately licensed under this title if this  
26 title so requires.

27 Sec. 21.76.060. DELEGATION OF POWER TO SETTLE CLAIMS. A cooper-  
28 ative agreement may delegate to the board of directors, or authorize  
29 delegation by the board to another person or group, the power to

1 compromise, arbitrate, or otherwise settle claims on behalf of the  
2 arrangement.

3 Sec. 21.76.070. EXCESS INSURANCE. A cooperative agreement may  
4 authorize the board of directors to purchase excess or catastrophic  
5 insurance on behalf of the joint insurance arrangement. The cost of  
6 the insurance shall be apportioned in the manner specified in the  
7 joint insurance agreement. The board may purchase insurance under  
8 this section only from an insurer authorized to do business in the  
9 state or from an unauthorized insurer if the insurance is placed  
10 through a licensed surplus lines broker.

11 Sec. 21.76.080. JOINT INSURANCE FUND. (a) A joint insurance  
12 arrangement shall establish a joint insurance fund. The fund consists  
13 of money

14 (1) contributed by members of the joint insurance arrange-  
15 ment through budgetary appropriations or transfers from a self-insur-  
16 ance reserve; and

17 (2) collected by the joint insurance arrangement through  
18 subrogation of a claim paid from the fund to a member of the arrange-  
19 ment.

20 (b) An expenditure may be made from a joint insurance fund only  
21 to pay claims, losses, or benefits, including interest on them, and  
22 the administrative and adjustment expenses incurred in connection with  
23 them, involving the types of protection for which the fund provides  
24 coverage as specified in the joint insurance agreement.

25 (c) The administrator shall keep the fund separate from other  
26 funds of a member of a joint insurance arrangement.

27 (d) For each type of protection offered by the joint insurance  
28 arrangement, the method of accounting must show the order, source,  
29 date, and amount of each payment from the fund.

1 (e) Within 60 days of the end of the fiscal year, the adminis-  
2 trator shall furnish a detailed report of the operation and condition  
3 of the fund to the board of directors and the director of insurance.  
4 The report furnished to the director of insurance shall be available  
5 for public inspection.

6 (f) Money held by a fund as reserves and money not needed for  
7 daily operations may be invested by the board of directors.

8 (g) A fund may not be terminated unless the administrator certi-  
9 fies that an amount of money sufficient to pay accrued and contingent  
10 expenditures has been placed in a fully collateralized escrow account.

11 Sec. 21.76.090. FILING OF AGREEMENT. The board of directors  
12 shall file a copy of the cooperative agreement with the director of  
13 insurance at least 60 days before the effective date of the agreement.  
14 The agreement shall be available for public inspection.

15 Sec. 21.76.100. REGULATIONS. A cooperative agreement may au-  
16 thorize the board of directors to adopt regulations not inconsistent  
17 with law for the fair and equitable administration of the joint insur-  
18 ance arrangement and the joint insurance fund.

19 Sec. 21.76.110. SUBROGATION. A joint insurance arrangement has  
20 a cause of action for reimbursement of money paid to a participating  
21 member for a loss or injury if the participating member recovers money  
22 for the loss or injury from a third party. The joint insurance ar-  
23 rangement also has a direct cause of action for reimbursement against  
24 a third party responsible for loss or injuries sustained by a partic-  
25 ipating member if the joint arrangement has paid money to the partic-  
26 ipating member for the loss or injuries.

27 Sec. 21.76.900. DEFINITIONS. In this chapter

28 (1) "adjustment expenses" means expenses for investigative,  
29 processing, legal, actuarial, arbitration, and settlement services

1 incurred in the adjustment of losses, claims, or benefits;

2 (2) "administrator" means a person or group appointed by  
3 the board of directors to administer a joint insurance arrangement or  
4 a joint insurance fund;

5 (3) "board" or "board of directors" means the board of  
6 directors provided for in a cooperative agreement;

7 (4) "cooperative agreement" means a written agreement  
8 entered into by two or more entities described in AS 21.76.010 for the  
9 purpose of establishing, operating, or participating in a joint insur-  
10 ance arrangement;

11 (5) "fund" or "joint insurance fund" means a fund estab-  
12 lished under AS 21.76.080;

13 (6) "joint insurance arrangement" means a joint insurance  
14 arrangement authorized under AS 21.76.010.

15 \* Sec. 13. AS 21.39.155(a) is amended to read:

16 (a) The director may require carriers, except a reciprocal  
17 insurer formed by and insuring only a group of municipalities or  
18 nonprofit public utilities under AS 21.75 or a joint insurance ar-  
19 angement formed under AS 21.76, as a condition of writing a line of  
20 insurance dealing with workers' compensation, to participate in an  
21 assigned risk pool if the director finds that mandatory carrier part-  
22 icipation is in the public interest.

23 \* Sec. 14. AS 21.80.180(5) is amended to read:

24 (5) "insolvent insurer" means an insurer

25 (A) authorized to transact insurance in this state,  
26 except an assessable reciprocal insurer formed by and insuring  
27 only municipalities or nonprofit public utilities, a joint insur-  
28 ance arrangement formed under AS 21.76, the Medical Indemnity  
29 Corporation of Alaska, and the Health Care Providers Joint

1 Underwriting Association established under AS 21.88, either at  
 2 the time the policy was issued or when the insured event  
 3 occurred, and

4 (3) determined to be insolvent by a court of compe-  
 5 tent jurisdiction;

6 \* Sec. 15. AS 21.80.180(6) is amended to read:

7 (6) "member insurer" means a person, except an assessable  
 8 reciprocal insurer formed by and insuring only municipalities or  
 9 nonprofit public utilities, a joint insurance arrangement formed under  
 10 AS 21.76, the Medical Indemnity Corporation of Alaska, and the Health  
 11 Care Providers Joint Underwriting Association established under  
 12 AS 21.88, who

13 (A) writes any kind of insurance to which this chap-  
 14 ter applies under AS 21.80.020 including the exchange of recipro-  
 15 cal or interinsurance contracts, and

16 (B) is licensed to transact insurance in this state;

17 \* Sec. 16. AS 21.36.210(e), 21.36.230, and 21.36.300 are repealed.

18 \* Sec. 17. This Act takes effect immediately in accordance with AS 01.-  
 19 10.070(c).

Original sponsors: Sund, M.M.Miller,  
Hurley, et al

1 IN THE HOUSE

BY THE LABOR AND  
COMMERCE COMMITTEE

2 CS FOR HOUSE BILL NO. 589 (L&C)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FOURTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to disability insurance."

7 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

8 \* Section 1. AS 21 is amended by adding a new chapter to read:

9 CHAPTER 55. STATE DISABILITY INSURANCE.

10 ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

11 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a  
12 nonprofit incorporated legal entity to be known as the Comprehensive  
13 Disability Insurance Association. Membership consists of all insurers  
14 licensed to transact disability insurance in the state and all li-  
15 censed hospital or medical service corporations in the state. All  
16 members shall maintain membership in the association as a condition of  
17 doing disability insurance business in the state.

18 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of  
19 directors of the association shall be made up of seven individuals  
20 selected by participating members, subject to approval by the director  
21 of the division of insurance. In determining voting rights at mem-  
22 bers' meetings, a member is entitled to vote in person or proxy. The  
23 vote shall be a weighted vote based upon the member's cost of disabil-  
24 ity insurance derived from or on behalf of state residents in the  
25 previous calendar year, as determined by the director. In approving  
26 members of the board, the director shall consider, among other things,  
27 whether all types of participating members are fairly represented.  
28 Members of the board may be reimbursed from the association for expen-  
29 ses incurred by them as members, but may not otherwise be compensated.

1 by the association for their services. The costs of conducting meet-  
2 ings of the association and its board of directors shall be borne by  
3 members of the association.

4 Sec. 21.55.030. GENERAL POWERS. The association may

5 (1) exercise the powers granted to insurers under the laws  
6 of the state;

7 (2) sue or be sued;

8 (3) enter into contracts with insurers, similar associa-  
9 tions in other states, or with other persons for the performance of  
10 administrative functions;

11 (4) establish administrative and accounting procedures for  
12 the operation of the association.

13 Sec. 21.55.040. OVERSIGHT BY DIRECTOR. The association shall  
14 submit its articles, bylaws, and operating rules to the director for  
15 approval.

16 Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association  
17 is exempt from the Administrative Procedure Act (AS 44.62).

18 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from  
19 the payment of fees and taxes levied by the state or any of its polit-  
20 ical subdivisions except taxes levied on real or personal property.

21 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

22 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association  
23 shall make available to residents the following types of disability  
24 insurance plans:

25 (1) a group state plan for groups of from 3 - 25 residents,  
26 subject to the prohibition against fictitious groups in AS 21.36.190;

27 (2) an individual state plan for residents who are standard  
28 risks according to criteria established in regulations adopted by the  
29 director; and

1 (3) an individual state plan for residents who are high  
2 risks according to criteria established in regulations adopted by the  
3 director.

4 (b) For each type of plan listed in (a) of this section, the  
5 association shall offer three alternatives related to deductibles as  
6 described in AS 21.55.120.

7 (c) The association shall make available to residents who are 65  
8 years of age and older a medicare supplement plan. The plan shall  
9 provide coverage of 50 percent of the deductible and copayment re-  
10 quired under medicare and 80 percent of the charges covered in AS 21.-  
11 55.110 to the extent that the charges are not paid by medicare. The  
12 coverage shall include a limitation of \$1,000 per person on total  
13 annual out-of-pocket expenses for the covered services. The coverage  
14 may be subject to a maximum lifetime benefit of not less than  
15 \$100,000.

16 (d) The association may not deny coverage under a state plan to  
17 a resident who satisfies the requirements of AS 21.55.300 - 21.55.310.  
18 The association may determine whether a person is a standard risk or a  
19 high risk in accordance with the director's regulations.

20 Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE  
21 PLANS. Except as provided in AS 21.55.120 - 21.55.160, the minimum  
22 standard benefits of a disability insurance plan offered under AS 21.-  
23 55.100 shall be benefits, including coverage for catastrophic illness,  
24 with a lifetime maximum of \$1,000,000 per individual, for reasonable  
25 charges or, when applicable, the allowance agreed upon between a  
26 provider and a carrier for charges actually incurred, for the follow-  
27 ing health care services, rendered to an individual covered by the  
28 plan for the diagnosis or treatment of nonoccupational disease or  
29 injury:

- 1                   (1) hospital services;
- 2                   (2) professional services that are rendered by a physician
- 3 or by a registered nurse at the physician's direction, other than
- 4 services for mental or dental conditions;
- 5                   (3) the diagnosis or treatment of mental conditions, as
- 6 defined in regulation of the director, rendered during the year by
- 7 one or more physicians on other than an inpatient basis or, at their
- 8 direction, by their staffs of registered nurses, up to a yearly maxi-
- 9 mum benefit of \$1,000;
- 10                   (4) legend drugs requiring a physician's prescription;
- 11                   (5) services of a skilled nursing facility for not more
- 12 than 120 days in a calendar year if the services commence within 14
- 13 days following a confinement of at least three consecutive days in a
- 14 hospital for the same condition;
- 15                   (6) home health agency services, as defined in regulations
- 16 of the director, up to a maximum of 180 visits in a calendar year if
- 17 the services commence within seven days following confinement in a
- 18 hospital or skilled nursing facility of at least three consecutive
- 19 days for the same condition, except that in the case of an individual
- 20 diagnosed by a physician as terminally ill with a prognosis of six
- 21 months or less to live, the home health agency services may commence
- 22 irrespective of whether the covered person was previously confined or,
- 23 if the covered person was confined, irrespective of the seven-day
- 24 period, and the yearly benefit for medical social services may not
- 25 exceed \$200; in this paragraph, "medical social services" means
- 26 services rendered under the direction of a physician by a qualified
- 27 social worker holding a master's degree from an accredited school of
- 28 social work, including assessment of the social, psychological and
- 29 family problems related to or arising out of the covered person's

1 illness and treatment, appropriate action and utilization of community  
2 resources to assist in resolving the problems, and participation in  
3 the development of treatment for the covered person;

4 (7) use of radium or other radioactive materials;

5 (8) outpatient chemotherapy for the removal of tumors and  
6 treatment of leukemia, including outpatient chemotherapy;

7 (9) oxygen;

8 (10) anesthetics;

9 (11) nondental prosthesis and maxillo-facial prosthesis used  
10 to replace any anatomic structure lost during treatment for head and  
11 neck tumors or additional appliances essential for the support of the  
12 prosthesis;

13 (12) rental of durable medical equipment that has no per-  
14 sonal use in the absence of the condition for which it was prescribed;

15 (13) diagnostic x-rays and laboratory tests as defined in  
16 regulations of the director;

17 (14) oral surgery for excision of partially or completely  
18 unerupted impacted teeth or excision of a tooth root without the  
19 extraction of the entire tooth;

20 (15) services of a licensed physical therapist rendered  
21 under the direction of a physician;

22 (16) transportation by a local professional ambulance to the  
23 nearest health care institution qualified to treat the illness or  
24 injury;

25 (17) confinement in a facility established primarily for the  
26 treatment of alcoholism and licensed by the state, or in a part of a  
27 hospital used primarily for this treatment, for a period of at least  
28 45 days within any calendar year;

29 (18) other services that are medically necessary in the

1 treatment or diagnosis of an illness or injury as may be designated or  
2 approved by the director.

3 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan  
4 may require deductibles of \$200 a person, \$500 a person, or \$750 a  
5 person. The amount of the deductible may not be greater when a ser-  
6 vice is rendered on an outpatient basis than when that service is  
7 offered on an inpatient basis. Expenses incurred during the last  
8 three months of a calendar year and actually applied to an individ-  
9 ual's deductible for that year shall also be applied to that individ-  
10 ual's deductible in the following calendar year. The \$200 maximum, the  
11 \$500 maximum, and the \$750 maximum may be adjusted yearly to corre-  
12 spond with the change in the medical care component of the consumer  
13 price index, as adjusted by the director. The base year for the  
14 computation shall be the first full calendar year of operation of the  
15 association.

16 (b) A state plan shall require a maximum copayment of 20 percent  
17 for charges for all types of health care in excess of the deductible  
18 and 50 percent for services described in AS 21.55.110(3) in excess of  
19 the deductible.

20 (c) The sum of the deductible and copayments required in any  
21 calendar year under a plan may not exceed a maximum limit of \$1,000  
22 per covered individual or \$2,000 per covered family. Covered expenses  
23 incurred after the applicable maximum limit has been reached shall be  
24 paid at the rate of 100 percent, except that expenses incurred for  
25 treatment of mental and nervous conditions shall be paid at the rate  
26 of 50 percent. The \$1,000 and \$2,000 maximums shall be adjusted  
27 yearly to correspond with the change in the medical care component of  
28 the consumer price index as adjusted by the director.

29 (d) In this section, "consumer price index" means the consumer

1 price index for all urban consumers for the Anchorage Metropolitan  
2 Area compiled by the Bureau of Labor Statistics, United States  
3 Department of Labor.

4 Sec. 21.55.130. BENEFIT LIMITATIONS. (a) A state plan shall  
5 limit benefits with respect to each pregnancy, other than a pregnancy  
6 involving complications of pregnancy, to a maximum of \$250. In this  
7 subsection, "complications of pregnancy" means

8 (1) conditions requiring hospital stays, when the pregnancy  
9 is not terminated, whose diagnoses are distinct from pregnancy but are  
10 adversely affected by pregnancy or are caused by pregnancy, such as  
11 acute nephritis, nephrosis, cardiac decompensation, missed abortion  
12 and similar medical and surgical conditions of comparable severity,  
13 but does not include false labor, occasional spotting, physician-  
14 prescribed rest during the period of pregnancy, morning sickness,  
15 hyperemesis gravidarum, pre-eclampsia and similar conditions associ-  
16 ated with management of a difficult pregnancy not constituting a noso-  
17 logically distinct complication of pregnancy; and

18 (2) nonelective caesarean section, ectopic pregnancy that  
19 is terminated, and spontaneous termination of pregnancy, that occurs  
20 during a period of gestation in which a viable birth is not possible.

21 (b) A state plan may limit lifetime benefits to a maximum of not  
22 less than \$1,000,000 per covered individual.

23 Sec. 21.55.140. PREEXISTING CONDITIONS. (a) A preexisting  
24 condition exclusion in a state plan may not exclude coverage of a  
25 preexisting condition unless

26 (1) the condition first manifested itself within the period  
27 of six months immediately before the effective date of coverage in a  
28 manner that would cause a reasonably prudent person to seek diagnosis,  
29 care, or treatment;

1 (2) medical advice or treatment was recommended or received  
2 within the period of six months immediately before the effective date  
3 of coverage; or

4 (3) the condition is pregnancy existing on the effective  
5 date of coverage.

6 (b) A policy may not exclude coverage for a loss due to pre-  
7 existing conditions for a period greater than 12 months following the  
8 effective date of coverage. An individual state plan issued as a  
9 result of conversion from a group state plan shall credit the time  
10 covered under the group state plan toward the exclusion for preexist-  
11 ing conditions. An individual high risk plan issued as a result of  
12 conversion from an individual standard risk plan shall credit the time  
13 covered under the standard risk plan toward the exclusion for preex-  
14 isting conditions.

15 Sec. 21.55.150. CARE AND SERVICES NOT COVERED. A state plan may  
16 not provide benefits for charges for the following:

17 (1) care for an injury or disease either

18 (A) arising out of and in the course of an employment  
19 subject to a workers' compensation or similar law or where the  
20 benefit is required to be provided under a workers' compensation  
21 policy to a sole proprietor, business partner, or corporation  
22 officer; or

23 (B) to the extent benefits are payable without regard  
24 to fault under a coverage statutorily required to be contained in  
25 a motor vehicle or other liability insurance policy or equivalent  
26 self-insurance;

27 (2) treatment for cosmetic purposes other than surgery for  
28 the prompt repair of an accidental injury sustained while covered or  
29 for replacement of an anatomic structure removed during treatment of

1 tumors;

2 (3) travel, other than transportation by local professional  
3 ambulance to the nearest health care institution qualified to treat  
4 the illness or injury;

5 (4) private room accommodations to the extent it is in  
6 excess of the institution's most common charge for a semiprivate room;

7 (5) services or articles to the extent that the charge  
8 exceeds the reasonable charge in the locality for the service;

9 (6) services or articles that are determined not to be  
10 medically necessary, except for the fabrication or placement of the  
11 prosthesis as specified in AS 21.55.110(11) and (2) of this section;

12 (7) services or articles the provision of which is not  
13 within the scope of the license or certificate of the institution or  
14 individual rendering the services or articles;

15 (8) services or articles furnished, paid for or reimbursed  
16 directly by or under any law of a government, except as otherwise  
17 provided in this chapter;

18 (9) services or articles for custodial care or designed  
19 primarily to assist an individual in the activities of daily living;

20 (10) service charges that would not have been made if no  
21 insurance existed or for which the covered individual is not legally  
22 obligated to pay;

23 (11) eyeglasses, contact lenses, or hearing aids or the  
24 fitting of them;

25 (12) dental care not specifically covered by this chapter;  
26 and

27 (13) services of a registered nurse who ordinarily resides  
28 in the covered individual's home, or who is a member of the covered  
29 individual's family or the family of the covered individual's spouse.

1           Sec. 21.55.160. COORDINATED COVERAGE. The minimum standard  
2 benefits of a state plan may be satisfied by catastrophic coverage  
3 offered in conjunction with basic hospital or medical-surgical plans  
4 on an expense incurred or service basis as approved by the director as  
5 providing at least equivalent benefits.

6           Sec. 21.55.170. STATE PLAN PREMIUMS. (a) The association may  
7 not charge a rate for coverage issued by or through the association  
8 that is excessive, inadequate, or unfairly discriminatory.

9           (b) The association shall use separate scales of premium rates  
10 based on age for individual risks and group risks. The association  
11 may charge a higher premium for a high risk plan than for a standard  
12 risk plan.

13           (c) Notwithstanding (a) of this section, the schedule of premi-  
14 ums for coverage under each type of state plan listed in AS 21.55.100  
15 shall be designed so that each type of plan is self-supporting. The  
16 premiums shall be based on generally accepted actuarial principles.

17                           ARTICLE 3. ADMINISTRATION OF PLANS.

18           Sec. 21.55.200. SUBMISSION OF PLANS. A member of the associa-  
19 tion may submit to the director for approval a policy of disability  
20 insurance or medicare supplement that is being proposed to serve as a  
21 state plan. The time and manner of the submission and approval shall  
22 be prescribed by regulations of the director.

23           Sec. 21.55.210. SELECTION OF WRITING CARRIERS. The association  
24 may select policies and contracts, or parts of them, submitted by a  
25 member of the association, or by the association or others, to develop  
26 specifications for bids from a member that wishes to be selected as a  
27 writing carrier to administer a state plan. The selection of the  
28 writing carrier shall be based upon criteria including the member's  
29 proven ability to handle large group disability insurance cases.

1 efficient claim paying capacity, and the estimate of total charges for  
2 administering the plan.

3 Sec. 21.55.220. DUTIES OF WRITING CARRIERS. (a) The writing  
4 carrier shall perform the administrative and claims payment functions  
5 required by this section. The writing carrier shall provide these  
6 services for a period of three years, unless a request to terminate is  
7 approved by the director. The director shall approve or deny a re-  
8 quest to terminate within 90 days of its receipt. A failure to make a  
9 final decision on a request to terminate within the specified period  
10 shall be considered an approval. Six months before the expiration of  
11 each three-year period, the association shall invite submissions of  
12 policy forms from members of the association, including the writing  
13 carrier. The association shall follow the provisions of AS 21.55.210  
14 in selecting a writing carrier for the subsequent three-year period.

15 (b) The writing carrier shall provide to all eligible persons  
16 enrolled in a state plan an individual policy or certificate, setting  
17 out a statement of the insurance protection to which the person is  
18 entitled, with whom claims are to be filed, and to whom benefits are  
19 payable. The policy or certificate must indicate that coverage was  
20 obtained through the association.

21 (c) The writing carrier shall submit to the association and the  
22 director on a monthly basis a report on the operation of the state  
23 plans. Specific information to be contained in the report shall be  
24 determined by the association.

25 (d) Claims shall be paid by the writing carrier and shall indi-  
26 cate that the claim was paid under a state plan. A claim payment  
27 shall include information specifying the procedure to be followed in  
28 the event of a dispute over the amount of payment.

