Approved April 1, 1986
Date

MINUTES OF THE House COMMITTEE ON Judiciary.

The meeting was called to order by Chairman Joe Knopp at
Chairperson

3:30xx a.m./p.m. on Feburary 12, 1986 in room 313-S of the Capitol.

All members were present except:

Representatives Douville and Duncan were excused.

Committee staff present:
Jerry Donaldson, Legislative Research Department
Mary Torrence Revisor of Statutes Office
Jan Sims, Committee Secretary

Conferees appearing before the committee:
John Myers, Executive Assistant to the Governor
J. Robert Hunter, National Insurance Consumer Organization
Anne Wigglesworth, M.D.
Jerry Slaughter, Kansas Medical Society
Dotson Bradbury, Greenwood County Hospital

The Chairman announced that a public policy position from the Kansas Farm Bureau had been handed out to the committee and asked that the members review same. (Attachment 1) The Chairman announced that members had been presented with a balloon of HB 2661 as pertains to the amendment providing for a pinhole in the cap, and asked that members review it prior to tomorrow's meeting.

John Myers, Executive Assistant to the Governor appeared before the committee on behalf of Governor Carlin. He presented the Governor's position on HB 2661. Mr. Myers said Atch. 2 that the Governor feels that this is overall a worthwhile bill but the focus has come upon the tort reform and cap provisions which the Governor views as too simplistic and irresponsible. The Governor remains unconvinced that a cap will truly meet the Medical Society's need of lower premiums. The Governor feels a cap will prevent any provision for future medical needs of victims. It is doubtful, based upon testimony before the committee by St. Paul Insurance Company that the cap will have any beneficial effect on premiums in that the current moratorium is nationwide and includes other states that have imposed caps. The Governor believes that the insurance industry needs further investigation relative to limiting liability when only responsible for base coverage. Mr. Myers expressed the Governor's concern with the constitutionality of HB 2661 as presently drafted stating it addresses over 20 issues in one bill. The Governor has proposed pertinent measures in HB 2876 and 2879 through 2883 and urges the committee's attention to them.

Rep. Shriver asked Mr. Myers if the Governor was open to any negotiation on the issue of the cap and John responded that Governor Carlin was. Rep. Wunsch asked what complaints the Governor's o-fice had received from victims and committee conferees relative to appointments to the Board of Healing Arts. Mr. Wunsch said the committee has been advised that nominations for those appointments from the Kansas Medical Society have not been appointed. Mr. Myers responded that he was not aware of any complaints having been received.

Mr. Myers introduced J. Robert Hunter, President of the National Insurance Consumer Organization. (Attachments 3, 4 and 5). Mr. Hunter stated that the current crisis is a manufactured crisis intended to raise profits to insurers and reduce victims' rights. He spoke of the cyclical periods of property and casualty insurance pointing out that we are currently in the bottom portion of a cycle. Even admitting a premium shortfall, Mr. Hunter feels the return on net worth of insurance companies is sufficient to insure their own continuation. He said the statistics do not justify their increasing premiums and redlining certain physicians. The increases of property and casualty company stock have been dramatic and in excess of the Dow Jones average. This is not the sign of an industry about to collapse. Mr. Hunter stated that the problem is a soluble one requiring both federal and state reforms. Tort reform is necessary but only along with insurance reform. He feels that the data does not justify the insurance industry's desire for caps.

He pointed out the insurance environment in Canada contains an insurance company's wish list of provisions; yet the system in Canada is in more crisis now than ever.

Mr. Hunter said that attorney fees on both sides are too high. He said defense attorneys have a tendency to hold litigation up in an attempt to create paperwork and increase fees.

Mr. Hunter feels experience rating should be used more, and the states could take over the reinsurance business and that self insurance is another option to be considered.

As pertains particularly to Kansas, Mr. Hunter asked if doctors get a limit on their liability what will follow with other professions. He stated that the cost of insurance was less than 1% of the cost of medical care. He feels the amounts are not too large, but the allocation of those costs is not fair.

When asked by Mr. Knopp what will happen if the companies are the only players in this game and we call their bluff, Mr. Hunter responded that the entire underwriting could be turned over to the JUA which is already in place, but he really doesn't think the insurance companies will pull out of Kansas. When asked what would happen if the committee does not call the companies' bluff, he stated that the committee should ask the companies what they would absolutely promise in exchange for giving up Kansans' rights.

Jerry Slaughter of the Kansas Medical Society appeared before the Committee stating that he does not believe this crisis is an insurance ripoff. He asks if that is the case where are all the companies that would stand to gain so much. (Attachment 6). He pointed out that the Health Care Stabilization Fund is a state administered insurance company and it is broke. It has $19 million but $47 million of claims are in the pipeline. He added that the JUA has lost $7 million and is broke. In light of testimony today, Mr. Slaughter said he is happy to see that Section 16 pertaining to expert testimony has been retained. He says that the bad doctor theory just does not hold up. Other states with tougher peer review than this bill contains do not have lower premiums. Frequency and severity of claims has increased over the last 10 years. This is a multi-faceted problem and cannot be addressed in terms of only one segment of the bill. It is important that the bill be kept intact.

Dr. Anne Wigglesworth of Wamego appeared before the committee to relay what is happening to physicians and hospitals in small Kansas communities. She explained that much of her work is now defensive in nature and results in higher patient cost. At the same time physicians are being asked to contain costs. Dr. Wigglesworth also feels her relationship with patients has been changed due to the fact that her attitude has had to change in light of malpractice cases. She now has to view each patient as a potential adversary. 25% of the physicians of Wamego have left or retired due directly to malpractice premiums. Doctors are being pushed out of the system because of this crisis and they are not all bad doctors. She stated that she and her partner feel they have maximized the amount of income they can generate in their area but do not know how much longer they can continue to pay ever increasing premiums. Because of other medical staff in Wamego retiring she is now forced to move the hospital portion of her practice to Manhattan. This will have an economic effect in Wamego and result in layoffs of the hospital's personnel. She feels she cannot give the quality of care necessary to protect herself from malpractice litigation with the reduced staff in the Wamego hospital.

Dotson Bradbury, Administrator of the Greenwood County Hospital appeared before the committee explaining that his hospital currently staffs three general practice physicians and one board certified surgeon. Of the general practitioners one has discontinued OB services. The other two are continuing for one more year and will wait and see what happens with this legislation and the effect it has on their premiums before making a decision on whether to continue that practice. With such a small staff serving such a large geographical area, the citizens of the area stand to suffer a great deal if these physicians discontinue their practices.

The Chairman reminded committee members that tomorrow's meeting will be in Room 519-S.

The meeting adjourned at 5:45 P.M.

Fleener 2/12

Kansas Farm Bureau

PUBLIC POLICY STATEMENT

Statement To:

HOUSE JUDICIARY COMMITTEE

RE: Medical Malpractice . . . Tort Reform . . . H.B. 2661

Topeka, Kansas
February 12, 1986

Presented by:
Paul E. Fleener, Director
Public Affairs Division
Kansas Farm Bureau

Mr. Chairman and Members of the Committee:

My name is Paul E. Fleener. I am the Director of Public Affairs for Kansas Farm Bureau. Your schedule is filled with conferees on this important issues . . . medical malpractice, or **Provisions relating to Tort Reform.** We ask, Mr. Chairman, that you provide our public policy statement on this issue to each of the members of your committee. If your time permits we will present it to your committee. Otherwise we respectfully request that this be made a part of your hearing record so that the views of farmers and ranchers on this important legislation can, after all, be heard.

Our members have followed with interest the legislative activity on Medical Malpractice. We were present during the 1976 Interim when exhaustive studies were held and **many** remedies were advanced. A package of 13 bills was the product of that Interim Committee study. Twelve of those bills passed into law. Yet, **the problem continues nearly unabated.**

Attachment 1
House Judiciary
2-12-86

Awards are astronomical. Medical practitioners are regrouping, retrenching, or retiring.

In the rural communities of this state, the medical malpractice problem poses not just serious, but dire prospects and consequences. Our farmers and ranchers have continued to study this issue. They examined it again before our 1985 Annual Meeting and expressed themselves this way on this issue:

Health Care and Professional Liability

We believe there is a threat to health care in this state because of the cost and availability of professional liability insurance coverage for health care providers.

The increased incidence of medical malpractice claims has caused the cost of insurance coverage to soar, reduced the availability of coverage, and contributed to higher patient fees. We believe health care delivery would be improved and the medical malpractice insurance problem corrected by the enactment of state legislation which would:

1. **Prohibit publication of the dollar amount sought in a medical malpractice suit;**
2. **Limit the amount of money which can be recovered in a medical malpractice suit;**
3. **Modify and restrict the use of the contingency fee system by the legal profession; and**
4. **Reduce the statute of limitations and time of discovery for an alleged act of negligence or omission.**

Mr. Chairman, and Members of the Committee, to the extent H.B. 2661 addresses the items of greatest concern to our members ... namely procedures to stabilize the soaring costs of medical malpractice insurance and the availability of that coverage, and

the **limitation on the amount of money which can be recovered in a medical malpractice suit**, we support the legislation.

We thank you for making our policy position known and available to all of your committee members.

Myers 2/12

STATE OF KANSAS

OFFICE OF THE GOVERNOR
State Capitol
Topeka 66612-1590

John Carlin *Governor*

Testimony to the House Judiciary Committee
HB 2661
Executive Assistant to the Governor
John Myers
February 12, 1986

Mr. Chairman and members of the committee, I'm John Myers, Director of Policy for Governor Carlin, and I'm here to testify on his behalf. The Governor has followed closely the hearings of the Interim Committee on Medical Malpractice, the Bell Commission on Tort Reform and this Committee. He recognizes the severity of this issue and is committed to finding an equitable and sound solution to this comprehensive problem. After lengthy consideration of House Bill 2661, he has concluded that he cannot support this legislation in its present form.

While House Bill 2661 has many worthwhile measures, no one would deny that the primary focus of the bill is to place a one million dollar cap on the recovery rights of malpractice victims. This simplistic approach to the problem is neither responsible or necessary.

The Governor has heard the pleas of the Medical Society that a cap on awards is the only true solution to our problem. However, he also has spoken with individual doctors across the state - urban and rural. Like Dr. Browning who testified before you on Monday, many doctors admit they don't know whether or not a cap is the solution, they just want lower premiums.

The Governor also has heard the pleas of medical malpractice victims that a cap will arbitrarily limit the amount they can recover, regardless of actual expenses incurred and future medical care needed. Just this week, this Committee heard about a victim who will have incurred one million dollars or more in actual medical expenses before any judgment is made. The effect of House Bill 2661 on this case would be to prevent any provision for future medical care.

The Governor also has listened to the pleas of independent insurance companies that a cap on awards is essential. These same individuals also say, however, that such a cap will have little effect on their premiums and that they can make no guarantee of lower premiums if House Bill 2661 is passed. A representative of St. Paul insurance recently informed this Committee that his company was placing a two-year moratorium on writing any new medical malpractice insurance coverage nationwide. States that already have a cap also are included in this moratorium. At best, it's highly speculative that we would derive any benefit from a cap when states with caps in place are not looked upon favorably by the insurance industry.

Attachment 2
House Judiciary
2-12-86

Our major problem with this issue is that we are not asking the right questions of the right people. We have studied the Board of Healing Arts, the Health Care Stabilization Fund and tort reform. But we have not asked the tough questions of the private insurance industry. No one has asked why the insurance industry in Kansas wants a limit of $1 million on victim's rights when they are only responsible for the first $200,000 of any award.

Clearly more information is needed to get to the real root of the liability insurance problem. The problem is not limited to medical malpractice. It is an industry-wide concern. The place to start addressing the problem is with the private insurance industry and the time to start addressing it is today.

One last concern that I would like to bring to the attention of the Committee is the possible unconstitutionality of House Bill 2661. The intentional grouping of more than 20 independent measures into one bill gives rise to the possibility of the entire measure being found unconstitutional. This was pointed out by Legislative Counsel to the Interim Committee. Although the format may present a political advantage to the proponents of House Bill 2661, it shows a geniune lack of concern for the problems facing Kansas doctors. The Governor will not jeopardize legitimate measures by being a part of such an irresponsible approach. I strongly urge the Committee to consider the six measures proposed by Governor Carlin embodied in House Bills 2876 and 2879 through 2883. I thank you for the opportunity to address you. Before I introduce Mr Hunter, I will answer your questions.

At this time, I would like to introduce Robert Hunter, President of the National Insurance Consumer Organization of Alexandria, Virginia. He appears at the invitation and expense of Governor Carlin. Mr. Hunter is an actuary and a former federal insurance administrator under Presidents Ford and Carter. His resume is attached to my testimony.

J. ROBERT HUNTER

CONSULTANT TO CONSUMERS AND GOVERNMENTS ON PUBLIC POLICY MATTERS AND TECHNICAL MATTERS DEALING WITH INSURANCE

Presently: President of the National Insurance Consumer Organization, a non-profit public interest group formed to aid and educate insurance consumers.

