

ALASKA LEGISLATURE COMMITTEE FILES 1985-1986 86/2

4161 SLAB INSURANCE INFORMATION 1041

This paper is addressed to California legislators, regulators, the news media and the public.

Together, the Alliance of American Insurers, the American Insurance Association, the Association of California Insurance Companies and the National Association of Independent Insurers ("the trades") represent 869 insurance companies that write more than half of all property and casualty insurance premiums in California.

FINANCIAL RESULTS

1984 was the worst year ever for the U.S. property-casualty insurance business, and it is estimated that 1985 results will be even worse.

The 1984 results were the culmination of an unbroken string of underwriting losses that began in 1979. Underwriting losses grew at an average annual rate of \$3 billion through 1983 and then jumped by \$8 billion in 1984. Total underwriting losses for the 1979-1985 period will approach \$80 billion.

Until 1983, growing investment income, fueled by high interest rates, was able to offset underwriting losses. But in 1984, a 10.6% increase in investment income (\$1.7 billion) was not able to overcome a substantial increase of \$8 billion in underwriting losses, and the industry sustained the largest net operating loss in its history. In 1984, pre-tax operating income (the combination of investment income and underwriting results) plunged to a negative \$3.8 billion.

In 1984, there were underwriting losses of \$16.8 billion in commercial and professional lines. These losses were 79% of all underwriting losses in 1984, whereas premiums for commercial and professional lines were only 51.3% of total industry premiums. In contrast, personal and commercial lines have historically had closely parallel loss ratios.

General liability (combined ratio:* 152) and medical malpractice (combined ratio: 170) were especially hard hit. The combined ratios mean that actual expenditures and incurred obligations exceeded earned premium income by 52% and 70%, respectively, in these lines. Total underwriting losses in 1984 were \$3.2 billion for general liability and \$1.2 billion for medical malpractice. These underwriting losses of \$4.4 billion for general liability and medical malpractice were 21% of all underwriting losses in 1984, whereas premiums for these lines were only 7% of total industry premiums. Under the most optimistic assumptions, investment income available in the market today falls far short of making up underwriting losses of this magnitude.

In 1983 and 1984, reinsurers were hit even harder by losses than the direct market. Historically, reinsurers' combined ratios closely paralleled those of the industry as a whole. In 1983, however, reinsurers had a six point higher combined ratio than the direct market (118 as opposed to 112), and in 1984, the reinsurers' combined ratio was ten points higher (128 as opposed to 118).

*The combined ratio is the ratio of incurred losses, loss adjustment expenses and policy holder dividends to earned premiums plus the ratio of underwriting expenses to written premiums. For example, a combined ratio of 150 means that insurers paid out \$1.50 in losses and expenses for every \$1 they received in premiums.

Although the overall combined ratio for the industry declined from 118 in 1984 to 116 for the first six months of 1985, and the combined ratio for commercial lines declined from 128 to 122 for the same period, the industry nonetheless sustained a net operating loss of \$2.3 billion for the first six months of 1985. The net operating loss for the first nine months of 1985 was \$3.7 billion. If this trend continues, the industry may well experience a greater net operating loss in 1985 than in 1984.

THE CONSEQUENCES

These escalating financial losses had the following consequences:

- the partial or total withdrawal of major reinsurers in the United States, Britain and Western Europe from difficult U.S. liability lines (for example, environmental pollution and asbestos containment contractors' liability).

- a plunge in the industry's annual rate of return on net worth to 1.7% in 1984. The rate of return on net worth was actually negative for 50 of the top 100 insurer groups. While the industry's annual rate of return recovered to 5% for the first six months of 1985, it is still almost ten percentage points below the average rate of return for the Fortune 500 companies.

- a significant increase in the number of companies found to be financially impaired. In 1984, regulators found 20 companies to be insolvent. In 1985, an additional 22 became insolvent. In addition, companies representing more than 20% of industry premiums have failed at least four "early warning" tests established by the National Association of Insurance Commissioners.

In sum, severe recent losses have produced less capacity to write insurance and an increased number of companies that are insolvent or facing major financial difficulties.

The financial condition of the U.S. property/casualty industry in 1984 necessitated large and widespread premium increases in liability lines and reduced the availability of coverage for commercial and professional buyers. Underwriters also became more cautious in deciding what terms to offer to which buyers. In liability lines, by the spring of 1985, liability insurance was not available at any price to some buyers in some lines of insurance, either through the admitted market or the surplus lines market. In addition, reinsurers began withdrawing from the market. Lloyd's of London expressed dismay with continuing losses in the North American market and seriously restricted the flow of reinsurance to U.S. insurers. Without reinsurance, primary insurers had no choice but to restrict their premium writings drastically, causing availability problems in nearly every commercial line. Buyers for whom availability has been particularly a problem in 1985 include: day care center operators, municipalities, nurse-midwives, toxic waste facility operators and truckers.

By and large, liability lines -- and especially those where shortages of capacity developed -- present the greatest risk of losses, just at the time when the commercial insurance industry desperately needs predictable, manageable business in order to create stability and reasonable profits as a basis for expanding its capacity.

In the 1980-84 period, as events turned out, insurance companies seriously underpriced their products. The warning signs were there as the

frequency and severity of losses increased. But it took net losses in 1984 to bring home to the industry the absolute necessity of substantial price increases and selectivity in underwriting. In part, underpricing was due to the vigorous competition among insurers during that period for premium income to employ at high yields in financial markets. But the decisive factor in underpricing was the inability of underwriters to predict with any degree of accuracy the losses they would eventually be required to pay. The expansionist, almost capricious nature of the liability system and the costs this would eventually entail were seriously underestimated by insurers.

EXPANSION OF THE CIVIL LIABILITY SYSTEM

As recently as twenty years ago, the tort law was a tightly configured system of rules under which losses were transferred from fault-free plaintiffs to clearly identified, negligent defendants. Causation was strictly construed, and latent injury claims were a thing of the future. The organizing principles of the liability system were the fairness of shifting losses where clear negligence could be shown and the general deterrence of others that was thought to result. Compensation of victims was important, but it was to be accomplished under a standard of fairness to all parties.

Today, things are far different. Negligence has been eroded or done away with as a standard, and assumption of the risk and contributory negligence have all but disappeared. Causation requirements have been overcome by judicial or statutory presumptions, and mass torts (usually with a long gestation or latency period) are now commonplace.

Californian's have become far more litigious in the last few

years. For example, the number of personal injury lawsuits arising out of auto accidents increased 38 percent in the period 1970-1984. The number of other personal injury lawsuits increased 190 percent over the same period. Overall, the incidence of litigation per 100,000 California residents has increased 54 percent since 1970.

Individuals and groups differ as to the desirability of these developments. But their impact on the property-casualty industry is clear. Costs are way up and over time must be adequately reflected in premiums. More fundamentally, the industry has great difficulty in predicting its losses and making adequate provision for them. The unpredictability and costliness of the liability system, as it has evolved, bear a direct relationship to the current problems with availability and affordability.

A detailed discussion of all of the changes in the tort system in recent years that have affected insurance availability and costs is beyond the scope this paper. A few examples, however, will illustrate the scope and complexity of the problem:

- The doctrine of joint and several liability has been combined with the rule of comparative negligence to create a situation where a party who was only minimally responsible for an accident may have to pay for all the damages arising out of the accident. (American Motorcycle Assn. v. Superior Court 20 Cal 3rd 578 1978)
- An "entitlement" psychology has become deeply rooted in American society. This encourages adversarial proceedings and a feeling that every "wrong", no matter how defined, should be put right by somebody.
- The Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA) imposes a regimen of nearly absolute liability for the costs of toxic waste clean-up. Through judicial interpretation, CERCLA applies retroactively to conduct occurring before its enactment in 1980.

Moreover, one or more defendants, among many potentially responsible, may be held solely or disproportionately accountable for damages through rigorous application of the doctrine of joint and several liability. (See paper on pollution liability-Tab 2).

- There has been an erosion of traditional fairness doctrines that found liability based on what the defendant knew or should have known when he acted or failed to act (Becker v. IRM Corp. 38 Cal. 3rd 454 1985). In Becker, the California Supreme Court held that a landlord could be held strictly liable in tort for latent defects in the premises, even when the landlord did not create or know about the defect, but acquired the property with the defect already in existence. As Justice Lucas said in his dissenting opinion in this case, "any landlord, even one renting the family home for a year, will now be the insurer for defects in any wire, screw, latch, cabinet door, pipe or other article on and in his premises at the time they are let despite the fact that he neither installed the item nor had any knowledge or reason to know of the defect."
- There has been a gradual shift from traditional requirements that responsibility must be proved against particular, identifiable defendants to theories of enterprise liability (Sindell v. Abbott Laboratories, 26 Cal.3rd 588 1980). This case established "market share" liability for producers of fungible goods.
- Insurance contracts have increasingly been ignored, even when the language is clear. The most egregious recent example is Jackson Township v. Hartford Accident & Indemnity, 186 N.J. Super.156 (1983), in which the pollution exclusion in a standard general liability policy was read against clear policy language and intent to include coverage for the gradual seepage of pollutants from the insured's land.
- Relative to indemnity to claimants, the costs of resolving disputes have risen astronomically. Illustrative of this is the growth in loss adjustment expenses, of which 90% are legal fees. As a percentage of damages, allocated loss adjustment expenses have risen from less than 15% in the late 1950s to almost 40% in 1984. A special ISO study indicates that costs may well approach 50% of the ultimate settlement value for claims reported in the last three years. A study by the Institute for Civil Justice finds that only 37 cents of every \$1 expended in litigating asbestos claims reaches claimants.

INDUSTRY PROPOSALS

In light of the expansion of the liability system, the insurance industry firmly believes that there will be no permanent and satisfactory solution to problems of insurance availability and affordability in commercial lines until changes are made in the liability system.

Here is a brief list of such reforms:

- passage of the "deep pocket" initiative on the June, 1986 ballot.
- extension of the reforms contained in the Medical Injury Compensation Reform Act (MICRA) to all personal injury and wrongful death actions.
- limitations on and reasonable standards for the awarding of punitive damages.
- state of the art reforms that will assure that liability is based on the standards in effect at the time a product is produced or the time the service in question took place.

These changes, which will be explained later in greater detail, will help to restore predictability to the process of assessing liability risks and will permit a more expeditious and economical resolution of disputes.

Until such lasting, structural changes in the liability system can be made, the insurance industry recognizes that it has a responsibility to respond to the needs of insurance buyers, both in decision-making by individual companies and discussions on public policy issues with legislators and regulators.

In order to address insurance availability and affordability problems in the short term and longer range, the Alliance of American Insurers, the American Insurance Association, the Association of California Insurance Companies and the National Association of Independent Insurers offer the following proposals. The trades are willing to work toward solutions based on these proposals with legislators, regulators and the public.

1. Reasonable Limitations on the Cancellation or Non-Renewal of Commercial Insurance Policies

The industry acknowledges the need for reasonable limitations that cover individual and block policy cancellations; notice of changes in policy terms; and notice of non-renewal. The industry believes that a reasonable balance should be struck between the buyer's need for stability and time to react if changes are necessary, and the insurer's need for a degree of flexibility to respond to changes in the individual risk or impairments in the financial status of the insurer or its reinsurers.

2. Voluntary Market Mechanisms

Many in the industry have been and are working actively with regulators and producers to broaden the availability of coverage in such difficult lines as day care liability. Evidence of this is the "Cal-Care" market assistance plan that the industry set up last year to handle problem risks in the day care area. Provided that regulators and

legislators understand that a market assistance plan is not a panacea, and that there are lines in which the volatility and dimensions of the underlying exposure make voluntary efforts difficult if not impossible to undertake, the industry is ready to continue its work with regulators, under their leadership, to maximize the opportunities to write difficult lines in the private market.

An additional virtue of voluntary efforts is that they can rather quickly document the extent and characteristics of the problem, so that further steps, if any are needed, can be considered in light of the facts.

Voluntary plans also enable insurers to review the loss control procedures of difficult-to-insure commercial buyers and make helpful suggestions. By minimizing hazards through a loss control plan, the buyer may be able to provide a potential insurer with the assurance necessary to provide desired coverage.