29 (e) The writing carrier shall be reimbursed from the state plan

1 premiums received for its direct and indirect expenses. Direct and  
2 indirect expenses shall include a pro rata reimbursement for that  
3 portion of the writing carrier's administrative, printing, claims  
4 administration, management and building overhead expenses that are  
5 assignable to the maintenance and administration of the state plans.  
6 The association shall approve cost accounting methods to substantiate  
7 the writing carrier's cost reports consistent with generally accepted  
8 accounting principles. Direct and indirect expenses may not include  
9 costs directly related to the original submission of policy forms  
10 before selection as the writing carrier.

11 (f) The writing carrier shall at all times when carrying out its  
12 duties under this chapter be considered an agent of the association  
13 and the director.

14 Sec. 21.55.230. OPERATION OF THE PLAN. (a) Upon notification  
15 as an eligible person or group under AS 21.55.320, a person or group  
16 may enroll in a state plan by payment of the appropriate state plan  
17 premium to the writing carrier.

18 (b) An employer that has in its employ one or more eligible  
19 persons enrolled in a state plan may make all or a portion of a state  
20 plan premium payment directly to the writing carrier.

21 (c) At least 85 percent of the state plan premiums paid to the  
22 writing carrier shall be used to pay claims; not more than 15 percent  
23 may be used for the payment of agent referral fees under this chapter  
24 and for payment of the writing carrier's direct and indirect expenses  
25 under this chapter.

26 (d) Each contributing member of the association shall share the  
27 losses due to claims expenses of the state plans for plans issued or  
28 approved for issuance by the association, and shall share in the  
29 operating and administrative expenses incurred or estimated to be

1 incurred by the association incident to the conduct of its affairs.  
2 Claims expenses of the state plan that exceed the premium payments  
3 allocated to the payment of benefits shall be the liability of the  
4 contributing members. Contributing members shall share in the claims  
5 expense of the state plans and operating and administrative expenses  
6 of the association in an amount equal to the ratio of the contributing  
7 member's total disability insurance premium, received from or on  
8 behalf of state residents, as divided by the total disability insur-  
9 ance premium received by all contributing members from or on behalf of  
10 state residents, as determined by the director.

11 (e) The association shall make an annual determination of each  
12 contributing member's liability, if any, and may make an annual fiscal  
13 year end assessment if necessary. The association may also, subject  
14 to the approval of the director, provide for interim assessments  
15 against the contributing members as may be necessary to assure the  
16 financial capability of the association in meeting the incurred or  
17 estimated claims expenses of the state plans and operating and admin-  
18 istrative expenses of the association until the association's next  
19 annual fiscal year end assessment. Payment of an assessment is due  
20 within 30 days of receipt by a contributing member of a written notice  
21 of a fiscal year end or interim assessment. Failure by a contributing  
22 member to tender to the association the assessment within 30 days  
23 shall be grounds for termination of the contributing member's member-  
24 ship. A contributing member that ceases to do disability insurance  
25 business in the state remains liable for assessments through the  
26 calendar year during which the disability insurance business ceased.  
27 The association may decline to levy an assessment against a contribut-  
28 ing member if the assessment would not exceed \$10.

29 (f) Net gains, if any, from the operation of the state plans

1 shall be held at interest and used by the association to offset future  
2 losses due to claims expenses of a state plan or allocated to reduce  
3 state plan premiums.

4 ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.

5 Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a)  
6 Subject to AS 21.36.190, a state resident or a group of from 3 to 25  
7 state residents is eligible to enroll in a state plan described in  
8 AS 21.55.100.

9 (b) Additional eligibility requirements may not be imposed by  
10 the director, the association, or a writing carrier.

11 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON OR GROUP. (a)  
12 A person or group may enroll in a state plan by submission of a cer-  
13 tificate of eligibility to the writing carrier. The certificate must  
14 include the following:

15 (1) name, address, age, and length of time at residence of  
16 the applicant;

17 (2) name, address, and age of spouse and children if any,  
18 if they are to be insured; and

19 (3) a designation of the plan desired, including deductible  
20 option chosen.

21 (b) A person may not be covered by more than one policy under  
22 this chapter at any one time. Upon ceasing to be a resident of the  
23 state a person is not eligible to purchase or renew coverage under a  
24 state plan.

25 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days of  
26 receiving the certificate described in AS 21.55.310, the writing  
27 carrier shall either reject the application for failing to comply with  
28 the requirements of AS 21.55.300 and 21.55.310 or forward the eligible  
29 person a notice of acceptance and billing information.. Insurance is

1 effective immediately upon receipt of the first month's premium, and  
2 is retroactive to the date of the application, if the applicant other-  
3 wise complies with the requirements of this chapter.

4 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The  
5 association, under a plan approved by the director, shall disseminate  
6 appropriate information to the residents of the state regarding the  
7 existence of the state plans and the means of enrollment. Means of  
8 communication may include use of the press, radio, and television, as  
9 well as publication in appropriate state offices and publications.

10 (b) The association shall devise and implement means of main-  
11 taining public awareness of the provisions of this chapter and shall  
12 administer this chapter in a manner that facilitates public participa-  
13 tion in the state plans.

14 (c) The writing carrier shall pay an agent's referral fee of \$50  
15 to each insurance agent who refers an applicant to a state plan, if  
16 the application is accepted. Selling or marketing of qualified state  
17 plans is not limited to the writing carrier or its agents. The refer-  
18 ral fees shall be paid by the writing carrier from money received as  
19 premiums for a state plan.

20 (d) An insurer that rejects or applies underwriting restrictions  
21 to an applicant for disability insurance in the state shall notify the  
22 applicant of the existence of the state plans, the requirements for  
23 being accepted, and the procedure for applying.

24 ARTICLE 5. GENERAL PROVISIONS.

25 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

26 (1) formulate general policies to advance the purposes of  
27 this chapter;

28 (2) supervise the creation of the State Comprehensive  
29 Disability Insurance Association;

1 (3) approve the selection of the writing carrier by the  
2 association and approve the association's contract with the writing  
3 carrier including the coverages and premiums to be charged;

4 (4) appoint advisory committees;

5 (5) conduct periodic audits to assure the general accuracy  
6 of the financial data submitted by the writing carrier and the asso-  
7 ciation;

8 (6) contract with the federal government or another unit of  
9 government to ensure coordination of the state plans with other gov-  
10 ernmental assistance programs;

11 (7) undertake directly or through contracts with other  
12 persons studies or demonstration programs to develop awareness of the  
13 benefits of this chapter;

14 (8) contract with insurers and others for administrative  
15 services; and

16 (9) adopt regulations necessary to administer this chapter.

17 Sec. 21.55.500. DEFINITIONS. In this chapter

18 (1) "association" means the Comprehensive Disability Insur-  
19 ance Association created in AS 21.55.010;

20 (2) "state plan" means a policy of insurance offered by the  
21 association through a writing carrier;

22 (3) "writing carrier" means the insurer or insurers select-  
23 ed by the association and approved by the director to administer a  
24 state plan.  
25  
26  
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29

Testimony to the Hawaii House of Representatives Committee on Health and Committee on Consumer Protection and Commerce, October 22, 1985.

My name is William K. Scheuber. I am President of Medical Underwriters of California, a management company owned by the Alameda-Contra Costa Medical Association. Medical Underwriters operates Medical Insurance Exchange of California which provides professional liability insurance to about 740 medical doctors in Hawaii, and to more than 3400 doctors in Alaska, Idaho, Nevada and California.

I understand that you would like to hear from us our views of the professional liability situation as it now confronts insurers and the doctors they insure. I presume that you would also like some suggestions as to what you might consider doing about it here in Hawaii.

In the past 15 months MIEC has increased the number of doctors it insures in Hawaii by 400, a growth of 135%. Such growth is unusual in the insurance industry, but we take no credit for salesmanship because MIEC has no salesmen. The growth occurred because almost nobody else has been offering Professional Liability insurance in Hawaii for more than a year. Nobody else is offering it because it is the judgement of insurance professionals that it is impossible to make a profit on medical malpractice insurance, and worse that it is a virtual certainty that such insurance will result in losses of massive size. Hawaii is not alone with this reputation. Private companies along with special funds set-up by state legislatures have abandoned Professional Liability, or gone broke, in almost every state in the Union in the past ten years. Two of the 42 companies newly formed by doctors in 1975 and since have gone broke after less than ten years of existence; at least three are in my opinion presently insolvent, and at least a dozen more are in a condition I would not want our company to be in.

(Exhibit I) (Exhibit II)

Until the 1975 "malpractice crisis," insurance companies had never separated professional liability from other kinds of losses. After the first five years of keeping separate statistics, Best's, the insurance rating service, (not known for colorful writing), reported in January of 1980: "Medical Malpractice, now in its sixth year as an individual line, has demonstrated its ability to stun the underwriter... Since five years ago, experience has deteriorated drastically... it shows an underwriting loss of \$960 million and a combined loss ratio of 116%."

In another five years - this year - it was even worse. This January, (Exhibit III), Best's reported underwriting losses for medical malpractice alone, of \$3.4 billion for the previous five years, an average combined loss ratio of 147%. (Combined Loss Ratio is all losses and loss costs incurred divided by premiums earned.) It estimated loss for the 1984 year alone at \$1.1 billion. Best's six month report from January 1, 1985 to June, 1985 increased the combined loss ratio to 169%. The numbers tell the story, and they are mournful numbers.

This is what is happening now, this year. But the past gives us no comfort, either, because it tells us that the present will only get worse. The company which for twenty-five years covered the New York State sponsored doctors' program withdrew from the program in 1974, eleven years ago. It never received more than 40 million in annual premiums, and in the 25 years of its coverage, its total premium was \$225 million. Its losses when it quit, eleven years ago, were under \$100 million. In the next ten years, to the present, the carrier has paid more than 355 million in claims and claims expenses. In 1984 alone, its tenth year after it stopped insuring, it paid out \$30 million. It still has 1300 known claims to dispose of. It still receives new claims at the rate of 200 each year.

*This is why reserves for future losses are as high as they are*

This time it is the reinsurers who are suddenly alarmed. The past ten years have identified Professional Liability as the worst loser in the whole property-casualty insurance industry which, in America, is itself a big loser. The uniquely American Liability Industry is now receiving frantic attention from the reinsurance industry, world wide. They are raising American rates by shocking percentages or, when coverage expires, refusing to renew it on any terms. They are behaving in 1985 just as the primary insurers did in 1975.

Some grand old names in the dignified world of reinsurance are seeking mid-term to pull out of contracts they are already committed to. This is unprecedented behavior.

Mr. Peter Miller, Chairman of Lloyds of London, spent a large part of this summer traveling among the insurance centers of the United States, stating (Exhibit IV) (Exhibit IVa), on behalf of Lloyds of London, the thesis that casualty risks in the United States -- he didn't mention any other countries -- have become uninsurable. Only the most optimistic he says, will continue to insure them and only with huge rate increases. He's not the only one talking like this.

The following are representative quotes from "Business Insurance" (Exhibit V), a trade publication, which covered last month's meeting of worldwide reinsurers, among them the largest American Reinsurers. The meeting was held, appropriately, in Monte Carlo.

"No one wants North American casualty business. Even the reinsurers with the capacity to write U.S. risks are refusing, because of large losses and their assessment that it is impossible to properly price U.S. casualty insurance."

"They are saying that the tort system - and the courts - in the United States make casualty business uninsurable. They say they have no ability to ascertain what losses will be."

"The reaction is the same in the Far East."

"Reinsurance rates could jump as much as 500% to 1000% for the most risky long-tail casualty business." Risky long-tail casualty business is exactly what Medical Malpractice Insurance is. (Exhibit VI).

You may reasonably ask: Well, if it's so bad, what's MIEC doing here? We came to Hawaii for the same reason we came into existence in 1975: because no company would insure our doctors. A little less acutely, the same thing happened in Hawaii. The doctors needed us because most sensible doctors didn't want to practice medicine without insurance coverage, so they had to create their own insurance company. We will continue to be an insurance company owned by its policyholders as long as the policyholders are willing to pay whatever premiums are necessary for us to survive and prosper and to serve them. The doctors in turn of course will include those premiums in their costs as long as patients and the legislators who fund government programs are willing to pay them. Either the premium rates will go up to pay the losses or losses will diminish to the point where our owners can lower the premiums. Doctors will certainly lower the premiums if it becomes possible to do so. They don't want to make money from each other as owners of an insurance company. They do want an insurance company that can and will continuously provide reliable and equitable protection.

We have some suggestions on how to begin to lower those premium rates, rather than just letting the crisis ride. As a doctor-owned company, we've done something the commercial insurance industry never did. Out of the tremendous motivation which is prevalent among doctors to avoid damage and lawsuits, we've taken vigorous action in loss prevention, claims administration, and underwriting, in an organized program

designed to reduce injuries and losses. With the help of doctors and legislators, we've explained and defended the reforms which were enacted in 1975 by the California Legislature at the urgent request of the public and the medical profession.

Ten years after their enactment the four most important of the California reforms have been found constitutional. The reforms are the best that any State in the nation has enacted, and their effect is just beginning. They place a limit on awards for pain and suffering, place limits on the percentage of the award which the plaintiff's lawyer can charge as a fee, permit the jury to know what other resources were available to the patient for the payment of losses, so he is not paid twice for the same loss, and permit the use of periodic payments to assure that the money will be used for the patient's needs and for the purpose intended. We believe that these reforms (Exhibit VII) are the best hope of diminishing losses in California in the next five to ten years, and we respectfully suggest that the Hawaii Legislature as the Legislatures of other states are doing, consider the California reforms as a start toward a long term solution.

As it always has, the Plaintiff's bar everywhere is exercising its creativity in developing new grounds for litigation. Plaintiffs lawyers are now diligently expanding in the courts their pleas for punitive damages, their allegations of "Bad Faith" on the part of the insurance carrier against the insured in the administration of claims, and worst of all, expanding the extremely profitable abuse of the "Deep Pocket" doctrine, which says that a defendant who is only 1% responsible for an injury must pay the entire loss if the other defendants are not able to pay. It will be obvious from our Exhibits (XXI through XXVII) that the motivation for these maneuvers has nothing to do with justice, but has a lot to do with the winning of huge legal fees, based on a percentage of the award. This has proved outrageously

responsibility for difficult and dangerous medical situations with potential for massive and long-term damage, experience the biggest lawsuits and the biggest losses. In New York State and everywhere else, it is the Professors of neurosurgery in the medical schools who have multiple law suits against them, with multimillion dollars at risk. They are certainly not incompetent, but their services are difficult and complex. Any bad result highly-skilled doctors are involved in is viewed as a potential jack-pot by the plaintiff's bar.

3. 80% of all losses incurred in the forty years between 1935 and 1975 were incurred in the five years between 1970 and 1975. The frequency continues to increase at the same rate. Without much doubt, this is because modern medicine is becoming more difficult and complex, and because public expectations are high.
4. It isn't our "legal system" which is bad. It's the exploiters of the legal system who are bad. A lack of public vigilance and protest over many years has permitted them to arrange everything to suit themselves. The defense attorneys take some of the blame, and say of their plaintiff colleagues: "For too long the Association of Trial Lawyers has monopolized the attention of Appellate Court Judges." They need to be limited, and watched. What most needs to be watched and limited is the profitable contingency fee, which is the great motivator for chicanery and injustice. It motivates some plaintiff attorneys to exploit damage by creating liability where it does not exist. Combined with the twin threats of punitive damages against the

defendant and bad faith against the carrier, contingency percentages can and do make the plaintiffs attorney aspire to become an instant millionaire. This motivates a depressing number to engage in the equivalent of legal extortion and blackmail.

One organization of defense counsel (California Defense Council) is embarrassed and frightened by the activities of their plaintiff colleagues, and is trying to prevent the Golden Goose from being killed: "As we have travelled around the country drumming up support for California Defense Council, we are impressed by... an almost universally shared preception that unless something radical is done, the system as we know it is not long for this world."

5. Plaintiffs attorneys are too often overpaid for their work, since lawyers are usually the only ones permitted to judge its value. We know of a case in which the plaintiffs attorney was paid, with a judge's approval, a fee of \$640,000 for arranging a settlement in the case of a child who was paralyzed at birth and was 18 months old at the time of settlement. Without going to court or arguing a case, the plaintiff's lawyers fee amounted to \$35,500 a month for the 18 months which elapsed between the injury and the settlement, more than \$1,000 a day including Saturdays, Sundays and Holidays. Because the premium out of which this fee was paid ultimately comes from sick people who pay doctors fees, one medical society asked the judge on what basis he approved \$640,000. The judge made no analysis of the time spent or services rendered, and replied only that this fee was not unusual.

In another settlement, an agreement was reached to pay the injured patient \$16,000 per month for life. The patient's age gave him a life-expectancy of 20 years. His attorney also will receive, as his fee, \$16,000 per month, for the rest of his life. The attorney, however, has a life-expectancy of 30 years.

We think the system can be a good and fair one, but it needs examination, modification, and public vigilance over the activities of the insurance industry, the lawyers, and the courts, as well as over the medical profession.

The officers and executives of MIEC will consider it a privilege to provide this committee and the Hawaii Legislature with any further information, research experience or counsel we may possess in our specialized field which may assist in improving the situation in Hawaii, as we have done in other parts of the country.

BS/lmm/COR7

# Best's Comparison of Professional Liability Carriers

## MIEC Receives "A" Rating

The 1984 Best's Key Rating Guide has been published and distributed. For the first time, many of the physician-owned carriers formed in the mid-to-late '70's have been assigned a rating by Best's. The guide compares significant premium, surplus and loss reserve figures and ratios of 23 physician-owned carriers and three commercial carriers showing 1983 year-end results. Some are compared to 1982 figures:

The following are highlights of this comparison:

- Eighteen doctor owned companies were eligible for a Best's rating this year. Only seven, including MIEC, received a rating of "A" (Excellent). Three received "B+" or "B" (Very Good) and the other eight received "Deferred" or "Omitted" ratings. This is hardly a resounding vote of confidence in the financial or managerial strengths of doctor-owned insurance companies by the insurance industry's premier financial rating service.
- Premium to surplus ratios, an important indicator of an insurance company's financial strength and margin of safety, deteriorated at 14 (61%) of the 23 companies. Given the long-term, cumulative and unpredictable, although generally negative trend of medical malpractice loss development, this is a disturbing fact. Premium to surplus ratios greater than 2:1 were reported by eight (35%) of the 23 companies in 1983, compared to five (22%) in 1982. The average premium to surplus ratio of all 23 companies was 1.53:1. MIEC's premium to surplus ratio was a conservative 0.45:1.
- Total net written premiums of the 23 companies were \$600 million, up less than 1% from 1982.
- Loss reserves continue to grow rapidly as might be expected in this line of business. The ratio of loss reserves to surplus provides another indication of the safety margin available to policyholders. The average ratio of loss reserves to policyholder surplus of the 23 companies was 6.86:1 and ranged as high as 25:1 at one of the

carriers. At a 25:1 loss reserves to surplus ratio, a 4% underestimation of loss costs on pending claims would wipe out the surplus of the company, threatening its continued existence. MIEC's loss reserve to surplus ratio was 1.91:1.

- Seven of the companies (30%) reported loss reserve to surplus ratios of more than 5:1, up from six (26%) in 1982. Only six of the companies reported improvements in the loss reserve to surplus ratios compared to 1982. MIEC was one of those six.
- The number of policyholders insured by the 23 surveyed companies declined from almost 110,000 in 1982 to just over 101,000 in 1983. This reflects the increasing competition from commercial carriers which has been a growing concern for several years. It also reflects the disappearance of the Florida company, currently in rehabilitation by the insurance department of the State of Florida, and California's PSIE which was absorbed by a commercial carrier earlier this year.
- Average surplus per policyholder for the 23 companies increased to \$3,856 from \$3,358 in 1982, but some companies have less than \$1,000 surplus per policyholder. MIEC's surplus per policyholder was \$8,969.
- Nine of the companies suffered overall reductions in policyholders' surplus between 1982 and 1983. MIEC recorded a 26% gain in surplus between 1982 and 1983.

MIEC received an "A" rating which was accompanied by the following comment from Best's:

"Based on our current analysis of the exchange's financial position and operating performance, we assign a Best's rating of 'A' (Excellent). After careful review of your financial statement, we are pleased to be able to assign a Best's rating of 'A.' This reflects successful operating results over the past five years and conservative liquidity and leverage positions."

Copies of this comparison of professional liability carriers is available at ACCMA headquarters.

II

Mr. Scheuber

**NORCAL**  
Mutual Insurance Company

Justin N. Tierney  
President & Chief Executive Officer

333 Market Street  
San Francisco, CA 94105  
(415) 777-4200  
(800) 652-1051

June 14, 1985

Mr. Donald J. Fager  
President  
Board of Trustees  
Physician Insurers Association of America  
Two Princess Road  
Lawrenceville, NJ 08648

Dear Don:

Thank you and the other members of the Board, including Jim Todd, for your understanding of my concerns and your willingness to let me attend the meeting of the Board of Trustees on Monday, June 24, at the O'Hare Hilton.

As background for the meeting, I thought it best to amplify my few comments at the Annual Meeting in Atlanta.

All of the members of the Board should have received a copy of a letter addressed to me by Al Yamashiro, NORCAL's Vice President and CFO, dated May 9 which contained the financial results and underwriting experience for thirty of the PIAA member companies. The data for the other companies was not available at the time of the compilation.

My concerns can be grouped in four areas:

A. The Financial Stability and Security of Doctor Owned Companies Is Critically Impaired.

1. Twenty-eight of thirty companies have reported 1984 underwriting losses.
2. Twelve of the twenty-eight companies with 1984 underwriting losses had insufficient investment income to overcome the underwriting loss.
3. Seven companies have discounted their loss reserve, further diminishing the ability of each of these companies to have sufficient funds to pay their ultimate losses.
4. Twenty-eight of the thirty companies have accumulated \$1.3 billion in underwriting losses which in turn will be further impacted by adverse development of the reported \$3.2 billion of losses outstanding and not paid.

California being a notable exception—have a far poorer loss record. That is to say, the full story of this business, the extent of its distress, is seen only partially in the 122.6% combined ratio of commercial insurers. And in this story of losses past and losses to come lurks a dividend payout still in excess of 10% which over the past five years has aggregated \$6.6 billion, making a mockery of the five-year pre-dividend underwriting gain of \$390 million. If it were not for the payout of \$1.5 billion in dividends to policyholders in 1984, investment income in the workers' compensation line would have exceeded the underwriting loss.