Formerly:
Federal Insurance Administrator
Deputy Federal Insurance Administrator
Chief Actuary, Federal Insurance Administration
Associate Actuary, Mutual Insurance Rating Bureau
Associate Actuary, Mutual Insurance Advisory Service
Actuarial Supervisor, National Bureau of Casualty Underwriters (now Insurance Services Office)
Underwriter, Atlantic Mutual Insurance Company
Underwriter, Centennial Insurance Company

Experience: Operated a large Federal agency (budget of $1/2 billion per year) for four years, operating a major property insurer, a major reinsurance company and insurance regulatory functions. Consultant to the White House, OMB, all Federal agencies on such issues as National Health Insurance, Wage/Price and Economic Stabilization, Product Liability Insurance, No-Fault Auto Insurance, Workers' Compensation Insurance, and Redlining. Appeared as an expert witness in many states on issues such as insurance ratemaking, availability techniques, affordability, classification reform. Actuarial experience includes establishing public sector flood and federal crime insurance and riot reinsurance rates; automobile ratemaking and other property/casualty insurance ratemaking in the private sector. Have consulted for the states of Florida, Massachusetts, New Jersey, North Carolina and South Carolina as well as for several federal agencies.

Actuarial Designations: Fellow, by examination, of the Casualty Actuarial Society
Member, American Academy of Actuaries
Member, International Actuarial Association

Award: HUD Secretary's Award for Excellence for work performed from 1971-1977

Publications: Taking the Bite Out of Insurance, Volume I: Investment Income in Ratemaking, 1980

Commissioner's ALERT, Number 1: Gas Prices and Auto Rates, 1981

Workers' Compensation Insurance Ratemaking, with Raymond Hill, 1982

Investment Income and Profitability in Property/Casualty Insurance Ratemaking, with John W. Wilson, 1983

"A Study of Feasibility of Risk Retention Groups for Hazardous Waste Facilities", in CPCU, Winter, 1983

Hunter 2/12

WHAT HAPPENS TO INSURANCE RATES WHEN "TORT REFORM" LEGISLATION IS ENACTED?

Virtually every "tort reform" measure the insurance industry is seeking is currently the law in Ontario, Canada (See Chart 1). Yet the insurance industry is raising premiums by 400%, cancelling coverage in mid-term and refusing to provide coverage at any price in Ontario, Canada just as it is in the United States. For example:

- The insurance industry has refused to provide insurance at any price for Ontario day care centers (See Exhibit 1).

- The insurance industry has refused to provide insurance at any price to all but 1 of 121 Canadian School Boards responding to a questionnaire (See Exhibit 2).

- The insurance industry has refused to provide liability insurance for Toronto and many other cities (See Exhibit 3).

- The insurance industry has refused to provide liability insurance at any price to the Canadian national ski teams, which have never had a major claim against them (See Exhibit 4).

- The insurance industry has raised premiums 1000% and at the same time reduced coverage for the Ontario intercity bus industry (See Exhibit 5).

- Hospitals in Toronto can still get insurance, but only at "greatly increased" premiums (See Exhibit 6).

- An insurance company renewed the Ontario School Bus Operators Association's policy on December 1 -- at 400% more than it charged the year before (See Exhibit 1).

If any of the organizations denied coverage were ever sued -- and many of them have never been sued in the past -- they would be sued under the laws of Ontario, where pain and suffering awards are capped at $185,000, punitive damages are virtually non-existent, contingency fees are prohibited and the plaintiff must pay the defendant's attorney's fees if he loses. Yet the insurance industry is raising its rates 400% and more, cancelling policies in mid-term and refusing to provide coverage at any price both in the U.S., which has not enacted the tort provisions the industry seeks, and in Ontario, Canada, where such provisions have long been in the law.

Attachment 3.
House Judiciary
2-12-86

Exhibit 1

Toronto Star
Friday, January 10, 1986

Liability coverage crunch may shut day-care agencies

By Elaine Carey Toronto Star

Two of the largest day-care agencies in Metro may be forced to close down next month because they have been unable to renew their liability insurance.

Family Day Care Services, which provides care for about 600 children through home care and a school-age centre, and Cradleship Creche, which cares for another 550 children, say they can't get insurance at any cost.

Cradleship's policy expires Jan. 31 while Family Day Care has until the end of February to try to find some solution, said John Pepin, its executive director.

"But our agent and two others have been trying everywhere and there just isn't anything," he said. "If it's hitting us this way, it will eventually hit the others as well."

'Pay 1,000 per cent'

Family Day Care, one of the oldest registered charities in Canada, has been in operation for 135 years and has never had an insurance claim, he said. Its premiums rose 65 per cent last year to about $2,500 but this year the insurer refused to renew the policy.

"At this point we are willing to pay 1,000 per cent more if necessary, but we can't even get a quote," he said.

Dr. Myrna Francis, executive director of Cradleship Creche — which has operated for almost 50 years without a claim — said their insurer refused to renew their policy when it expired Dec. 31, but granted them a month's extension to try to find other insurance. But insurers simply say they will no longer issue policies to day-care centres.

The provincial Day Nurseries Act requires day-care centres to have liability insurance to operate, she said, and they have informed the province of the situation.

'Deficit financing'

"We are just waiting to hear form the government and we will very shortly have to decide what course of action to take," she said.

Pepin said the implications of putting 1,150 children out of day care are "horrendous. Most of these people are low-income and without day care they would lose their jobs.

"Even if we do get some kind of ministerial approval to operate without insurance, if there was ever a suit and we're not protected, we put ourselves in a very vulnerable position," he said. "We can't afford to self-insure — we have barely enough funds as it is and we end up deficit financing every year. Where would we find the funds to cover it?"

The liability insurance industry in Canada has hit a crisis because of skyrocketing court awards and falling interest rates. Many companies have simply refused to issue policies for vulnerable groups, including four of Metro's municipal governments and the Metro School Board, which are now self-insuring.

Insurers cite problems in the United States, where several day-care centres have been charged with sexually abusing children in their care, as one reason for their unwillingness to renew day-care policies.

Umbrella Day Care Coalition, which arranges insurance for 185 non-profit day-care centres in Metro, did manage to get insurance Oct. 1 for only a slight premium increase, "but we had to stay away totally from American insurance companies," director June Hall said.

The U.S. company they had been dealing with for years refused to renew at all, she said, and up until a week before the policy expired "no one would touch it." The coalition eventually found a British insurer who was willing to take on the policy.

But Pepin said that company and others willing to renew policies two months ago are now flatly refusing, claiming that one suit involving a small child could cost them millions.

"I think, as all these day-care organizations come up for renewal, they will find enormous problems," he said.

Higher insurance rates hit school bus operators

By Kim Zarzour Toronto Star

School bus companies and school boards are bracing themselves for hefty vehicle insurance increases that threaten to put some smaller bus operations out of business.

If school boards don't take the brunt of the increase, officials say, parents may have to find another way to get their children back and forth to school.

Metro area boards spent about $70 million transporting more than 123,000 students last year. Board officials say the cost of that service will increase considerably when the new busing contracts are negotiated in the spring.

Insurance companies blame the higher rates — which are also causing problems for municipalities, school boards and trucking companies — on increasing frequency and cost of claims and higher court awards to accident victims

Bus operators and school boards said yesterday that the situation took them by surprise.

"It just seemed to hit us in November and December," said Ted Moorhead, president of the School Bus Operators Association of Ontario. Moorhead said he was shocked by a 400 per cent increase when he renewed his insurance Dec. 1.

Charter bus companies have already been hit with big jumps in insurance rates. Gray Coach Lines, Ltd. recently hiked the price of monthly commuter passes to cover higher liability insurance premiums. The Ontario Motor Coach Association has called for an investigation by a legislative committee.

Moorhead said most school bus operators haven't yet been hit by the increases, but they fear it's inevitable.

While some operators say the increases will be no more damaging than the soaring gas prices of recent years, others, especially the smaller companies, are worried.

"I can't take any large increases without going bankrupt. If it goes up 100 or 200 per cent, then I'll have to think about closing my doors," said Ronald Young, who operates a fleet of 50 buses for the Peel Board of Education. "The school board is going to have to bear the brunt of the increase, and they in turn will have to pass it on to the taxpayers."

William McWhirter, transportation officer with the Toronto board, said school boards will just have to find the money somewhere.

"If we don't realize that the whole industry is in trouble and try to help them out, then we're not going to have any transportation service at all."

The bus operators association has scheduled a meeting to discuss the insurance problem next week.

Exhibit 2

416/963-0311

555 Yonge Street
Toronto, Ontario
M7A 2H6

Ministry of
Consumer and
Commercial
Relations

BACKGROUND NOTES - January 9, 1986

SUBJECT: LIABILITY INSURANCE

INSURANCE CLASS: SCHOOL BOARDS

121 of the 165 boards (excluding Canadian Forces Board and Treatment Centres) responded to an insurance questionnaire distributed in early December 1985 and at this time only one board has been unable to obtain liability insurance coverage at all. The board is the Moose Factory Island District High School Area.

Several boards have had to reduce the maximum liability insurance coverage that was available to them last year.

The premium increases have ranged from a low of 12% to a high of 563% over the previous year's premium.

Several boards have indicated that new exclusions have been imposed on them by the insurance industry, such as sports related activities, shop programs, and environmental issues. At this time the only boards to have advised us that this has been given to them in writing by their insurance broker are the Wellington County Board of Education and the Kirkland Lake Board of Education. The Wellington County Board of Education has halted all physical education programs until further notice.

We are currently working with the Ontario Association of School Business Officials to review that options are available to school boards to solve this problem.

No board is expected to close because of a lack of insurance.

The Ontario Association of School Business Officials has been trying for some time to arrange a co-operative for school boards under which they would insure each other. Planning for this continues, and OASBO has asked for Ministry of Education assistance in collecting the required data. The Ministry is considering this request, which includes a request for financial assistance (about $25,000).

An inter-ministry work group has been formed to examine the entire insurance situation, led by Consumer and Commercial Relations. The Ministry of Education has representation on this committee.

Exhibit 3

Toronto Star
Friday, January 10, 1986

'Crisis' team to investigate soaring price of insurance

By Denise Harrington Toronto Star

A provincial task force will look at government-run coverage and tougher insurance regulations in a bid to solve the crisis of soaring premiums facing Ontario cities, school boards and hospitals.

"This government is not prepared to stand aside while this crisis threatens some elements of our economic and social system," Consumer Minister Monte Kwinter told the Legislature yesterday.

The task force, under former Economic Council of Canada chairman David Slater, will examine the costs and availability of liability insurance in Ontario and whether rules governing the industry could be improved to ensure stable rates.

Kwinter also announced yesterday a new plan to pay limited compensation to customers of bankrupt insurance companies.

The government will help hospitals pay for massive premium increases if they face "true financial hardship," Kwinter promised.

Replying to questions in the Legislature, Kwinter said the Liberal government is not considering offering automobile insurance or public sickness and disability insurance.

☐ Metro day-care agencies may close without insurance. Page A4.

"At the present time the government's preference is not to be in the insurance business," Kwinter added outside the Legislature.

"On the other hand, if the case can be made, and if it can be documented that this would be the route to go and makes economic sense and provides the kind of services required, we would certainly look at it."

Metro and the municipalities of Toronto, York, Etobicoke and East York have been unable to get any insurance coverage against personal injury for 1986. The province is encouraging municipalities to set up insurance pools to handle soaring rates and lack of coverage.

'Doing nothing'

Opposition Leader Larry Grossman complained that Kwinter has, "after six months of literally doing nothing," decided to appoint a task force "that will take a minimum of another three months before anything happens."

New Democratic Party leader Bob Rae said the government should introduce a sickness and disability insurance plan for all Ontarians, as well as an auto insurance scheme similar to those in Manitoba and Saskatchewan.

But Kwinter pointed out public insurance plans in those two provinces were facing deficits this year. He said the problem of soaring premiums was worldwide because of high court awards, low interest rates paid on investment on premiums, and competitive cut-rate premiums offered several years ago.

Outside the Legislature, Kwinter said the government will set up a plan to provide a maximum of $200,000 in coverage to customers of companies that go bankrupt. All panies will be asked to pay into und at rates to be set later.

Exhibit 4

Globe & Mail
Jan. 15/86

Insurance problems may curtail season for Canadian skiers

Special and Canadian Press

OTTAWA

Canada's national ski teams may have to leave the World Cup circuit at the end of this month because of an insurance problem that could also cripple competitive skiing across Canada.

Ron Payment, executive director of the Canadian Ski Association, says the inability to get sufficient liability insurance may force the association not only to call home its national teams but also to cancel all domestic competitions.

Most provincial ski programs and some club programs would also be affected, since they are tied to the CSA's insurance policy. The CSA executive plans an emergency meeting on Jan. 25 in Ottawa.

Glenn Wurtele, the national head coach, said yesterday in Kitzbuehel, Austria, that he hadn't been told that the teams might be called home or even that there is an insurance problem.

"It certainly is news to me. I find it extremely hard to even envision it happening; I really can't imagine something happening on that scale."

Mr. Wurtele said he could not see Sport Canada, with its huge investment in Olympic sports, allowing the teams to be called home.

The association is one of a growing group of sports organizations finding it difficult to purchase liability insurance at an affordable cost.

The CSA says it was first told that the price of liability insurance would double, and then found that coverage was unavailable at any price.

The association's current coverage on national alpine, cross-country, jumping, free-style, biathlon and nordic combined skiers, coaches and staff ends on Jan. 29, after several extensions by the New York-based American Home Assur-

SKI — Page A2

Ski teams can't get liability insurance

● From Page One

ance Co.

"I'm not sure what will happen after that," Mr. Payment said yesterday. "The odds are good we won't have insurance. The executive must decide what to do.

