Kansas Legislative Research Department September 5, 1986

MINUTES

SPECIAL COMMITTEE ON TORT REFORM AND LIABILITY INSURANCE

August 14-15, 1986
Room 313-S -- Statehouse

Members Present

Representative Joe Knopp, Chairman
Senator Paul Burke, Vice-Chairman
Senator Neil Arasmith
Senator Paul Feleciano
Senator Bob Frey
Senator Jeanne Hoferer
Senator Bill Mulich
Senator Nancy Parrish
Representative Art Douville
Representative Ken Grotewiel
Representative Rex Hoy
Representative Robin Leach
Representative Bruce Mayfield
Representative Mike O'Neal
Representative Mike Peterson
Representative John Solbach

Staff Present

Mike Heim, Kansas Legislative Research Department
Jerry Donaldson, Kansas Legislative Research Department
Chris Courtwright, Kansas Legislative Research Department
Mary Hack, Revisor of Statutes Office
Nedra Springler, Secretary

Conferees Present

Professor Jim Concannon, Washburn University School of Law
Dan Lykins, Kansas Trial Lawyers Association
John McCabe, National Conference of Commissioners on Uniform State Laws
Gene Schroer, Kansas Trial Lawyers Association
Marjorie Van Buren, Office of Judicial Administration
Tom Theis, Attorney, Topeka
Bill Sneed, Kansas Association of Defense Counsel
Steven Hornbaker, Kansas Trial Lawyers Association
Mike Sexton, Kansas Trial Lawyers Association

Conferees Present (continued)

David Litwin, Kansas Coalition for Tort Reform
Jan Pacey, Forrest T. Jones and Company
Kyle Nieman, Crum Forster Manager Corporation
George Henderson, CIGNA Corporation
Henry Katz, Hartford Insurance
Paul Genecki, Victor O. Schinnerer and Company
Tom Wright, Employers Mutual Casualty Company
Ernie Mosher, League of Kansas Municipalities
Tim Brown, National Association of Insurance Commissioners
Chris Senior, Hartford Specialities Company
Ted Fay, Kansas Insurance Department

August 14, 1986
Morning Session

The Chairman, Representative Joe Knopp, called the meeting to order at 10:20 a.m. and stated the agenda for the two-day meeting would address tort reform issues and also the insurance area. He introduced Tim Brown of the National Association of Insurance Commissioners, who explained that this group is doing a documentary videotape to be used by state insurance departments across the country in training employees. No objection was raised to his request to videotape the meeting for this purpose.

Professor Jim Concannon, Washburn University School of Law, gave a statement (Attachment No. 1) concerning the collateral source rule as it affects Kansas tort cases. He gave examples of how abolishing the collateral source rule would financially affect the wrongdoer, injured party, and the subrogation rights of the insurance company and gave arguments for retaining and for abolishing double recovery. He pointed out a criticism of the collateral source rule is that, in permitting double recovery, it increases costs but double recovery occurs only when the insurance company does not have the right of subrogation. He gave examples of how abolishing the rule complicates the comparative negligence statute and stated that K.S.A. 60-3404, abolishing the collateral source rule in medical malpractice actions, fails to take into account the importance of comparative fault on the collateral source rule. The potential for injustice would be great if this statute is adopted for tort cases generally where plaintiffs often are partially at fault. He recommended that collateral source payments be credited first to that portion of total damages attributed to the injured party's fault and then to the defendant. He said this would prevent double recovery and prevent the insurance carrier from receiving a windfall. Professor Concannon also recommended that the jury continue to determine total damages without considering reductions for collateral payments which should be deducted by the judge. The jury could determine future damages and other unliquidated collateral benefits by answering a separate question listed on the verdict form regarding the value of future collateral payments upon which the judge should base his decision. He pointed out that the Department of Commerce Draft Uniform Product Liability Law proposed that the reduction of damages to account for collateral source payments be done by the judge. Professor Concannon said clear standards for when damage

awards will be reduced for collateral source payments should be provided for judges to follow. In his opinion, K.S.A. 60-3403 fails to state clearly the effect of subrogation rights, it fails to account for comparative fault, and it fails to have the judge implement the modification. Each type of collateral source should be considered separately for changes because separate policy considerations are involved, he said.

There was discussion regarding subrogation rights imposing additional costs on consumers, causing parties to pay two or three different times for the same case. Professor Concannon said some proportional amount of the collateral source payment could be factored into the plaintiff's recovery for attorney fees. Another alternative would be to permit subrogation rights for all types of insurance. He believed the prohibition against any mention to the jury of the parties having any sort of insurance was created in the days when insurance was not the factor in trials as it is today. He agreed subrogation rights should be tied in more closely with the collateral source rule than current law provides.

Dan Lykins, representing the Kansas Trial Lawyers Association (KTLA), said another representative would address the appeal of 1985 S.B. 110. He directed his remarks to the collateral source rule which he did not believe should be abolished. He said victims, for the most part, are not presently getting double recovery, and he gave examples of these cases. He noted that juries do not know about subrogation rights of insurers and attorney fees being deducted from amounts awarded. He said juries assume that insurance pays these costs. Changing the rule to apply to all tort cases would be even more unfair to victims. KTLA opposes abolishing the collateral source rule, he said.

John McCabe, representing the National Conference of Commissioners on Uniform State Laws, gave a review of the Model Periodic Payment of Judgments Act which was promulgated in 1980 by his group because of the insurance crisis and as a result of a joint study by the American Bar Association (ABA) and the American Medical Association (AMA) regarding medical malpractice. It was drafted by the Uniform Law Commissioners (ULC) to be used as a guide for states interested in the topic and is geared to catastrophic cases. The jury determines damages then the court decides future awards which are paid in installments. The act addresses only real and tangible damages and not punitive awards. He explained the figure to provide for inflation adjustments was based upon 52 weeks of Treasury Bills rates as being the most reliable source. An explanation of the model law is in Attachment No. 2. A copy of the act containing a history and comments is in Attachment No. 3.

In response to questions, Mr. McCabe said, under the law's provisions, juries would base future loss such as future medical cost and future lost earnings on current value. Initially, discounts are set by statute but are adjusted yearly and the index system accounts for the fluctuation of the purchasing power of the dollar. If an insurance company wanted to determine its loss today, it can write a premium annuity and charge enough to take into account future payments. If the Treasury Bill rate is used as a measure, annuities will usually do better than other investment devices. There is no limit on attorney fees in the act and these can be paid in a lump sum or periodically.

The use of Treasury Bill rates as the measure was discussed. A member questioned whether picking an arbitrary index might violate the defendant's constitutional rights or deny full recovery. Mr. McCabe said it is very hard to get competent testimony from economists and, because the concern is with the real changes in the purchasing value of the dollar, there was no better way his group could figure future payments. He pointed out the act was a model, not a uniform act. The purchasing value of the dollar if interest rates go up is taken into account and awards go up accordingly on a yearly basis.