3. Insurance Availability Clearinghouse

The insurance industry will work with the National Association of Insurance Commissioners (NAIC) to develop and implement a clearinghouse to exchange information on the various voluntary market mechanisms and to encourage positive market response in difficult lines. This process has begun.

4. New Commercial General Liability Policy

With the uncertainties involved in trying to anticipate

future losses accurately in an ever-changing legal environment, actuarial pricing has become all but impossible for some risks. Expansive interpretations affecting any area of tort liability are likely to find application in other areas as well, making even the so-called profitable risks of a few years ago potentially uninsurable.

The Insurance Services Office has recently introduced a new Commercial General Liability Policy (CGL), including a claims made form. By itself, the CGL will not and cannot solve all of the current insurance availability or affordability problems, but its use by the industry would be a positive step in restoring a degree of underwriting confidence in the general liability marketplace. Predictability is an essential ingredient in the insurance business, and without predictability some risks will no longer be assumed.

The new CGL policy, with policy aggregate limits, encourages both the insurer and the insured to evaluate the risk objectively. The parties can then determine adequate limits and a definite coverage amount. Moreover, the introduction of a claims made version of the CGL allows for precision in determining the coverage period, avoids the stacking of limits and policies that now occurs and avoids costly litigation over policy application. Finally, the provision for "tail coverage" at the termination of a claims-made policy allows the insurer and policy holder to treat coverage for "Incurred But Not Reported" (IBNR) losses and its price separately, providing it only when it is needed rather than in every policy, defining the insurer's financial commitment, and pricing the coverage based on a reasonable loss expectation.

5. New Capacity

Many insurance companies are adding capital, both to assure that present business is adequately funded and to enable the writing of new business. This, coupled with adequate pricing, will do much to overcome availability problems. The industry recognizes, however, that there are limits on the amount of new capital that can be generated from insurance sources, at least until there is substantive reform of the liability system. The industry, therefore, supports efforts by businesses and others to add capacity to the marketplace through appropriate self insurance.

There are, in addition, exposures that are simply too difficult for the private market to write under current rules because of the impossibility of measuring or even defining the exposure represented by businesses. Risks posed by toxic substances, such as asbestos and chemical wastes, are generally viewed by insurers as falling into that category. Unless such exposures can be clearly defined and limited by reform of the liability system, it may be that risks such as those posed by toxic waste facilities will have to be funded, in whole or in part, by public funds. Otherwise, an unacceptable choice must be made between requiring businesses to bear financially unacceptable risks themselves and imposing an involuntary and potentially catastrophic burden on the insurance industry. Clean-up costs for known toxic waste facilities have been estimated at \$22 billion to \$100 billion by federal government

sources. Imposing even a substantial fraction of these costs on the insurance industry under the Jackson Township theory would leave little if any capacity left for all other risks consumers and businesses expect the industry to assume.

CIVIL JUSTICE REFORMS

Unless reforms are enacted to reduce the number and size of personal injury lawsuits, and unless balance is restored to the rules by which those lawsuits are decided, consumers and their insurers can, at best, expect only temporary relief from the problems plaguing the commercial insurance marketplace.

The costs of the system place great financial burdens on claimants, defendants, business and the professions, and, ultimately, consumers and taxpayers. Rapid changes in legal rules through court decisions create unpredictability that fosters litigation and discourages out-of-court settlements. As a result, insurance underwriters cannot accurately price insurance coverage. Businesses hesitate to invest in innovative products. Professionals practice their crafts defensively for fear of litigation -- often performing unnecessary tasks and procedures for which consumers must pay. The cumulative results of the system's problems are slower economic growth, higher prices for consumers, higher taxes, higher premiums, greater costs for self-insured businesses, fewer jobs and slower technological change for society.

As major "consumers" of the civil justice system, insurance companies have accepted the responsibility to offer fair and sensible solutions that restore balance to the system while protecting the rights of those who are injured as a result of the negligence of others.

The following program of reforms will be actively pursued by the trades and other interests during the coming months:

1. Joint and Several Liability.

The rule of joint and several liability allows an injured person to recover the entire judgment from any defendant regardless of the defendant's degree of fault. If the defendant who is primarily at fault has no assets or insurance, the "deep pocket" defendant must pay the total amount of the award even though the deep pocket may be minimally responsible for the accident.

After four unsuccessful attempts to modify the deep pocket doctrine in the California Legislature, a coalition of business, professional and insurance groups has joined with cities and counties to qualify an initiative on the June 1986 ballot. This initiative, the Fair Responsibility Act of 1986, retains the rule of joint and several liability for economic damages such as medical bills and lost wages, but applies the rule of several liability to non-economic damages such as pain and suffering and emotional distress. This compromise approach guarantees that injured people will be fully compensated for their out-of-pocket expenses such as medical bills and lost wages, both present and future. However, it provides relief to "deep pockets" in that they would only be required to pay their proportionate share of intangible damages such as pain and suffering and emotional distress. The passage of this initiative is viewed as a crucial first step in restoring a measure of equity to our liability system.

2. Extension of MICRA Reforms to All Personal Injury and Wrongful Death Actions.

Ten years ago, in response to a crisis in medical malpractice liability, the California Legislature enacted sweeping reforms in statutes regarding health care professionals. The legislation was entitled the Medical Injury Compensation Reform Act (MICRA).

Last year, after 10 years of litigation, the California and U.S. Supreme Courts upheld major provisions of this Act. Since the day the Governor signed the Act in 1975, skeptics predicted that it would be ineffective. The only real test of such a measure is hard data. Here it is:

	<u>Nationwide</u>	<u>California</u>
Average size of malpractice awards	\$974,000	\$396,000
Premium increase in average policy since 1975	300%	150%
Premium increase in average policy in 1985	33%	15%

These figures present evidence of the kind of savings that can be realized if significant tort reforms are enacted. The MICRA reforms apply only to tort actions against health care professionals, however, and they should be broadened to apply to all personal injury and wrongful death actions, so that savings can be realized across-the-board.

The tort reforms contained in MICRA are:

-- Periodic payments of awards in excess of \$50,000. Periodic payments of large awards assures the injured person will receive the health care as needed for the rest of that person's life. Plaintiff's

attorneys like the lump sum benefits because they often can get larger fees. Family members like the lump sum benefits because it gives them the opportunity to enjoy the benefits sooner. However, periodic payments are designed to provide the cost of care for the rest of the injured person's life. They assure that the money will be there for the purpose the jury intended. It is true that if the injured person's life is short, the payments will be shortened, but in view of the purpose of these particular funds, it should properly be a shortened payment period. Loved ones are not left without anything. The law specifically provides the appropriate payment for support of dependents so family members are assured the security they should have. MICRA only prevents windfalls when there is no longer a need for further care.

-- Collateral sources of benefits received by the claimant may be admitted into evidence. Under this provision, if the injured party has already received reimbursement for medical expenses from a collateral source (such as health insurance) and has paid nothing out of pocket, the jury is told about it. There is no reason why an injured party should be paid for an expense that is not incurred. It is true that many people purchase a medical insurance policy and personally pay for it, but such medical benefits may also be provided as part of employment or some other source for which nothing has been personally paid. If the injured party personally paid for the policy, this fact may be revealed to the jury by the plaintiff. How much is received from collateral sources which offset out of pocket expenses and what personally may have been paid for that benefit can be properly placed before the jury to weigh as part of its judgment on the amount of the award. No one is penalized and the change avoids "double recovery" by the plaintiff. In sum, the jury is entitled to know and consider the whole story.

-- A sliding scale contingency fee system. MICRA provides for a sliding scale attorney fee system, as opposed to the contingency fee system used in other cases where the plaintiff's attorney takes from one-third to one-half of an award or settlement. Under MICRA, a plaintiff's attorney could collect as a fee 40% of the first \$50,000 recovered, 33 1/3 of the next \$50,000 recovered, 25% of the next \$100,000 recovered and 10% of the remainder. This is no burden on the plaintiff's lawyer. This schedule of fees was examined by the courts and approved. Of course, attorneys would like more money, but the sliding scale system is designed to assure the claimant will receive a fair share of his or her recovery. Attorneys are fully reimbursed for all the costs of the trial they may have advanced.

-- A \$250,000 cap on non-economic damages. Non-economic damages are highly subjective and often are determined by the emotional responses of a jury. Without a cap, the extraordinary demands presented by persuasive plaintiffs attorneys can result in huge awards for intangible damages, such as pain and suffering. Because these damages bear no relationship to the cost of living, indexing the cap for inflation, as some have suggested, makes no sense. The validity of MICRA's \$250,000 cap has been upheld by the California and U.S. Supreme Courts. In fact, in the Fein decision, the state Supreme Court stated that:

...serious questions [have been raised] as to the wisdom of awarding damages for pain and suffering in any negligence case, inter alia, the inherent difficulties in placing a monetary value on such losses, the fact that money damages are at best only imperfect compensation for such intangible injuries and that such damages are generally passed onto, and borne by, innocent consumers...(Fein v. Permanente Medical Group)

It is important to remember that the cap applies only to non-economic damages. The injured party still receives compensation for all economic damages such as medical expenses, loss of earnings and other costs incurred both in the past and in the future.

Only now are we able to learn the real value of this ceiling as a means of keeping jury awards within reason. The \$250,000 cap was set to help define the maximum loss and provide a measure of certainty and predictability. This enables insurers to hold down the cost of basic insurance subject to the limit.

In summary, MICRA has demonstrated that there are tangible benefits to substantive tort reform. These benefits should be extended across the board so that professionals and businesses serving other areas of society can share in them.

3. Reform of Punitive Damages.

Punitive damages are awarded in personal injury cases to punish defendants for fraudulent, oppressive or malicious acts. They are awarded in addition to both economic and non-economic damages. In California, there is no limit on either the amounts awarded in punitive damages or the number of times a defendant may be assessed punitive damages.

Punitive damages are said to serve the dual purpose of punishment and deterrence, but these are functions of criminal and not civil law. Defendants in a criminal action are afforded various constitutional and procedural safeguards which are not provided in a civil action. For example, defendants in a civil case are punished by punitive damages even though the plaintiff does not have the burden of

proving his claims beyond a reasonable doubt, but only by a preponderance of the evidence. In addition, a unanimous jury verdict is not required for an award of punitive damages, only a 3/4 jury vote is necessary.

Punitive damages verdicts often are based on subjective and emotional responses of a jury. And unlike criminal law, the act that is punished is not clearly defined as unlawful nor is the punishment to be imposed clearly set out. Unpredictable and excessive damage awards are the result. The jury can punish without limits, and the defendant must face the possibility of punitive damages time and time again for the same mistake, contrary to the constitutional prohibition of double jeopardy in criminal cases.

Punitive damages become a windfall for the plaintiff and his attorney who often claim that the award actually serves the best interests of society. But the cost of these awards ultimately is passed on to the consumer in the form of higher priced goods and services. Thus, society pays for this windfall.

While the courts are pondering constitutional protections for defendants in personal injury cases, measures should be enacted to eliminate the abuses of punitive damages. This should include caps on punitive damage awards, defining the standard of conduct and proof required to support a punitive damages award and eliminating multiple awards.

4. Product Liability Reforms.

The wide variation among state product liability laws makes it difficult for insurance companies to accurately predict the potential

liability risks of the manufacturers they insure. Uniform product liability legislation on the federal level is necessary because products are often manufactured in one state, distributed in another, and used in a third. Legislation that would help resolve the confusion of conflicting product liability laws (S. 100) is now being considered in Congress. In addition, California should consider proposals to balance the rights of plaintiffs with the rights of defendants. Constructive suggestions include modifying the rule of strict liability, establishing reasonable time limitations within which a suit may be filed, and adoption of a "state of the art" defense. A "state of the art" defense would mean that products manufacturers and professionals would be judged by the standards prevailing at the time the good or service was produced.