"If we don't find re-insurers . . . it could mean recalling all the teams and it could affect all of our developing teams leading to 1988," the year of the Winter Olympics in Calgary.

Mr. Payment said he understands that U.S. teams may also be having insurance problems. He said, however, that European ski teams don't face the sort of problem confronting Canadian teams, at least in part because accident settlements tend to be lower in Europe.

He said he has been trying to get more information on the European situation to see if he can glean any pointers to help Canadian ski teams deal with their difficulties.

CSA was first advised by its insurance agent it could expect to pay between $90,000 and $100,000 for $10-million in liability insurance for 1986. Mr. Payment said the CSA, which has never had a major liability claim against it, was willing to pay that amount, but later found that insurance companies had backed away from offering liability insurance at any price.

In 1984, the CSA paid $7,000 for liability insurance, with the premium rising to $47,000 last year.

Mr. Payment said the association has been unable to find coverage from any of about 100 companies it has approached. That leaves the association with the option of going through the remaining three months of the season without liability insurance.

"If we had no insurance, it would expose the coaches and staff to (possible) lawsuits and we could have mass resignations," Mr. Payment said. "Some volunteers have indicated they will resign if there is no insurance."

The CSA is considering buying accident insurance for the skiers, but that is expensive and it does not cover the volunteers, coaches, staff and the association.

"If a skier becomes paralyzed, accident insurance may pay $250,000, but he may decide to sue. A settlement of a few million isn't unusual."

The increased difficulty of getting adequate liability insurance, a result of large claim settlements in North America, has affected all Canadian amateur sports organizations.

Hugh Glynn, president of the National Sport and Recreation Centre, had no instant remedy, but said the problem needs immediate attention. He said he informed Otto Jelinek, the Minister of Fitness and Amateur Sport, about the situation before Christmas, but has not had a reply.

"One thing is for certain: the Government must step in. They will bring volunteer organizations to a standstill, if they keep this up. It appears to be a pressure tactic (by the insurance companies) to bring action from the Government.

"Our organizations have gone as far as Lloyds of London and they have turned us down."

Rob Toller, a spokesman for Mr. Jelinek, said on Monday that the minister was extremely concerned about the situation and was "seeking the best advice he could find" from the sports community and the insurance industry.

"But really, he doesn't know just what he can do to ease the situation."

Barbara McDougall, Minister of State for Finance, indicated in Parliament on Monday that she will be bringing in new policies to deal with the general problem of liability insurance, but she did not elaborate on what those initiatives would be. A special committee of the Ontario Legislature already has been struck to study the situation.

Exhibit 5

416/963-0311

555 Yonge Street
Toronto, Ontario
M7A 2H6

Ministry of
Consumer and
Commercial
Relations

BACKGROUND NOTES - JANUARY 9, 1986

SUBJECT: LIABILITY INSURANCE

INSURANCE CLASS: BUSES

Since the OMCA wrote the Premier on September 18the, senior staff from MTC and CCR have been involved in meetings and initiatives aimed at assisting the bus industry. Notably, arrangements were made with the Facility Association to provide insurance coverage for this industry, the Honourable Ed Fulton has met with the OMCA and has gained insight into the insurance crisis from the industry's perspective, and the Deputies from MTC, CCR, and Tourism and Recreation have met to seek solutions to this problem.

The Deputy Minister of CCR met with representative from the Ontario Motor Coach Association on November 23, 1985.

EFFECTIVE IMMEDIATELY bus carrier tariff increases will be approved by the Minister MTC without referral to the OHTB. This will allow tariff increases due to insurance premium increases to be approved in a week instead of the previous 30-60days.

The intercity bus industry in Ontario is facing increased costs of liability insurance. Premiums have increased ten-fold from levels of $2000-3000 per coach to $20000-24000 per coach for much less coverage.

Exhibit 6

THIS IS THE EXHIBIT OF INSURANCE CANADA.

416/963-0311

555 Yonge Street
Toronto, Ontario
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Ministry of
Consumer and
Commercial
Relations

BACKGROUND NOTES - January 9, 1986

SUBJECT: LIABILITY INSURANCE

INSURANCE CLASS: HOSPITALS

In June of 1985, the Ministry of Health became aware of a major price increase in hospital liability insurance.

July 8, 1985, the staff of the Ministry of Health met with representatives of the Ontario Hospital Association and their insurance brokers.

Both the Ministry of Health and the O.H.A. met with the Superintendent of Insurance subsequently to review options/alternatives that might be available.

The Ontario Hospital Association has established a Task Force, including an observer from the Ministry of Health to review the alternatives available to the industry. The review will include examination of options such as self insurance, change in coverage from occurrence to claims made, etc.

A group of 20 Metro Toronto hospitals are conducting a similar, but independent, review.

The hospitals of the Province are still able to purchase liability insurance, although at a greatly increased premium.

In terms of the increased premiums, the Ministry of Health has not made any overall provision for the costs but is reviewing each hospital's overall financial position and is prepared to provide additional funds in cases of true financial hardship.

Hunter 2/12

COMPARISONS BETWEEN "TORT REFORMS" SOUGHT BY THE INSURANCE INDUSTRY AND THE LAW OF ONTARIO, CANADA

In most of the 50 states, the insurance industry is seeking legislation that would make it more difficult for injured people to win lawsuits and would limit the amount of money they could recover if they do win. The law of Ontario, Canada (where the insurance industry is raising rates just as it is in the United States, see Chart 2) already contains the provisions the insurance industry seeks, as the following chart shows:

The insurance industry wants:	Ontario, Canada has:
A. Caps on compensation for pain and suffering -- e.g., for quadriplegia or brain damage -- typically of $250,000.	A. Caps on compensation for pain and suffering. Ontario has a cap of $100,00 in 1978 Canadian dollars ($185,000 in current Canadian dollars). See Andrews v. Grand and Toy Alberta Ltd., 2 S.C.R. 229 (1978); Ontario Law Reform Commission Report on Products Liability, at 62 (1979) (hereinafter "Ontario Law").
B. Restrictions on punitive damages: e.g., limiting punitive damages to a specific amount or a specific multiple of the compensatory award, or absolutely prohibiting punitive damages.	B. Restrictions on punitive damages. In Canada, punitive damages are virtually unknown in tort cases. They are allowed only for intentional torts. Ontario Law at 75; Linden, Canadian Tort Law, at 49-51 (1977).
C. A prohibition on injured people specifying the amount they seek in the complaint (in legal jargon, eliminating the *ad damnum* clause).	C. A prohibition on injured people specifying the amount they seek in the complaint. In Ontario, the plaintiff is not permitted to demand a specific amount in the complaint. See Gray v. Alanco Development, Inc., 1 O.R. 597 (1967); Ontario Law at 75.
D. Restrictions on contingency fees -- e.g., by establishing a sliding scale that reduces the percentage of the award the lawyer can receive as the award gets larger.	D. No contingency fees. In Ontario, contingency fees are prohibited. Ontario Law at 72, 75.
E. Restrictions on the role of the jury -- e.g., taking the authority to determine the amount of punitive damages away from the jury, or requiring the jury to answer detailed interrogatories that limit its discretion.	E. Restrictions on the role of the jury. There is no constitutional right to a jury trial in Canada. Most trials are judge trials. Ontario Law at 74, 102-04.

Attachment #4
House Judiciary
2-12-86

F. Penalties for "frivolous" suits -- e.g., requiring the plaintiff to pay the cost of defending such a suit.

F. Penalties for "frivolous" suits. In Ontario, if the plaintiff loses he must pay the defendant's attorney's fees, as well as his own. Ontario Law at 72, 76.

Hunter
2/12/86

NATIONAL INSURANCE
CONSUMER ORGANIZATION

TESTIMONY OF

J. ROBERT HUNTER
PRESIDENT
NATIONAL INSURANCE CONSUMER ORGANIZATION

BEFORE THE
HOUSE JUDICIARY COMMITTEE

THE LIABILITY CRISIS IN INSURANCE

TOPEKA, KANSAS
FEBRUARY 12, 1986

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

Attachment 5
House Judiciary
2-12-86

OVERVIEW

The nation is losing its liability insurance. Day care centers are being forced to close; nurse-midwives are losing their insurance so birthing centers are shutting down; doctors are marching on state capitals; cities, transit authorities, even whole states are losing their liability insurance. One of the leading auto insurers in the District of Columbia has pulled out. The list goes on and on.

And prices have skyrocketed. In 1985, insurance premiums rose by almost $25 billion, more than $100 for every man, woman and child in the US. 1/

Are these practices of insurers justified?

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

Property-Casualty insurance has a cyclical profitability, as Chart Number 1 shows. 2/ In 1985, if you accept the insurer's whopping reserve increases as valid, they earned about a 6% rate of return on net worth (equity). That is too low. 3/ If their premiums had been 3% higher, they would have earned a rate of return on net worth of about 13%, more than enough for an industry of the low to average riskiness of Property/Casualty insurance.4/

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

- A 70% increase for OB/GYNs in Maryland (totally unjustified -- see Exhibit I).
- 300% to 900% increases in lawyer and architect malpractice insurance premiums around the country.
- Increases of 200% to 500% for the day care centers who can get insurance. Many can't.
- 300% to 1000% increases for public transit authorities.
- One Northeastern state's liability insurance premium was $100,000 for $100 million of coverage last year. This year it's $400,000 for $3 million in coverage.

The statistics don't justify any of this!

THE LAST CYCLE BOTTOM - 1974/5

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

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

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

But look at what happened; their profits skyrocketed to all time record levels. Insurers learned that the state regulators would, during the panic, give away the store in rate increases. Insurers also learned that state legislators would act to reduce victims' rights in the wake of the panic (over half the states did so 6/). The fact that insurers achieved much of their 1975 legislative agenda and now are back for a bigger bite from the apple is very significant.

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

THE HEAT IS ON

One property/casualty official has stated that: "It is right for the industry to withdraw and let the pressures for reform build in the courts and in the state legislatures." 7/ Reinsurance, a critical aspect of maintaining available and affordable insurance rates may not be available from overseas because syndicates would "simply not write reinsurance for the American casualty industry" in 1986. A representative of that overseas market (Lloyd's of London) was recently reported to have said that if a new policy form is not adopted by state regulators, reinsurance wouldn't be provided to American liability underwriters. When I recently testified before the Maryland Governor's Special Medical Malpractice Committee, a medical malpractice insurance company executive told the committee that higher rates for ob/gyns in Maryland were put into their filing because the reinsurer required it, not because the rates were actuarily justifiable (which they weren't). The reinsurers heavy-handed role in this crisis it typified by their threats to state legislatures (in Alaska), insurers on coverage (in New Jersey) and insurers on price (Maryland) as shown in Exhibit I.

Wall Street knows what is going on. Chart Number 2 shows that the property/casualty stocks have soared to record highs almost doubling the Dow Jones Industrial Average rise for 1985. In 1985, the Best's Property/Casualty Stock Index was up by 50% compared with a 27.5% Dow Jones increase. 8/ Wall Street expects state regulators to allow excessive rate increases; Wall Street is right! During 1985, the surplus of insurers has skyrocketed by almost $8 billion, over the year earlier figure, a growth of 12%. 9/

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

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

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

At the top of the cycle a few years ago, the now-dreaded liability insurance policy rates were being slashed wildly and even being sold after the insured event happened, such as in the case of the MGM Grand Hotel fire where liability coverage was written months after the fire. 14/ Chart #3, labeled the "National Insurance Strike," shows the effect of rate cutting during 1981 and 1982 upon the profit levels of insurers. As you can see, the insurers cut about $1.5 billion in premiums over this interval and the resulting impact upon insurers profits was vastly significant---they plummeted. Chart #4 shows the profit levels insurers would have enjoyed had insurers not cut their premiums, but only maintained them at 1981 levels. Chart #4 shows great disparity between actual profits and those able to have been realized had insurers simply held the line on premiums. Obviously, if premiums were increased at the same level as, say, the Consumer Price Index, insurer profits could have been even higher than the levels indicated in Chart #4. The national problem of insurer profits is clearly and convincingly self-inflicted.

If tort reform was so desperately needed in 1974 and 1975, why not in 1981? Why again today? Do you think the courts periodically grant excessive verdicts and then return to reason for years in direct correspondence with the insurance cycle? Of course not. The crisis is within the insurance industry, not in the courts.

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

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

Now, we are asked to take the insurance industry's word that there is a tort problem and that limits on pain and suffering or on overall damages must be imposed so that rates will go down.

I am not generically opposed to tort reform when needed. I succeeded in getting two presidents to support national no-fault auto insurance. Then, as opposed to today, we had a careful, 21 volume study by DOT, and the bill we supported gave significant new victim compensation in return to the limits placed on victim's rights to sue. Now, insurers put forth no study but only anecdotes to support their "reform" proposals, none of which offer anything for victims. When asked if they would guarantee coverage at more reasonable prices if they got their wish list of tort law changes, the insurers have constantly said that they could not guarantee that.

We must ask why the insurers, who advocate change and thus have the burden of proof, do not come forward with detailed data line by line, state by state to show the need for such reform. Insurers control the data, why don't they publish it? I must conclude that either they have not studied the data in their control, in which case they are really in the dark as to whether reform is needed, or they have the study and it doesn't help their case. I challenge they again today: give us the data to show the need for reform.