The impact of a mandatory structured law was discussed. Mr. McCabe said the bottom line and appeal of this system is that it takes care of real injuries and problems without diminishing actual damages awards. A member noted that mandatory structured settlements can put plaintiffs in the position of needing to settle for lesser amounts than actual damages, can take away bargaining power, and can discourage settlements. Mr. McCabe said settlements would be more fair and the fundamentals of liability and damage would not be diminished with structured settlements. Additional information provided by Mr. McCabe regarding periodic payments and bodily injury awards is in Attachment No. 4.

Gene Schroer, of the Kansas Trial Lawyers Association, discussed structured settlements under provision of H.B. 2661, effective July 1, 1986, which mandates structured settlements under certain circumstances. He said the difference in the wording in the annuity judgment in New Sections 13 and 15 will cause problems because requirements in those sections cannot be applied logically, and they discriminate between claimants in differing circumstances. The difference regarding the cost of an annuity contract can result in differing costs for the annuity in hundreds of thousands of dollars and differing benefits to the injured party. Although structured settlements generally benefit both the claimant and the insurance company in negligence litigation, these statutes may create more problems than they correct because of delay in the Supreme Court interpretation of questionable areas of the new law which will place attorneys for both the claimant and the insurance company in the position of not knowing for some time the consequences of insurance exposure. He objected to using the consumer price index as the basis for changing the allowable cap for pain and suffering for noneconomic loss while the index is not used to determine inflation or deflation. The Kansas Wrongful Death statute also seems to be in conflict with the new sections of H.B. 2661. Mr. Schroer stated the annuity sections, New Sections 13 through 16 should be rewritten. The KTLA's recommendations and rationale for them are in its position statement (Attachment No. 5).

In response to questions, Mr. Schroer said less than 20 percent of personal injury cases presently result in structured settlement, but the dollars involved are high. Large awards usually result in voluntary structured settlements before and after trial. He had not seen the model act and had no opinion regarding it. He said present value and inflation will stay within 3/8 percent of each other, resulting in the jury believing that present value and inflation will offset each other. He did not know if an index was adequate to accurately reflect future medical expenses, but believed its use might result in less money awarded. He believed juries should be told whether or not there is insurance involved because they make good decisions 99 percent of the time. He opposed mandatory structured settlements because 95 percent of the large damage award cases are voluntarily settled this way now.

The Committee was recessed for lunch.

Afternoon Session

The Chairman reconvened the meeting at 1:45 p.m.

Marjorie Van Buren, representing the Office of Judicial Administration, called attention to language in a 1986 appropriations bill (Attachment No. 6) requiring the Judicial Administrator to collect data from plaintiffs' attorneys regarding personal injury civil litigation and the Supreme Court Order of July 17, 1986 (Attachment No. 7) issued to comply with the requirement. She pointed out that, although the Legislature required the Judicial Branch to implement a data collecting system, no money was appropriated to sustain the system; work has begun to get the system started. Costs of development and publication can be absorbed by the Judicial Branch, but additional funds will be needed. Costs for data processing have increased since the budget was set. She said attorneys would file the required data when cases are ended. She listed the types of information to be given on the form, noting that persons involved in the cases are not to be identified. The Kansas Bar Association helped develop the form and data needed. Chapter 61 cases are included. Getting information concerning out-of-court settlements would be difficult. The Chairman requested that the Committee receive a copy of the form and information as it is obtained with the understanding that this is not public information.

Tom Theis, Topeka attorney, addressed the issue of mandatory structured settlements and post judgment settlements. Such settlements normally deal with future economic loss and pain and suffering. Kansas requires juries to reduce damages to present value, determine what future damages will be, and arrive at what they feel is appropriate for the future. He supported mandatory structured judgments. He objected to the use of some economists' testimony in trials which requires additional time to educate the jury in detailed economic theory, specifically those economists that use history rate figures.

Mr. Theis said the best evidence of present value is not an economist's statement based on a guess without any risk taking himself, but rather the insurance company using predictions based on actuaries and physicians who rate life expectancy. Mr. Theis said relying on economists' testimony is pure guess, where an annuity is not. He had no problem with the amounts juries arrive at but, in order for them to reduce damages to present value, they have to decide life expectancy.

Bill Sneed, Kansas Association of Defense Counsel (KADC), gave a history and outline of problems with punitive damages (see Attachment No. 8). He recommended that courts should have specific directions to follow. He advocated a bifurcated trial, one part to determine if punitive damages should be assessed, and in the other, the judge would assess the amount. No evidence of the defendant's financial status should be admissible during the first phase of trial. Cases should be founded on facts proved beyond a reasonable doubt or on clear and convincing evidence. Punitive damages awards should be divided

between the state and the plaintiff, with 95 percent going to the state and 5 percent to the plaintiff. Finally, punitive damages should not be allowed to be assessed against an employer for acts of employees or agents unless authorized by the employer. Mr. Sneed said the punitive damages doctrine needs consideration and reform. Additional information furnished by Mr. Sneed is in Attachment No. 10 and concerns preliminary results of a current study of punitive damages being done by the American Bar Association.

See Attachment 9 from Minnesota

In response to questions, Mr. Sneed said it is the intention of his group to provide guidelines for punitive damages because of the increasing number of lawsuits where punitive damages are requested for no reason. It was not the position of KADC that there is a specific crisis in Kansas, only that guidelines should be established. Mr. Sneed recommended the Committee examine the Minnesota law for a definition of when punitive damages should be awarded.

Steve Hornbaker, Junction City attorney representing the KTLA, said his group opposes eliminating or changing punitive damage laws in Kansas. He pointed out that judges can determine before the trial gets to a jury if a case is frivolous, and attorneys can be disciplined for filing them. He noted that a Farmers Insurance Group model statute was introduced into Kansas legislation in 1984 which would limit punitive damages, shift the burden of proof to beyond a reasonable doubt, and place part of the award with the state. As a result of the bill's introduction, the Kansas Bar Association studied the issue of punitive damages and recommended no changes in the Kansas law. The fear that awards threaten the financial condition of corporations was unfounded by factual cases. Punitive damages serve as a deterrent against companies placing on the market products which they know are dangerous. Under Kansas law, there is no cause of action for "bad faith" by insurance companies. He said this eliminates problems insurance companies have had in other states regarding "bad faith" failure to pay claims or settle cases. He objected to limiting the amount of recovery to plaintiffs to 5 percent of the award. He said this would make it economically impossible for plaintiffs and attorneys to prosecute punitive damage portions of a case. Mr. Hornbaker's statement is Attachment No. 11 and contains a state-by-state analysis of punitive damage cases as of February, 1984; the Rodino news release; and insurance statistics of amounts received and paid out by insurance companies.