5. Reforms Targeted to the Needs of Specific Buyer Groups.

The trades are actively examining each area in which buyers have had difficulty in purchasing adequate coverage to determine whether there are specific legislative, regulatory or private sector proposals -- beyond the general reforms enumerated above -- that might be advanced. With respect to units of government, a package might include partial or total immunity for defined governmental activities and a reasonable cap on awards. For asbestos removal and hazardous waste cleanup contractors, it may be possible to tie liability explicitly to a failure to comply with state standards adopted after extensive technical and political consultations.

ILL-ADVISED CONSTRAINTS
ON THE INSURANCE MARKET

The insurance industry needs a period of time to re-establish reasonable profitability. This in turn will permit the generation of new capacity to handle increasing exposures. The return to profitability and the attraction of new capital have already begun, but as the figures cited earlier in this paper attest, the process has a way to go before the industry can compete effectively with other users of capital.

This healing process could be undercut or even stopped by ill-considered actions by regulators or legislators. There are four such ill-advised actions that, if taken, would significantly impair the ability of the industry to fund the liability system in the future. The common denominator of such measures is that they force a largely market-oriented, competitive industry to write risks that would not necessarily be written voluntarily, usually at inadequate prices. The four such actions are:

1. Financial Responsibility Provisions -- Such laws or regulations require a class or classes of buyers to show that they are financially able to meet tort judgments by the purchase of insurance or (in some instances) self insurance arrangements. While aimed at buyers, such provisions place great pressure on legislators and regulators to require the writing of insurance, whether through residual market mechanisms or otherwise. Where the underlying exposures are large and unpredictable, such as in the environmental area, financial responsibility requirements place a severe burden on buyers that cannot be

legitimately met by insurers.

2. Involuntary Market Mechanisms -- These entities, which typically require all or a portion of the admitted property-casualty insurance industry in a state to absorb deficits of the pooling mechanism, tend to become inadequately funded, "take all comers" residual markets. And if they insure all comers, there are fewer incentives for dangerous businesses to maintain high safety standards. Involuntary mechanisms also mask underlying liability system problems by passing the costs of a malfunctioning system on to insurance buyers, and have generated large deficits that must, for the most part, be borne by the insurance industry. Thus, involuntary mechanisms could, if used extensively, add significantly to the liabilities of the industry at a time when financial results are inadequate.

3. Administered Pricing -- The responsibility for the present problems is not the fault of California's insurance rating law. Nonetheless, proposals are surfacing to make the law much more restrictive, despite the fact that serious availability problems exist in all states regardless of the type of rating law in effect. These proposals, while logical to those who propound them, are based on false assumptions. First, they assume that insurers deliberately underpriced their product, which is not the case. Interest returns on investments were increasing at a rate which justified the conclusion that the rate was adequate to pay losses and produce a profit. Instead, much of the problem should be laid to the fact that insurers are paying losses today based on premiums collected 10, 20, even 30 years ago on risks they did

not intend to assume but are required to assume by legislative and judicial decisions.

Secondly, it is assumed that the California Insurance Department should have foreseen that the price of insurance was inadequate and it should have forced an increase in prices. This presumes a prescience on the part of regulators which cannot exist. No regulator could have foreseen the events of recent years.

Any movement to more restrictive rating laws can result only in restricting the growth of the insurance business and the availability of insurance to the public on competitive terms.

4. Onerous Restrictions on Cancellation and Non-Renewal --

The industry acknowledges that some constraints on freedom of contract may be needed under current conditions. However, a regulation (as adopted in New Jersey) that in effect makes the insurance commissioner the decision-maker on all renewals, cancellations and changes in terms in the state would remove all underwriting discretion from insurers. Such a regulation is likely to discourage additional insurers from doing business in the state and to make currently admitted insurers reluctant to write new business.

CONCLUSION

Historically, California has relied primarily on the private insurance industry to assume and spread risks generated by the liability system. There has been a consensus that a free market system provides the most efficient way to identify, quantify and distribute such risks.

Implicit in this consensus, however, has been the assumption that the insurance mechanism can handle an expanding liability system, at least within broad limits. Due to the escalating and unpredictable expansion of the liability system in recent years, this assumption is no longer automatically true, and the consequence is the current liability crisis. Therefore, as a matter of public policy, the choice is between doing nothing to constrain the liability system (in which case the insurance industry will continue to struggle in attempting to accommodate the expanding system) and working towards a balanced, more predictable system (in which case the insurance industry will be able to operate much more effectively in making coverages available at reasonable prices).

There are a number of early signs that, for many affected buyer groups, the availability crisis is beginning to ease. Underwriters are beginning to look for market niches and opportunities in certain areas. Additional capital is beginning to flow back into the reinsurance markets.

All of this is evidence of a healthy recovery by the insurance industry, even in the face of difficult liability system conditions. For the reasons noted above, the recovery will not be total or permanent unless and until substantive reform is achieved, but these developments point the way to a more liveable situation while reform efforts proceed. The industry is committed to helping in this process by working with legislators, the Insurance Commissioner, and others to make coverage as available as possible.

POLLUTION LIABILITY INSURANCE

BACKGROUND

Until recently, insurance protection against liability for bodily injury or property damage arising out of the handling of hazardous substances was provided under two different policy forms.

The Comprehensive General Liability (CGL) contract provided coverage for damages arising out of an "occurrence" during the policy period that involved the policyholder's business operations. The policy excluded liability for occurrences on property within the "care, custody or control" of the policyholder and, from 1973 onward, excluded all pollution liability except that resulting from "sudden and accidental" occurrences.

Liability insurance policies define the term "occurrence" to mean "an accident, including continuous or repeated exposure to conditions, which results in bodily injury or property damage neither expected nor intended from the standpoint of the insured." The policy limits, i.e. the amount of coverage purchased by the insured, is the maximum amount that will be paid for all damages, regardless of the number of persons involved. For example, an automobile accident in which a driver loses control of his vehicle and damages four other cars constitutes one occurrence rather than four separate occurrences.

The term "sudden and accidental" is used to describe an instantaneous event which occurs by chance, in contrast to an event which occurs over a period of time.

The Environmental Impairment Liability (EIL) form was developed to fill the void created by the CGL's "sudden and accidental" limitation. The EIL policy provided coverage for claims made during the policy year arising out of non-sudden or gradual pollution incidents in the past.

The insurance industry's ability to provide a market for environmental liability insurance depends in part on its ability to predict, with a reasonable degree of accuracy, the exposures which it undertakes to assume, and the extent to which it can rely on the language of its contracts to limit those exposures.

Liability schemes embodied in federal and state environmental protection laws, expansive judicial decisions reinterpreting the plain language of insurance contracts, and increasingly sophisticated technological tools permitting the detection of very small quantities of toxic and hazardous substances have, in recent years, made pollution liability virtually uninsurable. As a result, any individual business or public entity subject to statutory and common law liability for the handling of hazardous wastes or substances is experiencing acute difficulty in finding liability coverage.

PROBLEMS

Nearly absolute liability: CERCLA (federal Superfund), as well as many state derivatives, imposes liability for cleanup costs and damage to natural resources resulting from "releases" of hazardous substances that is absolute except when a potentially responsible party can establish that the release was caused solely by an act of God, an act of war, or by a third party with whom there was no direct or indirect contractual relationship. The im-

pediment to insurability here is the absence of any consideration of a person's conduct in the imposition of liability. The imposition of vicarious liability for others' careless conduct on those who have complied with the law means that an insurer's evaluation of the risk its own policyholder presents has no bearing on the liability that policyholder may be required to assume. A risk that is not predictable is, by definition, uninsurable.

Joint liability: Some courts have interpreted CERCLA to require the liability of defendants to be joint (each defendant liable for all the damages) rather than several (each defendant liable only for his contribution to the cause of the damages). The impediment to insurability here is the impossibility of predicting the extent of a policyholder's exposure to liability resulting from activity in which others are also engaged. An insurer cannot responsibly price the policyholder's exposure in a legal system in which the policyholder may be held liable for harm caused by others, whether or not the policyholder contributed to that harm. Exposure which cannot be priced is, by definition, uninsurable.

Liability without causation: At least one court has held that CERCLA requires no showing by the government that a substance for which the defendant was responsible has been released or threatens to be released from the site at issue. The policyholder is therefore liable, not for the release of a hazardous substance, but rather for the mere presence of the substance at a site from which someone else's substance has been released. Insurance against such a "non-event" is impossible to price.

Retroactive liability: The courts have applied CERCLA provisions ret-

roactively to owners and operators of waste sites, and to generators and transporters of hazardous wastes. Thus, a policyholder becomes liable for behavior which was not negligent at the time it occurred. A risk that does not exist at the time a policy is issued cannot be priced, nor can an insurer collect an additional premium for a contract that has expired.

Insurance coverage decisions: A series of lower and intermediate appellate court decisions has led insurers to conclude that the entire cost of cleaning up hazardous waste sites, estimated between \$22 billion and \$100 billion, will be forced onto expired and existing policies which were never intended to bear this responsibility. The most damaging precedents are those growing out of the contamination of wells serving 97 families by seepage of hazardous wastes from a landfill owned and operated by Jackson Township, New Jersey. The courts in the Jackson Township cases effectively eliminated the pollution exclusion by writing the word "sudden" out of the CGL's policy language; evaded the policy's indemnity limits by ruling that each of the wells constituted a separate "occurrence;" and applied the "bodily injury" coverage terms to plaintiffs who never alleged any actual harm. If the latter case had been upheld, it would have opened the door to an unlimited number of claims for present damages for possible future harm. Equally alarming was a holding in a separate case, subsequently overturned on appeal, requiring an insurer to defend and indemnify its insured against cleanup liability for contamination of the insured's own property. The court simply ignored the CGL exclusion for property under the "care, custody and control" of the insured, and the fact that the contamination had not caused harm to any third party.

Yet to be decided is a suit filed in California in 1983 by Shell Oil

Company. Shell is seeking to recover cleanup costs imposed by the EPA, the U.S. Department of the Army, and the California Department of Health Services from its 270 primary and excess insurers between 1947 and 1983. If the court finds for Shell, insurers will be forced to absorb billions of dollars in current and future claims for which no premium was collected and no claims reserves established.

The long line of adverse court decisions has impelled foreign reinsurers to withdraw entirely from the American pollution liability market and forced primary insurers to exclude coverage for sudden and accidental pollution liability from the new CGL policy.

CALIFORNIA

Some estimates of the cost of cleaning up the nation's abandoned waste sites greatly exceed the entire capacity of the insurance industry to write policies of all types. However staggering the figures may be, they do not include the cost of compensating individuals for bodily injury resulting from exposure to toxic materials.

A report issued in mid-1985 by the California Commission for Economic Development estimated that \$2.7 billion in claims for toxic injuries are pending in the state's courts. The largest suit, \$850 million, was filed on behalf of 5,000 plaintiffs whose wells were polluted by toxic substances leeching into groundwater from the Stringfellow Acid pits in Riverside County. Another action, on behalf of 495 plaintiffs against a Kern County school district, begs \$50 million in purely speculative damages - the increased risk of cancer from drinking fountain water contaminated by DBCP.

ASBESTOS ABATEMENT CONTRACTORS

Since 1982, when the EPA issued the Asbestos-in-Schools Identification and Notification Rule, the public has become acutely aware that the presence of deteriorating asbestos-containing materials poses a potential threat to the health and safety of school children and employees. Although very little is known about the risk of non-occupational exposures to asbestos, it is widely recognized that improperly removed asbestos places building occupants at greater risk of exposure than leaving undamaged materials in place.

Friable asbestos has been identified in hundreds of school buildings throughout California. The estimated cost of removal exceeds \$90 million.

The rush to remove asbestos from schools and other public buildings has created a demand for contractors that far exceeds the supply of those who have any experience with asbestos abatement work. Many unqualified contractors have been attracted to a potentially lucrative new field of business. Only a handful of states including, most recently, California, have attempted to address the problem by issuing uniform training and licensing requirements. Without such standards, insurers have no way to judge the qualifications or risk characteristics of an applicant for insurance.

Any asbestos risk poses special problems. The latency period for asbestos-related illnesses ranges from 15 to 40 years. It is impossible for the underwriter to predict how many of those exposed will become ill, when they will become ill, and what the cost will be to provide medical care and compensation when they do become ill.