When I was Federal Insurance Administrator, I got Presidents Ford and Carter to support National No-Fault Auto Insurance. We had the data so we knew, for example, what the trends in costs with and without lawyers was, knew how victims fared under the system, etc.

Suppose someone suggested capping auto awards? It would have saved money but the data makes it clear that that would have been wrong. Victims of serious economic damages were undercompensated, the data revealed, whereas minor injuries were overcompensated. How do we know if a similar state of affairs exists in, say, Day Care centers unless we have data?

Also, the data will enable balanced legislation to be proposed. The insurers propose a take-away program totally adverse to future victims of damages. In no-fault we had balance: unlimited medicals, prompt payment guarantees and the like in return for restrictions on certain rights to sue.

We need data; we need balance; when we get these things I will support tort reform because then it will be reform, not just an insurer profit guarantee.

THE KANSAS EXPERIENCE

Chart Kansas 1 shows that the Kansas experience for all property/casualty insurance written in the state follows the countrywide cyclical pattern, albeit with higher returns. Chart Kansas 2 shows that the medical malpractice insurance experience has been good. Chart Kansas 3 shows that insurers cut premiums sharply after 1980, not the behavior of insurers facing mounting court verdicts. Chart Kansas 4 shows that, even with the income cuts, the returns for liability insurance in Kansas have been excessive.

WHAT IS TO BE DONE?

Insurance premiums represented 11.1% of the disposable income in this country in 1984, near 12% in 1985. 16/ Insurance is the fourth leading purchase Americans make (behind food, housing and federal income taxes, although it passed federal taxes this year). If we are to see any relief, specific steps will have to be taken at both the state and federal level to end this insurance company misbehavior.

THE MCCARRAN-FERGUSON ACT

In 1944, the US Supreme Court found that insurance was interstate commerce and, thus, subject to anti-trust and other federal statutes. In 1945, Congress passed the McCarran-Ferguson Act which exempts insurance from the federal anti-trust laws (except should intimidation, coercion or boycott occur). Congress delegated the authority to regulate insurance to the states with no standards for regulatory excellence and no ongoing congressional oversight. Indeed, the Federal Trade Commission (FTC) cannot even study insurance under current law 17/ unless Congress specifically authorizes it in advance.

The immensely important McCarran-Ferguson Act was adopted by that earlier Congress without benefit of a hearing. The legislative history makes it clear that President Roosevelt wanted only a short, two or three-year moritorium after which anti-trust laws would fully apply. 18/ That is, in fact, what both houses of Congress adopted but their language was somewhat different, requiring a conference. Mysteriously,

the conference committee reported back a bill that continues in effect today; an infinite moritorium.

Every independent study of insurance concludes that the states have failed miserably in their attempts to regulate this giant industry. 19/ The states have allowed this crisis to happen. Had regulators had the political will and been properly equipped to keep prices to statutory standards (all states require that the rates be "not excessive, not inadequate, not unfairly discriminatory") we would not be in the mess we are in today with clearly excessive prices going into effect routinely around the nation and unfair mid-term cancellations, coverage and price changes rampant.

WHAT SHOULD CONGRESS DO?

First, it should subject the insurance industry to the anti-trust laws, thus preventing insurers from acting in concert to raise prices. Since 1944, the McCarran-Ferguson Act has allowed insurance companies to fix prices, while price-fixing in other industries is punishable by three years in jail. We specifically propose a two-year sunset provision during which time the insurers, the states and the federal government can prepare for the change.

Second, it should create a federal office of insurance to monitor the industry and establish standards for state regulators to follow. Although insurance is a national, $310 billion business, accounting for 12% of our gross national product -- more than any other item except food and housing -- only the states regulate the insurance industry. Because state insurance commissions are often under-staffed (half the states have no actuaries to analyze rate filings) and have a "revolving door" relationship with the industry (state insurance commissioners typically come from and return to the industry), state regulation has not always protected the public.

Third, Congress should repeal the insurance industry's exemption from Federal Trade Commission jurisdiction. In 1979, after the FTC published a study critical of the life insurance industry, Congress prohibited the FTC from ever again studying -- let alone prosecuting -- any sector of the industry. There is no principled justification for this exemption.

Fourth, it should expand the Risk Retention Act which currently allows manufacturers -- but not other businesses, such as day care centers and nurse-midwives -- to join together self-insure or to buy insurance at a lower rate. This would pre-empt state laws prohibiting such group buying. Automobile owners, for example, who must now buy insurance individually, could reduce their premiums by 10% a year by buying it in groups.

Fifth, Congress should establish a national insurance industry-funded reinsurance program. Reinsurance is insurance for insurance companies: the insurer pays the reinsurer a premium, and the reinsurer agrees to share the risk with the insurer. Because the reinsurance market is dominated by Lloyds of London, which is not subject to federal regulation, US insurers have no effective recourse when Lloyds raises its rates, as it did last year. A US reinsurance program would compete with Lloyds and exert downward pressure on reinsurance rates, which in turn would enable insurers to reduce their rates. There is precedence for this in the Riot Reinsurance Program that kept insurance available in inner-city areas during the late 1960's and early 1970's and yet made the Treasury $125 million. 20/

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

Lloyds and the other foreign reinsurers are much like OPEC in their ability to shut off the flow of reinsurance to a specific line of insurance or a specific state. It is dangerous, in my view, for America's economy to be so in the hands of an unregulated (even by Parliament), private entity. Questions must be put to Lloyds such as what is your current experience in each line of insurance you write and have recently refused to write (What is the Directors and Officers experience in the USA, What are your claims paid year to year, Who made the decision to drop D&O coverage? etc). These important questions are impossible to ask and verify today, due to Lloyds freedom from review by anyone in the world.

If Lloyds will threaten small states like Alaska (see Exhibit 1), mustn't the US act? They might pull out of a small state as they threaten to do to Alaska, but never the whole country, which contributes well over half of their income. Federal help is needed to overcome these abuses.

The goal of both the federal reinsurance and the regulation of foreign reinsurers must be to secure Insurance Independence for the USA, a goal NICO believes can be reached by 1990 if the federal government will act. The Federal Insurance Office we propose can help determine what tax or other incentives will enable Americanizing the reinsurance market by 1990.

WHAT SHOULD STATES DO?

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

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

2) The US General Accounting Office noted that the most critical deficiency in the regulation of insurance by the states was in the shortage of proper staff for adequate regulation. The GAO pointed out that this was a function of money and increased resources for targeted staff development for actuaries, accountants and lawyers will improve the quality and extent of state regulation of the insurance business. Regulators need to develop staff in the critical areas outlined and must be given sufficient resources to do so.

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

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

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

6) Insurance regulators need better data verification techniques either through conducting their own, more frequent audits or using outside auditors. Recent charges by the NAIC president that data has been falsified strikes at the core of

state regulation of insurance. If we cannot trust the annual statements, then state regulation of insurance is a fraud and a sham.

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

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

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

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

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

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

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

There is less coverage because of the timing of coverage involved in the policy and the proposed inclusion of defense costs inside the limit makes coverage illusory. If a buyer has a million dollar claim against it and a million dollars are spent by the insurer defending the suit from which the loss accrued, there is nothing to pay for the loss but the

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

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

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

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

behalf as a complement to the efforts of the Public Advocates.

CONCLUSION

America deserves a better deal on its insurance. The federal government cannot sit idly by and let the insurance industry hold day care providers, nurse-midwives, small businesses and others, hostage in a large game beyond the providers' control. Congress has a responsibility to the nation to review the massive delegation it made to the states in 1944. Through federal effort, the tactics of insurers every 10 years at cycle bottom can be dealt with in a systematic way that adds the stability to our economy that insurance is meant to deliver. Periodic price gouging can be stopped. The federal government must act responsibly in the area of insurance regulation and take appropriate remedial action now.

FOOTNOTES:

1/ Best's Insurance Management Reports, December 30, 1985.

2/ Source of data: Citibank Economics and Insurance Services Office. (1985 from Forbes.)

3/ Source : Forbes Magazine. The III now admits that the p/c industry had a positive return on net worth last year, conceding the point that the industry did not lose money last year.

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

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

> Sen. Laxalt: Is malpractice always a loser as far as carriers are concerned?
>
> Mr. Hunter: If they charge these rates, they could not help but win. (Page 141.)

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

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

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

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

8/ Source of data: Best's Property/Casualty Stock Index, A.M. Best and Company, Oldwick, NJ. December 31, 1984 index = 416.30; December 31, 1985 index = 624.33. Dow Jones industrial Average December 31, 1984 = 1211.57; December 31, 1985 = 1546.67.

9/ According to the Best's Insurance Management Reports of December 30, 1985, Policyholder surplus grew from $63.4 billion as of 12/31/84 to $71.0 billion as of 12/31/85.

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

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

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

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

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

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

15/ NAII and ISO, "1985: A Critical Year," p.30 (Spring 1985).

16/

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

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

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

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

19/ See, for instance, Issues and Needed Improvements in State Regulation of the Insurance Business, General Accounting Office (Oct. 9, 1979) (hereinafter, GAO Issues); The Invisible Bankers, Andrew Tobias (Linden Press, 1982); The Life Insurance Game, Ronald Kessler (Holt, Rinehart and Winston, 1985);"Protection for Sale: The Insurance Industry," NBC-TV News (1981); Risk, Reality and Reason, the Conference of Insurance Legislators (September 1983).
One of the tests of state preparedness to deal with a crisis in availability and pricing of liability insurance is actuarial staff. Of the 52 states (including DC and Puerto Rico) NICO surveyed, we find that 26 have actuaries. So one-half of the states have no actuaries at all.
There are 62 actuaries employed by the states, of the 7,682 actuaries in the nation. It is well known in the industry that those best suited to deal with matters pertaining to liability insurance are those who have passed the examinations enabeling them to be "Fellows" in the Casualty Actuarial Society. State regulation has only 8 such persons. They are employed by only 5 states [Connecticut (1), Massachusetts (1), Michigan (1), New Jersey (1) and New York (4).]
Aetna Life and Casualty Insurance Company alone employs 126 actuaries. Travelers has 100.

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

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

Exhibit I, Sheet 1

EXERPTS FROM TAPE OF HEARING OF MARYLAND GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE--OCTOBER 22, 1985

(A discussion of whether it was appropriate to give much weight to total limits data when reviewing classifications with small, non-credible size was held. This related to Mr. Hunter's charge that Maryland Medical Mutual had, unjustifiably, raised OB/GYN rates 70% when he felt a 10% reduction was indicated)

PRESIDENT OF MEDICAL MUTUAL: You can't totally ignore the total limits column, particularly when you are getting pressure from reinsurers...

Mr. Hunter: ...maybe the reinsurer forced them to do it...

PMM: ...so in order to keep their participation on cover we had to acceed to some strong suggestions from the reinsurers to beef up the rate charged to the OB's and it might be relevent to point out Med Mutual is...the only company in the state writing OB's...

Hunter: It sounds to me like the reinsurers forced them to raise it beyond what was reasonable...regulators (should be)...given the authority to look at these kinds of issues...whether it's reasonable to force changes on primary companies that may not be justified by the data.

CHAIR: What is the status of Maryland regulation of reinsurers?

Mr. Muhl (Maryland Insurance Commissioner): There is none

Chair: And is there in other states?

Muhl: None...

Hunter: ...They (the reinsurers) are forcing changes that may be distasteful...Medical Mutual in New Jersey is screaming about some things they don't want and their doctors don't want but the reinsurers in London are out of the reach of any regulation and they're saying 'if you don't do it we'll leave you high and dry' and I think it's unfortunate that London can call the shots in New Jersey or Maryland or some place else.

Muhl: I agree with you...

EXERPT FROM LETTER OF OCTOBER 3, 1985, BY PETER SWEETLAND, PRESIDENT OF NEW JERSEY STATE MEDICAL UNDERWRITERS, INC.

Reinsurers' fears over the unknown dimensions of the "tail" have led to a nearly total insistance on "claims made" policies. Today we are one of only a handful of companies still issuing the occurrence form. We realize that claims made offers some advantage to an insurance company in providing the opportunity for quicker reaction to perceived rate deficiencies. We also believe, however, that the claims made form would be a disservice to our insured members. Conceptually, it is more expensive in the long term, and a major portion of that expense is rolled up in a "balloon" payment at the end. All our intentions to stay an occurrence carrier could be in vain if reinsurers insist that they will offer no alternative. Unfortunately we have <u>no regulatory protection against overreaction in London</u>; the U.S. companies are behaving the same way; and other alternatives such as the Australian market are far too unstable financially for long term exposures such as ours. (emphasis added)

EXERPT FROM REPORT OF CASUALTY INSURANCE COLLOQUIM HELD FOR ALASKA STATE LEGISLATORS BY THE INSURANCE INDUSTRY ON SEPTEMBER 17, 1985, AT CAPTAIN COOK HOTEL, ANCHORAGE, ALASKA

Jeff Johnson (LeBoeuf, Lamb of New York; general counsel in the United States for Lloyd's of London).

If you change your tort laws in Alaska, you will have a market here when the rest of the United States will not. Lloyds is pulling out of the United States as a reinsurer--they have already pulled out of Connecticut, New York and New Jersey--and they're continuing to pull out of more states.