Mike Sexton, KTLA, said the two cases regarding the 1985 medical malpractice collateral source law are on appeal with the Kansas Supreme Court and are scheduled for a hearing in October and should be decided before the 1987 Legislative Session. He then addressed the concept of an itemized jury verdict list which indicates the amount to be awarded in medical bills, lost wages, mental anguish, and disability; KTLA supports this concept. He noted that 15 years ago Kansas required special verdict questions to be answered by juries. If any were marked wrong, the case was subject to appeal. KTLA does not support this type of list. Mr. Sexton said KTLA supported itemized lists so the specific amount for pain and suffering awarded by a jury would be known.

In regard to H.B. 2661, Mr. Sexton said a lawsuit had been filed in Johnson County regarding its constitutionality, the outcome of which will affect pending cases. A Sedgwick County district judge has already declared it unconstitutional.

David Litwin, representing the Kansas Coalition for Tort Reform, presented proposed legislation for tort reform which this group believes should be enacted. He noted that members of the Coalition include representatives from business, various professions, and the insurance industry and was formed to reduce the number of conferees appearing before the Committee. The proposed legislation regarding punitive damages (Attachment No. 12) is identical to 1985 S.B. 110 and applies to punitive damages generally and not just to medical malpractice. The group is not asking that punitive damages be abolished, but amounts awarded should be appropriate and not arbitrary. He did not know if there was a crisis regarding punitive damage awards in Kansas, but his group believed that the law in this area should be examined periodically. Proposed legislation regarding the collateral source rule (Attachment No. 13) would require that all amounts from collateral sources except life insurance received by the claimant is to be admitted as evidence. The group did not discuss extending the list to include income tax exemptions. Proposed legislation regarding itemized jury verdicts (Attachment No. 14) lists items to be categorized. Attachment No. 15 proposes legislation to require the court, at the request of the parties, to instruct the jury if the award is subject to taxation.

In response to further questions, Mr. Litwin said a group of about 30 Coalition members met and agreed to changes in legislation and the proposals were written by a subcommittee. There are about 80 to 90 members on the mailing list with varying degrees of activity in the organization. Although he could not say the legislation proposed would improve the liability insurance situation in Kansas, he was convinced that the basic problem was with the civil justice system and not with the insurance industry. Courts determine rights and settle damages and these proposals would help assure that awards were appropriate. In his opinion, moderating awards would affect the liability insurance crisis. In regard to proposed legislation for punitive damages, Mr. Litwin said the language is identical to the medical malpractice bill and the Coalition's position is that punitive damages should be difficult to recover since they are punitive and different from other damages the civil justice system awards. Although punitive damages may be awarded rarely, they affect the behavior of people. Just the fear that they might be assessed unfairly has an effect on people and businesses. He believed that medical malpractice legislation was enacted even though no punitive damages had been paid by doctors in Kansas because doctors were afraid of what might happen to them. Business people and other professions also have this concern. He pointed out that information from Insurance Services Office (ISO) proved there was a negative gap between premium income and payout which indicated the problem does not lie with the industry. A memo from the Coalition (Attachment No. 16) approved proposals submitted by Mr. Litwin. It also lists additional tort reform topics as being of concern to members.

Staff called attention to additional information furnished to the Committee: a fact sheet from the General Accounting Office (GAO) regarding tax policy and financial cycles in the property/casualty insurance industry (Attachment No. 17); a news release from Congressman Peter Rodino concerning the Judiciary subcommittee's investigation findings (Attachment No. 18); a response to the news release from ISO (Attachment No. 19); a fact booklet published by ISO on insurer profitability (Attachment No. 20); a GAO report regarding the profitability of the insurance industry (Attachment No. 21); a staff memo listing major tort reform changes implemented in Kansas over the

past 12 years (Attachment No. 22); an article from Consumer Reports regarding the liability insurance crisis (Attachment No. 23); and an article from the ABA Journal regarding punitive damages (Attachment No. 24).

During Committee discussion, points were made that, since it was difficult to determine what benefits had been gained in making past changes in tort and insurance laws, the two issues should be considered separately. There was nothing to justify making tort reforms to benefit the insurance industry. It was suggested that the problem was broader than just insurance and the example of firemen filing suits because of injuries or mental anguish caused by fires also involved the civil justice system. Possible subjects for Committee consideration other than those on the agenda were discussed. The suggestion was made that H.B. 3114 clarifying immunity for governing body members of municipalities, vetoed by the Governor because of two subjects in the bill, should be reconsidered.

The Chairman recessed the meeting at 4:15 p.m.

August 15, 1986
Morning Session

The Chairman reconvened the meeting at 9:20 a.m., stating the agenda for the day would focus on the insurance industry.

Staff gave background information regarding the scheduling of conferees to address insurance matters. Names of conferees were obtained with the aid of the Insurance Department. A copy of a letter sent to conferees by staff requesting them to appear and containing suggested areas to be addressed is attached (Attachment No. 25).

Jan Pacey, representing Forrest T. Jones and Company, Kansas City, Missouri, insurer of school boards and the attorneys through the Kansas Bar Association (KBA), said this company was an associated group brokerage firm which develops programs that sponsors buy. His firm does not set rates. After a company has been found to write a policy the way his group thinks it should be written and at rates it thinks are reasonable, his firm continues negotiations with the chosen underwriter to make sure it is able to maintain the policy in difficult times. He said two of his firm's clients are KBA and its Lawyers Professional Liability Program and the Kansas Association of School Boards (KASB) which sponsors a program for school boards. The latter protects the board and district from errors and omissions liability and legal action mostly in the areas of hiring, firing, and expulsions of students. Neither policy covers claims for bodily injuries, sickness, death, or property damage. Both policies are written on a claims made basis. Both policies have deductibles anywhere from $500 to $200,000 with the KBA group having a $1,000 deductible. In both instances the rates for the two policies were predicated on Kansas experience with national experience also considered. As the insurance program matures, an attempt is made to give the Kansas experience factor greater weight.

Mr. Pacey furnished information concerning the Lawyers Professional Liability Program insured through St. Paul Fire and Marine (Attachment No. 26) and the School Board Legal Liability Insurance (Attachment No. 27) which gives figures showing Kansas experience with earned premiums versus loss ratio and compares Kansas with the national ratio. Paid losses and paid expenses exceeded earned income in Kansas in three of the years listed in Attachment No. 26. Members expressed concern that the figures did not show investment income, reserves, nor expense costs.