With billions of dollars in legal and compensation costs for work-related asbestos disease claimants looming on the horizon, and additional billions in property damage claims already filed, insurers are not in a position to assume any additional asbestos exposures.

An insurance market for abatement contractors might be created if states established removal standards, issued uniform training and licensing standards, and provided certified contractors tort immunity for non-negligent behavior.

SOLUTIONS

Realistic short and long-term solutions to the pollution liability insurance problem must address the underlying insurability issues.

First, federal Superfund must be amended to eliminate retroactive liability and to provide for equitable apportionment of cleanup costs among all potentially responsible parties.

Second, federal and state laws must relieve insurers of any liability for waste cleanup defense and indemnity costs under past policies that did not expressly obligate insurers to provide the coverage.

Third, state common law must become more predictable. The courts must set clear standards of liability based on negligence, as well as standards for those damages that are compensable and which of those damages are covered by the insuring contract.

Fourth, there should be a clear statutory separation of cleanup liability and liability for third-party bodily injury and property damage. Prefunding the inevitable cleanup actions at waste sites authorized under the Resource Conservation and Recovery Act (RCRA) might enable insurers to provide protection against liability for bodily injury and property damage to users, generators, transporters, storers and treaters of hazardous materials. Fees assessed on all persons using a permitted site would provide an assured source of funding for future cleanup actions, act as an incentive to sound disposal practices by conditioning cleanup relief on compliance with RCRA requirements, and provide recovery to persons harmed by an accident.

Finally, California should abandon its flirtation with the notion that more punitive laws will result in prompter cleanup of the state's hazardous wastes sites. Federal Superfund's legal scheme has resulted in the expenditure of \$1.6 billion and the cleanup of only six sites of the more than 800 on the National Priorities List. If we have learned anything during the course of the past five years it is that cleanup of abandoned waste sites is a societal, not a legal, problem. The job can be accomplished expeditiously only by proceeding to do it, and not by pursuing potential deep pockets in the courts, or devoting thirty to forty percent of the funds available for cleanup to legal expenditures.

PROFESSIONAL LIABILITY INSURANCE

California is one of the few major states without a full-blown medical malpractice insurance crisis this year. A major reason for this is the passage 10 years ago of the Medical Injury Compensation Reform Act (MICRA), which instituted several important reforms in our civil justice system with respect to medical malpractice actions.

The major provisions of MICRA are:

1. A limit of \$250,000 is placed on awards for general damages (pain and suffering).
2. Evidence of collateral sources of benefits are authorized to be disclosed to juries.
3. A sliding scale contingency fee system is established, so that a plaintiff's attorney could collect as a fee 40% of the first \$50,000 recovered, 33 1/3% of the next \$50,000 recovered, 25% of the next \$100,000 recovered and 10% of the amount over \$200,000 recovered (normal contingency fees range from 1/3 to 1/2 of the entire amount recovered).
4. Judgments for future damages of over \$50,000 must be paid in periodic installments, rather than a lump sum, if requested by either party.

5. Actions must be brought within three years of the date of injury or one year from the date the plaintiff discovers the injury.

Although in effect for 10 years, the provisions of MICRA were frequently disregarded by judges, apparently due to doubts about the constitutionality of its provisions. However, constitutional challenges were finally disposed of by the U.S. and California Supreme Courts in 1985, and it is expected that California courts will now give full weight to the tort reforms contained in MICRA.

Although there are real problems in the medical malpractice insurance business in California with respect to obstetricians and nurse-midwives, the overall situation is much better here than it is nationally.

For example, according to the California Medical Association, the average size of malpractice awards nationally is \$974,000, while in California it is \$396,000. The average malpractice insurance policy nationally costs 300% more now than in 1975, while in California, the same policy costs just 150% more than in 1975. During the past year, the cost of the average malpractice policy rose 33% nationally, while it went up 15% in California.

The lesson to be learned is that MICRA's reforms have helped in California and these reforms should be broadened to encompass all personal injury lawsuits, not just malpractice claims.

Other types of professional liability insurance that are not covered

by MICRA, such as legal malpractice and architects' and engineers' liability, are experiencing severe problems with both availability and affordability.

Legal malpractice insurance rates are going up 200-400% this year and carriers are withdrawing from the market.

California leads the nation in lawsuits brought against attorneys. Nationally, about one claim is filed for every 17 lawyers in practice and a third of all claims result in a payment to the plaintiff. In California, it is estimated that one claim is filed for every ten lawyers practicing and nearly half of the claims filed result in a payout. For every \$300 legal malpractice payout, it is estimated that \$150 goes to defense lawyers, \$100 to plaintiff's lawyers and \$50 to the plaintiff.

Architects and engineers are being sued as a matter of course nearly every time an injury takes place in a building. If someone slips on a step, the architect can be sued for negligently designing the step so that it did not prevent someone slipping upon it. Even though the architect or engineer being sued may be found to be without fault, the frequency with which these types of actions are brought and the expense of defending them in court has made architects and engineers virtually uninsurable in many instances.

Real estate agents recently found they were having trouble buying liability insurance due to a court case which broke new legal ground by finding that a listing real estate broker was liable for negligence to the buyer of a home for a failure to make a careful and diligent visual inspection of the

property and report any "red flags" which that inspection disclosed.

This new duty on real estate agents and brokers was imposed retroactively in order to be able to award the plaintiff money. The court forced the insurer in this case to pay for an exposure that didn't exist when the policy was purchased and for which no premium had ever been paid. This new duty was subsequently clarified, but not overturned, by the legislature.

These examples illustrate the problems caused by our increasingly litigious society. The desire of people to find a deep pocket to pay for each and every wrong done to them, and the willingness of the courts to help find that deep pocket, have created a situation where many legitimate businesses are considered too risky to insure.

Extending the provisions of MICRA across the board to all personal injury actions would go a long way toward lessening the problems that are being experienced. Beyond that, judges and juries must come to understand that our civil justice system should not be used as a substitute for social welfare. Professionals who have not been negligent in their duties should not be held responsible for injuries that are beyond their control.

GOVERNMENT LIABILITY INSURANCE

BACKGROUND

Court decisions in the last few years have proven that you can fight City Hall - and be handsomely rewarded. The size and frequency of judgments against government entities in the 1980's have increased to the point that many insurance companies are hesitant to provide insurance for municipalities and other government entities.

Historically, cities, counties, states, school districts, transit districts, etc., have enjoyed sovereign immunity from lawsuits that arise from the performance of government functions. When this doctrine was deemed unfair by the courts, state laws were changed to allow citizens to sue for damages from injuries that resulted from the negligent or willful acts of government entities.

In 1978, the California Supreme Court combined the rule of joint and several liability with the rule of comparative negligence to create a situation where the party who is only minimally responsible for an accident may have to pay for all the damages arising out of the accident. This decision encourages lawyers to search for "deep pockets" to blame for accidents in the hope that a jury will find even a slight degree of negligence on the part of the deep pocket. The most common victims of the deep pocket rule are taxpayers who are often sued for no other reason than the simple fact that an accident occurred on a public street.

PROBLEMS

A League of California Cities survey found that 162 cities, one-third of California's total, paid over \$19 million in judgments and out-of-court settlements from deep pocket claims in fiscal year 1983-1984. Two years earlier, the cities had paid about one-fourth of that. Over \$210 million in claims are still pending.

Public entities must also defend themselves against lawsuits that were unheard of a few years ago. Although overturned on appeal, a county supervisor was held personally liable by the trial court for the county's decision to enforce a zoning ordinance. A school district in Alameda has been sued for \$35 million for a high school football player's injuries. Public entities face enormous liability exposure for handling and disposing of toxic waste. The California Supreme Court has just ruled that transit districts are responsible for protecting passengers from the actions of other passengers.

Because of these lawsuits, cities, counties, and other public entities are finding it increasingly difficult to secure adequate and affordable insurance coverage. The League has testified in Sacramento that more than 50 California cities are uninsured or dangerously underinsured, and the list grows as policies expire. Local governments that can find insurance face premiums that are as much as ten times what they were last year. Cutbacks in essential services to pay insurance premiums and court judgments are the result.

SOLUTIONS

Senator John Foran (D-San Francisco) has introduced Senate Bill 75 to more fairly apportion damages in lawsuits while protecting the economic interests of people who are injured in accidents. The bill retains the rule of joint and several liability for economic damages - medical expenses, lost wages, and property damage - thus guaranteeing the plaintiffs will be fully compensated for their loss. However, it provides that non-economic damages - pain and suffering, emotional distress, loss of companionship - will be apportioned according to the degree of fault of the defendants. Thus, if a city is found to be 10 percent responsible for an automobile accident and the person who is 90 percent responsible is uninsured, the city would still be responsible for 100 percent of the plaintiff's lost wages, medical bills, and property damage, but only 10 percent of the award for those intangible damages such as pain and suffering and emotional distress.

Senate Bill 75 represents the fourth attempt to limit the rule of joint and several liability. The Senate has passed Senate Bill 75 and similar legislation by wide margins only to see it stall in the Assembly Judiciary Committee.

Responding to the urgent need for reform, California's business, medical, professional and insurance groups have joined with cities and counties to give California voters the opportunity to limit the waste of the deep pocket rule. The Fair Responsibility Act of 1986, which will appear on the June ballot, will accomplish the same ends as Senate Bill 75. Because of the continuing deadlock in the legislature, the ballot initiative appears to offer the best hope of restoring a measure of fairness to the liability system.

DAY CARE LIABILITY INSURANCE

With an increasing number of single parent families and families with two working parents, the need for day care in California has never been greater. It is estimated that there are more than 100,000 family (in-home) day care providers in California, 33,000 of whom are licensed as required by state law. In addition, there are thousands of child day care centers, which provide care for more than 12 children at a site outside the home.

Effective January 1, 1985, family day care operators (those caring for 1 to 12 children in their own home) were required by state law to carry \$300,000 per occurrence liability insurance for their day care operations, or alternatively, to obtain a signed slip from each parent stating that the parent was aware that the home was without liability insurance.

Many California family day care operators obtained insurance through Mission Insurance Company. In July of 1985, Mission notified its day care policyholders that it would be cancelling or non-renewing this coverage due to severe financial problems, including the loss of reinsurance.

AVAILABILITY PROBLEMS

Normally, this situation would have created simply some inconvenience, as policyholders switched to another insurance company. However, this notification came after a period of increasing awareness concerning widespread cases of child abuse in day care situations, and during a period featuring the most severe underwriting losses ever experienced by the in-

insurance industry. The result was that for a period of time, the day care operators who were being cancelled or non-renewed had no place to purchase alternative coverage in the regular insurance market.

After a few weeks, another insurance company stepped in and voluntarily began writing day care insurance, but by that time, there was a perception that a legislative solution was needed for the day care insurance "crisis." Bills were introduced to establish a "Joint Underwriting Association." The JUA would have forced all insurers to write day care insurance and share premiums and losses on a pro-rata basis, based on their liability insurance premium volume. These bills were opposed by the insurance industry because they would have resulted in a barrier to any insurer wanting to compete voluntarily for day care business. The bills would have established the JUA as the sole underwriter of day care liability risks in certain areas, and thus would have resulted in an uncompetitive environment and higher premiums for policyholders over the long term.

The insurance industry responded to the perceived availability crisis in day care by forming what is called a "market assistance program." This program, dubbed "Cal-Care," is a voluntary effort by insurance companies to help day care operators who are having trouble finding insurance. Participating "Cal-Care" insurers agree to review problem day care risks and to attempt to find coverage for them in the regular insurance marketplace.

AFFORDABILITY

The affordability of day care insurance is another problem frequently mentioned by family day care operators.

There is no question that the cost of day care insurance has risen

steeply within the last year. The reasons include a greater perceived risk as cases of child and sexual abuse come to light, the large losses experienced by some insurers of child care centers, the poor underwriting results experienced by the insurance industry, and the decreasing financial capacity within the insurance industry to underwrite commercial liability insurance.