Exhibit L, [illegible]

LLOYD'S FACT SHEET

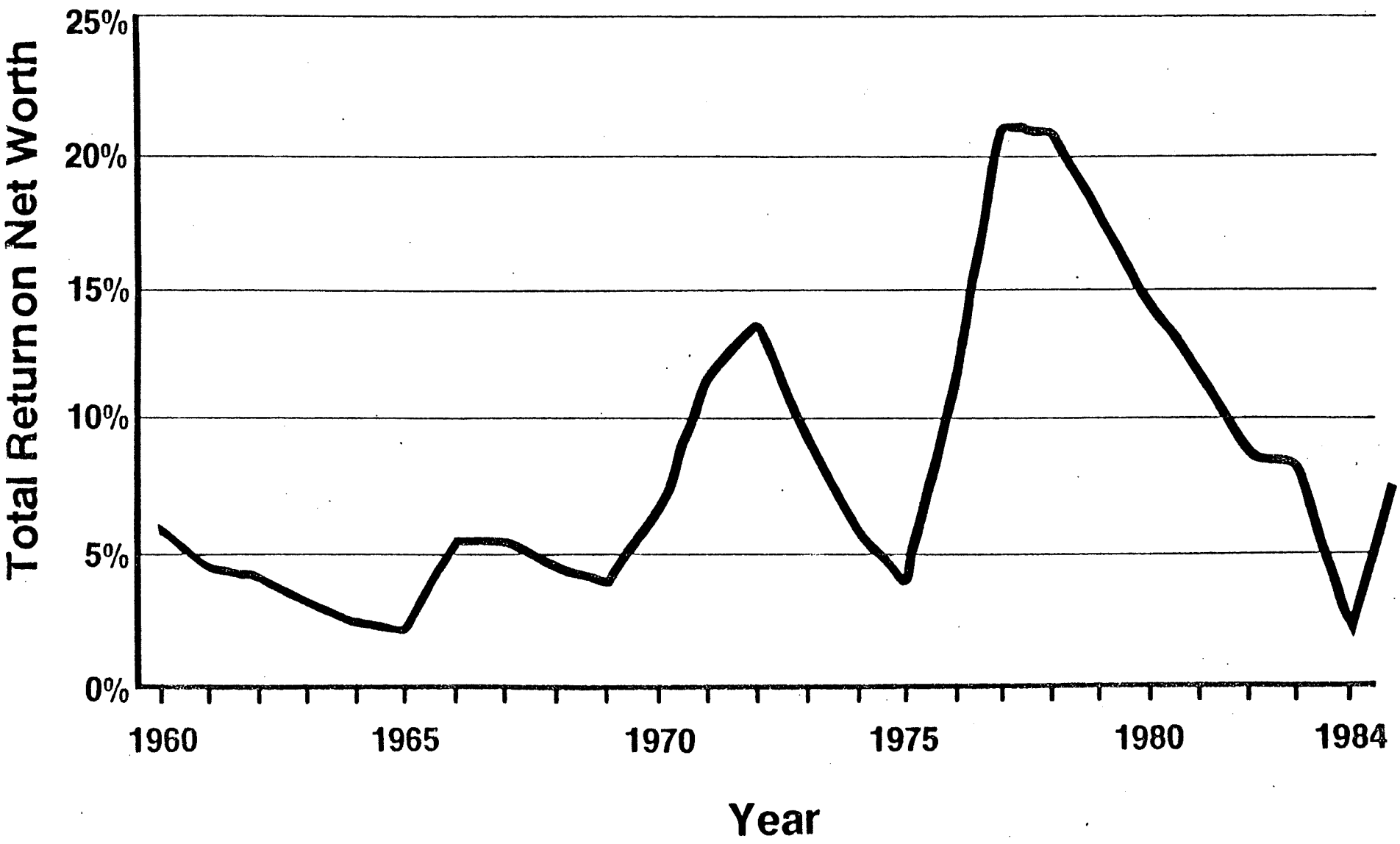
In 1986, Lloyd's expects to write eight billion pounds in premiums (nearly $12 Billion), "over half of which would come from the United States." Washington Post, January 5, 1986.

During the first nine months of 1985, the American reinsurance companies had worldwide premiums written of $6.1 Billion (annualized, the premiums written for 1985 are estimated to be $8.1 Billion).
Source: Reinsurance Association of America as reported in Business Insurance, December 23, 1985.

Lloyd's is not subject to regulation by the federal government of the United States. State governments, responding to a survey conducted by the National Insurance Consumer Organization, indicate that they do not have regulatory control over Lloyd's. Only two states licence some of the Lloyd's syndicates as insurance companies and thus require any of the reports and other requirements imposed on U.S. insurers. Only one state responding to the survey has undertaken a review of the syndicates' licenced financial condition (Illinois in 1984). The states responding to the survey indicate that trade practices and market conduct examinations of Lloyd's have never been undertaken in the U.S. Periodically, Lloyd's files a certified copy of its "Statuatory Statements of Business Made By the Council of Lloyd's" with each state. The latest report is as of December 31, 1983. Insurance regulation of Lloyd's is essentilly non-existent in the U.S., NICO has concluded.

CHART 1

THE "CYCLE" AND CONSUMER ABUSE



BEST'S PROPERTY/CASUALTY STOCK INDEX

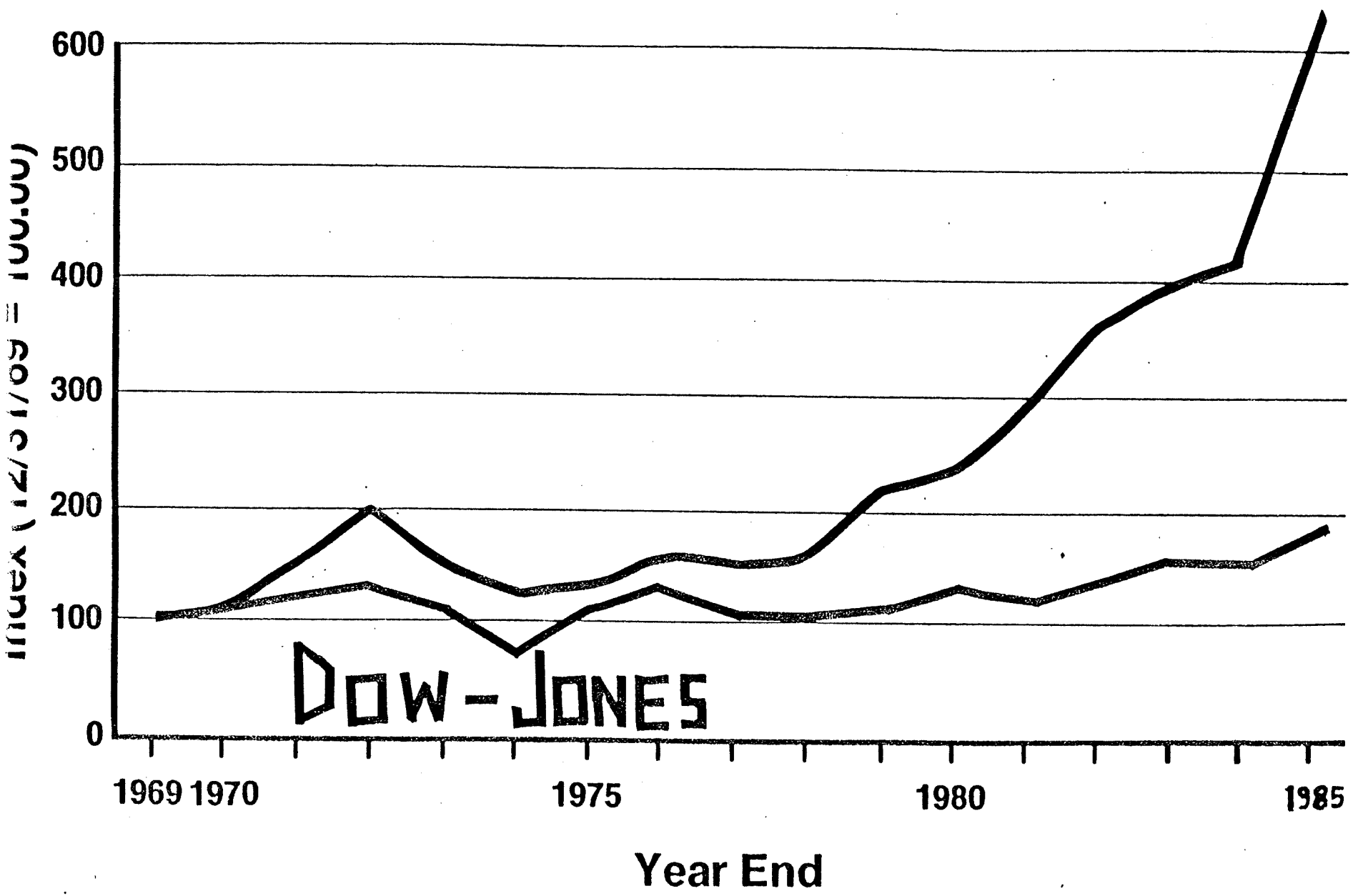
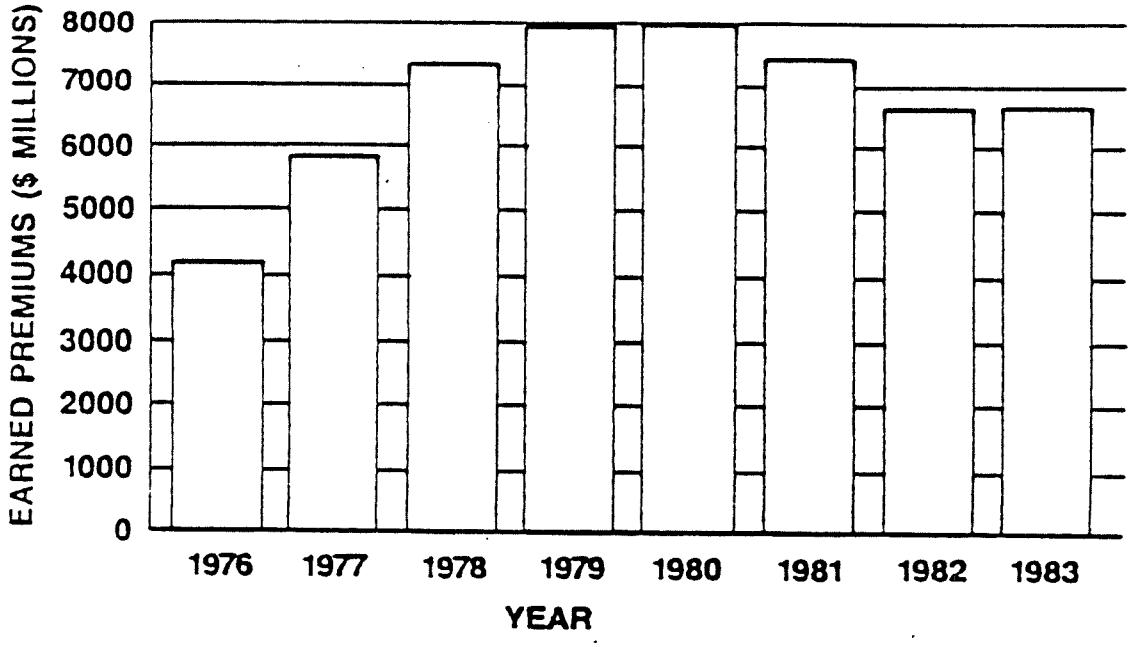