Mr. Pacey said the KBA, during the past two years, has held educational seminars on risk management in an attempt to cut down the number of claims. This is beginning to show results. He estimated that 5 percent to 10 percent of the total number of Kansas lawyers in private practice are not insured. If they were mandated to carry malpractice insurance, he believed insurance rates would jump upward. He said some may not have insurance presently because they cannot buy it. In regard to school board insurance, Mr. Pacey estimated that his firm insures 55 percent to 60 percent of the school districts in Kansas. He did not know how many school districts were insured. He did not believe a law that would exempt individual school board members from liability would reduce rates because Kansas already has a hold-harmless law covering boards as entities. He said, in Kansas, there has been no problem with school board liability insurance, and rates are about the same as in 1978 ...when more competition was involved. In response to further questions, Mr. Pacey said St. Paul is in the process of not renewing one school policy in Kansas based on losses in that school district. St. Paul has suggested ways the district could eliminate or reduce problems. So far the school district has not responded.

Kyle Nieman appeared as a representative of Crum Forster Managers Corporation, Chicago, insurer for CPAs and other lines. Most of his testimony was in response to questions. He said his company supports tort reform regarding liability exposure and recommends eliminating joint and several liability. His company furnishes countrywide programs for accountants and includes other states' experience when determining rates. Rate increases for Kansas is similar to the rest of the nation's, increasing from 50 percent to 75 percent in 1979 to 85 percent to 100 percent in 1986. With 275 practicing units in Kansas covered by his company, the average charge per person is between $900 and $1,100. There is no significant difference in rates per individual charged for firms with ten or 200 employees. Mr. Nieman was asked why Kansas should change tort laws if insurance companies would not lower rates for CPAs. He responded that there have been a lot of losses and rates are established based on what the actuary tells the company it can do. Most of the increases in rates have affected the medium-sized firms of five to 25 employees. This group has enjoyed low rates over the years, but this group loss experience requires higher rates. In regard to requiring the uninsured CPA firms in Kansas to advertise that they are not covered by malpractice, Mr. Nieman said many doctors are doing this now. If tort reform is enacted this year in Kansas, rates would not be affected the next year. Insurance companies are cringing at action other states are taking.

Mr. Nieman was requested to furnish figures regarding loss ratios for Kansas compared to national loss ratios in table form similar to Attachment Nos. 26 and 27 and any experience in Kansas where CPA defendants have had to pay claims for pain and suffering or punitive damages. It was pointed out that Kansas did away with joint and several liability about ten years ago. Mr. Nieman said punitive damages impact the insurance industry because not all state laws are the same. He explained his company was a holding company under which there are insurance companies, one of which is North River Insurance Company.

George Henderson, CIGNA Corporation, insurer of school boards and other lines, said this corporation has written $37,500,000 in premiums for property and casualty insurance in Kansas. Losses have been $32,000,000. This information came from annual statements filed with the Insurance Department. He noted these statements are available to show Kansas experience in all lines. Most of Mr. Henderson's further remarks were in response to questions.

Mr. Henderson said CIGNA uses ISO rate making plans and utilizes its state and class experience but does not receive state-by-state information. Although this data is in the system, underwriters cannot get it. Mr. Henderson said tort reform will not have an immediate effect on rate reduction but would eventually. He believed that problems with pollution liability were due to joint and several liability laws. The industry got hit with a lot of claims because of joint and several liability laws where policies were interpreted to cover what they never were intended to cover such as the asbestos problem. High interest rates affected underwriting practices, but, with interest rates going down, he believed underwriters would get back to basics. A state's experience will not determine a state's rate unless it has enough businesses in that class to get its own rate. Mr. Henderson did not believe schools have a liability insurance problem in Kansas. CIGNA quotes rates to them all the time but does not get the business. In regard to day care liability coverage in Kansas, CIGNA wrote 35 policies in 1983 and now writes 65 day care centers. The average rate for a licensed, accredited day care center is $3,000.

In response to further questions regarding tort reform, Mr. Henderson said tort reform would, in the long term, make policies available that are not available now, but, because of court interpretations, it could not be determined what the price would be. The industry is making positive responses in states like Connecticut and Washington where tort reforms have been made. Companies in those states have either withdrawn requests for rate increases or made rate reductions on good faith. Companies are working for rate reductions without statutory requirements to do so. He suggested members have input from insurance commissioners from those two states. If there is no collateral source rule, benefits would not be paid twice which raises costs for consumers. If consumers want duplicate payments, then they will have to bear the costs of coverage. In regard to mandating that the industry supply certain information to the Insurance Commissioner concerning investment income and loss experience in Kansas, Mr. Henderson said companies are trying to put this information together now which takes time, but he had no objection to a law in this regard. The industry does not keep tabs on the total number of claims as there has been no need for this information on a state basis. A member pointed out the need for the Legislature to know what the price or insurance will be if it makes reforms.

Henry Katz, representing Hartford Insurance, insurer for municipalities, said his company wrote $42 million in premiums in Kansas in 1985. It works with PENCO, a managing agent company under which Hartford provides municipal liability insurance in 28 states. It started in Kansas in 1982. He said that Kansas' Tort Claims Act and a conservative climate were major inducements to enter the state, especially in the municipal liability field. Very little needs to be done to the Act. There were 57 municipalities insured by Hartford in 1985. Tort reform in other states is reflected in Hartford's prices. The company recognizes tort reform in other ways with the use of tort reform modified policies. Legislatures should look at the effect of the civil justice system on society first and on insurance second, but the ultimate purpose should be what the cost of the system will be. Punitive damages have a serious effect on insurance, he said.

In the 28 states in which Hartford does business regarding municipal liability, Mr. Katz said 18 states have higher in rates than Kansas, and Kansas is lower than ISO advisory rates. He introduced Chris Senior of the Hartford Specialties Company, who assisted him in giving figures regarding Kansas premiums and the loss ratio. Mr. Katz said he would furnish the Committee with charts reflecting this information. Losses are computed with 66 percent being the break-even number. Kansas has already reached 49.7 percent loss ratio in 1986. Countrywide losses have been devastating with a 136 percent loss ratio. The high percentage of losses with the number of claims and amount of awards increasing is discouraging.

Mr. Katz suggested that the structured settlement provisions should be re-examined to address the right of the injured party to future damages that will never be incurred. On the death of the plaintiff, any amount of future wages should be paid, but pain and suffering and future medical bills should not go to the estate as a windfall. This change would reduce costs. Immunity should be considered for part-time and voluntary public officials and protection given from costs of litigation. He recommended an internal cap on noneconomic losses. He said he would provide the number of cases in Kansas where municipalities paid for pair and suffering. Mr. Katz stated his suggestions did not address big problems but concerned areas where costs might be reduced. He agreed that part of the problem was the public's attitude toward litigation and the fear of being sued.