Court decisions have played a large part in increasing the price of day care insurance and decreasing its availability. Professional day care centers' liability coverage is provided through general liability insurance policies, which exclude coverage for criminal acts, including sexual and physical abuse of children. However, courts have side-stepped the exclusion for criminal acts by allowing plaintiffs to sue for "negligent hiring" or "negligent supervision" when such crimes take place.

Many small family day care operators obtained their insurance through a "business pursuits" endorsement to a homeowners policy. (Business pursuits are normally excluded from homeowners coverage.) Some courts have ruled the homeowners policy, even without the business pursuits endorsement, covers family day care liabilities, despite the fact that business pursuits were excluded from coverage.

The California Supreme Court applied an exception to the business pursuits exclusions for "activities which are ordinarily incident to non-business pursuits." The court noted that "it is difficult to conceive of an activity more ordinarily incident to a non-commercial pursuit than the home care of children," even where the insured is caring for the children for com-

pensation. These kinds of court rulings have led many insurers to conclude they cannot rely on policy exclusions and have increased the reluctance of many insurers to provide any kind of coverage where a day care operation is conducted on the premises.

SOLUTIONS

Availability problems associated with day care operations have been addressed by insurers coming back into the market to provide insurance coverage voluntarily and by the voluntary "Cal-Care" market assistance program.

Problems associated with the affordability of day care insurance have been addressed in legislation passed in 1985 (SB 1064 by Seymour & AB 929 by Allen, et al), which lower the required insurance for family day care operators to \$100,000 per occurrence, \$300,000 maximum annual aggregate. This should help to stabilize insurance rates for family day care operators by lowering the maximum annual risk to the insurer to \$300,000. Under the old requirements, an insurer could be forced to pay \$300,000 for each injury, should a disaster strike. This meant an unlimited potential loss for the insurer, thus increasing the cost and drying up the availability of the coverage.

In addition, AB 929 declares that it is against public policy to insure day care risks under the homeowners policy, unless a separate endorsement has been obtained and an additional premium has been paid. It prohibits the cancellation of a homeowners policy solely for the reason that there is a day care operation on the premises and also prohibits, for a specified period, the non-renewal of a homeowners policy for that reason.

There has also been legislation to increase the enforcement of regulation and laws regarding day care operations.

With the passage of legislation and the response of the voluntary insurance marketplace to the problems associated with day care insurance this year, it is hoped that the day care insurance market will stabilize in 1986.

MOTOR CARRIER LIABILITY INSURANCE

BACKGROUND

The nation's trucking industry and bus transportation companies have encountered serious difficulties obtaining liability insurance required by federal law.

The current situation was brought about in part by the Motor Carrier Act of 1980, which requires liability insurance minimums ranging from \$750,000 for carriers of non-hazardous cargo to \$5 million for haulers of hazardous waste. State-imposed liability limits for intrastate operators have also been raised. Society's concern with environmental pollution and fear of hazardous materials heavily influenced legislators toward including the high-limit insurance requirement in legislation intended primarily to deregulate the trucking industry.

Similar problems were created for bus companies by the Bus Regulatory Reform Act of 1982, which set insurance minimums ranging from \$1.5 million to \$5 million, depending on the passenger capacity of the bus.

PROBLEMS

Along with rising claims costs, adverse judicial decisions extending coverage and overly generous jury awards, the substantial insurance requirements for cargo and passenger motor carriers come at a time when insurers are experiencing severe financial and capacity problems. Because of technical aspects in the federal law for cargo motor carriers, insurers are uncertain of their actual exposure as the limits required vary depending on the cargo. As a result, insurance companies have difficulty in properly pricing the risk involved for an individual insured.

Adding to this, a large-scale influx of high-limit motor carrier, bus, and other commercial auto business is simply more than the residual markets can deal with effectively. If the 12,500 new entrants into the trucking industry since 1980 were required to maintain \$750,000 of insurance, underwriters would have to provide \$9.4 billion in new insurance coverage.

Exacerbating the problems associated with the demands for expanded coverage is a severe constriction in the reinsurance market. Often, when reinsurance is available, it is prohibitively expensive. Greater risk exposure, particularly with operators who are less financially stable and have no safety record, also affects the motor carrier insurance system.

Small trucking firms and independent owner/operators have the most difficulty securing insurance. Generally, the largest trucking companies with good safety histories and claim results are finding a market. Many private carriers, local businesses, and even municipalities fall under federal high limit requirements because they occasionally transport hazardous substances. These conditions could continue to deteriorate because of increased coverage demands and limited market capacity.

SOLUTIONS

Residual market mechanisms cannot be viewed as the solution to these problems. Existing pooling mechanisms partially insulate small and medium insurers from a series of large losses, but overall capacity limitations of the insurance industry will inhibit the mechanisms' effectiveness. In the end, the costs of residual market mechanisms are absorbed by all individual automobile insurance policyholders.

Federal and state legislators and regulators should review high liability limit requirements and consider lowering them selectively. That review should include redefining the types and sizes of motor and passenger carriers required to maintain the higher limits. Exemptions from federal requirements might be considered for carriers having less exposure to loss.

Any further regulation of intrastate carriers' liability limit requirements should take into account probable maximum loss, population density, and geographic and topographic conditions.

More attention should also be given to inspection and safety. Deregulation has resulted in an influx of new carriers, and this competition has placed greater cost pressures on operators. In some cases, safety has been sacrificed because of deregulation. The federal and state governments should review their inspection requirements and procedures.

DIRECTORS AND OFFICERS LIABILITY INSURANCE

BACKGROUND

Purchasers of directors and officers (D&O) liability insurance, particularly financial institutions, report facing larger deductibles, lower limits, more restrictive endorsements, shorter policy durations, and higher premiums. A survey of purchasers conducted during the second quarter of 1985 reported premium increases from 50 to 500 percent and, in a few industries, a true availability problem.

One example of the tightening market is a bank which had its limits reduced from \$15 million to \$10 million, its deductible increased from \$50,000 to \$750,000, and its premium increased 22 times. Financial institutions which had been able to obtain limits in 1984 up to \$200 million are having difficulty now finding limits of \$30 million.

Those industries experiencing particular difficulty are electric (nuclear) utilities, new high tech businesses, wildcat oil and gas companies, research and development enterprises, real estate developers, highly leveraged businesses, petrochemical companies and the steel industry.

Company size does not seem to influence ability to obtain the desired coverage, but capacity constriction has probably hurt larger risks more than smaller risks. Loss experience has been better for smaller not-for-profit policyholders than large profit-making companies.

PROBLEMS

Underlying problems responsible for the capacity shortage include:

- o Significant reduction in reinsurance because of the general condition of domestic and foreign reinsurance markets, combined with reinsurers' perceptions of price inadequacy, the American civil justice system, and the increase in potential liability for directors and officers;
- o Policyholders' well-publicized breaches of traditional relationships with D&O insurers -- Bank of America (\$95 million) and Chase Manhattan (\$175 million) are suing some of their own managers and attempting to collect under their D&O policies;
- o Federal agencies, such as FDIC and FSLIC, that have insured failed banks and savings and loans are attempting to recoup some of their losses by suing former directors and officers;
- o Court decisions hold directors and officers to an increasingly strict standard of conduct by reducing the scope of the business judgment rule so that coverage designed for true mismanagement is becoming a "business judgment errors and omissions policy;"
- o Increase in hostile takeovers and other business practices likely to generate claims (greenmail, poison pills, golden parachutes);
- o A greater concern that directors and officers are not representing the interests of their shareholders may also result from recent corporate battles;
- o The general financial condition of primary insurers;
- o Growth in demand for directors and officers coverage; and,

- o Underpricing in prior years.

In 1984, D&O insurers were paying out three to four times as much in claims as they received in premiums. Average policy limits increased by 45 percent between 1982 and 1984, with a dramatic increase in those purchasing limits over \$50 million. The number of companies seeking D&O insurance increased by eight percent during this period with growth in demand greatest among companies with assets under \$25 million.

The average defense cost for claims in 1984 was \$461,000, up from \$365,000 in 1982. Average total cost of a D&O claim (defense cost plus losses) adjusted for inflation was \$1.62 million in 1984 compared to \$1.34 million in 1982 (up 21%).

Since 1984, there has been a dramatic reduction in capacity. Several major companies have withdrawn from the market and those remaining have significantly curtailed their writings and reduced coverage limits. The few new entrants are offering relatively low limits.

Although the London market popularized D&O coverage, it has not been a major writer recently because underwriters thought U.S. rates were too low. London brokers are reportedly offering primary coverage with limits up to \$20 million. Business is up 100 to 200 percent and much of the business is being placed.

Capacity reduction reflects the current financial condition of primary

carriers and reinsurers. The facultative reinsurance market has all but dried up. It has been estimated that 60 to 75 percent of reinsurers writing facultative reinsurance for D&O risks have withdrawn from the market. To date, primary carriers have been able to obtain treaty coverage. However, it is expected that they will face some difficulties when current treaties expire.

SOLUTIONS

Insurers have responded to broader liability with endorsements excluding certain liability from coverage. There is no standardization, but the new exclusions include:

- o Claims arising from pollution and environmental impairment;
- o Claims brought by government agencies (the so-called "regulatory" exclusion) aimed at FDIC and FSLIC suits; and,
- o The Bank of America-type situations where the policyholder sues its own directors and officers or where one director sues another.

Customers have responded by looking for alternatives to insurance. Twenty-three of the largest banks are studying options such as pooling arrangements and formation of a captive. A group of mid-sized banks is exploring the possibility of forming an offshore association captive. A regional bankers' association has formed its own insurance company, capitalized at \$3 million to provide D&O coverage to its 2,200 members. One organization is forming a new insurer to provide liability coverage for large companies. It reportedly will offer \$50 million coverage in excess of \$50 million.

GLOSSARY

Aggregate Limit - An overall cap on the insurer's liability under a policy.

Allocated Loss Adjustment Expense - All loss expenses which can be assigned to a specific loss. These would include expenses such as legal fees, court costs and medical reports.

Capacity - The total amount of insurance or reinsurance available from a company, or the insurance market in general.

Claims Made Policy - A policy that provides that it will cover only those claims first made during the policy period.

Comparative Negligence - The legal doctrine by which the negligence of the parties is compared, and a recovery is permitted notwithstanding the contributory negligence of the plaintiff.

Earned Premium - That portion of written premium equal to the expired portion of the time for which the insurance was in effect.

Incurred But Not Reported - (IBNR) Those losses which have occurred but have not yet been reported to the insurance company. Insurers establish a reserve to account for IBNR.

Incurred Losses - The total value of all individual losses which occurred during a given time period. Incurred losses include both losses that have been reported to the insurer and losses that have been incurred but not reported.

Insurance Services Office (ISO) - A nonprofit corporation that makes available rating, statistical, actuarial, policy form and related services to property/casualty insurers.

Investment Income - Insurance company income earned from invested premiums and capital. This income is reported to regulators each year in the insurer's annual statement.

Joint and Several Liability - A legal doctrine that allows a plaintiff to recover the total amount of the judgment against any defendant who is found to be negligent, even though other defendants may be negligent to a greater degree.

Loss Adjustment Expense - All loss expenses which can be assigned to a specific loss (allocated loss expense) and expenses which cannot be assigned to a specific loss, such as claim department expenses.

Occurrence Policy - A policy that provides coverage for injuries that have occurred during the policy period.

Policyholder Dividend - A share of surplus allocated to a policyholder.

Premium - The consideration paid for an insurance policy.

Reinsurance - The insurance by one insurer, called the reinsurer, of all or part of the risk of loss of another insurer.

Reserve - An insurer's estimated liability for unpaid claims and expenses.

Surplus - The excess of assets over liabilities.

Tail Coverage - An endorsement to a claims made policy extending coverage for losses incurred but not reported.

Underwriting Results - Money earned or lost by an insurer in its insurance operations, as distinguished from money earned or lost in the investment of assets.

Written Premium - The entire amount of insurance premium collected on contracts issued by the insurer during a period of time.



INSURANCE SERVICES OFFICE, INC.