**MISCELLANEOUS LIABILITY**

We come to that category of insurance, long-tail liability, with its giant loss reserves and their potential of throwing off such a stream of investment income that underwriting considerations (supposedly) can be ignored.

It is with the liability lines that some companies exchanged underwriting prudence for a seat at the financial poker table and started a chain reaction of price cutting that pulled the whole commercial side of the property/casualty insurance business into its worst underwriting decline. Admittedly other factors entered into this deplorable scenario, but the overriding rationale (in what turned out to be a decision to substitute finance for insurance) was simply that investment income, at interest rates at one time running up to 20%, offered a quicker route to a profitable bottom line.

And now the day of reckoning is here. The combined loss and expense ratio in liability business passed the 150% mark in 1984 as the pure loss ratio jumped by nearly 10 points and the underwriting loss topped \$4.1 billion. Approximately 25% of the total underwriting loss for the industry last year came from coverages producing 7.1% of the premium volume.

If any section of the business actually went out of control during the competitive frenzy of 1979-1984, it was liability insurance—and like the dilemma of workers' compensation, the turnaround can't be accomplished with anything resembling speed. It takes years for long-tail losses to surface and years more for them to be settled.

The use of loss reserves as an investment income producer is supposed to be the formula for making money in this business, but the record of the past five years is devastating in insurance terms and the investment solution no longer exceeds the underwriting loss. There was in 1984 the single redeeming feature of a 15% increase in miscellaneous liability premiums, little enough and long overdue when lined up against a 35-point rise in the pure loss ratio in the same 12 months.

Medical malpractice as a separate line of insurance was born of a crisis in 1975 and after only a few years of confusing rearrangement has returned to the point of desperation. No part of the industry handling this business is doing so with success. The stock companies, with 59% of the volume, have a combined ratio of 161%, up 20 points from 1983; the mutuals, including some of the so-called bed pan companies, have 20% of the business and a 172% combined ratio, up six points; and the reciprocals, 21% of the total and mostly professionally sponsored companies, are sporting a 166% combined ratio.

Where does this business go from here? Doctors still insured with commercial companies are, in at least two states, restive and planning to start their own companies. In another state an effort was made to put a proposition on the ballot last November that would have put a cap on malpractice tort awards. Medical malpractice premium volume rose an estimated 16% in 1984, but pure losses were up by 26% and the pure loss ratio for the line is estimated at 110%. The dollar underwriting loss came to 65% of earned premiums. Can that be remedied in a single year? The answer to the medical malpractice dilemma would seem to lie in large part outside the realm of insurance, but it is to be hoped that the insurance concept will not be lost in the process of restoring equity to a situation that is obviously out of hand.

**Medical Malpractice**

Year	Net Premiums Written \$000	Loss & LAE Ratio %	Und. Expense Ratio %	Combined Ratio		Statutory Und. Gain or Loss After Divs. \$000
				Before Divs. %	After Divs. %	
<b>Stock Companies</b>						
1980	721,963	106.84	17.78	126.62	127.04	-19,863
1981	723,032	119.23	20.15	139.39	139.66	-284,781
1982	814,368	122.79	20.58	143.37	143.52	-346,589
1983	893,529	121.03	20.63	141.66	141.73	-364,141
1984*	1,080,000	141.00	20.10	161.10	161.17	-627,800
5 Yrs	4,232,892	123.93	19.92	143.85	144.03	-1,815,174
<b>Mutual Companies</b>						
1980	276,382	143.42	7.89	151.30	153.22	-136,199
1981	319,164	128.70	7.14	135.84	138.78	-118,123
1982	350,279	155.52	7.74	163.26	167.07	-224,351
1983	352,866	153.34	8.55	161.89	165.15	-232,388
1984*	355,000	160.80	8.50	169.40	171.90	-242,560
5 Yrs	1,653,691	149.11	7.98	157.10	160.04	-953,621
<b>Reciprocals</b>						
1980	276,612	99.72	10.63	110.35	111.89	-32,690
1981	294,085	114.84	10.25	125.10	130.42	-80,512
1982	323,702	139.57	11.21	150.78	154.13	-140,814
1983	317,849	139.62	12.21	151.83	155.68	-167,224
1984*	375,000	150.20	12.20	162.40	166.20	-232,050
5 Yrs	1,587,248	130.33	11.37	141.70	145.28	-653,290
<b>Total Industry</b>						
1980	1,274,957	114.14	14.08	128.22	129.20	360,752
1981	1,336,281	120.62	14.87	135.49	137.39	-483,416
1982	1,448,349	133.82	15.52	149.35	150.97	-711,754
1983	1,564,244	132.35	16.19	148.55	150.11	-763,753
1984*	1,810,000	148.86	16.19	163.05	164.37	-1,102,410
5 Yrs	7,473,831	130.88	15.46	146.34	147.82	-3,422,085

\* Estimated

# Losses, Fraud Hit Lloyd's of London

By BRUCE KEPPEL,  
Times Staff Writer

For nearly three centuries, Britain's venerable insurance market, Lloyd's of London, has withstood and richly profited from the periodic turbulence characteristic of the property-casualty insurance business. But the 1980s have been exceptionally unkind to the industry worldwide—and now Lloyd's is proving not to be immune.

Lloyd's, whose entrepreneurial zeal in insuring almost anything from a communications satellite to a starlet's bust is matched by shrewd assessments of the actual risks involved, paid out more in claims than it received in premiums in 1981, the most recent year for which figures have been audited.

## Investment Income

The \$55.7-million underwriting loss (based on current exchange rates) was more than offset, however, by investment income earned from the premiums, resulting in a net profit of about \$195 million.

Still, that was the market's slimmest profit since 1977. And 1982, now being audited, could produce the exchange's first net loss since 1965 and 1966, though not as great as the 8% loss in those years. Lloyd's Chairman Peter North Miller said in an interview last week in Los Angeles.

Miller laid much of the blame for Lloyd's change of fortune not to the cutthroat competition for premium income that has damaged or destroyed many a U.S. insurer but to liability litigation and extravagant court awards in this country. Lloyd's does 35% of its business in the United States, he said. "The courts in America tend to throw liability around a bit," Miller said.

He added this warning: "Without reform of tort law in the U.S., there will not be a market to cover the liabilities that Americans want to see covered." He cited pollution-cleanup insurance, which is now both required and difficult to find as a result of regulatory uncertainty in this country and multibillion-dollar litigation such as what followed New York's Love Canal disaster.

Miller has been voicing his warning across the United States, speaking to the National Assn. of Insurance Brokers at Sea Island, Ga., and then on the West Coast



*"Without reform of tort law in the United States, there will not be a market to cover the liabilities Americans want to see covered."*

—Peter North Miller, chairman of Lloyd's of London



ROB SCHUMACHER / Los Angeles Times

last week. Today, he heads for Kansas City to address state regulators attending a meeting of the National Assn. of Insurance Commissioners.

As if underlining the urgency of the industry's concern, a San Francisco Superior Court jury decided May 31 that Manville Corp., which is struggling with massive damage claims for asbestos poisoning from exposures dating back decades, had liability insurance during key periods over more than half a century ago—ever, though the actual policies could not be found and the originating companies have since merged into others.

That was good news for Denver-based Manville, but it sent another shudder through the already reeling property-casualty insurance industry.

## Interpretation of Liability

Court interpretations have in the past led to huge liability awards and created uncertainty for insurers, Miller said. Insurers must be able to calculate the true nature of the risks they are underwriting, he explained, and that is complicated by shifting interpretations of what constitutes liability.

"Lloyd's will insure almost anything," he said, "provided we can know what is required of us."

After the tanker Torrey Canyon foundered in the English Channel in 1967, spilling massive amounts of oil on British and French beaches and oyster beds, he said, it became impossible to get insurance against such a disaster. Lloyd's finally offered to provide coverage but only on specified terms.

"We said, 'Let's sit down and talk about what it is we can provide,'" Miller said, "and it's a helluva lot."

No one questions Lloyd's ability to withstand present adversities within the insurance market. Lloyd's record is superb compared to that of the industry in general. And its security is rock solid, with an estimated \$12 billion of reserves on top of \$5 billion of premium income.

Far more uncharacteristic is the persistent whiff of financial scandal that has tainted a handful of its 384 insurance syndicates in recent years—scandals regarding misuse of member funds. These events, whose very rarity provoked con-

# Changing market creates new role for brokers: Miller

By LINDA J. COLLINS

SEA ISLAND, Ga.—The tightening property/casualty insurance market is creating new responsibilities for insurance brokers, says Lloyd's of London Chairman Peter North Miller.

"There is more to placing insurance than just driving the hardest bargain possible for one's client. The broker has a responsibility to his client to see that the insurance industry continues to exist," Mr. Miller told the National Assn. of Insurance Brokers' annual meeting.

Brokers in recent years have too frequently tried to place business at any rate due to fear of competition and loss of business, said Mr. Miller, former chairman of Lloyd's broker Thomas R. Miller & Son (Insurance) Ltd. He said that brokers



Mr. Miller

should realize and stress to others that brokers, underwriters and clients all need to take a long-term view of the industry, rather than

focusing on short-term gains.

"We, the brokers, have a job to do as intermediaries when one of the parties with which we must negotiate is in one of three positions: either no longer there, because he has gone out of business or been sacked because of losses; or enfeebled and unable to give us the insurance answers which our clients require; or demanding prices and policy forms which make our clients shudder."

Turning to capacity problems created by the tightening market, Mr. Miller noted that Lloyd's capacity, expressed in terms of the British pound, has increased by 29% in 1985 over 1984.

The current U.S. legal climate and current liability policies written on occurrence forms are the major factors deterring Lloyd's underwriters from accepting certain types of U.S. liability risks, Mr. Miller explained.

"We begin to feel in England that it is not possible to insure liabilities in the United States, because the legal system is so heavily weighted against insurers," he said.

"We insurers have little faith that we shall receive justice at the hands of the American legal system," he added.



"However, over 60% of Lloyd's income is receivable in United States dollars, which have been steadily strengthening against the pound sterling. The effective rate for 1984 for premium income limit purposes was \$1.45 equaled 1 pound, and that for 1985 is \$1.16 equals 1 pound—being the exchange rate in each case at the first of January."

Taking this into consideration, Mr. Miller said: "One is left with a figure of true increase (in capacity at Lloyd's) in 1985 of perhaps 15%."

"The crisis of capacity, so much talked about, is not at Lloyd's," he stated.

However, Mr. Miller said that the projected shortfall in U.S. property/casualty insurance capacity, which the Insurance Services Office has estimated may reach more than \$62 billion by 1987, will continue to plague insurance buyers. "There is little or nothing that Lloyd's can, or indeed should, do to try to create all the new capacity apparently needed" in the U.S. marketplace.

"Our underwriters must—and I am sure will—remember they are actually in business to make a profit, and at last they have a chance of making an underwriting profit as well as a profit on investment income," Mr. Miller said.

# Reinsurance crunch real, experts agree

By LINDA J. COLLINS

HONOLULU—The reinsurance crisis is real and will continue to plague the insurance industry at least through 1986, a panel of insurance executives predicts.

As part of a discussion of "The Marketplace of Tomorrow" at the Independent Insurance Agents of America's annual convention earlier this month, a panel composed of an insurer, a reinsurance intermediary, an agent and a broker also predicted that:

- Facultative reinsurance capacity will decrease very rapidly during 1986.

- Underwriters at Lloyd's of London will insist on the use of the new claims-made policy by U.S. insurers seeking reinsurance.

- The insurance industry will remain cyclical in nature, although the swings of the cycle may moderate due to better data collection methods and the continued exodus of insurance companies and independent agents from the marketplace.

In addressing the current reinsurance crisis in the United States,

James J. Meenaghan, president and chief executive officer of the reinsurance broker John F. Sullivan Co. in Seattle, said that reinsurers' underwriting losses have been more severe than



Mr. Meenaghan

those experienced by direct insurers over the past five or six years.

"They've suffered worse underwriting ratios and they've suffered much bigger drops in surplus, or financial capacity, than have the domestic companies in the U.S.," Mr. Meenaghan explained. He added that the loss experience of reinsurers of U.S. casualty business in

of London, lead underwriters' unanimous message was that members of Lloyd's syndicates have no interest in writing U.S. business because of the reinterpretation of insurance contracts and large awards made by U.S.



Mr. Budd

courts, Mr. Budd said.

Facultative reinsurance, in particular, is disappearing very rapidly, he added.

"The feeling particularly in the foreign markets that don't live day-to-day with our legal system, is that the American legal system is totally out of control as respects the way in which insurance contracts are interpreted," Mr. Budd explained.

"They feel they have absorbed the worst of that economically, and I think they have the facts and figures to prove it."

These factors are spurring for-

eign reinsurers to issue a cry for widespread use by U.S. insurers of the Insurance Services Office's controversial new commercial general liability claims-made policy, which is scheduled for introduction in January.

Mr. Meenaghan said that reinsurers, particularly at Lloyd's of London, are insisting on—rather than simply encouraging—the use of the claims-made form.

"I think that some of the major financial entities in the world... are shell-shocked by the proliferation

of claims they have received for asbestosis, and on and on," Mr. Meenaghan said.

"They're absolutely insisting on a change" to the claims-made form if they are to continue to provide reinsurance coverage to the U.S. marketplace."

The claims-made policy is needed in the industry, Mr. Budd said, because insurance companies have to somehow contain the overall limit on what they are insuring. He added that there also is a deli-

Continued on next page

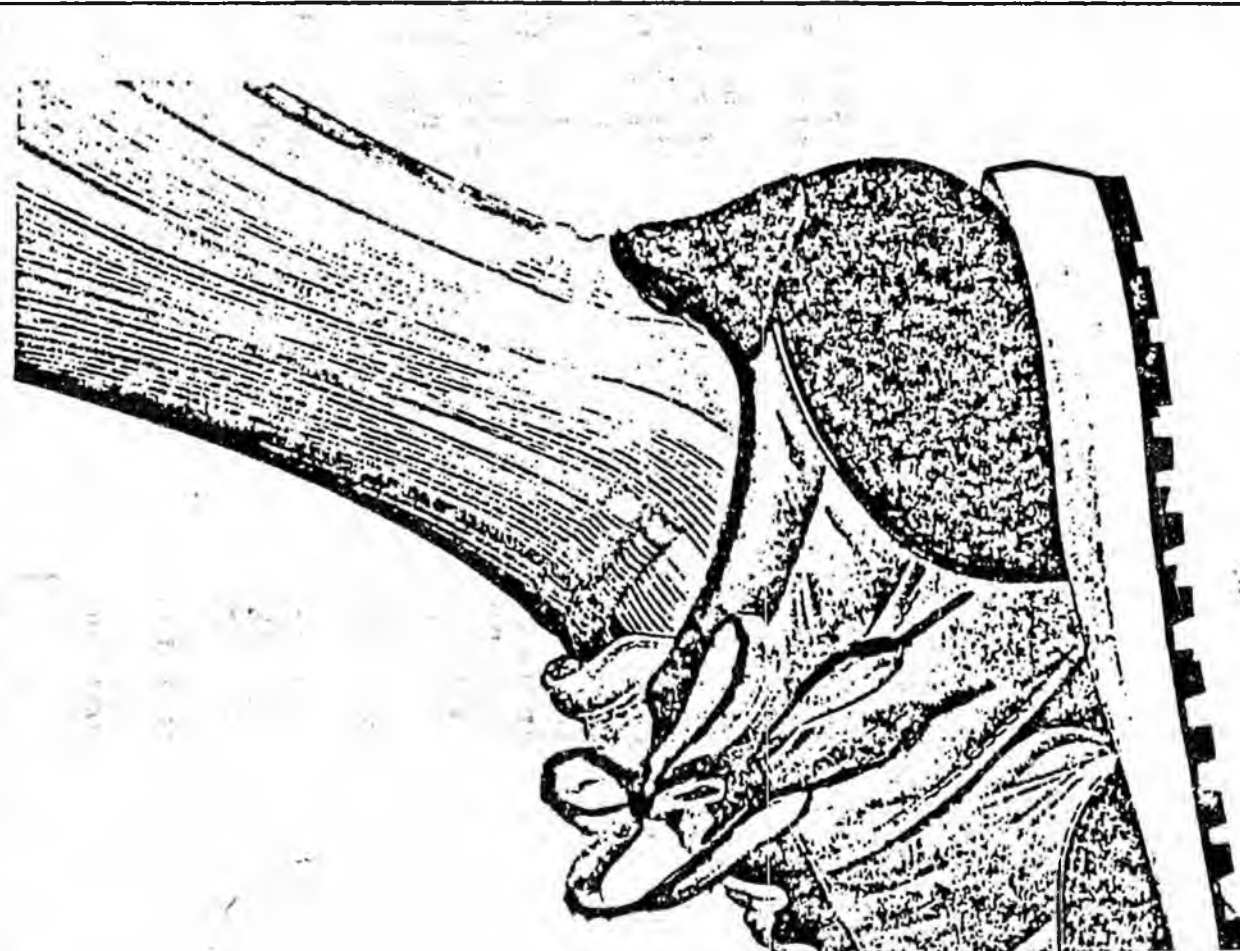


Exhibit VI



# Merrett Syndicates Limited

UNDERWRITING AGENTS & BROKERS

ARTHUR CASTLE HOUSE  
33 CREECHURCH LANE LONDON EC3A 5AJ  
REGISTERED OFFICE (REG NO 1035551)

TELEPHONE 01 283 3434  
TELEX 805986 MERRETT G

John  
Dear David

11th Jan 1985

As we are all only too well aware, we have just come off a most interesting renewal season for Treaty Reinsurance.

It is apparent that we have an opportunity at this time and essential that we reappraise our premium position on Treaty business. In any event, as you know, we have not been particularly interested in writing new business recently. I thought it would be a good idea, therefore, to put our own position in writing so that you can appreciate the fact that, for the foreseeable future, we will not be interested in writing any new Treaty Reinsurance either property or casualty. As you are aware from this most current renewal season, our prime responsibility is to existing clients. We will not be likely to change this attitude for some time.

I am letting you have this information in writing so you may make other arrangements for any new business you may be bringing into the market in the immediate future.

With kind regards,

Yours sincerely,

ROBIN A.G. JACKSON

Exhibit VII

CALIFORNIA "TORT REFORM" STATUTES  
UPHELD BY SUPREME COURT IN 1984-85

- I. Periodic payment of future damages exceeding \$50,000
- II. Changes to the collateral source rule
- III. Limitation on contingent fees
- IV. Limitation on recovery for non-economic damages

LIMITATION  
OF NON-ECONOMY  
DAMAGES

§3333.2. Recovery of Noneconomic Losses—  
Definitions.

(a) In any action for injury against a health care provider based on professional negligence, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.

(b) In no action shall the amount of damages for noneconomic losses exceed two hundred fifty thousand dollars (\$250,000).

(c) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital. Leg.H. 1975 Second Extra. Sess. chs. 1, 2, operative December 12, 1975.

Ref.: Cal Fms Pl & Pr, "Dentists," "Hospitals," "Physicians and Other Medical Personnel."

1976 Note: See Note at Code of Civil Procedure §364.

# Business insurance rates skyrocket

## Customers may ultimately foot bill

By Kim Favros  
Staff Writer

It costs \$32.50 for an office appointment with Dr. Conrad Anderson in Fremont.

And unless his malpractice insurance holds steady at \$10,000, the general practitioner next year may raise his fees.

A few miles away in downtown Hayward, residents of the Green



Conrad Anderson

**Anderson's \$10,000 malpractice premium insures him up to \$1 million per lawsuit and a maximum of \$3 million each year.**

Shelter Hotel on Main Street pay \$90 a week for a room with a bath, \$75 without. Their rates may go up.

"Somewhere along the line you have to pass on the costs," says hotel co-owner Dave Daveau, who two weeks ago learned his premium — if he doesn't change insurers — will cost \$42,000 this year. In 1984 his property-casualty-liability insur-

The news was even worse for Bob Oddone. He has to find new, and probably more expensive, insurance for La Club Moderne, one of Hayward's oldest drinking establishments.

Insurance agent Ed Boese began calling insurers the day Oddone learned the policy on his Main Street bar would not be renewed.

"There's absolutely nothing wrong with his (Oddone's) business," says Boese, a partner with Farrell, Boese and Whited insurance brokers in San Francisco.

"It's a problem with the insurance industry as a whole... and the little businesses like Bob's are merely the victims, not the cause."

Across the nation all kinds of businesses are facing insurance premium increases ranging from 25 percent to more than 1,000 percent. Others, such as Oddone's, are being dropped by insurers as unprofitable clients.

Hardest hit seem to be bars, liquor stores, restaurants, rental agencies and day care centers — businesses that have experienced increased insurance claims during recent years. But municipalities and professionals, including doctors, accountants and lawyers, face skyrocketing insurance bills because of generous court awards.

Industry analysts attribute the increases to insurance companies' big underwriting losses in 1983 and 1984.

During the "premium price wars" of the late 1970s insurance companies raised rates in a fierce competition for business, hoping to invest incoming monies at 18 and 20 percent interest rates.

"Insurers were willing to write almost any risk at any price," says George A. Porter, president of the Independent Insurance Agents and Brokers of California.

But interest rates — and the insurance industry's profit margins — began dropping at about the same time the nation's courts began approving huge casualty and liability awards.

Last year the industry reported \$1.8 billion in losses. Seventeen insurance companies went broke.

"I've been in the business 45 years and I haven't seen anything like this" says Boese, who specializes in hotel and apartment building

helping make up the insurance industry's losses through increased premiums are many East Bay businesses.

Insurance costs at Di (Auto Post) GMC in Fremont "went up 77 percent this year" says general sales manager Ron Freitas, who declined to provide figures. A common premium increase for auto dealerships is from \$5,000 to \$10,000, says a spokesman for the Northern California Motor Car Dealers Association.

Alameda County's medical malpractice insurance premiums increased this year from \$1.6 million to \$2.3 million. Highland Hospital had to increase its total coverage from \$30 million to \$100 million.

Owners of Arnie's Time Out, a neighborhood bar on Mission Boulevard in Hayward, reluctantly paid a new premium of \$3,000, up from \$1,400. "You have to have insurance," says co-owner Denis Bishop.