Paul Genecki, Senior Vice-President of Victor O. Schinnerer and Company, insurer for engineers and architects, said this company was not a risk bearer but was an underwriting managers' group for professional liability programs. Its insurer is Continental Casualty Company. This group has detailed data it supplies to national groups of engineers and architects and their insurance committees, although some of this available data may not be necessary for rate making. The cost of professional liability ranges between 3 percent and 18 percent of a firm's gross income for a policy, plus substantial deductibles which apply to defense costs and claims paid. In Kansas, there are not enough architects and engineers to establish a separate experience rate group. With 110 insured firms in Kansas paying $1 million in premiums annually, it does not take a significant claim to erode the premium base. However, Kansas experience is considered when rates are made.

Mr. Genecki gave five-year figures on earnings and loss ratios. The loss ratio was 108.4 percent. He estimated defense costs in Kansas to be 35 percent. Most claims do not involve bodily injury, but attorney contingency fees would be a factor. The rate base for Kansas, based on every $1,000 on ratable billings, is lower than most other states. The 1986 rate increase is about 34 percent. Dollars collected are higher because rates are based upon a firm's billings and most practices are growing. There have been major changes this year in exclusions as a direct result of reaction to asbestos and pollution problems. No policies have been canceled nationwide during the past five years, and there have been no refusals to renew in Kansas, although 12 policies have not been renewed or have been canceled nationwide because of nonpayment, extreme loss experience, or changes in the firm's practice. His group believes in loss prevention and works with firms before cancelling. Mr. Genecki said the Kansas conservative setting makes it a good place to do business and noted beneficial changes its Legislature has made. Tort reform aimed at bodily injury claims does not involve architects and engineers, but eliminating the collateral source rule would help. He also suggested establishing a criteria for expert witnesses with language similar to that in 1986 S.B. 540 being appropriate; establishing screening panels similar to that in S.B. 540; enacting legislation like Hawaii to eliminate frivolous claims; and requiring parties to get together and voluntarily settle claims before they get to litigation. Any tort reform that would get the court system back to fault based compensation systems would be beneficial. He strongly stressed that tort reform is more important to architects and engineers directly than to insurance companies, because they cannot buy first party policies and most of the problems are in defense costs.

In discussion regarding the rate making process for architects and engineers, Mr. Genecki said in the practice of these professions there is generally a direct correlation between their billings and amount of service provided which indicates the amount of liability exposure. Certain items are subtracted from billings. National experience is used in setting rates but are modified by Kansas experience. In regard to mandating risk management practices, Mr. Genecki said this would work to the extent there are identifiable risks supported by data. If data is available, insurers will work with associations to reduce losses.

The Committee recessed for lunch.

Afternoon Session

The Chairman reconvened the meeting at 1:45 p.m.

Tom Wright, Senior Vice-President of Employers Mutual Casualty Company, Des Moines, Iowa, insurer for municipalities and schools with a branch office in Wichita, said this company has written $6.5 million in general liability in Kansas over a five-year period. In his statement (Attachment No. 28), he provided statistics on pure loss ratios and noted other expenses which should be added to these losses. He estimated that defense costs of liability claims reported in 1983-84 to be 50 percent of loss payments. He pointed out problems insurers face with claims for events happening years ago which have to

be considered in the future also. It involves many variances and insurers face uncertainty as to how courts will interpret coverage of policies. He refuted the insurance "conspiracy theory" as the cause of the problems with the civil justice system. He suggested that the only statistics needed would be available through the insurance departments of the 50 states along with ISO data. The only meaningful statistic to an insurance executive is the bottom line and determination of combined loss and expense ratio. Mr. Wright expressed concern regarding the revolution in the civil justice system during the past 25 years. The free enterprise system with hundreds of insurance carriers applying sound underwriting principles does not need revision, but the civil justice system needs refinement. He suggested that judges participate more in decisions regarding the burden of proof and the existence of facts. The old rule regarding the burden of proof of "preponderance of evidence" should be reevaluated. Punitive damages should be proved "beyond a reasonable doubt" and pain and suffering by "clear and convincing evidence."

Mr. Wright was questioned regarding the lack of information regarding insurance reserves and investments. He pointed out that business is not written on the basis of investment income and statements filed with the Insurance Department will indicate investment income is not adequate to compensate for losses. Forty companies betting on investment income over the last five years are now insolvent. Because income is related to "swings," it is difficult to avoid "swings" when it is unknown what the investment income will be for the next few years. Companies that have losses in net worth one year still write business the following year. He believed the information the Committee was seeking regarding investments was available with the Insurance Department through annual statements. He was not sure how the Legislature could change public attitude regarding an insurance industry conspiracy, but others have suggested the possibility of setting up a state fund, forcing companies to write certain insurance, requiring professionals and manufacturers to pass on high costs of their insurance to consumers, and making tort reforms. He noted Kansas has eliminated some tort problems and, in his opinion, Kansas is not a problem to the insurance industry, although its burden of proof standard could be changed. In regard to risk management, Mr. Wright did not believe this should be mandated by government because insurance companies are already using this tool as a matter of competition and assistance in reducing losses. A member pointed out that Mr. Wright's figures indicate the industry had a net loss in 1986, but ISO figures indicate a 1.78 percent profit on net worth.

Ernie Mosher, League of Kansas Municipalities, said the League in the late 1970s hired a consultant firm, which does not write or sell insurance, to make an analysis of insurance needs of cities in Kansas in hopes of improving their insurance situations and adequacy of coverage. He reviewed the results of the insurance survey of municipalities done by the consultant, "Insurance Market Analysis" (Attachment No. 29), which indicates that availability of liability insurance is not so much the problem as affordability. Rates have increased 285 percent during 1982-85, although municipalities have not experienced significant increases in claims. Increases are not caused by actual Kansas loss experience, but by losses in other states. Pages 33-37 of Attachment No. 29 contain recommendations that the League could implement. The study concludes that premiums will be even higher with higher deductibles and additional exclusions and Kansas will be influenced by national trends even with improvements made with risk control. Mr. Mosher said the League's primary

objective is to get affordable and adequate coverage for public officials and professionals regarding civil rights, and costs of municipal liability need to be stabilized and based on Kansas risks. If a pooled program could be insured, unique safety and management standards could be employed which are not now available. The Kansas Tort Claims Act should be examined regardless of private insurance costs. The League has a committee working on tort reform suggestions which will be ready by September.

In discussion, Mr. Mosher said self-insurance may raise the rates to those not in the pool, and the League has serious questions regarding the premium level being sufficient to have more than one pool. However, it is proceeding in this direction in hopes that private insurers will be more vigorous in underwriting policies. He believed a Kansas pool would have an immediate effect to help municipalities and, if tort reform is made, the cost of participation in the pool would be reduced.