160 WATER STREET NEW YORK N Y 10038 (212) 487 5000

FINANCIAL CONDITION OF THE INSURANCE INDUSTRY- AN UPDATE

Earlier this year ISO and NAII jointly published a report on the status of the property/casualty insurance industry entitled "1985 A Critical Year". This analysis compared industry results for 1984 to preceding years and was a call for action during 1985 to return to profitability in insurance operations.

In Part I of the attached, ISO has summarized the findings of that report and we have provided additional analysis through the first 9 months of 1985.

Part II provides an analysis of the factors, internal and external, that have combined to cause current financial conditions.

It is intended that this analysis encourage regulators and the business community to coordinate their talents in addressing proper solutions which will lead to recovery.

SECTION I

I. FINANCIAL CONDITION OF THE INSURANCE INDUSTRY

During the past year, the property/casualty insurance business has come to the forefront as a major public issue. At this stage of the insurance economy and the U.S. civil justice system, the industry finds itself faced with both the need to dramatically raise prices to cover losses, and to face the fact that certain classes of business may be uninsurable.

This situation has generated a feeling of mistrust and cynicism on the part of the consuming public and has prompted regulators and others to search through a variety of possible solutions, frankly some good and some bad.

As part of an overall effort to put the present insurance availability and other marketplace actions and problems into perspective, it is necessary to understand the overall financial condition of the insurance industry. This is done not to condone or provide excuses for specific areas of concern but rather to provide information so that all affected parties will have sufficient information to properly address and understand the problem. Earlier this year ISC and the NAIJ jointly published a report on the status of the property/casualty insurance industry entitled "1985 A Critical Year". This analysis compared industry results for 1984 to preceding years and was a call for action during 1985 to return to profitability in insurance operations. We have summarized

1973-1974. However, while the 1973 ratio was 99 and rose to 105 in 1974, the 1983 combined ratio already stood at the ominous level of 112 before leaping to an unprecedented 118 in 1984 and has only improved to slightly under 116 as of September 1985. The improvement, as compared to the first nine months of 1984, is really due to an improvement in the expense ratio - the loss ratio was actually worse in 1985.

This deterioration in results has been led by the commercial lines. (See Exhibit II.) Historically, personal and commercial lines results have closely paralleled each other. Between 1967 and 1982, the difference between the combined ratios never exceeded 6 points. As recently as 1981, the ratios were only 2 points apart. Then in 1983, the gap grew to 12.5 points. In 1984, it expanded to over 20 points. These high ratios are of even greater concern than they would be otherwise because industry analysts agree that the commercial lines combined ratio is understated due to reserve inadequacy. Since many companies write mostly commercial lines business, the combined ratios for these insurers are much worse than they are for the industry as a whole.

General Liability in particular experienced disastrous results in 1984 with a combined ratio of 152. Results for the first half of 1985 are not appreciably better as General Liability's combined ratio "improved" to only 145. Simply stated, that means that the insurance industry pays out \$145 for every \$100

losses, the industry's pretax operating income - the combination of investment income and underwriting results - plunged to a negative \$3.8 billion in 1984 and a negative \$3.5 billion in the first nine months of 1985. (See Exhibit III.) This figure, pre-tax operating income, is the primary component of insurer income and represents the pre-tax profits from insurance operations. It is this component of income which is responsible for the long term viability of the industry. The huge \$3.8 billion loss in 1984 is the largest ever experienced in this industry. It may, however, be surpassed by the 1985 operating loss, as the first nine months operating loss exceeded \$3.5 billion. Although investment income has been rising gradually over the last several years, it is no longer able to offset the staggering underwriting losses which increased 60% in 1984 alone. Clearly, if the property/casualty insurance industry is to maintain its current capital base, let alone attract new capital to meet the insurance needs of a growing economy, the industry must improve its earnings.

A second measure of insurer profitability is the total rate of return on net worth. This measure includes operating income, realized capital gains, taxes and other miscellaneous income, and is often used to compare the profitability of insurance with other industries.

By this measure also, profits in the insurance business declined in 1984 for the seventh consecutive year. The

companies'. But in fact the rates of return trailed the Fortune 500 average throughout the 1980's.

Yet another ingredient adding to the poor financial condition of the insurance industry at year-end 1984 was the decline in policyholder surplus. Policyholder surplus is the difference between insurer's assets and liabilities and is a measure of an insurer's capacity to provide insurance coverage safely. This is the financial security, the uncommitted funds of an insurer, that stand behind every insurance policy. It is the quantity that provides the necessary cushion to support the shock of major catastrophes, stock market declines and loss reserve inadequacies. As a result of operating losses in 1984, industry surplus fell 3% to \$63.8 billion. In constant dollars, 1984 surplus was 3% below the 1980 level, which indicates that capacity may not be sufficient to meet the insurance needs of an expanding U.S. economy.

The 1984 drop in surplus would have been much worse were it not for the record-breaking influx of new funds into the industry. New funds represent additions to the capital structure of an insurance company. The two major sources of these funds are new stock offerings and contributions from non-insurance parent companies to insurance subsidiaries. Reasons for an addition to capital range from preventing an insolvency to expanding underwriting capacity.

reserve policies. Industry analysts believe that the industry is significantly underreserved, especially in the Commercial Lines. These facts, fueled by latent-injury claims, are driving the business to support ISO's policy-reform efforts and to advocate changes in the U.S. civil-justice system.

The decline in surplus and questions as to adequate loss reserves have raised concerns about the solvency of many insurers. In 1984, at least 22 property/casualty insurance companies were found to be financially impaired. Most of these companies were insolvent. Additionally, several sizable insurers were placed in rehabilitation by regulators with an indication given that liquidation could not be avoided. In total for 1984, companies accounting for more than one fifth of industry premiums failed 4 or more IRIS tests. As of mid-November 1985, 38 companies have become insolvent since the beginning of 1984. That is more insolvencies than in any full two-year period since guaranty funds were formed, and the books aren't yet closed for 1985.

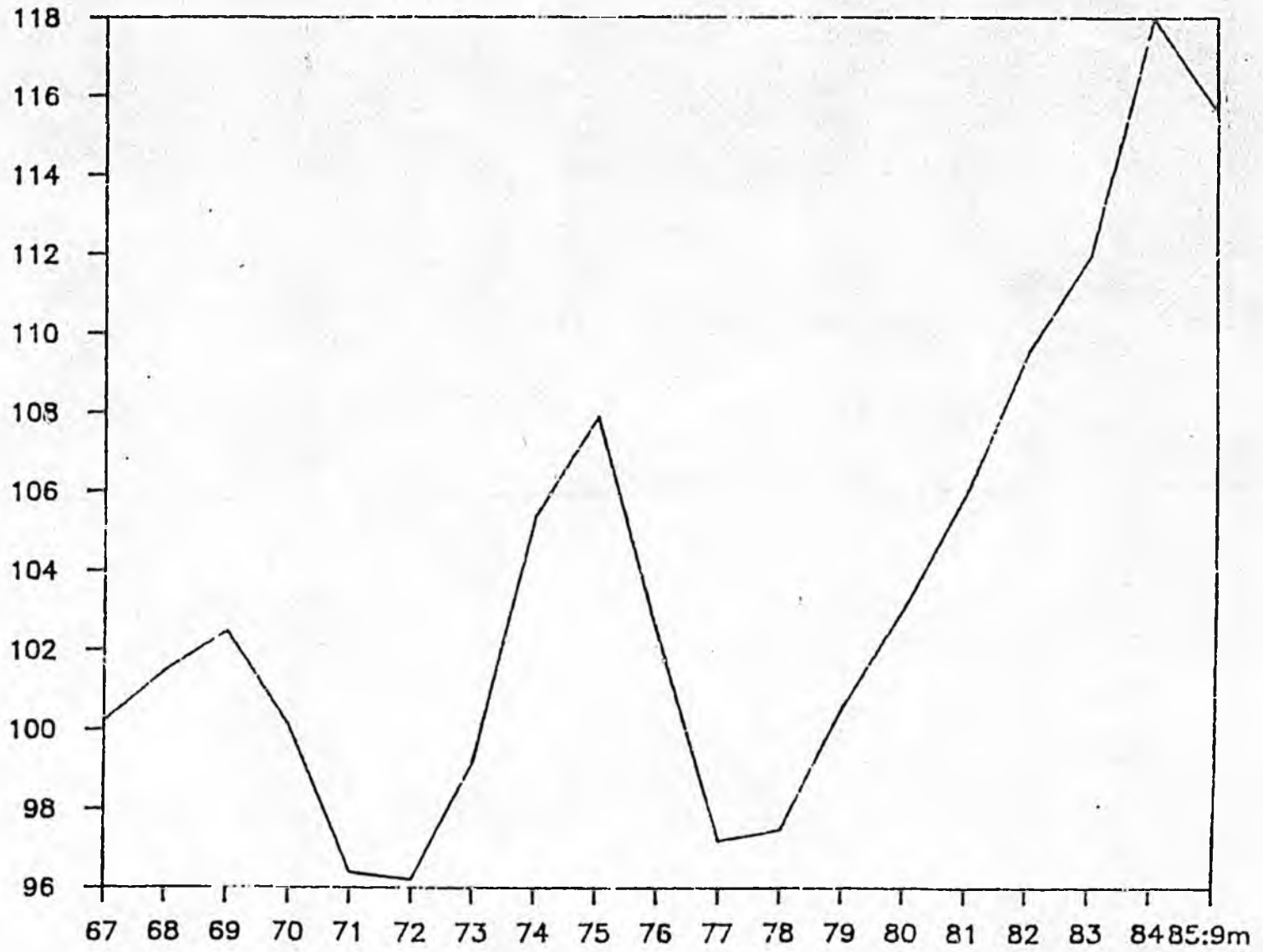
A.M. Best Company annually conducts a specialized financial analysis of most United States insurance companies and expresses its evaluation in the form of a rating. All companies rated "Excellent" are considered to be outstanding and have no material unfavorable variances from A. M. Best's averages. Lower ratings reflect increasingly unfavorable variances from A. M. Best's industry standards. An "Excellent"

has become a victim of fundamental changes in the civil justice system during the past decade. More and more, insurers have encountered court interpretations of prior insurance contracts which expand coverage beyond that which insurers intended. As a result, the availability and cost of insurance for current liability is significantly influenced by: insurers' concern about potential unanticipated past liability; the magnitude of potential liability, both past and future; the seeming inability to use contract language to prudently limit insurers' exposure; and a civil justice system that continues to create new theories of liability and to expand older theories.