Child-care providers statewide are being forced out of business by the huge increase in rates. In Southern Alameda County, insurance problems have shut down five homes.

The state's major home-care insurer is BMF Market Services of Sherman Oaks. Last year a home-care operator licensed for 12 children would have paid BMF \$270 for \$1 million in liability coverage and \$75,000 in accident, car accident and personal property coverage.

This year BMF is charging \$1,100 for only \$300,000 liability and the remaining \$75,000 coverage.

Other insurers are refusing to handle child-care policies following highly publicized allegations and convictions involving child abuse at day-care homes in Northern and Southern California.

The state Senate Monday approved an emergency measure requiring insurance companies to join a state-operated insurance pool for day-care centers. SB 1474 goes next to the Assembly.

Insurance costs for California physicians have eased somewhat since the state Legislature in 1975 imposed restrictions on medical malpractice suits.

Anderson's \$10,000 malpractice premium insures him up to \$1 million per lawsuit and a maximum of \$3 million each year.



Bob Oddone

Oddone has to find new, and probably more expensive, insurance for La Club Moderne, one of Hayward's oldest bars.

In 1983 more than 600 personal injury cases nationwide were settled with awards of \$1 million or more, reports show.

California particularly "has had a lot of serious problems with the number of lawsuits in the liability area," says Dennis Jay, spokesman for the National Association of Professional Insurance Agents.

In 1982 there were 13 awards or settlements over \$1 million statewide. A year later the number had risen to 19.

"We encounter insurance carriers around the country... these days when people fall on the sidewalk they no longer think 'I need better footing next time.' They think instead, 'I'll call my lawyer.'"

David Blackstone, an agent with Cooper McKenzie Murphy in Pleasanton, believes insurance companies are playing catch-up from the lowered premium rates they offered in the mid-70s.

"What they are really doing is within 1 or 1 1/2 years bringing in enough dollars in pay for their losses — they're making an increase quickly to make their financial statements look better."

The insurers are overreaching, Blackstone contends.

"If the insurance companies had stretched (the premium increases) over two or three years, it would have been a lot easier (for business), but they want to be profitable now."

And insurance rates are not expected to drop anytime soon, Porter maintains.

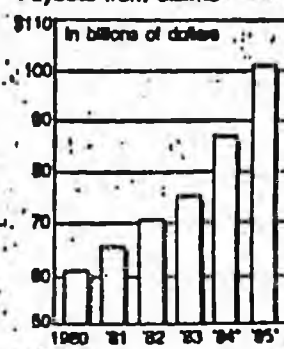
"We've been in a buyers market for five years. Insurance rates aren't going up, and won't be coming down in the foreseeable future."

"Each company is taking a much closer look at individual risks and pricing the product accordingly," Porter says.

"Premiums are going up... to ensure companies have the reserves and surplus to meet future claims expenses."

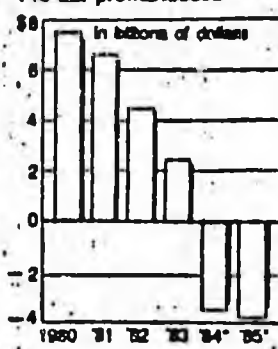
### Property-casualty insurance

Payouts from claims



\*Estimates  
Chicago Tribune Clute, Bruce Orr's Business Management Report, A.M. Best Co.

Pre-tax profit losses



"High risk" specialists such as obstetricians, neurosurgeons and orthopedic surgeons are paying \$35,000 to \$38,000 for the same coverage. In New York that coverage would cost \$100,000, says Anderson, a director with the Medical Insurance Exchange, which sells malpractice policies in Northern California, Nevada, Idaho, Alaska and Hawaii.

Also contributing to the rise in insurance premiums are increasingly generous court awards in personal-injury suits.

"The court system's broad interpretation... encourages lawsuits where financially responsible, adequately insured individuals and businesses end up paying for the mistakes of uninsured or underinsured entities," Porter says.

Exhibit XIV

## Editorial

# Damage awards harm economy

U.S. Attorney General Edwin Meese's warning should be heeded. In a speech at the State Bar's annual meeting in San Diego last weekend, he said enormous damage awards in injury lawsuits, often without proof of fault, threaten serious harm to the nation's economy.

Meese said the insurance industry is in a "position of precariousness" because of expanding liability. Small businesses are being forced to go without insurance and face possible bankruptcy from lawsuits. He said he favored "re-establishment of fault as the critical standard by which liability is determined."

The nation's top law enforcement officer focused on California Supreme Court decisions establishing a doctrine of liability in product cases that lets victims of defective products collect damages without having to prove fault. But he could also have taken on the "joint and several" liability rule established by California courts.

Under this rule, also known as the "deep pocket" doctrine, local governments and businesses can be forced to pay all of a damage award in a personal injury lawsuit, even if they're minimally at fault for an accident. If other defendants are unable to pay, it has encouraged lawyers to name cities, counties and businesses as defendants based on their ability to pay multimillion-dollar awards.

Meese put it mildly when he said that in our litigious society, "the desire for compensation has overcome a sense of balance." The situation has been worsened by broadened court interpretations of liability, jury verdicts based on sympathy rather than reason and ambulance-chasing lawyers waving the banner of victims' right to sue.

Last year, the average product liability award in the United States was \$1.07 million, up from \$345,000 just 10 years earlier. The average medical malpractice award was \$950,000. In 1983, 360 personal injury cases were settled with million dollar awards or more, 13 times the number in 1975.

One-fourth of the obstetricians and general practitioners responding to a California Medical Association survey said they had stopped or were considering stopping their delivery of babies in response to rising malpractice insurance premiums. Similar tales of liability insurance woes stemming from large damage awards are coming from almost every profession and industry.

Some Californians are taking matters into their own hands. Spurred by the Legislature's failure to act, the California Chamber of Commerce is urging business and public support for an initiative that would limit the amount paid for pain and suffering (non-economic losses) in deep pocket cases to the degree the defendant was at fault.

Other potential remedies include tighter definitions of liability, ceilings on damage awards, limits on trial lawyer fees that encourage pursuit of multimillion-dollar awards, greater use of arbitration, more restrictive statutes of limitation and periodic rather than lump sum payment of large awards.

Meese accurately described the bottom line. If the trend of increased damage awards continues, he warned, "the impact on our nation's economy could be almost devastating ... The size and unpredictability of these awards threatens to suppress the commercial vitality on which our nation's economy depends."

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# Capacity also tight in London market

By STACY SHAPIRO

Continued from previous page  
M&M's Mr. Sinnott.

A&A's Mr. Polstein says that last July A&A clients that wanted \$200 million to \$250 million in D&O coverage had to settle for about \$100 million. "Now it's a question of getting them \$50 million or \$75 million," he explains.

To find some of these more difficult coverages, brokers are turning more often to the surplus lines market.

"We've had to use surplus lines more, but we find it's more complicated," said Gene McCrory, president of North American Insurance Agency Inc. in Oklahoma City.

Robinson-Conner also is continuing to use the surplus lines market more, said Mr. Conner.

In one instance, an admitted insurer found out how much a policyholder was going to pay for coverage in the surplus market and said: "Well, if you're going to pay that much, we'll write it," Mr. Conner said.

Bartlett's Mr. Miles also reports using the surplus lines market more, but doesn't believe it is doing a good job.

"I don't think they have enough staff to answer all the demand for quotes," Mr. Miles said.

"Sometimes we had to go to the excess/surplus market and use creative marketing: different pieces at different layers with different insurers," said Donald R. Weber, chairman and chief executive officer of Financial Guardian Group Inc. in Kansas City, Mo.

In some cases to secure hard-to-place coverage, brokers are putting together policies with higher deductibles or large self-insured retentions.

"Some clients have volunteered to take deductibles, clients that heretofore wouldn't even discuss it," said Robinson-Conner's Mr. Conner.

But self-insurance is not a good alternative, especially for smaller clients that have paid only \$50,000

LONDON—To say that placing U.S. property and casualty risks in the London market is difficult is the "classic English understatement," says John Woodson, managing director of the international division of Lloyd's of London broker Willis Faber P.L.C.

Rates are rising and capacity is shrinking in London for all lines of business, observers agree.

"It is fairly common knowledge that London has extremely restricted capacity in the liability field," said Simon Harrap, managing director of broker Stewart Wrightson North America Group Ltd.

"Property is tight but not impossible, and wrongful acts—errors and omissions—is somewhere in between," Mr. Harrap said.

Americans are flocking to the London market, looking for much-needed capacity they cannot find in the U.S. market, sources in the market say.

Some are indeed finding new capacity. Willis Faber, for example, has 40% more American business on its books this year than it had last year, Mr. Woodson said.

But, many U.S. insurance buyers are coming away from London disappointed because the capacity they seek simply isn't there, brokers and underwriters say.

**'A lot of Americans fly over to spend time looking for capacity, and they are shocked when they arrive. There are more U.S. buyers coming over here on a wing and a prayer and many are disappointed by what they see,' Mr. Harrap says.**

"A lot of Americans fly over to spend time looking for capacity, and they are shocked when they arrive," Mr. Harrap said.

"There are more U.S. buyers coming over here on a wing and a prayer and many are disappointed by what they see," he added.

Mr. Harrap says buyers last year could buy excess liability limits of \$300 million.

"Now they're lucky to find \$50 million," he says.

"If everything is right and all markets pull together, \$150 million to \$200 million is the maximum amount a client can find in capacity" for liability risks, said Brian Hibbert, chairman of C.T. Bowring Insurance Ltd.

"In reality, though, it is more like \$100 million to \$125 million," Mr. Hibbert comments.

Rate increases can range anywhere from 25% to 400%, Mr. Hibbert added.

"Everything's up this year," he said. "And many policyholders do

not have full programs. You heard of the saying "Swiss cheese"? Well, if a program is layered to \$100 million, then it may be that none of the layers is complete or there are exclusions."

"Prices are increasing. Errors and omissions are up 100%, particularly for architects and engineers, where there is beginning to be a lack of market capacity," commented Colin Bird, who recently left Minet Holdings P.L.C. to join Lloyd's of London broker J. Besso & Co.

"The problem is new business. There is not a class of business that isn't distressed. Even property people are having their problems. And yet, business is coming from everywhere," Mr. Bird said.

"I've never known this before," he continued. "The whole world market is trouble. . . . The only bargain is that Lloyd's is still offering the most secure policy in the world, despite its troubles."

Adding to Lloyd's troubles is that

some underwriters are saying that, because they are taking in so much business at higher rates, they soon may reach the premium limits set by Lloyd's. However, brokers agree that underwriters seem to have saved enough capacity to write renewal business and some new, good risks.

Adding to the upheaval in London is the Insurance Services Office's proposed commercial general liability claims-made form, which is to take effect Jan. 1, and the claims-made umbrella form that is currently being drafted in London (see story, page 1).

The reinsurance market is particularly interested in the claims-made forms, said Nigel Huntington Whiteley, director of the North American division of E.W. Payne Ltd.), a subsidiary of Sedgwick Holdings P.L.C.

Mr. Huntington said that, by the beginning of the year, reinsurers "will probably not provide casualty reinsurance cover unless the ceding companies write on a claims-made form."

And, he adds that in the last six months, "there has been further reduction in capacity, particularly because of Lloyd's premium income limitations," Mr. Huntington said.

"The large industrial companies can't buy anything like they could since last year."

## Spicer & White members sue

LONDON—Lloyd's of London underwriting agency Spicer & White (Underwriting Agencies) Ltd. plans to transfer the management of Syndicate 895 to another agency after 172 members of the syndicate filed suit against Spicer & White.

The members sued Spicer & White in London High Court after agency withdrew its offer of a five-year interest-free loan to help members pay anticipated losses of 19 million pounds (\$26.4 million). The offer was backed by Chase Manhattan Bank and Spicer & White's parent company, Lloyd's broker Willis Faber P.L.C. (BF, June 2)

## High rates idle shrimp boats

ARANSAS PASS, Texas—Shrimp boats that would be fishing in the Gulf of Mexico are sitting in port even though the shrimping season began last week because some owners cannot afford the price of hull and liability coverage.

The cost of hull and protection and indemnity coverage combined have increased 100% to 300% for the shrimpers, according to Ralph Rayburn, executive director of the Texas Shrimpers' Association.

Exhibit XI

■ INSURANCE

# Rising Premium Charges Swamp Some Businesses

BY JEFF PELLINE

Commercial fishermen, home day-care operators, engineers, rental car dealers and truckers all have the same complaint: Soaring insurance costs are eroding profits and threatening to put many of them out of business.

Insurance companies generally agree, but they say the rate increases are justified. Insurers say that their losses are greater than ever, blaming the rash of huge liability awards from the courts, along with a drop in income from investments.

Seventeen insurance companies went broke last year, a near record, and the industry wants to reverse the trend as quickly as possible, according to the Insurance Information Institute.

"They're grabbing for straws, and we're at the bottom and getting the worst of

it," said Peter Kondrashoff, 44, a commercial fisherman who pays \$23,737 a year to insure his boat and three-man crew against property and casualty losses, up from \$18,544 last year.

"I'm terrified to see the bill for next year's rates, which I'll get next month," said Kondrashoff, who has been catching fish off the Northern California coast for 25 years and is paying more than ever for insurance.

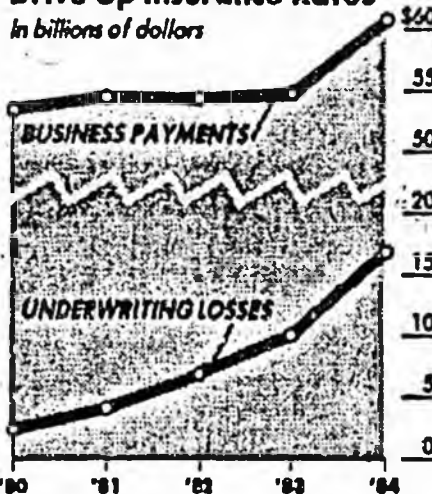
Examples abound of businesses' hardships because of rising insurance rates:

■ Thrifty Rent-A-Car, a 15-year-old car rental company based in San Francisco, filed for Chapter 11 bankruptcy protection on June 20, about a week after being told it needed to make a \$75,000 cash deposit to cover rising insurance premiums.

"It's probably going to put us out of business," said Bill Wristen, Thrifty's opera-

## BUSINESS INSURANCE COSTLIER AND SCARCER

Underwriting Losses Drive Up Insurance Rates  
In billions of dollars



Source: A.M. Best Co.

### Hard-to-Buy Insurance

The following types of insurance are the most difficult to get because of risk and the potential for large claims:

1. Municipal liability
2. Pollution liability
3. Liquor liability
4. Long-haul trucker coverage
5. Medical malpractice
6. Commercial fishing boat coverage
7. Asbestos removal from buildings
8. Consumer product liability
9. Day-care center coverage
10. Company director and officer liability

Source: Insurance Information Institute

tions manager. Under Chapter 11, Thrifty continues to operate while it devises a debt repayment plan and is protected from creditor lawsuits. (The car rental agency is an independently owned franchise of the national car rental chain that has the same name.)

The Thrifty franchise, which posts yearly revenues of \$5 million, has seen its insurance rates more than double to \$500,000 from \$215,000 in the past year, Wristen said. Other local independent car rental

Exhibit XII

# Public housing faces 1,300% insurance hike

By Sharon Bernstein  
LAT News Service

MARTINEZ — The insurance policy on the county's public housing projects will be canceled in early November and a new policy will cost the Housing Authority 13 times as much.

Under what housing officials say is the best offer they've received, property insurance will go from \$28,947 under Fremont indemnity, which canceled the Housing Authority's policy, to \$366,000 under Alexander and Alexander of San Francisco.

As an alternative to what he called the "outrageous" premiums, the Housing Authority's director, Perfecto Villarreal, has started setting up a \$500,000 self-insurance fund.

But officials at the federal Department of Housing and Urban Development said even if the county sets up its own fund, it will need emergency insurance for very large claims, and will probably still end up spending hundreds of thousands of dollars for insurance.

County Administrator Phil Batchelor said the Housing Authority is the fourth public agency to be hit with an insurance surprise this summer — the others are the county child care program for foster children, the mosquito abatement district and the health department, where doctors are faced with skyrocketing malpractice insurance costs.

Villarreal said he sent out 56 letters to insurance companies, soliciting bids for county coverage, and did not get one positive response.

The Board of Supervisors, whose members also serve as the board of the Housing Authority, has ordered Villarreal to write a letter to the state demanding a full scale investigation into insurance company practices with regards to public agencies.

Richard Payne, Senior Vice President of Alexander and Alexander, refused to comment on the tremendous increase in premiums to the Housing Authority.

But in a letter to Villarreal dated Sept. 3, Payne wrote: "I personally recognize that the premiums are extraordinarily high compared to what you paid last year, however, as far as I can determine that is all the market has to offer."

Bruce Vincent, a housing management officer with HUD in Washington, said Contra Costa's increase, which works out to 1,300 percent, is high, but it could be worse. "The average rate of increase for all lines (of insurance) is 400 percent," he said. "We've even seen one come in at 3,000 percent."

Vincent said one reason for the sudden increase in premiums is a change in investment markets for insurance companies.

Please see INSURANCE, Page 28



Times photo/Alan Girth  
All transit information booklets.

on downtown Concord.  
"Through this ordinance, we can attack and solve traffic problems together," said Taggart.

But Bob Kinert of PG&E suggested the ordinance should apply to more residential areas to spread the traffic burden fairly.

Unlike Pleasanton, a pioneer in transportation systems management, Concord isn't setting a goal of 20 or 30 percent and making all businesses conform to it. Instead, new developments must set a goal that the Planning Commission considers reasonable.

# State threatens insurance firms Wants to stop rising premiums

By Bill Snyder  
Times staff writer

SAN FRANCISCO — Hoping to slow a wave of stunning increases in commercial insurance premiums, a state agency is threatening to take legal action against some of California's 650 casualty companies.

Businesses ranging from banks to brake shops have found the cost of liability insurance increasing from 100 percent to 500 percent this year, while others have found it impossible to get insurance at any price.

Bruce Bunner, head of the state Department of Insurance, said the increases threaten the survival of some businesses and may be in violation of state law.

In a letter to chief executive officers of the state's property and casualty companies, Bunner warned that his department may bring charges of unfair trade practices against insurance companies that cancel or make drastic changes in commercial policies before they have expired.

Policy cancellations are estimated to be occurring three or four times more often this year

ship, said E. Harlan Miller, president of the brokers' association.

One East Bay contractor lost his insurance and almost went out of business. "The good news was he found another carrier. But the bad news was his premium increased from \$3,000 to \$10,000 a year," said Jorge Sandoval, a spokesman for the Department of Insurance.

In Richmond, liability insurance for the Alvarado Bank increased by about 100 percent this year, while the deductible portion of the policy jumped by 1,000 percent, said Alvarado's president Timothy Thompson.

"Other banks haven't been able to get insurance at any price," he said, noting that the financial industry may start its own insurance pool.

Liability insurance for the banks has nothing to do with stability of deposits, but covers everything from bonding employees to the taking of hostages during a robbery.

Particularly galling to Thompson is the fact that the 2-year-old bank had insurance problems even though it has never filed a

SLIDING SCALE  
CONTINGENT  
FEE

BUSINESS AND PROFESSIONS CODE

ARTICLE 8.5. CONTINGENCY FEE AGREEMENTS

Section

6146. Limitations; periodic payments.

6147. Contract; duplicate copies; contents; effect of noncompliance; application to contracts for recovery of workers' compensation benefits.

*Article 8.5 was added by Stats.1975, 2d Ex.Sess., c. 1, p. 3967, § 24.2*

*Heading of Article 8.5, "Contingent Fee Agreements: Medical Injury Claims", was amended by Stats.1982, c. 415, p. 1760, § 1, to read as it now appears.*

§ 6146. Limitations; periodic payments

(a) An attorney shall not contract for or collect a contingency fee for representing any person seeking damages in connection with an action for injury or damage against a health care provider based upon such person's alleged professional negligence in excess of the following limits:

(1) Forty percent of the first fifty thousand dollars (\$50,000) recovered.

(2) Thirty-three and one-third percent of the next fifty thousand dollars (\$50,000) recovered.

(3) Twenty-five percent of the next one hundred thousand dollars (\$100,000) recovered.

(4) Ten percent of any amount on which the recovery exceeds two hundred thousand dollars (\$200,000).

\* \* \* The limitations shall apply regardless of whether the recovery is by settlement, arbitration, or judgment, or whether the person for whom the recovery is made is a responsible adult, an infant, or a person of unsound mind.

(b) If periodic payments are awarded to the plaintiff pursuant to Section 567.7 of the Code of Civil Procedure, the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and include this amount in computing the total award from which attorney's fees are calculated under this section.

(c) \* \* \* For purposes of this section:

Asterisks \* \* \* indicate deletions by amendment

28 Cal.Code—8  
1985 P.P.

143

(1) "Recovered" means the net sum recovered after deducting any disbursements or costs incurred in connection with prosecution or settlement of the claim. Costs of medical care incurred by the plaintiff and the attorney's office-overhead costs or charges \* \* \* are not deductible disbursements or costs for such purpose.

(2) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500), \* \* \* or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

(3) "Professional negligence" is a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that the services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

(Added by Stats.1975, 2nd Ex.Sess., c. 1, p. 3967, § 24.2. Amended by Stats.1975, 2nd Ex.Sess., c. 2, p. 3959, § 1.185, urgency, eff. Sept. 24, 1975, operative Dec. 12, 1975; Stats.1981, c. 714, p. 2560, § 23.)

1975 Legislation.

Medical malpractice insurance, action for declaration of rights and duties, see note under Code of Civil Procedure § 164.

Operative effect of Stats.1975, 2d Ex.Sess., c. 2, see note under § 160.

Law Review Commentaries

Medical malpractice: Alleged "crisis" in perspective. Wylie A. Aitken (1975) 3 West.St.U.L.Rev. 27.

Patient's compensation board: Answer to medical malpractice crisis. Dennis E. Carpenter. (1975) 3 West.St.U.L.Rev. 15.

Price of health care availability: Economics of medical malpractice. (1979) 11 Southwestern L.R. 1371.

Proposed legislation: Amend MICRA to include mandatory mediation of medical malpractice claims. (1980) 14 U.S.F.L.Rev. 439.