In Committee discussion, the Chairman said the Tort Claims Act and further discussion regarding municipal liability would be considered at the September meeting. Other suggestions for consideration were made, including the role courts play in expanding liability coverage and the impact tort reform would have on the court system. Staff was requested to look at the Connecticut and New York laws and determine if rates dropped in those states because of reforms. Members expressed concern that figures given by insurers did not reveal the true picture. Staff was requested to ask the insurance conferees appearing at this meeting to furnish written statements and figures and to provide additional columns showing investment income, overhead expenses, and net profit. It was suggested that the Committee look at current pending legislation regarding insurance price regulation and ask the Insurance Commissioner to give his position on the bills. Another pending bill that limits policy cancellations should be considered with input from a consumer advocate.

Ted Fay, Insurance Department, said there were four proposals before the Citizens Committee: one addressing excess profits (a reserve control measure); one that allows the Commissioner to obtain data for the benefit of the consumer and not just for rate making purposes; one, which is not necessary for legislation regarding the gathering of additional data; and one for an assigned risk plan. Mr. Fay said the suggestion has been made before that investment income be considered when rates are set. Currently, the Commissioner sends out auditors to see if rates are being set properly. There is no way to avoid Kansas rates being affected by national standards.

Mr. Fay said the Citizens Committee is working in subcommittees and hearing from additional groups. It hopes to have its report ready in October.

The Chairman said the agenda for September would include preliminary discussion on tort reforms on the first day and pending legislation and proposals from the Insurance Commissioner and insurance regulations on the second day. Staff was directed to prepare a memo with a laundry list of all requests from conferees and interest groups and send it to members prior to the next meeting. These will be discussed first on the agenda. The Chairman stated the Committee, after the September meeting, would focus on proposed legislation.

The next meeting of the Committee will be September 11 and 12, 1986. The Chairman adjourned the meeting at 3:10 p.m.

Prepared by Mike Heim

Approved by Committee on:

September 12, 1986
(date)

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August 14, 1986

The Collateral Source Rule

Testimony before 1986 Special Committee on Tort
Reform and Liability Insurance
Professor James M. Concannon

The Collateral Source Rule historically applied in all Kansas tort cases as part of our common law. It developed because of a collision between two of the most basic principles of tort law: first, that a wrongdoer must pay the reasonable value of all harm the wrongdoer causes; and second, that an injured party is entitled to full recovery but is not entitled to double recovery.

The collision will arise when, for example, the injured party's spouse is a nurse who provides the injured party with nursing care at no cost. It is now impossible to give effect to both basic principles. If the wrongdoer is forced to pay the reasonable value of nursing care, the injured party receives a double recovery, i.e. a recovery for an amount the injured party did not spend. If we deny double recovery, then the wrongdoer receives a windfall, paying less than the value of the harm the wrongdoer has caused. The nurse-spouse intends to confer a benefit upon the injured party but the wrongdoer becomes the ultimate beneficiary.

Since the mid-1800's the law has resolved this problem by applying the Collateral Source Rule. The Rule is simply this: Payments made to the injured party or benefits conferred upon the injured party from collateral sources will not reduce the wrongdoer's liability and are not admissible in evidence. A source is collateral when it is other than the wrongdoer, i.e. it is collateral to the wrongdoer. The rationale most frequently articulated is that if we have to give a windfall to someone we should give the windfall to the innocent party rather than the wrongdoer. It has also been argued that forcing the wrongdoer to pay for harms actually caused increases the deterrent effect tort law is meant to have.

Attachment 1

To abolish the Collateral Source Rule is to allow these collateral payments to reduce the liability of the wrongdoer. To date, the Rule has been modified by the legislature only in medical malpractice actions. The 1976 legislature adopted minor changes as K.S.A. 60-471, a statute later held unconstitutional. A more comprehensive modification of the rule was made in 1985 and is codified as K.S.A. 60-3403. The rule continues to apply in other tort actions.

There are a number of categories of collateral sources:

(1) Insurance policies whether maintained by the plaintiff or by a third party such as a parent, spouse or employer. Included are fire insurance, collision automobile insurance, health insurance, and life and accident insurance.

(2) Employment benefits. These may be gratuitous, as when the employer continues to pay the employee's wages during incapacity although the employer is not legally required to do so. They may also be benefits arising out of the employment contract or a union contract, such as for sick pay. They may be benefits arising by statute, as in Worker's Compensation or the Federal Employers' Liability Act.

(3) Gratuities. This applies both to cash gifts such as payments from a public fund created to aid the victim and to the rendering of services. Thus, the fact that the nurse-spouse or a doctor do not charge for their services or that the plaintiff was treated in a veterans hospital does not prevent recovery of the reasonable value of the services.

(4) Social legislation benefits. Social Security benefits, welfare payments, pensions under special retirement acts, etc.

(5) Kansas has invoked the Collateral Source Rule as authority to exclude evidence that a plaintiff-spouse in a wrongful death case has remarried prior to trial. Pape v. Kansas Power & Light Co., 231 Kan. 441, 647 P.2d 320 (1982).

Within these categories, a further distinction needs to be drawn. Sometimes the provider of the collateral payment has a right of subrogation created either by law or by contract. What this means is a right of reimbursement: the provider of the payment is entitled to reimbursement out of the first dollars received by the injured party from the wrongdoer. In fire insurance, collision automobile insurance or no fault insurance, the insurance company is said to be subrogated to the rights of the injured party. An employer who pays Worker's Compensation

is given by statute certain subrogation rights. Reimbursement rights sometimes are provided by social legislation. Sometimes the party with reimbursement rights may bring an action against the wrongdoer even if the injured party does not. Sometimes there is no such right.

A strong argument can be made that the Collateral Source Rule should be abolished when the provider of the collateral payment does not have a right of subrogation or reimbursement. Let's use the example of Blue Cross-Blue Shield or another health insurance provider and assume it has paid plaintiff's medical bills. If the total claim against defendant is less than the limits of defendant's liability insurance, there is not likely to be much added deterrence from requiring defendant also to pay plaintiff's medical bills--they will be paid by defendant's liability insurer, not defendant. Further, since there is no right of reimbursement, the injured party will now be compensated twice. We legitimately could decide double recovery is undesirable because the combined premiums for plaintiff's health insurance and defendant's liability insurance theoretically are higher when both policies pay the same loss. An insurance actuary could tell whether this factor is actually considered in calculating premiums, but it can be argued as a matter of societal policy that we can only afford to have one insurance policy making the payment and we should thus designate either the health insurance coverage or the liability insurance coverage as primary.