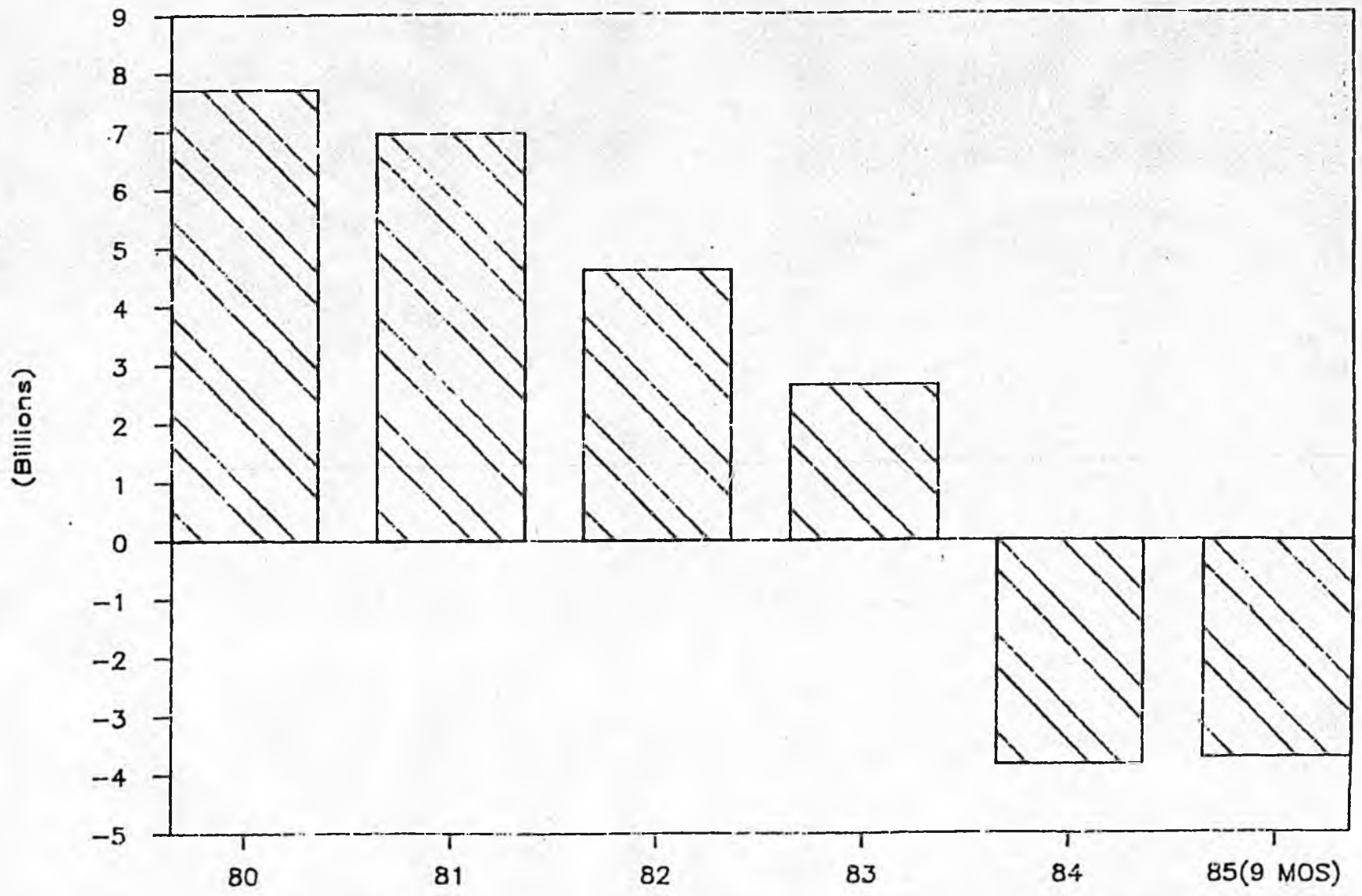
In addition to the growing level of losses suffered by the property/casualty industry, another illustration of the magnitude of the impact of legal costs on loss dollars is the growth in allocated loss adjustment expenses (of which 90% are legal fees). As a percent of damages, allocated loss adjustment expenses have grown from less than 15% in the late 1950's to almost 34% in calendar year 1983. Moreover, a special study of several companies' data indicates that the calendar year statistics may tend to obscure the full extent of recent growth. The study projects total legal expenses approaching one-half of ultimate settlement values for claims reported in the last three years.

Between 1978 and 1983, legal expenses grew 79%, more than twice the growth rate for damages. If these trends continue, \$19

COMBINED RATIOS:ALL LINES

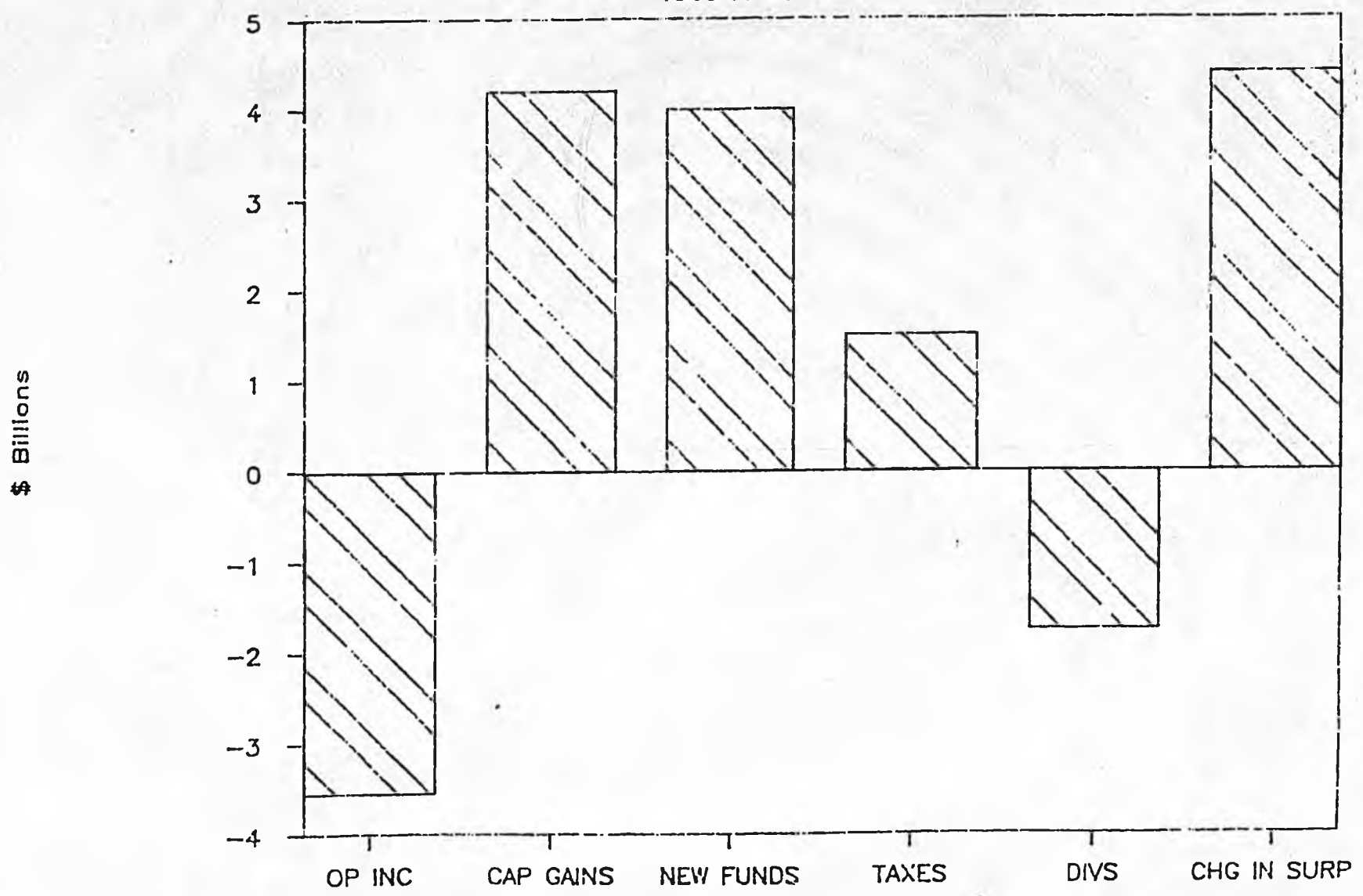


OPERATING INCOME



CHANGE IN SURPLUS AND ITS COMPONENTS

1985 FIRST NINE MONTHS*



* ISO estimates

SECTION II

II. FACTORS INFLUENCING FINANCIAL CONDITION OF THE INDUSTRY

The previous analysis of insurer's financial condition has shown an industry experiencing extremely unprofitable underwriting results, severely impacting the very solvency of many insurers.

This section will sketch the causes and implications of these unprofitable underwriting results. Although a complete answer is complex, two trends are clearly discernible as influencing and causing current conditions: a prolonged period of underpricing and rapidly expanding tort liabilities.

For the better part of seven years, the insurance industry has been engaged in a brutal price war. During the early 1980's, the price for commercial insurance was decreasing, sometimes sharply, as insurers vied for premium dollars to invest at the high interest rates then in effect. At the time, commercial customers did not complain. Indeed, many realized that commercial insurance in the United States was being sold below cost, even when investment income was considered.

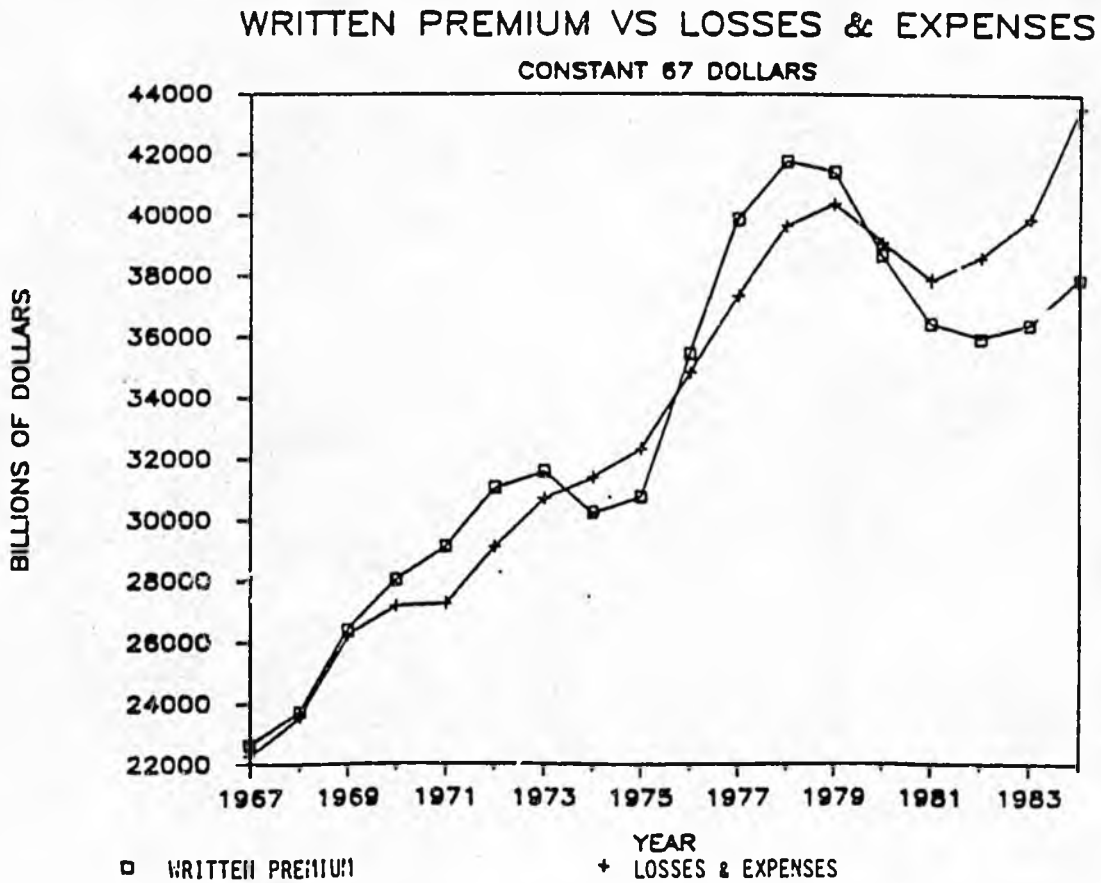
Meanwhile, the second problem -- expanded tort liabilities -- was becoming equally acute. During the first half of this decade, insurers have seen court after court reinterpret policy language and create coverages, retroactively, that were never contemplated or paid for when the policies were written. They also have watched the likelihood of a successful claim become more and more a function of the seriousness of the injury than