Library References

Attorney and Client ¶147.

C.J.S. Attorney and Client § 313 to 317.

Notes of Decisions

1. In general

Limitations on attorney contingent fee contracts are to be applied prospectively to contracts entered into after the effective date of c. 1, 2nd Ex.Sess., 1975, to avoid impairment of obligations. Op.Leg. Council, 75 A.J., 2nd Ex.Sess., 378.

COLLATERAL  
SOURCE

§3333.1. Introduction of Evidence of Amount Payable as Benefit in Action for Personal Injury—Health Care Provider Defined—Professional Negligence Defined.

(a) In the event the defendant so elects, in an

action for personal injury against a health care provider based upon professional negligence, he may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the personal injury pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or other health care services. Where the defendant elects to introduce such evidence, the plaintiff may introduce evidence of any amount which the plaintiff has paid or contributed to secure his right to any insurance benefits concerning which the defendant has introduced evidence.

(b) No source of collateral benefits introduced pursuant to subdivision (a) shall recover any amount against the plaintiff nor shall it be subrogated to the rights of the plaintiff against a defendant.

(c) For the purposes of this section:

(1) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider;

(2) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital. Leg.H. 1975 Second Extra. Sess. chs. 1, 2, operative December 12, 1975, 1976 ch. 1079.

Ref.: Cal Fms Pl & Pr, "Dentists," "Hospitals," "Physicians and Other Medical Personnel."

1976 Note: See note following Code of Civil Procedure §364.

§ 667.7. Action Against Health Care Provider  
With Judgment Ordering Payment of Future  
Damages in Whole or Periodically—  
Definitions—Legislative Intent.

(a) In any action for injury or damages against a provider of health care services, a superior court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds fifty thousand dollars (\$50,000) in future damages. In entering a judgment order-

ing the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

(b) (1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and attorney's fees.

(c) However, money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In such cases 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 in accordance with this subdivision.

(d) Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security given, pursuant to subdivision (a) shall revert to the judgment debtor.

(e) As used in this section:

(1) "Future damages" includes damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(2) "Periodic payments" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(3) "Health care provider" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Os-

teopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code; and any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code. "Health care provider" includes the legal representatives of a health care provider.

(4) "Professional negligence" means a negligent act or omission to act by a health care provider in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death, provided that such services are within the scope of services for which the provider is licensed and which are not within any restriction imposed by the licensing agency or licensed hospital.

(f) It is the intent of the Legislature in enacting this section to authorize the entry of judgments in malpractice actions against health care providers which provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the Legislature that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also the intent of the Legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time which might alter the specifications of the original judgment. Leg.H. 1975 Second Extra. Sess. chs. 1, 2, operative December 12, 1975.

Ref.: Cal Fms Pl & Pr. "Dentists," "Hospitals," "Physicians and Other Medical Personnel"; W. Cal. Pro., "Attorneys" § 6A.

# Tort Report

September 1985

## TORT REPORT

### INSIDE:

- MICRA Amendments Defeated
- MICRA Limits Upheld
- Montana Limits Punitives
- The Insurance Crisis
- Tobacco Litigation

*The Association for California Tort Reform is a statewide coalition of businesses and organizations dedicated to the reform of California's tort liability laws. Inquiries should be directed to ACTR, 1130 K Street, Suite 250, Sacramento, CA 95814, (916) 442-1111.*

## Assembly Refuses to Button Deep Pocket Coalition Moves Ahead on Initiative

Both SB 75 (Foran) and an alternate deep pocket bill, AB 1332 (W. Brown) were voted two-year bills by the Assembly Judiciary Committee last week. ACTR-sponsored SB 75 would have limited a defendant's liability for noneconomic damages to that defendant's proportion of fault as determined by the factfinder. This would be a change from the present law of joint liability which holds each defendant liable for the entire amount of the plaintiff's damages regardless of degree of fault. SB 75 stalled in Assembly Judiciary after approval by the Senate, repeating the pattern set by similar bills introduced in past legislative sessions.

AB 1332 was a spot bill by Elihu Harris, which was amended to give relief to cities and counties when the claim relates to traffic accidents. In a multiple defendant action, a public entity defendant would be held liable for noneconomic damages only to the proportion of fault as determined by the factfinder. Private sector defendants in the same action would still be held jointly liable for the

entire judgment. This measure merely reflects existing law regarding public entities in a somewhat narrowed interpretation. By protecting public entities only, the bill would shift additional costs to the private sector. Private sector defendants, already besieged with skyrocketing liability insurance premiums and increasing unavailability of coverage at any price for certain risks, would find themselves in a worse situation than the status quo.

### Assembly Inaction Spurs Initiative Effort

The same day the Assembly Judiciary Committee refused to give relief to all deep pocket defendants, a coalition of interests including business and government voted to move ahead on getting an initiative before the voters. The proposed initiative, which has been named the Fair Responsibility Act of 1986, would tie actual fault to liability for noneconomic damages similar to the provisions of SB 75. Work is now in progress to place the

*(continued on page 4)*

## Labor and Management Negotiating Termination Proposals

Lieutenant Governor Leo T. McCarthy recently served as a mediator in an attempt to bring labor and management together on a solution to wrongful termination litigation. ACTR, together with allied groups the California Employment Law Counsel, California Chamber of Commerce and other employer representatives, sponsored AB 1400 (McAlister) in the California Legislature this year. This bill provides incentives for employers and employees to arbitrate disputes over firings. The measure prohibits punitive damages in termination proceedings but retains compensatory relief for wrongful terminations.

Labor sponsored SB 1348 (Greene). That bill would require an employer to discharge an employee only for "just cause." Termination could be accomplished only after a Notice of Intent to Discharge was provided to the employee and the employer had an opportunity to exercise mediation and arbitration rights. The bill sets forth requirements for a fund for disbursement to the Department of Industrial Relations which would administer the program. Contributions would be mandatory from employers and employees.

McCarthy wrote to the sponsors of

both bills and invited them to a meeting in his office to discuss whether a compromise could be reached. The realistic political assessment is that no bill will be approved by the legislature unless labor and management can agree on a bill.

The initial meeting was productive and promising. The participants identified the following issues for further exploration and discussion: (1) the length of time a person must be employed to be covered by the provisions of the act; (2) additional incentives to ensure that arbitration is a preferred method of resolution rather

*(continued on page 4)*

Medical Underwriters of CA  
6250 Clarendon Ave.  
Oakland, CA 94618

Association for California Tort Reform  
1130 K Street, Suite 250  
Sacramento, CA 95814  
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## DEEP POCKET INITIATIVE

*(continued from page 1)*

initiative on the June '86 ballot. Contributions have been received from numerous supporters including ACTR, California Medical Association, California Chamber of Commerce, Association for California Insurers, California Manufacturers Association and Cal-Tax. A volunteer grass roots effort will be launched to gather signatures, and Dick Woodward of Woodward & McDowell, campaign managers for the initiative, believe a sufficient number of signatures can be gathered to put this troublesome issue before the voters in June.

## THE INSURANCE CRISIS *(continued from page 3)*

risks for the future are simply eliminating coverage of high risk areas and pricing available policies out of reach for many businesses. Bailing out of the markets on the part of insurers and reinsurers is most evident where risks of litigation are high, such as in pollution, directors' liability, municipal liability and professional malpractice. Good safety records are not determinative of whether a policy will be continued or at what price.

The insurance industry is likely to withdraw more coverage areas and raise premiums for available policies still higher so long as no action is taken to impose balance on our legal system. That balance

is not forthcoming from the courts, so either Congress or state legislatures must act. Even then, legislative remedies take time, and changes are likely to be slow and incremental. Proposals in California that would cap noneconomic damages or hold defendants liable only for their proportionate share of such damages, in accordance with their degree of fault as determined by the factfinder (SB 75), have hit repeated roadblocks in the Assembly. Meanwhile, it is clear that so long as courts continue to expand theories of liability and juries continue to award unrealistic amounts in damages, the prospect of an uninsured society draws ever closer to reality.

## MONTANA LIMITS PUNITIVES *(continued from page 2)*

outside the presence of the jury, that the plaintiff has presented a prima facie claim for punitive damages.

The most significant change effected by the new law is that in cases when punitive damages are awarded, they may not exceed \$25,000 or one percent of the defendant's net worth, whichever is greater. Previously, the only guideline was that the amount was to constitute punishment since it would be absorbed directly by the defendant and could not be covered by insurance. Although remittitur remains available in most jurisdic-

tions to reduce an award that is excessive, Montana has now statutorily mandated a cap on the amount that can be recovered on punitive damages. The significance of this new law can be appreciated best in light of the fact that punitives must be based on breach of a noncontractual obligation where the defendant has been found guilty of oppression, fraud, or malice, either actual or presumed. Evidently, the Montana Legislature determined that even conduct falling within these categories is insufficient to warrant imposition of punitives that could bankrupt a business.

## TERMINATION PROPOSALS

*(continued from page 1)*

than litigation; (3) constructing a two-tiered standard with just cause for line employees and good cause for legitimate business reason for managerial employees; (4) employer providing early notice explaining the reasons for the discharge to the employee so the employee would be able to prepare his case; (5) standards for when front pay would be a remedy in lieu of reinstatement. Another meeting was scheduled for October 8, at 10:00 a.m. in Lieutenant Governor McCarthy's office.

## Legal Affairs



THE OWNER OF PARIS' O'KITCH CAFES SUED McDONALD'S AFTER LOSING HIS FRANCHISE

## THE BACKLASH GROWS AGAINST FRIVOLOUS SUITS

A PLAINTIFF IS ORDERED TO REIMBURSE \$1.8 MILLION IN LEGAL FEES AFTER PRESENTING 'OBVIOUSLY FALSE' EVIDENCE

**T**here was never any love lost between Raymond Dayan and McDonald's Corp. In the early 1970s Dayan, a Chicago entrepreneur, waged a court fight to win a valuable franchise for McDonald's restaurants in France. So it was no surprise when Dayan marched back to court after McDonald's terminated his franchise in 1978. After a nine-month trial, Dayan lost his case in 1983. An Illinois court held that he violated McDonald's standards for quality, service, and cleanliness. But the case is important because of what happened next: The judge slapped Dayan with a bill for \$1.8 million for McDonald's legal fees and expenses.

In U.S. courts, unlike those in Europe, each side normally pays its own attorneys' fees. That "American rule," say critics, fosters litigation—especially against large companies. Plaintiffs, who often pay their lawyers only out of winnings, can force "deep pocket" companies to spend enormous sums, making almost any claim worth settling. Says J. Nicholas Miller, who teaches law at the University of Massachusetts at Amherst: "A plaintiff has almost nothing to lose except a little time."

That is beginning to change. Growing intolerance for frivolous suits is leading

to changes in the American rule. In the McDonald's case, Judge Richard L. Curry said that without Dayan's "untrue allegations" there would have been no dispute. In April, Illinois' intermediate appellate court agreed. The judges declared that Dayan, who now calls his Paris restaurants "O'Kitch," submitted "obviously false" evidence. McDonald's, said the judges, proved that there had been "indescribable unsanitary conditions," including evidence that "dog urine and excrement were found next to stored food. Rat poison was found spilled beside an 'oozing' carton of McDonald's sauce."

**REVIVING A 1933 LAW.** The McDonald's award is the most dramatic of several similar recent decisions from courts all over the U.S. The Illinois courts relied on an infrequently used 1933 state law that permits courts to assess fees against anyone who brings a suit based on claims that are "made without reasonable cause and found to be untrue." Many states have similar laws, but until recently judges have been reluctant to use them. The movement to punish those who bring frivolous suits may have been spurred last June when the U.S. Supreme Court, for the first time, assessed a charge against someone who had

brought a series of meritless appeals. And last summer federal rules went into effect that impose new duties on lawyers to be certain their cases are "well grounded in fact." Now, says attorney Daniel R. Solin, judges "are starting to say that just because you're an individual or a small corporation suing a large corporation does not mean that you have the right to bring a frivolous lawsuit."

Solin's New York firm, Solin & Breindel, has had two recent victories over fees on behalf of corporate clients. In one case, now being appealed, U.S. District Judge Gerard L. Goettel called a suit by two former employees of New York's St. Regis/Sheraton hotel "clearly one of the most frivolous employment discrimination actions ever brought." He ordered not only the plaintiffs but also their lawyer to pay \$10,000 each.

**COMPOUNDING A BIAS?** This is not the only way the American rule has been altered. Through scores of laws, Congress has said that in certain types of suits the winner can collect fees from the loser. Because those provisions were meant to foster certain kinds of cases, such as civil-rights suits, losing plaintiffs have rarely been made to pay their opponents' fees. That fact, say critics, together with a view of the courts as places to test novel theories, has encouraged baseless suits. Says John Cibinic Jr., a law professor at George Washington University: "We've gotten to the point where there are just plain silly suits."

But if the new interest in punishing those who bring frivolous suits is good for business, some worry that it may be bad for the legal system. The recent changes, says Oscar Chase, a New York University Law School professor, "make me nervous because they further an imbalance that I see as already existing in American litigation against less well-heeled parties." Says Gabe Kaimowitz, a civil-rights lawyer: "What judges are doing is trying to keep people like me out of the courts." Kaimowitz was recently ordered to pay more than \$19,000 in an employment-discrimination case that a federal judge declared was baseless.

Dayan says the ruling against him in the McDonald's case was unfair. "To me a frivolous lawsuit is if I sue you for no reason whatsoever. But I had a contract, and there was merit to it." He is appealing to Illinois' highest court. As part of the original decision, Judge Curry declared that since any appeal would be "a needless extension of a baseless lawsuit," Dayan could end up paying McDonald's fees for the appeals as well as the \$1.8 million. So far, McDonald's reports, it has spent \$500,000 on the appeals. Dayan is getting his day in court, but it may be an expensive one. ■

## ■ INSURANCE

## Some Firms Swamped By Rising Premiums

From Page 10

agencies say they're faced with similar troubles. They already are struggling to stay profitable, because ferocious price wars are keeping profit margins at razor-thin levels.

■ Last month, day-care center operators in Contra Costa County threatened to strike over rising premiums.

The 310-member Diablo Valley Day-Care Providers Association was fuming at rates that have jumped tenfold for some operators in the past year.

Some, such as Maria Martinez, who offers child care from her Pleasant Hill home, have been forced to pass the cost along to their customers. Martinez plans to raise her weekly rate by about \$8 to \$73.

Insurers defend the increases, saying they have been hit with huge underwriting losses. Well-publicized cases of child abuse in day-care centers have made day care a high-risk industry, said John McCann, a vice president of the Insurance Information Institute in San Francisco.

Mission Insurance of Los Angeles, one of the leading day-care center insurers, quit the business two months ago, reportedly because it was unable to get other companies

to share the risk in writing its policies. The procedure, known as reinsurance, protects one company from being hit with a large claim that could force it out of business.

■ Sarginson Distributing, a Modesto-based petroleum distributor, is paying about \$8000 for liability insurance that cost just \$1500 last year.

"We've had a very good insurance record, too," said owner John Sarginson. "I'm going to meet with my banker to talk about financing the new rates."

Initially, he was told the rates would rise to \$15,000 but he negotiated a lower price, arguing that a tenfold increase was unjustified.

"We can't afford this much longer," Sarginson said.

■ Commercial fishermen such as Kondrashoff are upset over higher rates caused by underwriting losses, primarily a result of crab fishing accidents in Alaska. Losses from Alaskan crab fishing accidents have totaled more than \$50 million in the past five years, far exceeding insurance premiums paid, according to Tom Caspell, an insurance broker with Durham & Bates in Portland.

"We've already been plagued by a lot of problems like poor fishing, and this puts an added strain on us," responded Kondrashoff.



Fisherman Peter Kondrashoff has been hard-hit by rising insurance rates for commercial fishing

Last week, members of Congress met with fishermen in Seattle to discuss their troubles. Next month, congressional hearings are scheduled in more cities on the West Coast and Gulf Coast. In October, Congress is expected to introduce legislation to help put a cap on the soaring rates, said Marc Rosenberg, vice president of the Insurance Information Institute in Washington.

Commercial fishing boat coverage, municipal liability, pollution liability, long-haul trucker coverage, medical malpractice, company director and officer liability, and day-care center coverage are among the most costly and hard-to-

get types of coverage.

Last week, professionals ranging from midwives to engineers gathered in Washington with consumer advocate Ralph Nader to decry insurance rates that have climbed as much as 1000 percent in recent years for some businesses. The rate increases "reflect a major economic crisis," Nader told a press conference.

While disputing Nader's charges that the crisis was "manufactured by a very wealthy insurance industry," insurers concede that a wide range of businesses are feeling the pinch.

"The real pressure is on the

small businessman who basically has no choice but to pay the premiums," said Robert Nevins, executive vice president of Fred S. James & Co., an affiliate of San Francisco-based Transamerica Corp. and the nation's fifth-largest insurance brokerage firm.

But insurers don't expect relief for at least two years. Nevins predicts that business insurance will rise an average of 30 percent this year and 20 percent or more in 1986.

Jury awards continue to escalate, resulting in underwriting losses that have outpaced interest income and surpassed previous records set from the 1906 San Francisco earthquake, according to the la-

sureurs. "It's a tried expression, but there's no such thing as a free lunch," Nevins said. "Somebody has to pay for the increased risk."

Last year, the nation's insurance companies posted a record operating loss of \$4 billion, their first loss in nine years, according to David Ostwald, vice president of the Insurance Services Office in New York. Although the loss is expected to be trimmed to \$2.9 billion this year, the industry won't return to profitability until at least 1988, Ostwald said.

Traditionally, insurance companies have relied on income from investments to boost earnings, said Richard Griebel, a spokesman for Novato-based Fireman Fund's Insurance Co. But recent falling interest rates have sharply cut the companies' ability to make money from their investments.

In addition, price-cutting for the past six years because of ferocious competition has kept rates lower than insurers wanted, Ostwald said. Normally, the industry experiences a cycle where rates hit bottom every three years.

"Insurance companies have been sitting their wrists and setting policies for far less than they should have," Ostwald said.

The rate-cutting cycle extended past three years because insurance companies were afraid they'd lose business to competitors, Nevins said.

"We hope that the insurance business will do a better job of controlling the ups and downs in the future — for everybody's sake," he said.

Exhibit A

## EDITORIALS

# The Deep Pocket

**A** SWIMMER RAN into the surf at Newport Beach and dived in. His head struck a sandbar, and he suffered serious head injuries and is now a quadriplegic.

He brought suit against the city, contending that the city was negligent because it did not post signs to warn him that waves caused undulations of the ocean bottom that could be dangerous. A jury agreed, and the city has been ordered to pay \$8 million in damages.

Newport Beach's 65,000 residents are wealthy enough, we suppose, to cover their liability. Other cities are not as affluent but are being put to the same risk. This is because a 1978 state Supreme Court decision put city treasuries up for grabs through an extraordinary widening of liability of public agencies. In a case called *American Motorcycle vs. Superior Court*, the court said that any defendant who contributed one percent or more to the damage offered by a plaintiff could be held responsible for the entire damage settlement if other defendants were unable to pay. This has become known as the Deep Pocket Theory.

There can be no question that the high court's decision has encouraged a floodtide of litigation, blaming cities for injuries because streets were inadequately lit, intersections were poorly designed, or stop signs were obscured.

The League of California Cities recently conducted a survey of the impact of Deep Pocket litigation upon local governments; 162 of the state's cities responded. They reported that over the last three fiscal years, they have paid out a total of \$42.4 million in judgments or settlements and that their potential liabilities

### San Francisco Chronicle

THE VOICE OF THE WEST

Richard T. Thieriot, Editor and Publisher

Charles de Young Thieriot, Publisher 1955-77

George T. Cameron, Publisher 1925-55

Founded 1865 by Charles and M.H. de Young

In current claims and suits amount to more than \$210 million. They have spent, in just three years, \$15.8 million in legal costs.

The city treasuries have been raided in other ways. If they assess potential litigation and find that a bush or a street light probably did contribute one or two percent to an accident, they often make the judgment that settling the case, buying out the plaintiff, even if everyone involved in an accident was unquestionably drunk, is the most prudent course of action. Proposition 13 in 1978 made it difficult to raise new taxes. Liability insurance costs have soared as a result of the new rash of suits: Hayward's insurance went from \$58,000 to \$225,000 — 388 percent of the original premium; Lodi's policy jumped from \$48,900 to \$248,000, rising to 505 percent of the original figure. And the deductible amounts on insurance policies have been increased, often to as much as \$500,000. If the trend continues, there is no question that Deep Pocket will mean future cutbacks of city services.

★ ★ ★

**THE EFFECTIVE** opposition of some powerful lawyers in the state stopped an effort to legislate reform in the last session of the state Legislature. They have both greed and compassion on their side, but neither justice nor reason.

When reform failed last year, it was before cities throughout the state encountered their huge increases in insurance premiums. The insurance emergency may give reform a better chance this year.

One measure before the Legislature, sponsored by Senator John Foran, D-San Francisco, would go part way toward solution. It would leave the cities liable for medical costs — even if they had minimal responsibility for an accident — but would require them to pay only their share of pain and suffering damage costs. Under that plan, a city found to be three percent responsible for an accident might still end up paying thousands of dollars in medical bills, but only three percent of the cost of pain and suffering.

That reform might curb the enthusiasm of some civil damage suit lawyers but would still leave the taxpayers vulnerable — which they should not be. True reform will come only with termination of the entire Deep Pocket doctrine the Supreme Court has inflicted upon local governments.

■ INSURANCE

# Rising Premium Charges Swamp Some Businesses

BY JEFF PELLINE

**C**ommercial fishermen, home day-care operators, engineers, rental car dealers and truckers all have the same complaint: Soaring insurance costs are eroding profits and threatening to put many of them out of business.

Insurance companies generally agree, but they say the rate increases are justified. Insurers say that their losses are greater than ever, blaming the rash of huge liability awards from the courts, along with a drop in income from investments.

Seventeen insurance companies went broke last year, a near record, and the industry wants to reverse the trend as quickly as possible, according to the Insurance Information Institute.

"They're grabbing for straws, and we're at the bottom and getting the worst of

it," said Peter Kondrashoff, 44, a commercial fisherman who pays \$3,737 a year to insure his boat and three-man crew against property and casualty losses, up from \$18,644 last year.

"I'm terrified to see the bill for next year's rates, which I'll get next month," said Kondrashoff, who has been catching fish off the Northern California coast for 25 years and is paying more than ever for insurance.