CHART 3

NATIONAL LIABILITY INSURANCE STRIKE



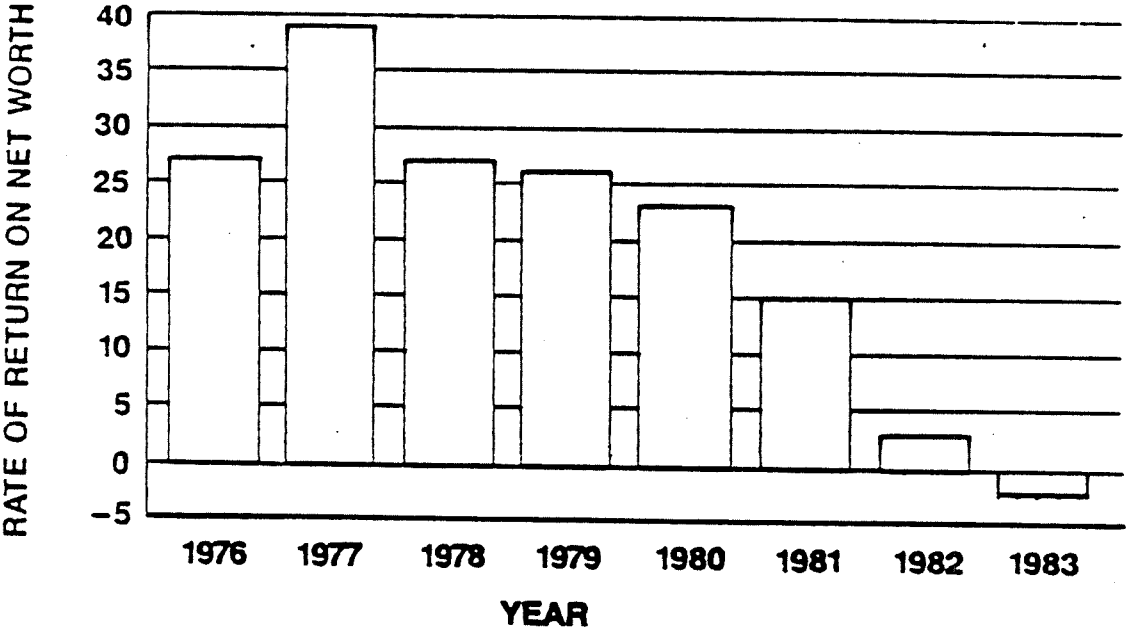
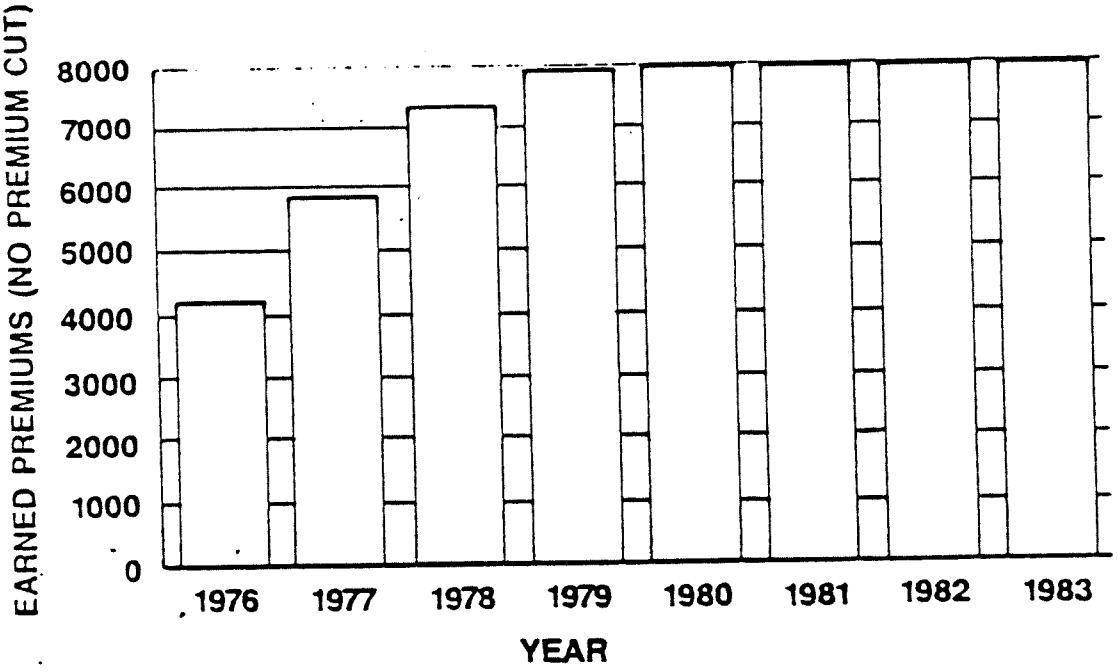
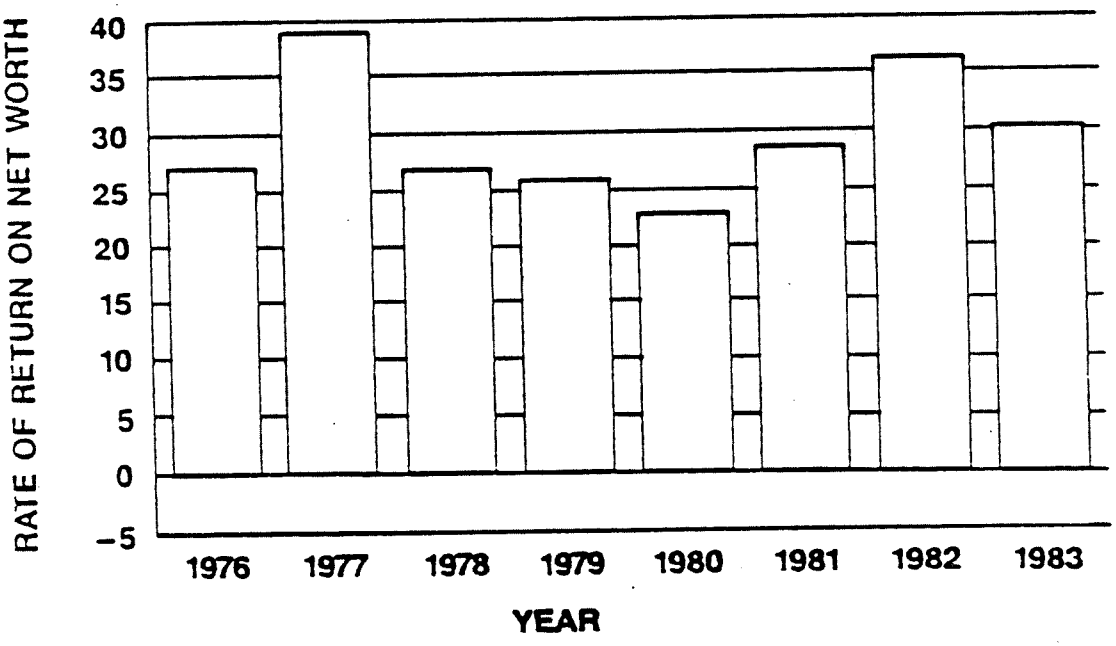


CHART 4

NATIONAL LIABILITY INSURANCE
STRIKE II





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

Year	Earned Premiums (Millions of $)	Actual ROR	All American Industry (3)
1976	$4160	27%	13.3%
1977	5865	39	13.5
1978	7334	27	14.3
1979	7943	26	15.9
1980	7969	23	14.4
1981	7416	15	14.0
1982	6627	3	11.0
1983	6671	-2	11.5
Average		19%	13.5%

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

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

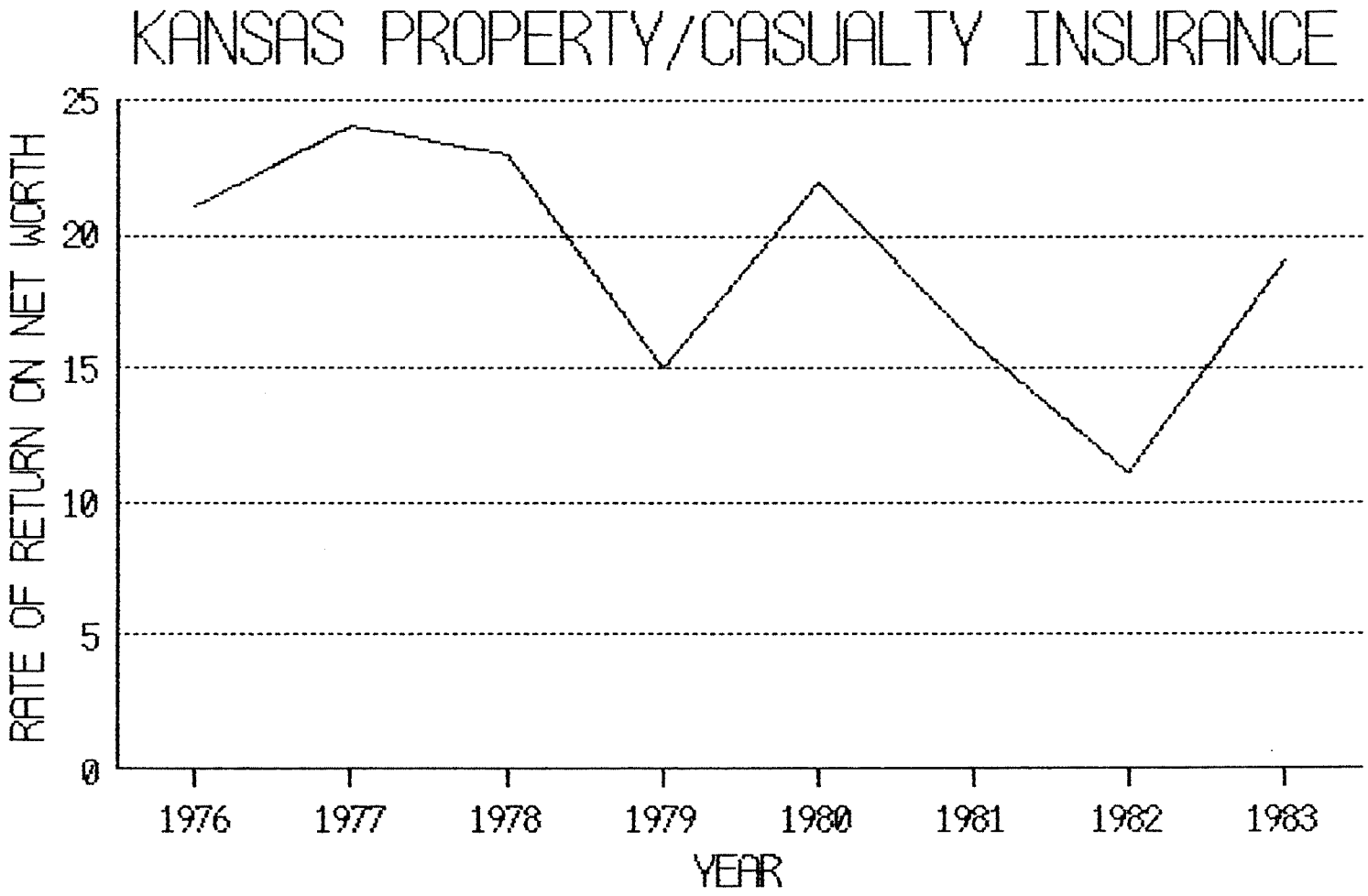
(3) Fortune 500, 1976-1980; Business Week, 1981-1983.

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

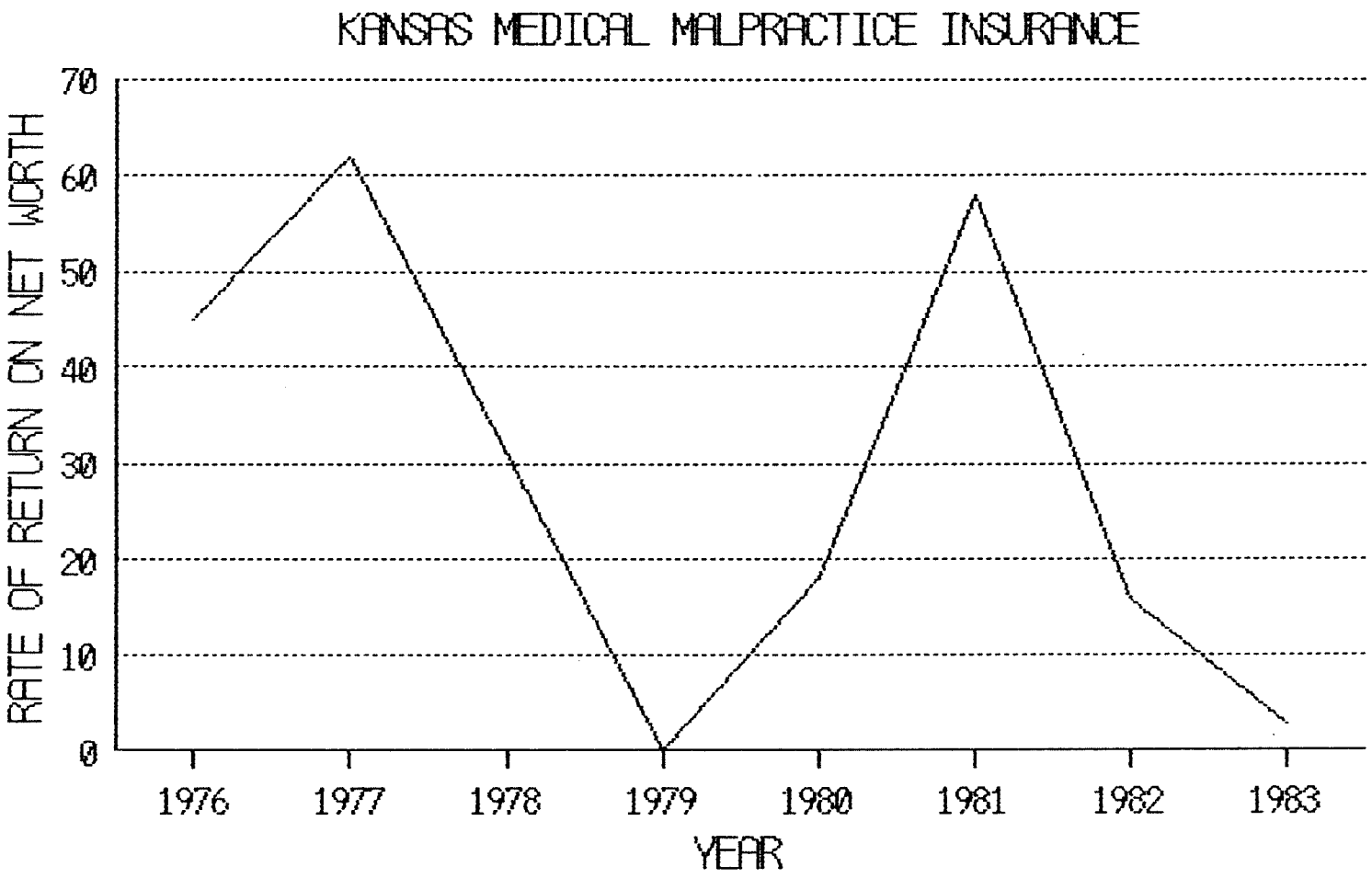
1981	29%
1982	37%
1983	31%
8-year average	30%

The problem is clearly rate cutting, nothing else!