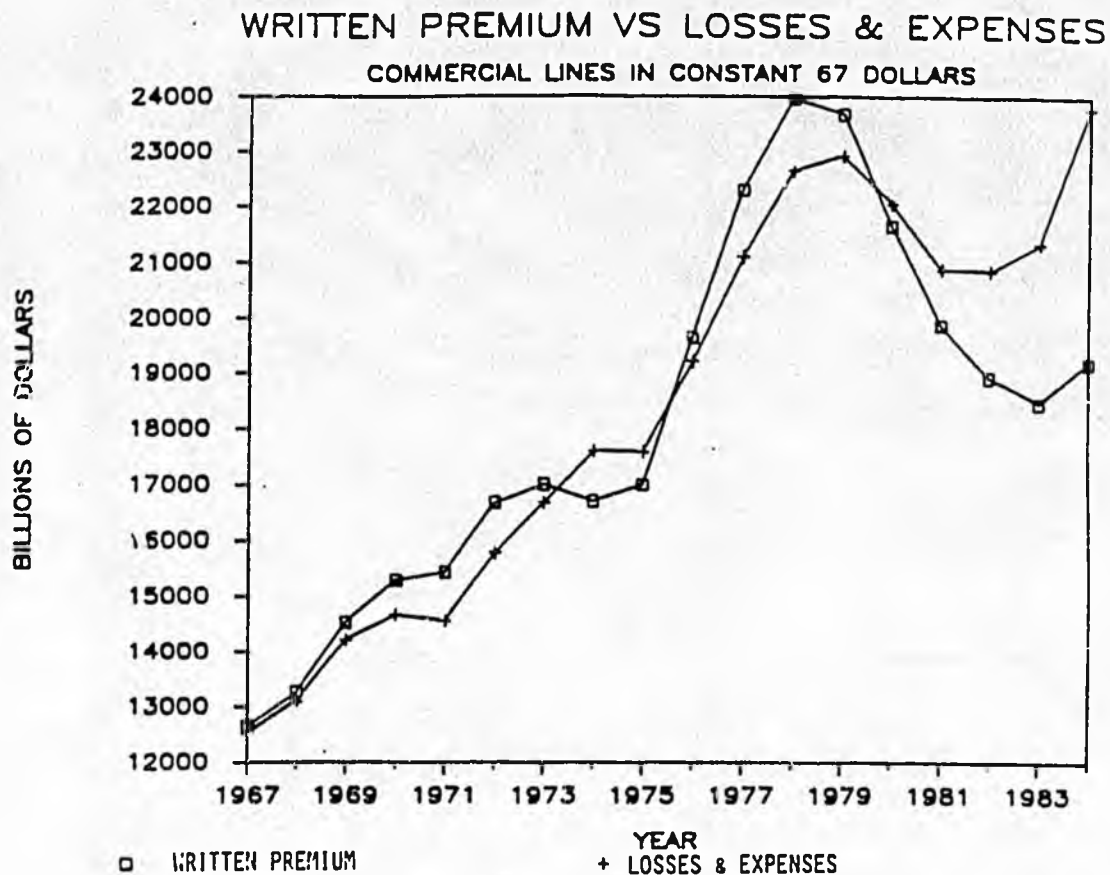
basis (i.e., adjusted for inflation). The comparisons have been performed on an all lines basis, and for commercial lines. The data clearly show that in recent years premium adequacy has deteriorated, significantly in the Commercial Lines.

All Lines

Exhibit 1 reviews total insurance premiums and costs on a constant 1967 dollar basis for the period 1967 to 1984.

EXHIBIT 1





Between 1967 and 1979, written premiums for commercial lines exceeded the sum of incurred losses, expenses, and policyholders' dividends in all but two years. Since 1979, premiums have not kept pace with costs, and the gap widened at an alarming rate.

In constant dollars, 1984 marked the first real increase after five consecutive years of declining written premiums. But 1984 written premiums were almost 20% less than premiums collected in 1978, before the decline in premiums began. At the same time, losses were at an all-time high.

In summary, insurer losses continued to rise, fueled by economic growth and inflation as well as expanding tort liabilities. However, at the same time, an intensely competitive insurance marketplace drove down premiums. Insureds have reaped the benefit of grossly inadequate prices for the past six years, and thus, when questions of affordability are raised, it must be emphasized that, for the average risk, prices at the beginning of 1985 were only returning to prior levels.

Additional premium increases can be anticipated since it is now clear that IBNR estimates in 1984 losses have been underestimated, due in part to judicial trends. In addition, there are several categories of risk which have been more substantially impacted by fundamental legal changes and other factors and thus the rate increases for these risks will be higher than the average.

The Commercial Lines Problem in Context

As outlined above, current availability and affordability problems are the result of the confluence of changes in the underwriting cycle and underlying frequency and severity trends due to expanding tort liabilities. Since 1979, the property/casualty industry has engaged in highly competitive practices which opted for cash flow underwriting, or emphasized marketing and investment operations over underwriting. In this

highly competitive market, other segments of the marketplace - agents, brokers, and commercial risks themselves - also actively participated in driving rates down.

The industry has finally realized that a business cannot indefinitely price its product below cost and expect to survive, and has therefore begun to bring prices in line with costs.

The current upward pressure on prices could be seen as a normal phase of the underwriting cycle. In an ordinary cycle, upward moves in prices would have been a proper response to diminishments in asset values and would have "corrected" the out-of-phase premiums/loss relationship. In other words, corrective price action would lead to respectable profitability quickly and effectively, as occurred both in 1969 and 1975, the low points of the past two cycles.

However, the current cycle differs significantly from previous downturns. This downturn was exacerbated by legislative and judicial trends. These increased loss and expense costs are occurring at the worst possible time in the underwriting cycle. In other words, just as the industry is responding to poor underwriting results through the normal internal dynamics of the underwriting cycle, unprecedented and, in some cases unmeasurable, liabilities have been imposed which have bent the cycle out of shape and placed long term solutions to profitable

insurance underwriting for some classes perhaps beyond the reach and ability of the private insurance industry alone.

Conclusions

The conclusion of this analysis is that price increases and capacity shortages have occurred as the outgrowth of the financial state of the industry. The documented financial problems of the industry have been caused both by downward pressure on prices in the past due to a fiercely competitive marketplace and fundamental changes in tort liability. This latter situation is not amenable to the normal corrective dynamics of the underwriting cycle since the root causes are not internal to the industry.

Finally this situation will affect various markets unevenly, with the more serious dysfunctions occurring in those classes or coverages most impacted by external legal trends.

STATEMENT OF
CHARLES H. FRITZEL
ASSISTANT VICE PRESIDENT FOR GOVERNMENT RELATIONS
NATIONAL ASSOCIATION OF INDEPENDENT INSURERS
BEFORE THE
SUBCOMMITTEE ON BUSINESS, TRADE AND TOURISM
COMMITTEE ON COMMERCE, SCIENCE AND TRANSPORTATION
U.S. SENATE
DECEMBER 3, 1985

My name is Charles H. Fritzel and I am the Assistant Vice President for Government Relations of the National Association of Independent Insurers (NAII).

NAII is a voluntary national trade association of over 500 property and casualty insurers. Our organization provides a truly representative cross section of the property and casualty insurance business in America. Our members range in size from the smallest one-state companies to very large national underwriters, and consist of both stock and non-stock companies. NAII member companies reflect all forms of merchandising -- independent agency, exclusive agency, and direct writers; and they include insurers which serve a general consumer market and those which specialize in serving particular consumer groups such as farmers, teachers, government employees, military personnel and truckers.

We very much appreciate this opportunity to testify on what is termed the "insurance availability and affordability crisis."

Just a few weeks ago NAIH held its 40th annual meeting. Our outgoing Chairman, Brad Mitchell, who is President of Harleysville Insurance Company in Pennsylvania, in his address to our membership spoke at length about the problems we are facing in the insurance industry. One of his statements stuck in my mind: He said that if a company entered the property-casualty business in 1967, in the 18 years from then until today, it experienced only five years of profitable underwriting. 1984 was the worst year we ever experienced.

In the first six months of this year, the industry's net after-tax income was \$1.1 billion, compared to \$562 million in the first half of '84, which, at first viewing, looks like an improvement.

But it is not sufficiently understood that the improvement was based on \$2.35 billion in realized capital gains and approximately a billion in tax credits resulting from the disastrous losses many companies have incurred in recent years.

The underwriting picture isn't getting any better either. In fact, the industry's underwriting loss rose \$1.3 billion over the comparable loss last year. We expect an underwriting loss which will probably exceed \$22 billion in 1985.

The bodycount of financially impaired companies hit a record 27 last year. Unlike the previous high of 20 insolvencies in 1975, which lasted only a year, the 1984 level is expected to continue through '85.

For the first time in history, the industry lost \$2 billion of its surplus last year solely through poor underwriting experience, at a time when the stock market was relatively stable and investment income was growing.

On top of that, it is estimated that the industry is at least ten per cent

In 1984, fifty of the top hundred insurers had returns on net worth that were in the red, a truly shocking performance in view of the fact that only 34 of the Fortune 500 had negative returns.

The usual explanations for the industry's illness include inflation, the recessions of the mid-70s and early 80s, and the bane of cash-flow underwriting.

But none of these is completely convincing. Insurers have weathered inflation and recessions for decades without getting beat up to this extent. And while it is true that some companies, in the commercial lines, nearly perfected Kamikaze pricing, cash-flow underwriting has been part of company operations since the 50s, when the shift from property to long-tail liability coverages amassed large amounts of cash in dormant reserves that could be used for investments.

No, something else, is at work and the numbers show it. This year, after six months of rate increases, a stable securities market and substantial investment gains, we still chalked up a disturbing operating loss of \$2.25 billion.

The reason is unrelenting, deepening losses. The industry has had five underwriting cycles since the 50s. They have gotten shorter on the upside, longer and deeper on the downside. The first three bottomed out at a combined ratio of 103, the fourth at 108, and the latest one at 118.

Something is pulling insurers deeper under water and holding them there. That something is the civil justice system.

We have all heard about the million dollar judgments and I won't bore you with more horror stories.

For the companies who have to pay outrageous claims, the financial shock can be severe. But they are not really the problem for the industry as a whole. As is usually the way with big things, it is the small, little-noticed changes that, over time, produce the big effect. What's happened to the civil justice system is what workers' comp lawyers call cumulative trauma.

In 1982, over 206,000 civil cases were filed in the federal district courts. No one knows how many were filed in the state courts, but in all likelihood, the number was even larger. In Los Angeles alone, the cost for the average civil case is \$20,860. Recently the general counsel of the Travelers estimated that their defense costs went up 79 percent in five years.

Yet, it's not the case that goes to trial and results in a multi-million dollar verdict that should overly concern us. It's the thousands of routine cases that are settled, because the courts' inconsistencies, and their eagerness to find ways to help the claimant hit the jackpot, that have destroyed insurers' faith in the legal process. Who can trust the courts when they change the rules in the middle of the game or rewrite contracts from the bench? What it all adds up to is not only more and larger claims payments, but higher administrative costs as well.

Deplorable conditions like these can be papered over with rate increases and more selective underwriting, but they will not be corrected until the tort system is reformed. We are in the same boat as our insureds - we are all victims of a runaway tort system, but we are the first victims in line. It's only a matter of time before the rest of society joins the infinite list of victims.

At a hearing back in September before the Commerce, Transportation and Tourism Subcommittee of the House Energy and Commerce Committee, NAI Vice President and General Counsel John B. Crosby summed up the short term prospects very well when he said, "In order to continue to provide the insurance protection necessary for a growing economy, the companies must return to a position of solvency and this can only be accomplished through price increases. In the short run this will be traumatic on the budgets of buyers, public and private. To do otherwise raises the prospect of driving a large segment of the industry into insolvency and forcing many buyers of insurance to go bare. As Forbes magazine put it not too long ago, 'a world without insurance' would result."

In order to keep price increases within some degree of reason, Mr. Crosby suggested the loss side of the equation must be dealt with. And it is here that public pressure for civil justice reform must be brought to bear.

In a number of states business coalitions have been formed to review the trends which have developed over the past decade and to recommend legislative remedies such as restrictions on punitive damages, limits on contingency fees, elimination of joint and several liability ... in short, they want what we want: the return of reason and common sense to the civil justice system.

The insurance industry, along with business and labor, have commissioned a study by the Rand Corporation to analyze the present tort system, and we hope to have those recommendations shortly.

The Insurance Services Office is proposing several changes which could have long-range benefits to the buyer. One is to give insurers (and their buyers) the option of using a "claims made" policy. This option will permit insurers to put a more realistic price on the commercial liability product as it eliminates the uncertainty brought about by claims discovered today that are due to occurrences which happened years ago.

The insurance industry is cooperating with state regulators, not conspiring with them, to develop open lines, market assistance plans, joint underwriting associations, and risk pools to name a few of the voluntary and unilateral actions being taken to address the crisis.

These are some of the actions being taken by the insurance industry. But they are short-term actions. The real solution lies with reform in our civil justice system.

Thank you.