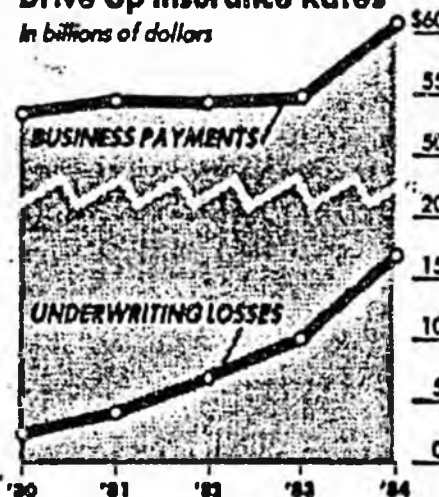
Examples abound of businesses' hardships because of rising insurance rates:

■ Thrifty Rent-A-Car, a 15-year-old car rental company based in San Francisco, filed for Chapter 11 bankruptcy protection on June 20, about a week after being told it needed to make a \$75,000 cash deposit to cover rising insurance premiums.

"It's probably going to put us out of business," said Bill Wristen, Thrifty's opera-

## BUSINESS INSURANCE COSTLIER AND SCARCER

**Underwriting Losses Drive Up Insurance Rates**  
In billions of dollars



Source: A.M. Best Co.

### Hard-to-Buy Insurance

The following types of insurance are the most difficult to get because of risk and the potential for large claims:

1. Municipal liability
2. Pollution liability
3. Liquor liability
4. Long-haul trucker coverage
5. Medical malpractice
6. Commercial fishing boat coverage
7. Asbestos removal from buildings
8. Consumer product liability
9. Day-care center coverage
10. Company director and officer liability

Source: Insurance Information Institute

tions manager. Under Chapter 11, Thrifty continues to operate while it devises a debt repayment plan and is protected from creditor lawsuits. (The car rental agency is an independently owned franchise of the national car rental chain that has the same name.)

The Thrifty franchise, which posts yearly revenues of \$5 million, has seen its insurance rates more than double to \$500,000 from \$215,000 in the past year, Wristen said. Other local independent car rental

Exhibit XII

# Public housing faces 1,300% insurance hike

By Sharon Bernstein  
UCI News Service

MARTINEZ — The insurance policy on the county's public housing projects will be canceled in early November and a new policy will cost the Housing Authority 13 times as much.

Under what housing officials say is the best offer they've received, property insurance will go from \$28,947 under Fremont Indemnity, which canceled the Housing Authority's policy, to \$366,000 under Alexander and Alexander of San Francisco.

As an alternative to what he called the "outrageous" premiums, the Housing Authority's director, Perfecto Villarreal, has started setting up a \$500,000 self-insurance fund.

But officials at the federal Department of Housing and Urban Development said even if the county sets up its own fund, it will need emergency insurance for very large claims, and will probably still end up spending hundreds of thousands of dollars for insurance.

County Administrator Phil Batchelor said the Housing Authority is the fourth public agency to be hit with an insurance surprise this summer — the others are the county child care program for foster children, the mosquito abatement district and the health department, where doctors are faced with skyrocketing malpractice insurance costs.

Villarreal said he sent out 56 letters to insurance companies, soliciting bids for county coverage, and did not get one positive response.

The Board of Supervisors, whose members also serve as the board of the Housing Authority, has ordered Villarreal to write a letter to the state demanding a full scale investigation into insurance company practices with regards to public agencies.

Richard Payne, Senior Vice President of Alexander and Alexander, refused to comment on the tremendous increase in premiums to the Housing Authority.

But in a letter to Villarreal dated Sept. 3, Payne wrote: "I personally recognize that the premiums are extraordinarily high compared to what you paid last year, however, as far as I can determine that is all the market has to offer."

Bruce Vincent, a housing management officer with HUD in Washington, said Contra Costa's increase, which works out to 1,300 percent, is high, but it could be worse. "The average rate of increase for all lines (of insurance) is 400 percent," he said. "We've even seen one come in at 3,000 percent."

Vincent said one reason for the sudden increase in premiums is a change in investment markets for insurance companies.

Please see INSURANCE, Page 28



Times photo/Alan Gersh  
transit information booklets.

on downtown Concord.

"Through this ordinance, we can attack and solve traffic problems together," said Taggart.

But Bob Kihert of PG&E suggested the ordinance should apply to more residential areas to spread the traffic burden fairly.

Unlike Pleasanton, a pioneer in transportation systems management, Concord isn't setting a goal of 20 or 30 percent and making all businesses conform to it. Instead, new developments must set a goal that the Planning Commission considers reasonable.

## State threatens insurance firms

### Wants to stop rising premiums

By Bill Snyder  
Times staff writer

SAN FRANCISCO — Hoping to slow a wave of stunning increases in commercial insurance premiums, a state agency is threatening to take legal action against some of California's 650 casualty companies.

Businesses ranging from banks to brake shops have found the cost of liability insurance increasing from 100 percent to 500 percent this year, while others have found it impossible to get insurance at any price.

Bruce Bunner, head of the state Department of Insurance, said the increases threaten the survival of some businesses and may be in violation of state law.

In a letter to chief executive officers of the state's property and casualty companies, Bunner warned that his department may bring charges of unfair trade practices against insurance companies that cancel or make drastic changes in commercial policies before they have expired.

Policy cancellations are estimated to be occurring three or four times more often this year

ship, said E. Harlan Miller, president of the brokers' association.

One East Bay contractor lost his insurance and almost went out of business. "The good news was he found another carrier. But the bad news was his premium increased from \$3,000 to \$10,000 a year," said Jorge Sandoval, a spokesman for the Department of Insurance.

In Richmond, liability insurance for the Alvarado Bank increased by about 100 percent this year, while the deductible portion of the policy jumped by 1,000 percent, said Alvarado's president Timothy Thomason.

"Other banks haven't been able to get insurance at any price," he said, noting that the financial industry may start its own insurance pool.

Liability insurance for the banks has nothing to do with stability of deposits, but covers everything from bonding employees to the taking of hostages during a robbery.

Particularly galling to Thomason is the fact that the 2-year-old bank had insurance problems even though it has never filed a claim.

Exhibit XIII

# Capacity also tight in London market

By STACY SHAPIRO

**'A lot of Americans fly over to spend time looking for capacity, and they are shocked when they arrive. There are more U.S. buyers coming over here on a wing and a prayer and many are disappointed by what they see,' Mr. Harrap says.**

Continued from previous page  
 M&M's Mr. Sinnott.

A&A's Mr. Polstein says that last July A&A clients that wanted \$200 million to \$250 million in D&O coverage had to settle for about \$100 million. "Now it's a question of getting them \$50 million or \$75 million," he explains.

To find some of these more difficult coverages, brokers are turning more often to the surplus lines market.

"We've had to use surplus lines more, but we find it's more complicated," said Gene McCrory, president of North American Insurance Agency Inc. in Oklahoma City.

Robinson-Conner also is continuing to use the surplus lines market more, said Mr. Conner.

In one instance, an admitted insurer found out how much a policyholder was going to pay for coverage in the surplus market and said: "Well, if you're going to pay that much, we'll write it," Mr. Conner said.

Bartlett's Mr. Miles also reports using the surplus lines market more, but doesn't believe it is doing a good job.

"I don't think they have enough staff to answer all the demand for quotes," Mr. Miles said.

"Sometimes we had to go to the excess/surplus market and use creative marketing: different pieces at different layers with different insurers," said Donald R. Weber, chairman and chief executive officer of Financial Guardian Group Inc. in Kansas City, Mo.

In some cases to secure hard-to-place coverage, brokers are putting together policies with higher deductibles or large self-insured retentions.

"Some clients have volunteered to take deductibles, clients that heretofore wouldn't even discuss it," said Robinson-Conner's Mr. Conner.

But self-insurance is not a good alternative, especially for smaller clients that have paid only \$50,000

LONDON—To say that placing U.S. property and casualty risks in the London market is difficult is the "classic English understatement," says John Woodson, managing director of the international division of Lloyd's of London broker Willis Faber P.L.C.

Rates are rising and capacity is shrinking in London for all lines of business, observers agree.

"It is fairly common knowledge that London has extremely restricted capacity in the liability field," said Simon Harrap, managing director of broker Stewart Wrightson North America Group Ltd.

"Property is tight but not impossible, and wrongful acts—errors and omissions—is somewhere in between," Mr. Harrap said.

Americans are flocking to the London market, looking for much-needed capacity they cannot find in the U.S. market, sources in the market say.

Some are indeed finding new capacity. Willis Faber, for example, has 40% more American business on its books this year than it had last year, Mr. Woodson said.

But, many U.S. insurance buyers are coming away from London disappointed because the capacity they seek simply isn't there, brokers and underwriters say.

"A lot of Americans fly over to spend time looking for capacity, and they are shocked when they arrive," Mr. Harrap said.

"There are more U.S. buyers coming over here on a wing and a prayer and many are disappointed by what they see," he added.

Mr. Harrap says buyers last year could buy excess liability limits of \$300 million.

"Now they're lucky to find \$50 million," he says.

"If everything is right and all markets pull together, \$150 million to \$200 million is the maximum amount a client can find in capacity" for liability risks, said Brian Hibbert, chairman of C.T. Bowring Insurance Ltd.

"In reality, though, it is more like \$100 million to \$125 million," Mr. Hibbert comments.

Rate increases can range anywhere from 25% to 400%, Mr. Hibbert added.

"Everything's up this year," he said. "And many policyholders do

not have full programs. You heard of the saying "Swiss cheese"? Well, if a program is layered to \$100 million, then it may be that none of the layers is complete or there are exclusions."

"Prices are increasing. Errors and omissions are up 100%, particularly for architects and engineers, where there is beginning to be a lack of market capacity," commented Colin Bird, who recently left Minet Holdings P.L.C. to join Lloyd's of London broker J. Besso & Co.

"The problem is new business. There is not a class of business that isn't distressed. Even property people are having their problems. And yet, business is coming from everywhere," Mr. Bird said.

"I've never known this before," he continued. "The whole world market is trouble... The only bargain is that Lloyd's is still offering the most secure policy in the world, despite its troubles."

Adding to Lloyd's troubles is that

some underwriters are saying that, because they are taking in so much business at higher rates, they soon may reach the premium limits set by Lloyd's. However, brokers agree that underwriters seem to have saved enough capacity to write renewal business and some new, good risks.

Adding to the upheaval in London is the Insurance Services Office's proposed commercial general liability claims-made form, which is to take effect Jan. 1, and the claims-made umbrella form that is currently being drafted in London (see story, page 1).

The reinsurance market is particularly interested in the claims-made forms, said Nigel Huntington Whiteley, director of the North American division of E.W. Payne Ltd., a subsidiary of Sedgwick Holdings P.L.C.

Mr. Huntington said that, by the beginning of the year, reinsurers "will probably not provide casualty reinsurance cover unless the ceding companies write on a claims-made form."

And, he adds that in the last six months, "there has been further reduction in capacity, particularly because of Lloyd's premium income limitations," Mr. Huntington said.

"The large industrial companies can't buy anything like they could since last year."

## Spicer & White members sue

LONDON—Lloyd's of London underwriting agency Spicer & White (Underwriting Agencies) Ltd. plans to transfer the management of Syndicate 895 to another agency after 172 members of the syndicate filed suit against Spicer & White.

The members sued Spicer & White in London High Court after agency withdrew its offer of a five-year interest-free loan to help members pay anticipated losses of 19 million pounds (\$26.4 million). The offer was backed by Chase Manhattan Bank and Spicer & White's parent company, Lloyd's broker Willis Faber P.L.C. (R1, June 3)

## High rates idle shrimp boats

ARANSAS PASS, Texas—Shrimp boats that would be fishing in the Gulf of Mexico are sitting in port even though the shrimping season began last week because some owners cannot afford the price of hull and liability coverage.

The cost of hull and protection and indemnity coverage combined have increased 100% to 300% for the shrimpers, according to Ralph Rayburn, executive director of the Texas Shrimp

Exhibit XIV

## Editorial

# Damage awards harm economy

U.S. Attorney General Edwin Meese's warning should be heeded. In a speech at the State Bar's annual meeting in San Diego last weekend, he said enormous damage awards in injury lawsuits, often without proof of fault, threaten serious harm to the nation's economy.

Meese said the insurance industry is in a "position of precariousness" because of expanding liability. Small businesses are being forced to go without insurance and face possible bankruptcy from lawsuits. He said he favored "re-establishment of fault as the critical standard by which liability is determined."

The nation's top law enforcement officer focused on California Supreme Court decisions establishing a doctrine of liability in product cases that lets victims of defective products collect damages without having to prove fault. But he could also have taken on the "joint and several" liability rule established by California courts.

Under this rule, also known as the "deep pocket" doctrine, local governments and businesses can be forced to pay all of a damage award in a personal injury lawsuit, even if they're minimally at fault for an accident, if other defendants are unable to pay. It has encouraged lawyers to name cities, counties and businesses as defendants based on their ability to pay multimillion-dollar awards.

Meese put it mildly when he said that in our litigious society, "the desire for compensation has overcome a sense of balance." The situation has been worsened by broadened court interpretations of liability, jury verdicts based on sympathy rather than reason and ambulance-chasing lawyers waving the banner of victims' right to sue.

Last year, the average product liability award in the United States was \$1.07 million, up from \$345,000 just 10 years earlier. The average medical malpractice award was \$950,000. In 1983, 360 personal injury cases were settled with million dollar awards or more, 13 times the number in 1975.

One-fourth of the obstetricians and general practitioners responding to a California Medical Association survey said they had stopped or were considering stopping their delivery of babies in response to rising malpractice insurance premiums. Similar tales of liability insurance woes stemming from large damage awards are coming from almost every profession and industry.

Some Californians are taking matters into their own hands. Spurred by the Legislature's failure to act, the California Chamber of Commerce is urging business and public support for an initiative that would limit the amount paid for pain and suffering (non-economic losses) in deep pocket cases to the degree the defendant was at fault.

Other potential remedies include tighter definitions of liability, ceilings on damage awards, limits on trial lawyer fees that encourage pursuit of multimillion-dollar awards, greater use of arbitration, more restrictive statutes of limitation and periodic rather than lump sum payment of large awards.

Meese accurately described the bottom line. If the trend of increased damage awards continues, he warned, "the impact on our nation's economy could be almost devastating ... The size and unpredictability of these awards threatens to suppress the commercial vitality on which our nation's economy depends."

"Our free press!"

# Business insurance rates skyrocket

## Customers may ultimately foot bill

By Kim Favors  
Staff writer

It costs \$32.50 for an office appointment with Dr. Conrad Anderson in Fremont.

And unless his malpractice insurance holds steady at \$10,000, the general practitioner next year may raise his fees.

A few miles away in downtown Hayward, residents of the Green

The news was even worse for Bob Oddone. He has to find new, and probably more expensive, insurance for Le Club Moderna, one of Hayward's oldest drinking establishments.

Insurance agent Ed Boese began calling insurers the day Oddone learned the policy on his Main Street bar would not be renewed.

"There's absolutely nothing wrong with his (Oddone's) business," says Boese, a partner with Farrell, Boese and Whited insurance brokers in San Francisco.

"It's a problem with the insurance industry as a whole... and the little businesses like Bob's are merely the victims, not the cause."

Across the nation all kinds of businesses are facing insurance premium increases ranging from 25 percent to more than 1,000 percent. Others, such as Oddone's, are being dropped by insurers as unprofitable clients.

Hardest hit seem to be bars, liquor stores, restaurants, rental agencies and day care centers — businesses that have experienced increased insurance claims during recent years. But municipalities and professionals, including doctors, accountants and lawyers, face skyrocketing insurance bills because of generous court awards.

Industry analysts attribute the increases to insurance companies' big underwriting losses in 1983 and 1984.

During the "premium price wars" of the late 1970s insurance companies raised rates in a fierce competition for business, hoping to invest incoming monies at 18 and 20 percent interest rates.

"Insurers were willing to write almost any risk at any price," says George A. Porter, president of the Independent Insurance Agents and Brokers of California.

But interest rates — and the insurance industry's profit margins — began dropping at about the same time the nation's courts began approving huge casualty and liability awards.

Last year the industry reported \$3.8 billion in losses. Seventeen insurance companies went broke.

"I've been in the business 45 years and I haven't seen anything like this," says Boese, who specializes in hotel and apartment building

Helping make up the insurance industry's losses through increased premiums are many East Bay businesses:

• Insurance costs at Di Giulio Pontiac GMC in Fremont "went up 87 percent this year" says general sales manager Ron Freitas, who declined to provide figures. A common premium increase for auto dealerships is from \$5,000 to \$10,000, says a spokesman for the Northern California Motor Car Dealers Association.

• Alameda County's medical malpractice insurance premiums increased this year from \$1.6 million to \$2.3 million. Highland Hospital had to increase its total coverage from \$30 million to \$100 million.

• Owners of Arnie's Time Out, a neighborhood bar on Mission Boulevard in Hayward, reluctantly paid a new premium of \$3,000, up from \$1,400. "You have to have insurance," says co-owner Daris Bishop.

Child-care providers statewide are being forced out of business by the huge increases in rates. In Southern Alameda County, insurance problems have shut down five homes.

The state's major home-care insurer is BMP Market Services of Sherman Oaks. Last year a home-care operator licensed for 12 children would have paid BMP \$279 for \$1 million in liability coverage and \$75,000 in accident, car accident and personal property coverage.

This year BMP is charging \$1,100 for only \$300,000 liability and the remaining \$75,000 coverage.

Other insurers are refusing to handle child-care policies following highly publicized allegations and convictions involving child abuse at day-care homes in Northern and Southern California.

The state Senate Monday approved an emergency measure requiring insurance companies to join a state-operated insurance pool for day-care centers. SB 1474 goes next to the Assembly.

Insurance costs for California physicians have eased somewhat since the state Legislature in 1973 imposed restrictions on medical malpractice suits.

Anderson's \$10,000 malpractice premium insures him up to \$1 million per lawsuit and a maximum of \$2 million each year.



Bob Oddone

Oddone has to find new, and probably more expensive, insurance for Le Club Moderna, one of Hayward's oldest bars.

In 1983 more than 400 personal-injury cases nationwide were settled with awards of \$1 million or more, reports show.

California particularly "has had a lot of serious problems with the number of lawsuits in the liability area," says Dennis Jay, spokesman for the National Association of Professional Insurance Agents.

In 1982 there were 13 awards or settlements over \$1 million statewide. A year later the number had risen to 19.

"We monitor insurance markets around the country... these days when people fall on the sidewalk they no longer think 'I need better footing next time.' They think instead, 'I'll call my lawyer.'"

David Blakesley, an agent with Cooper McKeele Murphy in Pleasanton, believes insurance companies are playing catch-up from the lowered premium rates they offered in the mid-70s.

"What they are really doing is within 1 or 1 1/2 years bringing in enough dollars to pay for their losses — they're making an increase quickly to make their financial statements look better."

The insurers are overreacting, Blakesley contends.

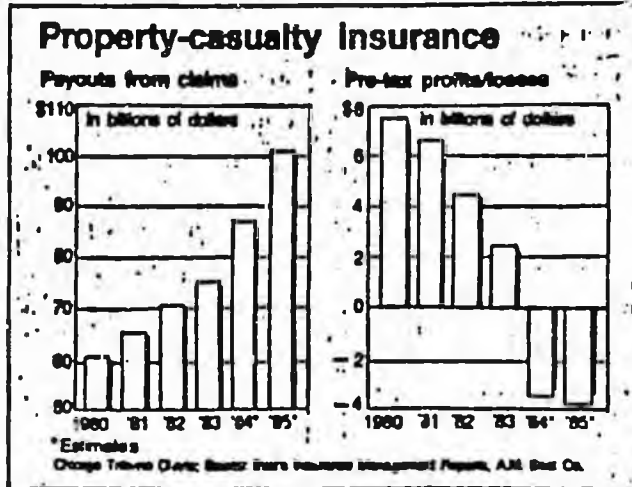
"If the insurance companies had stretched (the premium increases) over two or three years, it would have been a lot easier (for business), but they want to be profitable now."

And insurance rates are not expected to drop anytime soon, Porter maintains.

"We've been in a buyers market for five years. Insurance rates are going up, and won't be coming down in the foreseeable future."

"Each company is taking a much closer look at individual risks and pricing the product accordingly," Porter says.

"Premiums are going up... to assure companies have the reserves and surplus to meet future claims expenses."



"High risk" specialists such as obstetrician, neurosurgeons and orthopedic surgeons are paying \$35,000 to \$38,000 for the same coverage. In New York that coverage would cost \$100,000, says Anderson, a director with the Medical Insurance Exchange, which sells malpractice policies in Northern California, Nevada, Idaho, Alaska and Hawaii.

Also contributing to the rise in insurance premiums are increasingly generous court awards in personal-injury suits.

"The court system's broad interpretation... encourages lawsuits where fiscally responsible, adequately insured individuals and businesses end up paying for the mistakes of uninsured or underinsured entities," Porter says.



Conrad Anderson

Anderson's \$10,000 malpractice premium insures him up to \$1 million per lawsuit and a maximum of \$3 million each year.

Shelter Hotel on Main Street pay \$90 a week for a room with a bath, \$75 without. Their rates may go up.

"Somewhere along the line you have to pass on the costs," says hotel co-owner Dave Dyeane, who two weeks ago learned his premium — if he doesn't change insurers — will cost \$42,000 this year. In 1986 his property-casualty-liability insur-

Moraga

## Let people pet animals

The Contra Costa County Animal Shelter is continuously beseeching the public to "adopt a pet." They pull at our heartstrings with the cutesy pictures labeled, "Adopt Me!" and heart-tearing messages. So, in searching for a puppy, the animal shelter was my first choice.

What an experience! Not only was it disappointing, but I came away very angry. Two children and I walked through the kennel looking for a blond labrador-mix puppy. We found one stall that contained several puppies all asleep. I asked one of the workers if we might pet a puppy. He responded with a "no" and the rationale that the puppy might scratch us and we in turn might sue. In addition, he added a puppy could not be petted prior to adoption but I could adopt the puppy and take him home for a two-week trial period. No other alternative was offered, such as taking the puppy out of its cage. How was I supposed to know if the puppy was right for us? A shrug of the shoulders was the only response.