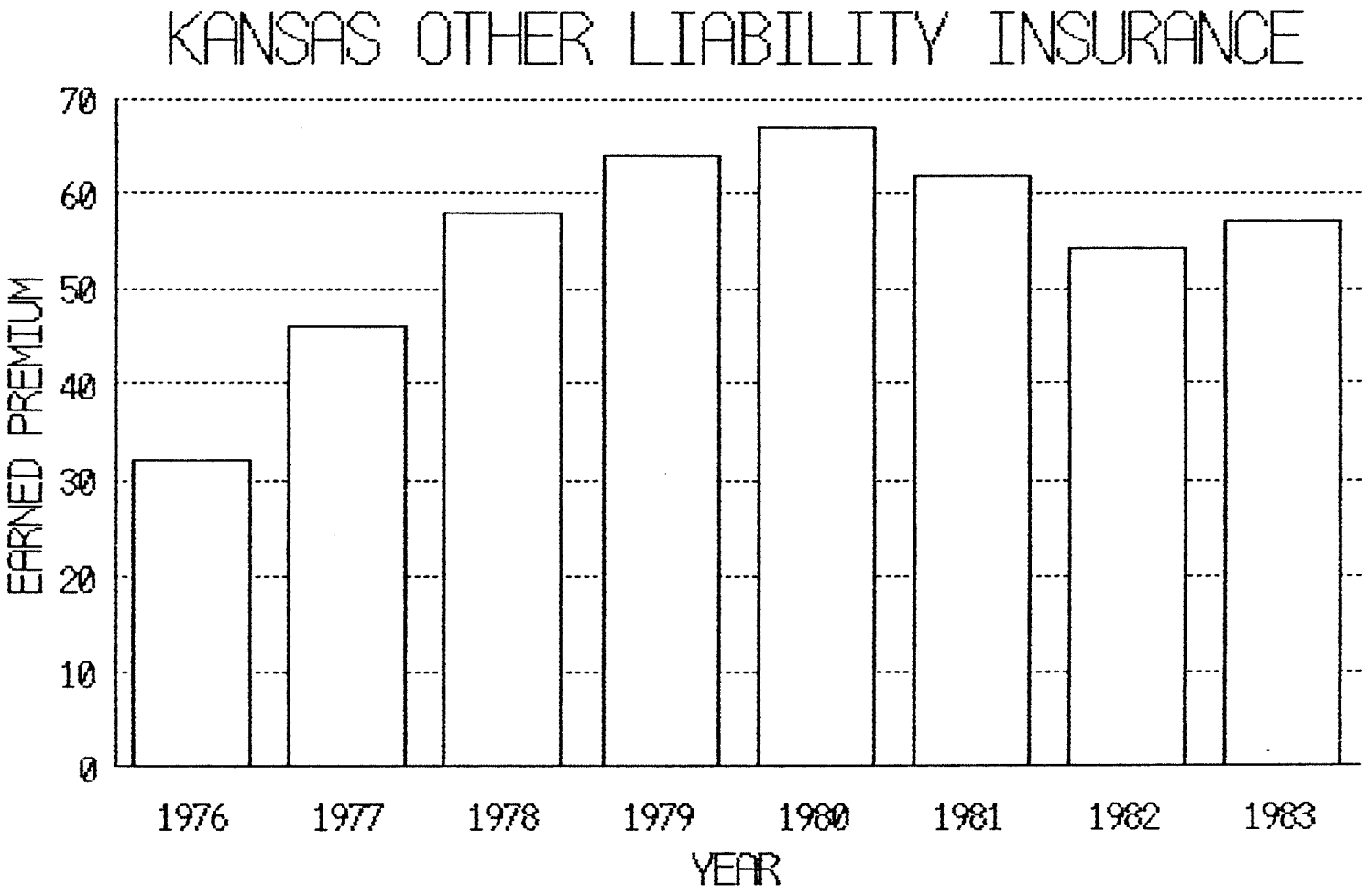
KANSAS 1


KANSAS PROPERTY/CASUALTY INSURANCE
RATE OF RETURN ON NET WORTH
25
20
15
10
5
0
1976
1977
1978
1979
1980
1981
1982
1983
YEAR

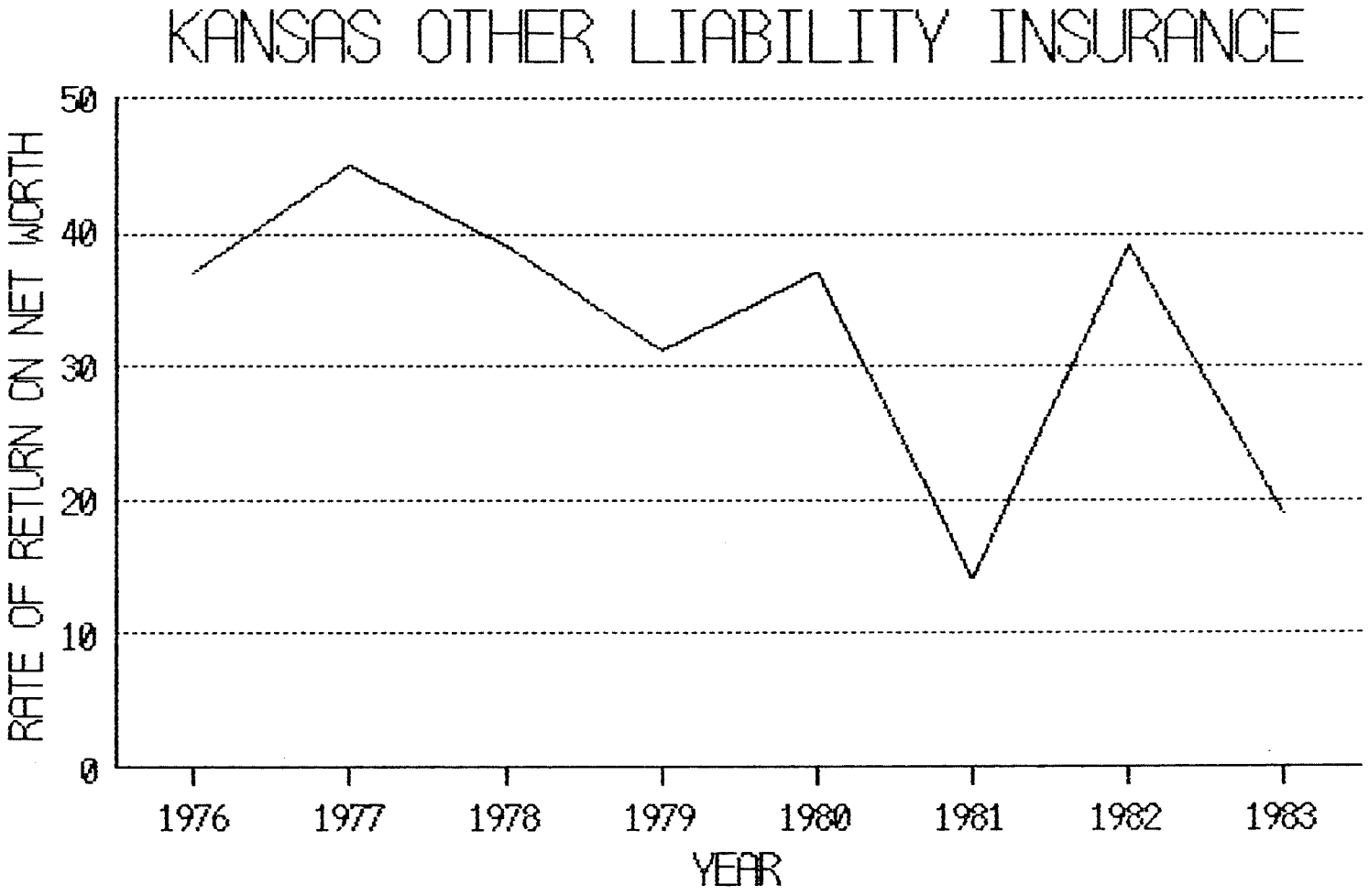
KANSAS 2


KANSAS MEDICAL MALPRACTICE INSURANCE
RATE OF RETURN ON NET WORTH
70
60
50
40
30
20
10
0
1976
1977
1978
1979
1980
1981
1982
1983
YEAR

KANSAS 3


KANSAS OTHER LIABILITY INSURANCE
EARNED PREMIUM
70
60
50
40
30
20
10
0
1976
1977
1978
1979
1980
1981
1982
1983
YEAR

KANSAS 4


KANSAS OTHER LIABILITY INSURANCE
RATE OF RETURN ON NET WORTH
50
40
30
20
10
0
1976
1977
1978
1979
1980
1981
1982
1983
YEAR

Slaughter 2/12

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

Testimony of the Kansas Medical Society
on the Tort Reform Issues of HB 2661
February 12, 1986

The Kansas Medical Society appreciates the opportunity to comment on the tort reform provisions contained in HB 2661. We support virtually all of the legal issue changes contained in HB 2661, in addition to recommending adoption of the amendments which we distributed last week.

In earlier testimony we have expressed our support for the quality assurance changes and insurance system refinements contained in HB 2661. The recommendations for tort reform are the third, and key element in this bill. Without the comprehensive approach contained in HB 2661, the malpractice problem simply can't be solved. We strongly urge you to keep all three elements of the bill intact.

The limitation on awards in the bill has been the most heavily criticized part of the legislation. As you have by now learned, there was virtual agreement among all concerned parties on the other 9/10 of the bill. However, as the actuaries this summer noted for the interim committee, it is only the items contained in the tort reform part of the bill which will have any beneficial effect on premiums. Experience from other states, such as Indiana, Louisiana and Nebraska, have shown that the wild growth in premiums can be halted, at the same time reasonably compensating injured patients. A key provision of the award limitation is a requirement for using structured awards or annuity contracts to fund future damages. This provision will stretch award dollars considerably, and will allow for injured patients to be taken care of adequately. Limits on awards are crucial if we want to seriously address the liability problem. It is the occasional, but rapidly growing, number of multi-million dollar awards and settlements that is creating such chaos in the liability system in Kansas.

Enclosed with this testimony is a copy of a position paper on medical malpractice which we have prepared for use with HB 2661. Also enclosed are copies of graphs we shared with the interim committee which illustrate some aspects of the Kansas liability problem.

We appreciate the opportunity to comment on the final provisions of HB 2661.

Attachment 6
House Judiciary
2-12-86

KANSAS MEDICAL SOCIETY
1300 Topeka Avenue · Topeka, Kansas 66612 · (913) 235-2383

MEDICAL MALPRACTICE: Position Statement of the Kansas Medical Society January 1986

We are drowning in a flood of litigation, which threatens to severely damage our health care system. Doctors and hospitals in Kansas believe the malpractice liability system must be significantly changed or access to medical care will suffer.

Over the last several years the number and size of malpractice claims has risen astronomically. In 1986 there will be an estimated 300 lawsuits filed, up from 26 in 1979, a 1,000% increase. The dollars paid out in awards and settlements this year will approach $23 million, up from $3.6 million in 1980. The total malpractice premium paid by doctors and hospitals this year will reach $48 million, up from $11 million in 1982. Malpractice coverage, required by law for all doctors, will cost a family practitioner who delivers babies $8,000-$12,000 this year. An obstetrician or a surgical specialist will pay $30,000-$45,000. Premiums are predicted to reach $100,000 for many physicians within two years.

These numbers are just one facet of the complex malpractice crisis which Kansas faces. Its effects are felt in many ways. It increases the cost of medical care for everyone. The cost of malpractice insurance is borne by all of us, including patients of doctors who have never been sued. The notion that million-dollar verdicts are paid by rich insurance companies is false. All Kansans pay when juries grant vast sums to plaintiffs and their lawyers.

The malpractice crisis has a profoundly corrosive effect on the doctor-patient relationship. The bond of trust and concern which enhanced patient care in the past is being pushed out by an attitude that doctor and patient may be adversaries in the courtroom if results aren't perfect.

The malpractice crisis has already restricted availability of care, notably in obstetrics, which is the fastest growing area of malpractice litigation. In a recent survey, one-fourth of Kansas doctors doing obstetrics had stopped, and another third were planning to drop obstetrics, all because of malpractice pressures. In the near future access to obstetrical care may be severely restricted in many areas of our state. Experts estimate that a young obstetrician entering practice today can expect to be sued eight times during his or her career.

Critics of malpractice reform, mostly lawyers, say the problem is caused by incompetent doctors. The available data and literature just doesn't support those claims, however. Over forty percent of all Kansas doctors have been sued for malpractice, but hardly anyone would concede that 4 out of 10 doctors are

incompetent. The fact is that many suits are filed which have no merit. Possibly a less than perfect result of treatment stimulated the suit. Doctors are human beings; they are not perfect. Considering the incredible medical advances in recent years, we have mistakenly come to expect a cure for every ill. Medicine is an inexact science, even in the best of circumstances, and it is impossible to expect a good outcome to all medical treatment.

There is a popular assumption, although false, that doctors don't want to "police themselves." That notion is absurd, for obvious reasons. No physician wants incompetent colleagues practicing medicine. Both the public and the profession suffer when that happens. Unfortunately when doctors do try to discipline a colleague in a hospital, they get sued, or the whole process ends up in legal maneuvering between lawyers, while the medical facts are shoved aside.