Of course, one alternative would be to retain the Collateral Source Rule but create a subrogation right in the health insurer. Then ultimate responsibility would fall on the liability insurer and health insurance premiums we all pay would theoretically be reduced. However, the public outcry is not that health insurance premiums are too high but that liability insurance premiums are too high. Thus, the other alternative is to abolish the Collateral Source Rule for health insurance payments so that the ultimate responsibility falls on the health insurer. Health insurance premiums will not change from current levels but liability insurance premiums theoretically will be reduced. There is also a solid economic analysis supporting this alternative, making health insurance primary. Since the health insurer by contract must pay in the first instance, leaving the loss there avoids the cost of shifting that loss to the liability insurance carrier through the legal system, by litigation, settlement, etc. Lower liability insurance premiums admittedly would benefit the wrongdoer but also would benefit innocent insureds as well.

The best argument that double recovery should be retained is primarily a practical one. Even a full recovery in tort litigation as a practical matter does not make the injured party whole. Under the American Rule, parties normally pay their own litigation costs and attorney fees and the injured party does so

out of the damage award. The Collateral Source Rule by permitting double recovery provides money to pay those costs and fees, thus allowing the award to come closer to making the injured party whole.

It can also be argued that the injured party is entitled to double recovery when the injured party has paid the premiums for health insurance, either directly or in exchange for lower wages in employer financed plans. The argument is that the wrongdoer should not benefit from prior payments plaintiff has made for plaintiff's own protection. The flaw in this argument is that few people buy health insurance with an expectation of double recovery which would be frustrated by abolition of the Collateral Source Rule. However, there are some equities behind this argument. If we eliminate double recovery by making health insurance primary, the wrongdoer at least should be required to reimburse the injured party for those premiums paid by the injured party to provide the collateral benefit. Without that, the injured party really would not receive a full recovery, which they do expect when buying health insurance. K.S.A. 60-3403 recognizes this principle when it admits evidence not only of health insurance payments but also of amounts paid to secure the collateral benefits.

I hope you have noticed that the only criticism of the Collateral Source Rule is that it permits double recovery with the attendant economic costs caused by double recovery. I hope you also have noticed that double recovery occurs only when the provider of the collateral payment does not have a right of subrogation.

To the extent that subrogation or reimbursement rights exist, e.g. in the employer who has paid Worker's Compensation benefits, the Collateral Source Rule is fully defensible. By creating the right of subrogation, the legislature has decreed the loss ultimately should fall on the liability insurance carrier rather than upon the Worker's Compensation carrier. The Collateral Source Rule forces the liability insurer to pay in full for the plaintiff's losses and the right of subrogation forces plaintiff to repay amounts advanced by the Worker's Compensation carrier thereby preventing double recovery by the injured party. Now, of course, the legislature could abolish subrogation rights (except those conferred by federal law) and then abolish the Collateral Source Rule as well, making Worker's Compensation coverage ultimately responsible rather than the liability insurance carrier. The question simply is: Where do we want to place the cost. To the extent subrogation rights remain, however, you pretty much have to keep the Collateral Source Rule. If the Collateral Source Rule is abolished but subrogation rights retained, the innocent injured party would receive less than a full recovery from the liability insurance carrier but still would have to repay the

provider of the collateral payment. The innocent party in essence would be paying for the privilege of being hurt.

K.S.A. 60-471 properly recognized that the Collateral Source Rule must be retained when there are subrogation rights and should be abolished only when it results in double payment. It provided that if there was a subrogation or reimbursement right, evidence of the collateral source payment was inadmissible and could not be used to reduce the damages recoverable. K.S.A. 60-3403 in a somewhat more haphazard way also recognizes this principle. It admits evidence both of the collateral source payment and of the extent to which the right to recovery is subject to a lien or subrogation right.

Carrying out the principle that the Collateral Source Rule should be abolished only when it actually results in double recovery also is complicated by our comparative negligence statute. Let me give an example. Under current law assume a plaintiff has suffered $50,000.00 in total damages in an automobile accident but has received health insurance benefits of $20,000.00 of that total. Because of the Collateral Source Rule, the jury will not learn of the $20,000.00 health insurance payment and presumably will return a verdict finding plaintiff's total damages to be $50,000.00. If plaintiff is found to be 40 percent at fault and defendant is found to be 60 percent at fault, plaintiff receovers a judgment against defendant for $30,000.00 (.60 X $50,000.00). Here, the $20,000.00 health insurance payment covers the $20,000.00 of damages attributable to plaintiff's fault and there is no double recovery. Plaintiff bought health insurance with the goal of making himself or herself whole in the event of a loss and it makes sense to credit collateral payments to amounts attributable to the fault of the injured party.

In this example let us suppose that we abolish completely the Collateral Source Rule and allow the jury to learn of the $20,000.00 health insurance payment. Presumably, the jury then would return a verdict finding plaintiff's damages to be $30,000.00 ($50,000.00 minus the $20,000.00 plaintiff already received). If plaintiff again is 40 percent at fault and defendant is 60 percent at fault, the comparative fault statute requires these percentages to be applied to the $30,000.00 net damage award returned by the jury rather than the $50,000.00 actual damages. Plaintiff will receive judgment against defendant for $18,000.00 (.60 X $30,000.00). Plaintiff's total recovery will be $38,000.00 ($18,000.00 from defendant and $20,000.00 from health insurance). Defendant's fault is actually responsible for $30,000.00 of plaintiff's total loss (.60 X $50,000.00). Abolition of this Collateral Source Rule would enable defendant to escape paying $12,000.00 of the loss defendant caused. By contrast plaintiff would be forced to absorb $12,000.00 damages without reimbursement even though plaintiff's goal in purchasing health insurance was to make

himself or herself whole even if plaintiff was partially at fault. Abolishing the Collateral Source Rule in this comparative fault example cannot be justified as preventing double recovery. Instead it prevents full recovery, giving the defendant's insurance carrier a windfall and forcing the injured party to bear a greater portion of the loss than is warranted by the injured party's fault.

K.S.A. 60-3403 is defective in failing to take into account the impact of comparative fault on the Collateral Source Rule. Perhaps the number of medical malpractice cases in which the plaintiff is assessed a percentage of fault is small. If so, the defect in K.S.A. 60-3403 will lead to injustice only occasionally. However, the potential for injustice is great if the same statute is adopted for tort cases generally where plaintiffs often are partially at fault. Any statutory change should provide that collateral source payments will be credited first to that portion of total damages attributable to the fault of the injured party and of the party who has provided the collateral payment. The damages awarded against the defendant should be reduced to the extent collateral payments exceed the share of total damages attributable to plaintiff's fault and that of the party who provided the collateral payment. In our prior automobile example, the $20,000.00 health insurance payment would equal the damages attributable to plaintiff's fault and there would be no reduction in the $30,000.00 judgment against defendant. If, instead, plaintiff was 10 percent at fault and defendant was 90 percent at fault, current law requires judgment to be entered against defendant for $45,000.00 (.90 X 50,000.00 total damages). Plaintiff keeps the $20,000.00 health insurance payment and enjoys a double recovery windfall of $15,000.00. Under my proposal for modification of the rule, the $20,000.00 health insurance payment plaintiff received would be applied first to offset the $5,000.00 damages attributable to plaintiff's fault (.10 X $50,000.00), then to reduce the award against defendant by the remaining $15,000.00. Judgment would be for $30,000.00 rather than $45,000.00. The evil of double recovery would be avoided but defendant's insurance carrier would not receive a windfall as under K.S.A. 60-3403.