I am sorry, but this is ridiculous. Surely some sort of controlled environment could be found to allow safe minimal contact to enable us to make such an important decision. Zoos, schools and pet shops all allow contact with young animals. I have been to other shelters in Morgan Hill and Monterey and not found this policy in existence.

CELESTE SHEEHAN  
Pleasant Hill

EXHIBIT XVII

Thursday, October 10, 1985

Contra Costa Times—Page 3A

# State insurance probe unlikely

## Deukmejian sees 'no basis' to investigate rising premiums

By Sharon Bernstein  
Times staff writer

SAN FRANCISCO — Gov. George Deukmejian said he was not prepared to authorize a state investigation of insurance practices, despite skyrocketing premiums that some fear could put new Contra Costa cities out of business.

The governor's remarks came during a question-and-answer session with reporters after a speech to the 1,200 delegates from 441 cities attending the League of California Cities annual conference.

Deukmejian compared the denial of liability insurance to cities, counties and large businesses to the medical malpractice insurance crisis that hit the state.

"It got to the point where insurance companies were raising the premiums so high" that the state was forced to step in, Deukmejian said. "There was some major legislation that was enacted and as a result of that the situation has improved somewhat."

But he said he would not support legislation that would force

Los Angeles Mayor Tom Bradley 'misstates the facts', says governor

— Page 15A

insurance companies to take on public agencies.

"I'm not sure we can legislate something like that — to make them insure somebody they don't want to insure," he said.

When insurance for the Contra Costa County Housing Authority went from \$28,000 to nearly \$400,000 last month, the state commissioner of insurance threatened to mount a formal investigation of insurance practices.

But Deukmejian said there was "no basis" for such an investigation.

At least one Northern California city — Tehama, 30 miles south of Redding — is considering disincorporating because it can't afford insurance, and Contra Costa officials say the high premiums could be a threat to newly incorporated cities here.

The governor said he would



Gov. George Deukmejian ...  
... against "deep-pocket" rule

support legislation to overturn the so-called "deep-pocket rule of insurance liability (that) insurance companies cite as one reason they want to stop insuring local governments."

Under the rule, which was set up primarily by the courts, a party

can be held liable for all the damages in an accident, even if the party is only 1 percent responsible.

That means someone can sue the city over a car accident if the other driver was uninsured and it can be proven, for example, that the city's stop sign was partially covered by trees, making the city partly responsible for the accident.

"We must reform the California Supreme Court's so-called deep-pocket rule," the governor said in his speech. "The ability of an injured party to sue and win damages, not based on fault but on the ability to pay, has reached absurd proportions."

Besides insurance problems, the governor also railed the Supreme Court for failing to implement the death penalty.

"We still face a Supreme Court that refuses to heed the will of the people and implement the death penalty," Deukmejian said. "Since I authored the state's death penalty law in 1976 (when he was attorney general) juries have imposed this punishment over 200 times, yet not one murderer has paid the ultimate price."

Exhibit XVIII

# Judgment has chilling effect on meteorology

## \$1.25 million award a precedent

Deep Pocket →

WASHINGTON (AP) — A judge's ruling that the National Weather Service must pay the families of men lost in a storm it didn't predict has given some meteorologists the chills.

The award of \$1.25 million to the families of three lobstermen in Boston last week was the first ruling against the weather service in the memory of many meteorologists.

But the decision was based on the failure of the weather service to keep a weather-measuring buoy operating properly, not merely because the service had not predicted the storm that struck the men's boat.

The Boston ruling came just two weeks after another judge in Florida refused to hold the weather service liable in the 1980 Sunshine Skyway disaster, when a ship struck a bridge during a sudden thunderstorm killing 35 people.

Nonetheless, weathermen are concerned that the Boston case could become a legal precedent and start an onslaught of lawsuits over weather forecasts.

"We are going to appeal. It's not over yet," said Don Witten, a spokesman for the National Weather Service.

"It gave me the chills," said Frank H. Forrester, a retired forecaster who formerly was a television weatherman in New York, Jacksonville, Fla., and Washington.

"Despite all the computers and whiz-bang machinery, there is an element of art (in forecasting) that

you have to recognize," Forrester said.

Weather predictions are improving regularly, but they are based on incomplete information and thus cannot be perfect, he said.

"If the Boston ruling prevails, we may have to introduce caveats in forecasts, such as 'This was prepared with an incomplete data base' or something of the like," suggested Tom Reppert of the National Weather Service.

"This would have to be in every forecast, because there is no such thing as a total data base ... it would not be a public benefit but would satisfy the letter of the law," he said.

The available data was the focus of the Boston decision.

In question was a wind sensor on a buoy in the ocean that was not working and had not worked for several weeks. Lawyers for the families of the lost men contended that negligence in failing to repair the sensor caused a wrong forecast.

"We weren't challenged on a forecast, whether the forecast was good or bad," said Witten. "We were challenged on negligence for failure to maintain a buoy. We have never lost a case on a forecast."

"A forecast is provided on the basis of what we know, and we don't know everything about the atmosphere," he said. "There is an element of uncertainty."

Forrester noted that several past lawsuits ended with rulings in favor of the weather service.

Exhibit ~~IX~~

## Let's Say Goodbye to Joint Liability

Survival of our system of tort reparations by civil trial depends today on recapturing its original fairness, reasonable efficiency, and accessibility. Yet at the same time, public derision of that system is mounting, as distorted liability theories, excessive costs, and backlogs proliferate. Without reform, our system must inevitably collapse, to be replaced by bureaucracies processing inequitable benefits under complex formulae at ultimately unaffordable premiums.

Unfortunately, the clamor for reform has consisted mostly of diatribes against symptoms, rather than examinations of root causes. Legislators have proposed pre-suit screenings, abolition of contingency fees, or limits on verdicts, hoping they can somehow avoid the constitutional objections.

While headlines of runaway verdicts have provided emotional fodder for such suggestions, lawyers know the causes of problems in tort claims are the injustices which have resulted from a generation of procedural fads, such as joint liability and third-party practice in tort. These symptomatic treatments defy substantive tort concepts, and must simply be eliminated. "Joint liability," of course, is not a liability doctrine at all: it is a collectibility doctrine. Its perpetuation during the development of "comparative negligence" over the last quarter of a century has led to entirely artificial financial responsibilities, no longer based on faulty conduct, but rationalized on the transferrability of those judgments imposed against causally innocent parties.

Fairness in tort reparations provides an injured person with an enforceable opportunity to prove that a defendant's breach of a legal duty was causally responsible for the injury. Fairness does not contemplate for payment merely because an injury exists, nor, even worse, because someone else can't pay. These are functions of contracts or insurance — or of that future bureaucracy — but not of tort recovery. Yet "joint liability" not only creates such distortions, but does so in the guise of "distribution of the loss"!

As with *Quasimodo*, one would think nothing more could be wrong with "joint liability." But it has fathered the monstrous third-party practice in tort! This frequently mind-boggling procedure assumes that the cure to the harshness of joint liability is to require a party who has already been required to overpay his fair share to bring a second action against a party who has not paid his fair share. The abolition of such absurdities will follow routinely when tort judgments are again founded on the legal principle with which every fair-minded person agrees: a person should pay for damages he has caused, but not for damages he has not caused.

Elimination of joint liability will therefore at once make our tort adversary system well again. No longer will tort claims be handled on contract theories, but will be decided on the issues of tort law. Is there a legal duty to the plaintiff? Has it been breached? Did the breach proximately cause compensable damages? Each party will defend only itself. No longer will artificial, often theatrical alliances be paraded before juries in the guise of "trial strategies." The evasion of time-honored laws of immunity, abatement, or release will end. Even the present absurdly wasteful discovery abuses will cease. The courts will again be both accessible and economically available for the fair resolution of tort disputes.

Torts occupy 40 to 90 percent of the business of all our nation's courts. Eliminating joint liability will necessarily have an immediate, obvious and inevitably favorable impact on our troubled economy.

We defense lawyers must make this our single most important goal in all of tort law. Not to do so will simply speed the deterioration of the public's confidence in the legal system.

## On The Record



John E. Guy  
Chairman, DRI Practice &  
Procedure Committee

Exhibit XIX

### End 'deep pocket' lawsuits

It was my privilege to preside over a critical workshop on municipal risk management at a League of California Cities' Executive Forum for mayors and councilmembers. The topics for discussion were the issue of "deep pocket" lawsuits which are threatening to bankrupt California cities and the importance of pending legislation, Senate Bill 75, which would make the current law more equitable (SB75 is vigorously opposed by the trial lawyers).

SB75, sponsored by Sen. John Foran, D-San Francisco, would put a stop to current practices that allow an injured party who wins a lawsuit to collect all damages from any named defendant who is just 1 percent at fault if other defendants are unable to pay. Juries too often appear to view the public entity as a ready, but unfortunately not willing, source of judgment funding.

Reviewing this information, the councilmembers and mayors came to the conclusion that it is vital to have immediate citizen-taxpayer input to the state Assembly Judiciary Committee. Letters from citizens urging support for SB75 could assist the cities of Contra Costa County to retain millions of public dollars. The city of Pleasant Hill is urging a massive, supportive letter-writing campaign.

I am very pleased with the recent Contra Costa Times editorial which urged citizen support of SB75. I hope that citizens will actively respond by the Aug. 19 committee hearing deadline. Every dollar that goes to pay high insurance premiums and unfair judgments ultimately reduces city services. It is critical that we let members of the Legislature know that we do not wish to finance the careers of "deep pocket" lawyers. SB75 plugs this hole in the system by structuring "pain and suffering" payments based on degree of fault, not on perceived ability to pay.

PAUL L. COOPER  
Councilman  
Pleasant Hill

*Small cities  
and the deep pocket*

*PH. @C Times  
14 Aug 85*

The open season on insurance companies in courtrooms all over the country has gone on so long that the insurers can no longer afford to play. Are you ready for...

# A world without insurance?

**A** 41-YEAR-OLD body-builder entered a footrace with a refrigerator strapped to his back to prove his prowess. During the race, he alleged, one of the straps came loose and the man was hurt. He sued everyone in sight, including the maker of the strap. Jury award: \$1 million.

Two Maryland men decided to dry their hot-air balloon in a commercial laundry dryer. The dryer exploded, injuring them. They won \$885,000 in damages from American Laundry Machinery, which manufactured the dryer.

An overweight man with a history of coronary disease suffered a heart attack while trying to start a Sears lawnmower. He sued Sears, charging that too much force was required to yank the mower's pull rope. A jury in Pennsylvania awarded him \$1.2 million, plus damages of \$550,000 for delays in settling the claim. (Sears appealed but eventually settled out of court.)

Isolated cases of absurdly generous awards? Far from it. Last year the average product liability award in the U.S. was \$1.07 million—up from \$345,000 ten years earlier—and the average medical malpractice award was \$950,000. In 1983 alone 360 personal-injury cases were settled with million-dollar awards or more, an incredible 13 times the number in 1975.

By Jill Androsky with Mary Kuntz and Barbara Kallen

Americans now seem to look on a civil suit against a corporation or municipality as a kind of lottery—a lottery to be played whenever they can. Last year there was 1 private civil

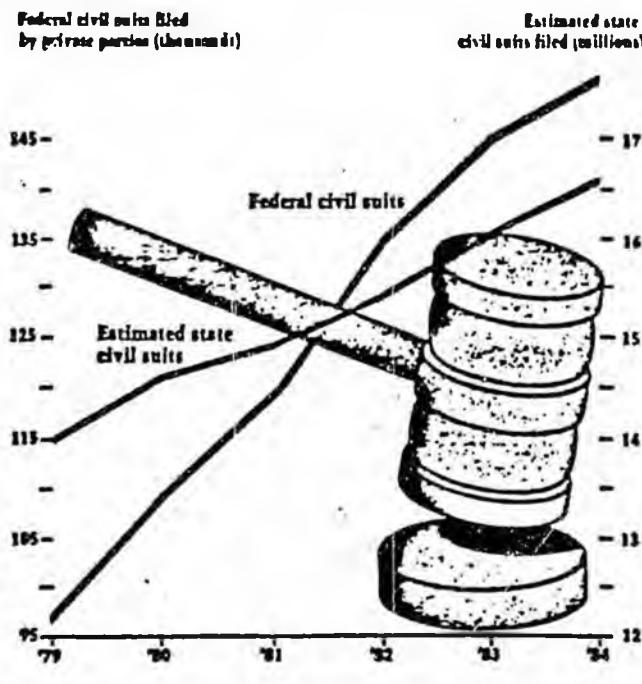
years ago. Just handling the paperwork probably cost taxpayers over \$360 million on all these actions last year. It cost insurance companies far more. In 1984 the property and casualty insurance industry as a whole paid out \$116.10 for every \$100 received in premiums—the worst numbers since the San Francisco earthquake and fire. Reinsurers, who take the brunt of the unpredictable risks, paid out nearly \$141 for every \$100 in premium income.

No industry can keep that up for long. "It's impossible for insurance companies to price liability products when they have no idea what the settlements and risks are going to be," says David O'Leary, a Hartford-based insurance analyst with the London brokerage firm of Fox-Pitt, Kelton. "Courts have expanded the definitions of liabilities for accountants and other industries to such an extent that insurers have started saying, we don't need the business."

For example, obstetricians can now be sued for "wrongful birth" if, for instance, a sterilized woman conceives. Accountants can be sued under "third party liability" by anyone who might reasonably have relied upon numbers they audited. The list goes on and on, and why not? Insurers have been picking up the tab and covering costs in part through their investment income for so long

## The litigation burden

There was 1 private civil lawsuit last year for every 15 Americans. And the best goes on: Federal civil filings by private parties are up 50% since 1979, while state filings are up 20%.



suit filed for every 15 Americans. An estimated 16.6 million private civil suits were tried in state courts last year. Another 150,000 private civil suits were tried in federal courts, which is nearly twice the number ten

13 insurers he does business with will be willing to write new commercial policies for anyone.

Companies will have to scramble for any type of coverage they can find. By far the most common strategy is to accept limits on coverage—higher deductibles, lower protection levels and, increasingly, exclusions for items such as legal defense costs and pollution liability. "We're paying more than double what we used to pay and we still haven't been able to replace all the coverage we lost," says Singer of Atlas Oil Co.

Insurers have also started pushing "claims-made" policies, which pay

risk manager Peter McDonough. "But that's not going to solve any of the major problems with the system."

Some companies are again setting up insurance captives, as they did in the mid-1970s. But captives are not very attractive from a tax standpoint (FORBES, Nov. 19, 1984), and they are risky to boot. Says O'Leary of Fox-Pitt, Kelton: "Many companies that set up captives ended up losing so much money that they have for the most part withdrawn."

But some see self-insurance as a curb on litigation. "I hope we're moving to the age of self-insurance," says Irving S. Shapiro, former chairman of

own version of disaster relief—a stock insurance company for big firms known as ACE, for American Casualty Excess Insurance. ACE will provide the final \$100 million in coverage—excess of at least \$100 million in self-insurance or policies. Eleven firms have jumped at the opportunity to join up—but that's out of the reach of many companies.

Industry insurance pools are popular with utilities, lawyers, accountants, fuel distributors and others. Of course, the exposure for any insurer of a single high-risk industry is enormous, even when only claims-made policies are sold. So some companies, instead, try to spread their risk by setting up multi-industry insurance pools. Result: High-risk companies, again, are out of luck.

The fact is, the problem cannot be dealt with solely from the insurance side of the equation. It must be approached from the legal side. So long as judges keep expanding the definition of liability and juries keep handing out astronomically high awards, the chilling prospect of a world without insurance draws ever closer.

One simple but unpopular solution would be to prohibit—or at least severely limit—the contingency fee system that encourages lawyers to seek the highest possible damages. "You don't see any other country having the kind of insurance problems that we have, because none of them have the kind of jury awards or contingency system we've got," says James Corcoran, New York State's superintendent for insurance.

But there are problems with such a move. "We may be the only country that really has a contingency fee system," says F. Lee Briley, a member of the three-lawyer consortium representing the Bhopal victims. "On the other hand, in most of the world, poor people go without any relief."

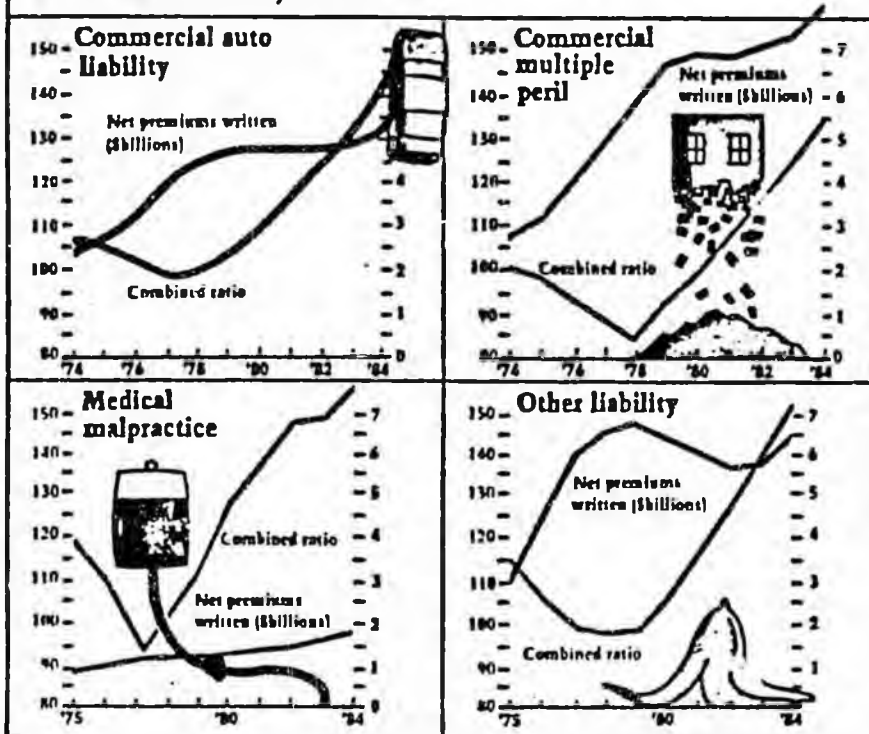
In the long run, maybe the only practical solution is legislative action to define liabilities and cap them at a fair and reasonable level. In New York, where obstetricians and neurosurgeons are turning away patients because of high malpractice insurance rates and where municipalities are scrambling for coverage, legislators have debated bills that attempt to cap liabilities for doctors and municipalities. Congress has contemplated a proposal by Senator Robert Kasten (R-Wis.) that would put a limit on corporate liabilities.

No longer do we have the luxury of pretending that the monster we have created will just go away.

It won't. ■

## Losing propositions

In four big commercial liability lines, insurers paid out from \$135 to \$160 for every \$100 of premium income taken in last year—a trend that has worsened steadily since 1978.



off only those claims filed during the policy term. Supporters of these insurance straitjackets argue that they will help insurers define their legal risks better and thus enable them to keep selling their products. But many are dubious. "Claims-made policies just postpone the problem," says Jon Harkavy, director of governmental affairs at the Risk and Insurance Management Society.

The last resort, of course, is self-insurance, either setting up a reserve fund to cover uninsured costs or, more commonly, paying them out of operating expenses. "Corporations of our size can afford to self-insure up to certain levels," says General Foods'

E.I. Du Pont and now a partner at Skadden, Arps. "Once lawyers realize they're suing a defendant who doesn't have an insurance firm with deep pockets beyond them, they'll sue somebody else." Unless, perhaps, the company is as big as Du Pont.

For companies that aren't as big as Du Pont—and even for some that are—self-insurance today carries the risk of being pushed into Chapter 11 tomorrow. Shapiro's solution: a federal disaster-insurance fund for corporations, similar to the federal flood-insurance program. But wouldn't such a pot of gold be even juicier bait for plaintiff lawyers?

Marsh & McLennan is testing its

that the system has taken on the look of natural law.

But insurers are not in the business of losing money. Their losses have become so appalling that at this point they are either raising their rates out of sight or getting out of the business. In April, Utica Mutual Insurance informed some 229 New York State municipalities that it would not renew their policies. Transit Casualty, a large carrier for restaurants in Connecticut, canceled most of that group's liability coverage. Mutual Fire, Marine & Inland Insurance announced it would not renew the malpractice policies of about 1,300 midwives as of July 3.

"I can't get any kind of coverage for sand-and-gravel and cement companies," says David Brennan, president of the Insurance Management Center, a Manchester, Conn. agency. "I've got one client who is a distributor of frozen chickens. Last year he paid \$25,000 for coverage. This year I can't get anyone to even give me a quote. It's the same thing with an insulated-wire manufacturer, a fish distributor and even a group of nuns who own real estate as investment properties."

If they are willing to pound pavements, most business people can still find insurance. But they are paying vastly more for much lower coverage. One supermarket chain, for example, saw its average rates go from \$8,000 per store a year and a half ago to \$40,000 per store. Florida Power & Light's premiums for general liability coverage doubled in 1984 over 1983. The coverage provided was halved, \$200 million instead of \$400 million.

Pricy, but at least it got protection. For industries that have been especially hard hit by lawsuits, prospects have gotten much worse. Consider Acmat Corp., a \$50 million (sales) asbestos-removal firm based in East Hartford. According to the firm, Cigna notified Acmat last December that all its coverage was being canceled because of its asbestos exposure. When Acmat protested, Cigna agreed to renew—so long as Acmat pulled out of the asbestos-removal business entirely. Acmat agreed, even though it meant "cutting our revenues in half

overnight," says Henry Nozko Jr., executive vice president. But even that drastic measure failed to satisfy Cigna, which canceled the company's account on Apr. 1.

Nozko approached over 30 carriers, including Lloyd's of London. All turned him down. Finally, he convinced Great American Surplus Lines and three other firms to give him coverage. The price, assuming last year's volume of business: \$6 million to buy \$6 million of general liability coverage, including only \$1 million of asbestos protection. That compares with \$300,000 last year for \$10 million of coverage. Why didn't he just

and accountants' malpractice. "Our agent notified us a couple of months ago that everybody in our business was being canceled," says Irwin Singer, president of Atlas Oil Co., a fuel distributor. "They didn't care how good our safety record was. In fact, the very company that canceled our coverage complimented us on it."