Another convenient scapegoat is the insurance industry. Lawyers like to blame "money-hungry" insurance companies for building up unnecessary reserves, and for charging premiums that aren't justified. A look at the data destroys that myth, also. In Kansas, over the last few years, insurance companies have been paying out more than they are taking in. Only two or three companies will even touch medical malpractice, and then only selectively. In fact, St. Paul, which insures about 40% of Kansas physicians, is not taking any new business in 1986. If the malpractice insurance business is so profitable, where are all the companies?

The cause of the malpractice crisis has many aspects, but clearly a major factor is the legal system itself. Consider these features of our tort litigation system: there is no objective standard of liability; there is no definite measure of compensation; the entire process is conducted at a high level of emotion and subjectivity; the cost of litigation is enormous; there is no restraint mechanism to prevent unnecessary litigation; there is no encouragement for prompt settlement; and finally, the system encourages higher and higher awards.

It's no wonder that the malpractice insurance system is going broke paying for the malpractice litigation system. It should come as no surprise that lawyers oppose change. Data from Kansas malpractice companies show that two-thirds of all the dollars expended in the system go to lawyers.

What is the solution? How can the individual's rights be preserved and the malpractice system brought under control? The answer lies in adopting reasonable reforms to the legal system, and strengthening the peer review and quality assurance system.

Doctors and hospitals must do everything possible to assure that quality medical care is delivered. Better reporting to the Healing Arts Board, more accountability for peer review activities, and the development of hospital risk management programs must all be implemented. On the other side of the coin, however, all the peer review in the world will not solve the problem without some fundamental reform of our obsolete legal rules.

Experience from other states has shown us that enacting reasonable limits on awards will greatly improve the liability insurance climate. Critics argue that award limits deprive plaintiffs of full recovery for their losses. However, experience from other states, such as Indiana, Louisiana and Nebraska, have shown that injured patients can be fully compensated even with award limitations in place. Two study committees in Kansas have recently recommended placing limits on awards. A 25-member Citizens' Committee appointed by Insurance Commissioner Fletcher Bell, and the Legislature's Special Interim Committee both came to the same conclusion - limits on awards should be adopted in Kansas, in addition to several other reforms. The Kansas Medical Society supports the recommendations made by the Legislative Interim Committee, especially as they relate to award limitations, screening panels, peer review and quality assurance activities (see attached). Both groups recommended using "structured awards," or guaranteed payments over several years, to stretch award dollars even farther. Experts have shown that $1 million up front can provide benefits of $10 million or more over several years, which will more than adequately take care of an injured patient throughout his or her lifetime. Limits on awards are crucial if we want to seriously address the liability problem. It is the occasional, but rapidly growing, number of multi-million dollar awards that is creating such chaos in the liability system.

We do not support anything that will get negligent doctors off the hook. In fact, with the tougher peer review and reporting requirements that have been suggested, we will see better discipline of health professionals. We have not recommended anything which will make it more difficult to bring or win a legitimate suit. Injured patients will still have their day in court, and can still be compensated for their losses.

Without a comprehensive approach, the malpractice problem simply can't be solved. The three elements of reform which must be enacted as a package are contained in the Malpractice Interim Committee Report: quality assurance/peer review enhancements, insurance system refinements, and legal (tort) system improvements. If these recommendations are adopted by the Legislature, we will see a tremendous improvement in the liability problem. Access to obstetrical and other high risk services will be preserved, and the runaway cost of the system can be brought under control.

FINAL RECOMMENDATIONS OF THE SPECIAL COMMITTEE ON MEDICAL MALPRACTICE
November 21, 1985

I. LEGAL ISSUES

Award Limitations. Awards for pain and suffering are limited to $250,000; and the total award for damages cannot exceed $1 million. The portion of the award for future damages must be in the form of a structured annuity.

Screening Panels. Either party in a malpractice action can ask for a screening panel, and the findings of such panels would be admissible in subsequent court action. Panels would be composed of three health care providers and an attorney chairman.

Attorney Fees. Attorneys fees must be approved for reasonableness, after an evidentiary hearing by the judge.

Expert Witnesses. To qualify as an expert witness, a physician must spend at least 50% of his or her time in clinical practice.

Itemized Verdicts. Itemization of verdicts would be required.

Post-Judgment Interest Rate. The post-judgment interest rate would be variable, tied to the one year treasury bill rate.

Settlement Conferences. Settlement conferences would be mandated to be held 30 days after discovery deadline. The recommendation includes certain incentives to settle.

II. PEER REVIEW, QUALITY ASSURANCE, AND REGULATION ISSUES

Peer Review and Risk Management. Provides for greater accountability and a more formalized structure for peer review. Risk management programs must be implemented by hospitals.

Composition of Healing Arts Board. Two lay members of the public would be added to the 13 member Healing Arts Board.

Penalties for Healing Arts Act Violations. The Healing Arts Board would be given more flexibility to levy civil penalties, or publicly censure a licensee in lieu of suspension or revocation of license.

Reporting Negligence. Health care providers, insurance companies, and others would be required to make timely reports to the appropriate licensing agency of negligent acts of health care providers.

III. INSURANCE ISSUES

"Tail" Coverage. To qualify for "tail" coverage by the Health Care Stabilization Fund, the health care provider must pay the required surcharge for three consecutive years.

HCSF Board of Governors. The responsibility of the Fund's Board of Governors is clarified as it relates to dropping fund coverage for multiple-claim health care providers.

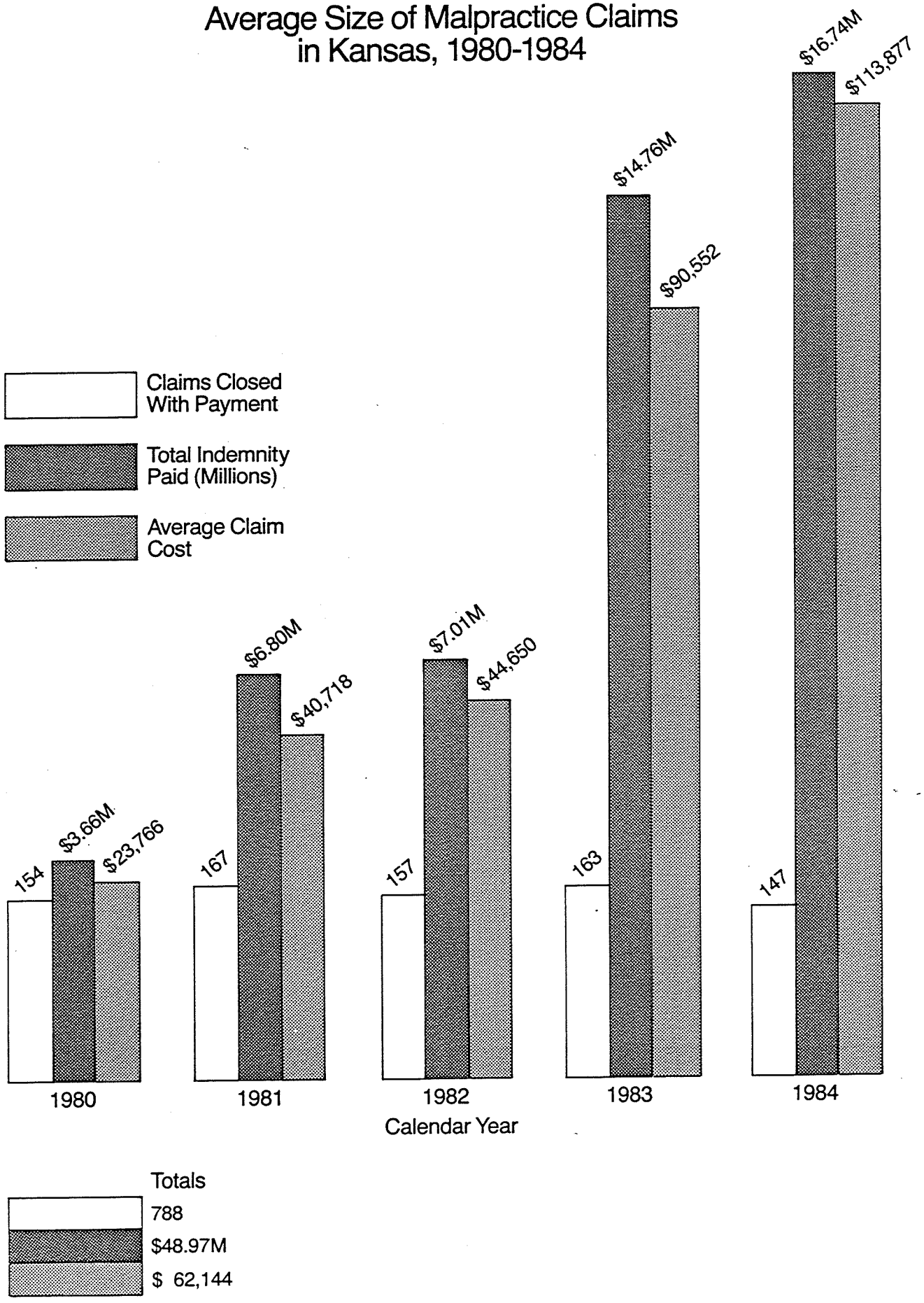
Surcharge Rating. The Insurance Commissioner is authorized to establish a surcharge based upon experience (claims history) and risk classification.

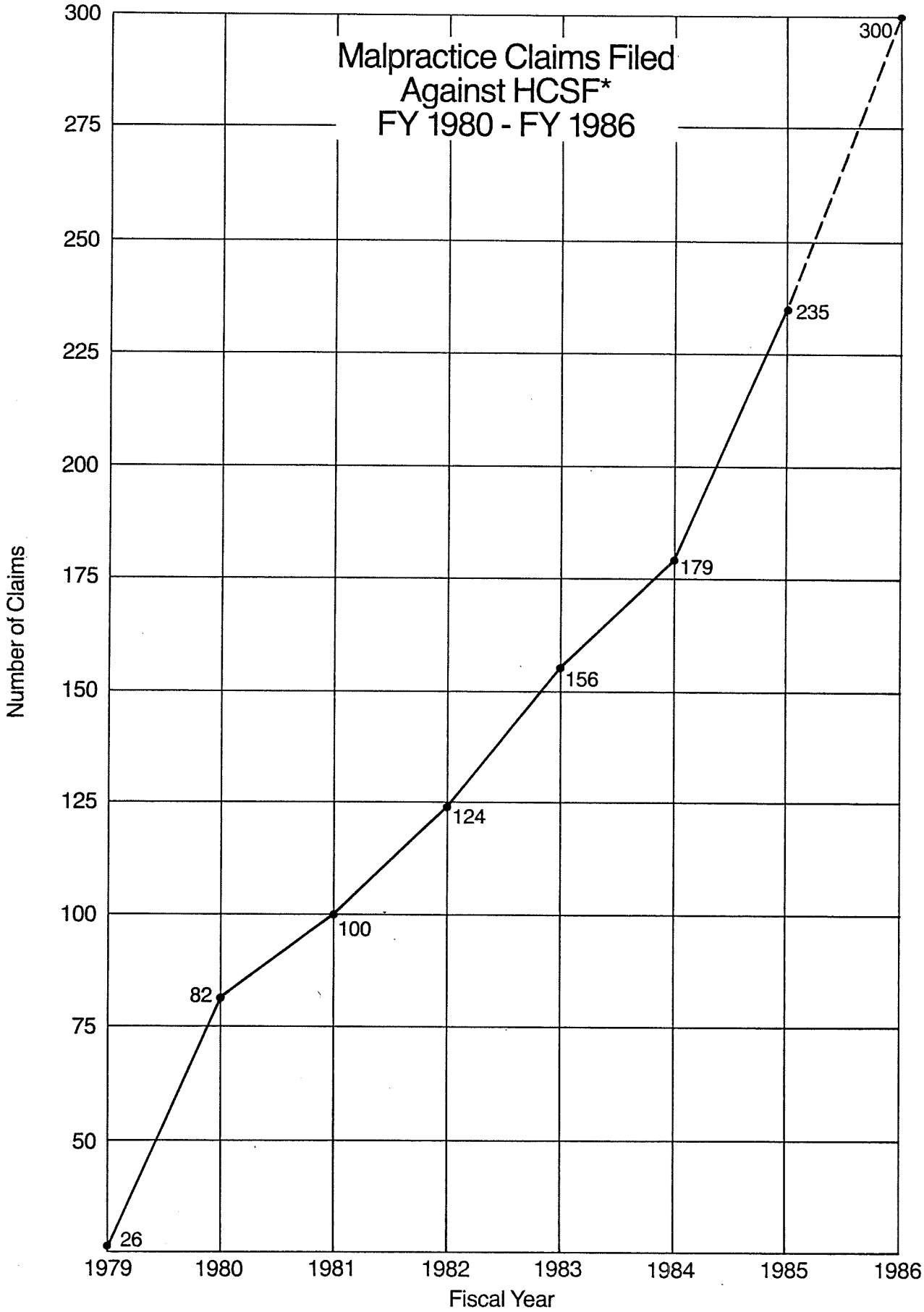
Installment Payment of Premiums. The committee recommends passage of SB 382, which allows for installment payment of surcharge premiums.

Proof of Insurance. The law is clarified to require health care providers to prove that they have malpractice insurance in effect before a license is issued.

Professional Corporation Insurance. The law would be clarified so that a professional corporation would not have to tender its primary limits in addition to the physician's, prior to the HCSF kicking in.

Average Size of Malpractice Claims in Kansas, 1980-1984





*Health Care Stabilization Fund