In some cases, the retreat can be gradual. "Our normal general liability policy used to exclude all pollution, unless it was sudden and accidental," says Chuck Henry, a second vice president at Travelers. "Then the courts started saying in some cases that if the insured did not intend to cause damage, it was 'sudden and accidental'—even if it took years for the stuff to seep out." Now Travelers completely excludes pollution coverage on its general liability policy and will underwrite environmental hazard coverage only at restricted levels and only for customers who also buy Travelers' general liability policy.

Even such restrictions aren't enough for some insurers. Since the beginning of the year frightened insurers have been pulling out of property and casualty lines like the British army at Dunkirk.

Property and casualty insurance has always been a boom and bust business, but the bust has never been this bad. Blame part of it on greed. After five years of cash-flow underwriting—that is, pricing products at a loss in underwriting terms in order to bring in extra dollars to invest at once-tempting interest rates—the industry has hit

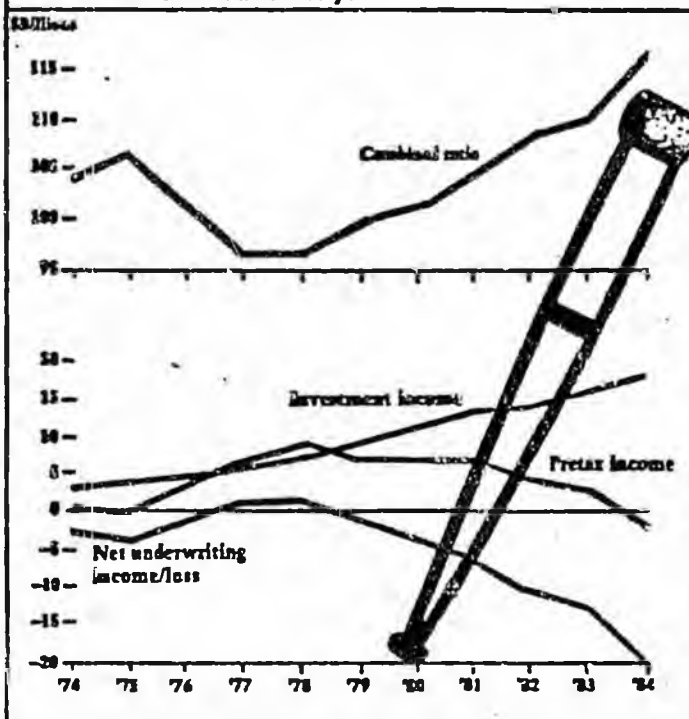
rock bottom. Last year it recorded a pretax loss of \$3.8 billion.

Face it: There's no way that the insurance industry can fully recover from its current downswing until Congress—or state legislatures—step in and impose order on our self-destructive legal system. Pennsylvania has already made a start with legislation that curbs pain and suffering awards from municipalities. But it's only a start. Remedies in law will not become effective overnight.

In the meantime, property and casualty insurance is going to become much tougher to get, at any price. For example, insurance agent David Brennan expects that by September none of

## A road to disaster?

For 8 of the last 11 years, property and casualty insurers have paid out more than they have gotten in premium income. Investment income had offset that worsening combined ratio until last year.



bank that \$6 million instead? "The policy gives us a worthless amount of protection, but we couldn't bid on public jobs without it," says Nozko.

A note on retributive justice: Now that legal-malpractice suits are becoming trendy, even lawyers are having a tough time finding coverage. Reuben & Proctor, an 80-member Chicago law firm, lost its coverage on July 1 from Crum & Forster's International Insurance.

The flight of insurers and reinsurers is most visible where the risks of winding up in a courtroom are great—both gradual and sudden-and-accidental pollution, directors' liability, municipal liability, medical malpractice

Exhibit ~~XII~~

## Coke Is Right

Coca-Cola officials are ready to go to jail to protect one of the world's great secrets. A federal judge ordered Coke to divulge its soft-drink formula in connection with a lawsuit. Coke refused and now faces contempt-of-court charges. The soft-drink formula is the latest victim of a legal system gone berserk.

Federal Judge Murray Schwartz of Wilmington, Del., is the would-be secret-breaker. He has acceded to a favorite trick of American plaintiffs—demanding such unreasonable court remedies that the defendant has no choice but to settle. In this case, some Coke bottlers are objecting to the price they have to pay for Diet Coke syrup. Coke charges its bottlers more for the low-cal recipe than for its new, Classic and Cherry brands. The bottlers say Coke should charge them the same for all Coke syrups.

The plaintiffs' lawyers hit on a great scheme. They say that Coke should have to prove that the diet syrup is significantly different. If the company is going to charge the bottlers more. The only way to know the relative costs to Coke, say the lawyers, is to see the formulas. They know how seriously Coke takes the 99-year-old secret. Only two executives know the equation and they're not allowed to fly on the same plane. Only a board resolution can ever release the magic formula from its bank vault. So, the lawyers no doubt figured, if they could get a judge to order Coke to hand over the formula then Coke would refuse and instead have to make a big out-of-court settlement, regardless of the merits of the case.

Enter Judge Schwartz. He told Coke that "nothing is sacred in civil

litigation," not even trade secrets. He said he'd try to make sure no one got the formula except for the plaintiffs and their lawyers. Understandably, Coke doesn't have much faith in such good-effort pledges. The truth is that the judge understood perfectly well what game the plaintiffs were playing. Sure, the judge said, ordering disclosure "could be a bludgeon in the hands of plaintiffs to force a favorable settlement." But he figured that sticking to the letter of pre-trial discovery law was somehow more important than the legal system making any sense.

The real question about this case is what it's doing in court in the first place. Last time we checked, the U.S. was still a free-market country. If bottlers don't want to pay for Diet Coke, they don't have to order it. Likewise, if Coke can find bottlers who will pay the premium for diet syrup, Coke can switch bottlers. That's how markets work. And the only way the free market can continue is for judges to do their job of upholding the rule of law by protecting property rights such as trade secrets.

This case is another reminder that the Office of Management and Budget needs to take a very close look at the federal courts. Here are a bunch of Coke bottlers suing Coke at the taxpayer's expense. As we've said before, the broad public receives little if any benefit from subsidizing the civil litigation conducted by large companies and their highly paid lawyers. The taxpayers have even less reason to support civil courts when judges invite the most obvious abuses of the system.

W.S.N.

18 Sept.

85



EXHIBIT XXIII

W.S.J. 26 Apr 85

### Judge Appoints 3 Lawyers To Coordinate Bhopal Suits

By a WALL STREET JOURNAL Staff Reporter

NEW YORK—A federal judge picked F. Lee Bailey, the prominent defense attorney, and Stanley Chesley, a Cincinnati lawyer with extensive experience in product liability cases, to serve on a three-man executive committee that will coordinate litigation arising from last December's gas-leak disaster at a Union Carbide Corp. plant in Bhopal, India.

In an order handed down yesterday, U.S. District Judge John Keenan said the third member will be Michael Ciesl, an attorney with the Minneapolis firm of Robins, Zelle, Larson & Kaplan, which is representing the Indian government in Bhopal litigation. The judge also named Jack Hoffinger, a New York lawyer, as liaison counsel. Mr. Hoffinger mainly will be responsible for communicating between the judge and the more than 80 lawyers whose cases have been consolidated in federal court here.

Messrs. Bailey and Chesley were leaders of two of the three factions of lawyers jockeying for control of the complex litigation stemming from the Dec. 3 Bhopal disaster in which an estimated 2,000 were killed and thousands of others injured. Both men have stated that they favor settling the case quickly (see story on page 29).

The members of the executive committee will, according to the judge's order, "frame and develop the issues" in the case and "prepare expeditiously for trial or settlement negotiations." They also are likely to receive the biggest legal fees. Though Judge Keenan left that matter to be resolved later.

Mr. Chesley wouldn't describe what he believed an acceptable offer in the Bhopal case should entail. "It's premature," he said, "I'm not interested in assessing anything right now except the number of claims and their severity."

interface between product liability lawsuits and worker compensation benefits. He quoted the AFL-CIO as telling the Commerce Committee that "the section on the relationship between worker compensation and third party litigation, in particular, has been redrafted to answer prior criticisms..."

This section would deduct workers' compensation benefits from the amount of the award in a successful suit, and permit neither manufacturers nor insurers nor employers to sue each other to recover what each other had paid out. The idea is to cut down on legal costs without affecting the right of a worker to sue for genuine defects in machinery. Currently, workers often will sue manufacturers of old machinery even though the defects were really caused by a lack of maintenance by the employer.

"In addition to improving product safety in the United States, the bill will reduce the burgeoning legal costs that now drain the product liability system," Sen. Kasten said. "It is shocking that 59 cents for every dollar going to victims goes to defense lawyers. It is equally shocking that 41 cents of the victims' dollar is taken by his other attorney."

#### 'Greed' of Attorneys

Sen. Kasten pointed out that in the recent settlement concerning Agent Orange "each injured person will receive a modest \$20,000, while each of the plaintiffs' attorneys takes home over \$2.5 million. The instability of product liability law fuels the greed of a few attorneys. This situation simply has to be put to a stop."

He argued against theories advanced by several attorneys' groups and some other senators that the legislation really would increase legal costs as cases

in each state have to be tried against the new law instead of established state law. Sen. Kasten insisted that "as a matter of legal history, it is true that whenever uniform statutes have replaced a jumble of common law, our legal system has operated more efficiently."

He responded to cynics who question why manufacturers would support legislation that will help victims. "The fact is that there is no hidden agenda," Sen. Kasten insisted. "The corporations are tired of wasting money on attorneys." With his product liability law, Sen. Kasten said, "both outside and corporate counsel will, so to speak, be looking at the same hymn book—costs will be controlled and they will fall."

#### Superfund Also Passed Up

Along with product liability legislation, the Senate also failed to act on reauthorization of the Superfund law this year.

Proponents of the legislation insisted it needed to be done this year so the Environmental Protection Agency could gear up its agenda and personnel. But the Administration and many industry groups wanted Congress to await the results of studies due after the election.

For insurers, the lack of final legislation means they will be fighting all over again battles won this year against creation of a new federal cause of action allowing victims to sue when they become ill with disease associated with chemicals found at a Superfund site.

The legislation to clean up abandoned waste dumps will have to be reauthorized next year since funding will run out on September 30, 1985.

Insurers have been very concerned about the idea that a new right to sue would be developed even though there currently is no way for the medical pro-

fession to ascertain which cancers or other illnesses stem from exposure to Superfund sites and which from other factors. "Had the federal cause of action in the House Committee bill become law, my industry's ability to furnish or price environmental liability insurance protection for any business handling hazardous substances would have evaporated," Crum & Forster Insurance Companies Vice President, Leslie Cheek III, said in a speech earlier this month. That provision was later removed on the House floor.

Similarly, Mr. Cheek wrote a letter to all senators urging that the Senate Environment and Public Works Committee's version of Superfund not be considered since it contained a victims' assistance demonstration program to establish five state experimental projects to compensate victims of illnesses associated with toxic wastes without any curtailment of the right to sue. This section of the bill, Mr. Cheek wrote, "constitutes a prototype national health and disability entitlement program whose costs and duration would be impossible to control or insure."

In other activities of note to the insurance industry, Manville Corp. announced it had agreed to join the Wellington Group, a consortium of asbestos producing companies and insurers which is trying to formulate a program to deal with claims of cancer and other illnesses by persons exposed to asbestos.

The group, named for Dean Harry Wellington of Yale Law School, wants to create a facility to pay claims without lawsuits, if possible, and to represent its members in lawsuits in order to cut the high costs of legal fees associated with each company maintaining its own team of legal experts. □

—Washington Correspondent



# 'Hordes of Lawyers, Hungry as Locusts'

## LAW

BY PHILIP HAGER AND MICHAEL A. HILTZIK

If you hurt your finger in a company softball game, you can go to court and win the right to sue for workers' compensation on the ground that the boss "expected" you to play.

You can run a stop sign, smash into a truck and — even if you were legally drunk at the time — sue and collect damages against the auto. Her that designed an allegedly faulty gas tank that exploded and burned you in the accident.

If the person you've been living with — but haven't yet married — is badly hurt in an accident, you can sue the responsible party for loss of consortium, provided you can show that your relationship possessed the "characteristics" of marriage.

These were not ordinary cases, but they serve to underscore the far-ranging nature of the thousands of lawsuits flowing through the courts. There has been a litigation explosion in the last decade. Last year, more than 240,000 new civil actions were filed in the federal courts — twice the number filed in 1975. It cost U.S. taxpayers about \$2.2 billion to process the more than 8 million civil suits filed in state and federal courts in 1982.

The country seems a wash in lawsuits. High-priced lawyers bring actions seeking millions in punitive damages. Small-claims courts brim with \$1500 disputes. A single antitrust case — *U.S. v. International Business Machines Corp.* — occupied a single judge and dozens of lawyers for 12 years at a cost of millions of dollars before it was withdrawn following a change of national administrations. Nearly 170,000 divorce cases land every year in the courts of a single state — California — representing about one-third of the civil caseload.

One law professor projected the previous 10 years' caseload into the 21st century and predicted that the annual federal docket would reach 1 million new cases by the year 2010, requiring the services of 8000 judges.

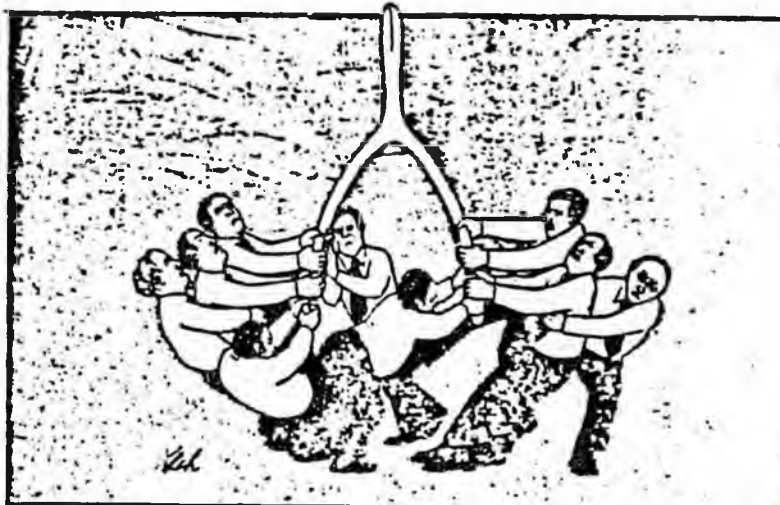
It is not simply the numbers that cause concern. Frivolous suits seem to become more common every year. A child sues his mother and father for "malparenting"; a student files suit against his school for his illiteracy; a patient sues her plastic surgeon for a belly-button left askew; a shooting victim chooses not to sue his assailant but this assailant's psychiatrist — on the theory that the doctor should have foreseen that his patient would run amok.

The law also intrudes into areas of society once seemingly beyond its reach, dictating how businesses are operated, whether a city can pick up trash more frequently in one neighborhood than another, how high school principals mete out discipline. Corporate executives, like sportsmen, are heard to complain that their every decision is governed by court-made rules, that they need lawyers looking over their shoulders just to get through the work day.

Many commentators ascribe the staggering caseload increase and the expanding reach of the law to the American impulse to transform every petty grievance into a full-blown lawsuit, aided and abetted by what Chief Justice Warren E. Burger calls "hordes of lawyers, hungry as locusts."

Is America an overlawyered society? Certainly there are enough lawyers. More than 600,000 are at work now, with 25,000 more graduating from law schools every year. That makes one lawyer for every 375 Americans. Two decades ago, the ratio was one lawyer for every 632 persons.

Philip Hager and Michael A. Hiltzik wrote this story for the Los Angeles Times.



Former White House counsel Lloyd H. Cutler, now in private practice in Washington, has estimated that the legal profession accounted for 1.4 percent of the U.S. gross national product in 1980, a percentage exceeded only by oil, auto, steel and several other major industries.

In the final analysis, it is the average citizen who pays this staggering bill — mostly through the higher prices companies and others must charge to cover the cost of litigation and insurance against the threat of it. High legal costs also mean more government expense and lost tax revenues. While individuals' legal bills are usually not tax deductible, the legal expenses of businesses are.

It is undisputed that some attorneys bring unnecessary or harassing lawsuits, prolong litigation by filing superfluous motions and requesting continuances, and sometimes turn the adversary system into a courtroom "sporting event," financed by the fees they charged their clients. But most authorities agree that the actual responsibility for congested courtrooms and mounting legal bills is widely shared.

Legislators make the laws, often with little concern for the extra court workload that may be created. Chief Justice Burger, for one, has recommended that every time Congress enacts a new law, it should be required to include a statement of how many extra cases will be generated. So far Burger's suggestion has been ignored.

And, by evading some controversial issues, Congress and state legislatures have driven into the court-houses two parties demanding a solution for their problems and answers to their disputes. The law on abortion rights, school desegregation, job discrimination and other prickly subjects has been made incrementally — case-by-case by judges, not legislators.

"The judiciary steps in because legislatures have been too cowardly to take on the important social issues of our times," said Merrill Niecher, a Los Angeles attorney. "The courts fill the vacuum."

"The public basically is insisting on a perfect system," said California State Bar president Dale Hann of Santa Barbara. "People want a remedy for every wrong. And the price for that is a lot of money being spent on lawsuits and a lot of clogging the courts."

Despite increasing caseloads, many Americans still find that the courthouse doors remain closed to legitimate grievances, such as contesting an eviction, resolving a consumer dispute or challenging a restriction on government benefits. Legal assistance programs, introduced with substantial funding as part of the "Great Society," are being cut back in a time of deepening federal deficits. And there is some newly emerging evidence that many legal disputes go unresolved — and, that in fact, Americans may not be as litigious as popularly believed.

The Civil Litigation Research Project, a federally funded study conducted largely by researchers at the University of Wisconsin Law School, attempted to learn how often a dispute involving \$1000 or more actually went to court. The study was based on random interviews of households and more than 1800 cases filed in state and federal courts in five states. The researchers found that only 11.2 percent of all grievances resulted in suits. Of those, the vast majority subsequently were settled or dropped before trial.

Nevertheless, the perception of America as a pathologically litigious society must come from somewhere.

According to surveys conducted in 1976 and 1977, the United States then had 1970 lawyers for every 1 million residents — nearly double the ratio of any other industrialized nation — but there were only 67.7 judges for every 1 million residents, putting the United States well behind France, Italy and West Germany. The ratio of lawyers to judges was the highest in the Western world, meaning that fewer judges were available to process the product of the world's largest legal community.

There is wide agreement among judges, lawyers and others that some reforms are long overdue — at the very least to remove from the court process the disputes that needn't be there.

"Congestion is inevitable if you only make cosmetic changes," warned Robert Gastus, an attorney for Public Advocates Inc., a public interest law firm in San Francisco. "We've got to radically alter the incentives for going to court."

Exhibit XXVI

~~...claim almost nine years after the birth of the child but within three years from discovery of the alleged malpractice. The court found that the case involved misdiagnosis and/or improper follow-up treatment and that the "foreign object" exclusion did not apply because the obstetrician was not involved in the implantation.—*Dunaway v. Ball*, 453 N.Y.S. 2d 313 (N.Y. Sup. Ct., June 21, 1982)~~

### **Attorney's fees exceed award**

A \$20,000 award of attorney's fees to a patient who obtained a \$15,000 malpractice award from a physician was not an abuse of discretion, a Florida appellate court ruled.

The physician contended that the award of attorney's fees was clearly excessive. The appellate court rejected the argument that the dollar amount of recovery controlled the award of attorney's fees. Noting the complexity of the litigation, the hours expended in preparation and trial, the skill and expertise of the patient's attorney, the court said the trial court did not abuse its discretion in awarding \$20,000 in attorney's fees.—*Baker v. Varela*, 416 So. 2d 1190 (Fla. Dist. Ct. of App., July 2, 1982)

THE IMPACT OF FEE ARRANGEMENT ON LAWYER EFFORT

Herbert M. Kritzer  
William L.F. Felstiner  
Austin Sarat  
David M. Trubek

January 1986

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PREFACE

This Paper focuses on the impact of fee arrangement on the amount of time lawyers are likely to devote to civil cases. Drawing on data collected by the Civil Litigation Research Project, the authors compare the behavior of lawyers working on an hourly fee basis with the behavior of contingent fee lawyers.

The contribution of Mr. Felstiner to this Paper, which is a reprint of an article appearing in Volume 19:2 of The Law and Society Review, is part of basic research conducted by The Institute for Civil Justice on the cost of settling disputes.

## THE IMPACT OF FEE ARRANGEMENT ON LAWYER EFFORT

HERBERT M. KRITZER\*  
WILLIAM L.F. FELSTINER  
AUSTIN SARAT  
DAVID M. TRUBEK

This paper focuses on the impact of fee arrangement on the amount of time lawyers are likely to devote to civil cases ("effort"). Drawing upon data collected by the Civil Litigation Research Project, we compare the behavior of lawyers working on an hourly fee basis with the behavior of contingent fee lawyers. Like previous work on this issue, the paper finds that fee arrangement does influence the amount of effort lawyers devote to a given case. However, contrary to previous work, the analysis indicates that the effect is not a simple effect on hours worked but a more complex effect on a number of aspects of lawyers' behavior. Together these produce an effect on hours that varies by size of case. For modest cases (with stakes of \$6,000 or less), contingent fee lawyers spend less time on a case than hourly fee lawyers. Yet we find no statistically significant evidence of a differential in effort for larger cases but rather an indication that, if there is an effect, it may be in the opposite direction.

In recent years there has been considerable discussion of the impact that various fee arrangements have on the nature of the services lawyers provide for their clients. In particular, a number of scholars have drawn on economic theory to model the effect of fee arrangements on lawyer behavior. Several of these theoretical studies reach the conclusion that lawyers paid on a contingent fee basis will spend fewer hours on a case than would be optimal for the client. They also suggest that lawyers paid on an hourly basis will put in more than the optimal number of hours. These analyses are used, in some cases, to draw policy conclusions about the contingent fee contract.

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\* This is a revision of a paper presented at the Midwest Political Science Association annual meeting, Palmer House Hotel, Chicago, Illinois, April 12-14, 1984. The analysis is drawn from the work of the Civil Litigation Research Project, which was sponsored by United States Justice Department Contract JA01A-79-0040; additional support was provided by the Research Committee of the University of Wisconsin-Madison Graduate School and by the University of Wisconsin Law School. We acknowledge editorial and other assistance from two anonymous reviewers and Felicity Skidmore.

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