Primarily because the impact of the comparative negligence problem cannot be determined before the jury assesses fault and determines the total amount of damages, it seems to me the reduction of damages to account for collateral source payments should be done by the judge, rather than by the jury. The jury should continue to return a verdict determining what plaintiff's total damages are without any reduction for collateral payments. Collateral payments then could be deducted by the judge alone. Ordinarily, the parties can be expected to stipulate to the amount of past payments in money and there will be no factual dispute. If the extent of future damages is uncertain because the duration of disability is uncertain, the extent of future collateral payments may also be uncertain. Here, the jury which determines future damages could separately determine by an

answer to a separate question on the verdict form the value of future collateral payments. The ultimate crediting of the future collateral payments against the judgment should be done by the judge based upon the jury's answer. The same procedure could be followed if it is necessary to determine the value of unliquidated past collateral benefits such as gratuitous services.

Present law in K.S.A. 60-3403(c) takes a different approach in medical malpractice cases, making reduction a jury decision which cannot take account of the determination of fault. The statute also mandates that in determining damages, the trier of fact "shall consider" both the extent to which damages awarded will duplicate collateral source payments and also the extent to which the award is subject to subrogation rights. The statute articluates no principled way for the jury to "consider" these factors and the jury is left without guidance to choose among the ways suggested by skillful lawyers in their closing arguments. In essence, the statute leaves it to the jury, and jury by jury, to decide whether to apply the Collateral Source Rule or not. The predictability needed for any change in the Collateral Source Rule to impact insurance rates is lost.

The Department of Commerce Draft Uniform Product Liability Law proposed that reduction of damages to account for collateral source payments be done by the judge. Its analysis explained that the proposal:

> does not alter existing law that prohibits the defendant from introducing in evidence the fact that the plaintiff has been indemnified by a collateral source. That approach was rejected because it would leave the trier of fact in the role of balancing the delicate policy elements that surround proposals calling for abolition of the Collateral Source Rule. Also, that approach would reduce the potential benefit of Collateral Source Rule modifications in that it would increase transaction costs and lower predictability and consistency in the allocation of collateral benefits. 44 Fed. Reg. 3018 (Jan. 12, 1979).

The legislature should provide clear standards, as it did not do in Section 60-3403, for when damage awards will be reduced by collateral source payments and when they will not. If clear standards are provided, the judge rather than jury can best be relied upon to carry out the legislative mandate.

In summary, assuming that the Collateral Source Rule is to be modified, K.S.A. 60-3403 is flawed in these respects:

(1) failure to state clearly the effect of subrogation rights;

(2) failure to account for comparative fault;

(3) failure to have the judge implement the modification.

K.S.A. 60-3403 has one excellent attribute which should be retained in any general legislation. Subsection (a) clearly states which collateral source payments are considered and which are not. The 1985 legislation was restricted to money payments which duplicate allowable elements of damages. Thus the 1985 legislation kept the current rule for the gratuitous provision of services as by the nurse-spouse. This was wise. Trials would be complicated and juries perhaps confused if we have to litigate the value of gratuitous services rendered. Also, we do not want to discourage people from helping those in need. Indeed, for this reason gratuitous payments also were excluded. Evidence of remarriage in wrongful death cases likewise was not included, consistent with the Legislature's approach to specific legislation on this topic.

The 1985 Legislature specifically decided not to reduce damages by the amount of life insurance. People often purchase life insurance to provide their families with a better standard of living after they die and not merely to replace lost earnings. Dollar-for-dollar reduction of damages because of life insurance payments might frustrate carefully considered personal financial plans.

In short, you must consider separately each type of collateral source because separate policy considerations are involved. Legislation must be drafted carefully to insure that it full eliminates the evil of double recovery but is not so broad that it leads to injustice.

UNIFORM LAW COMMISSIONERS'

MODEL PERIODIC PAYMENT OF JUDGMENTS ACT

If the actions of one person cause injury to another, and those acts constitute legal fault, the injured party has been able to collect monetary damages to make up for his or her losses. The injured party has been, traditionally, treated as if he or she is frozen in time and will never change. The award of money damages is made in one lump sum. It does not take into account what the injured party might become, or what the state of the economy might be in any period of the injured person's life.

In the last decade, this view of an injured person has changed to a perceptible degree, but not greatly. The vehicle for the change that has occurred is the "structured judgment." A "structured judgment" pays the award in installments. It is paid as loss accrues. For example, if damages contemplate future medical expenses, these are not satisfied in a lump sum at the conclusion of the lawsuit. They are paid, incrementally, as the expenses arise.

"Structured judgments" have certain advantages over lump-sum judgments, particularly when the damages are very great. Tortfeasors and their insurers are not required to raise the money, immediately, to pay a cash settlement. They are able to purchase annuities and to make investments from which installments can be paid from income. At the same time, the injured party can be guaranteed compensation as loss accrues, exactly when he or she needs it most. That compensation can be adjusted to account for fluctuations in economic conditions.

But there has been a substantial need for appropriate judicial authority to make structured judgments and to assure they are created and managed fairly. The Model Periodic Payment of Judgments Act is designed to fill that role.

Attachment 2

The Model Act provides statutory authority for "structured judgments." The capacity to "elect" structured judgments resides with the parties to litigation. If a party elects (in most jurisdictions, this will be by motion to the court) to come under the Model Act, the election is effective if all parties to the litigation have consented, or if no party files a timely objection, or, even after objection, the specific jurisdictional amount is exceeded (suggested amount is $100,000) and the objecting party is unable to show "that the purposes of this Act would not be served." The Model Act creates an alternative system of paying damages under these restrictions.

It is to be emphasized that the Model Act affects payment of damages. It does not change the substantive damage determination inherent to any personal injury action. The Model Act only applies to future damages. Damages accrued in the past continue to be paid as a lump sum.

The Model Act, then, focuses upon issues which are a problem in any alternative system of "structured judgments." What about payment of attorney's fees? They may be taken in lump sum or, periodically, as part of the structured judgment. What about inflation and cost of living? A structured judgment, under the Model Act, is indexed year by year to the interest rate for 52-week treasury notes. After long and agonizing consideration, this index appeared to provide the fairest and most consistent adjustment for fluctuating economic conditions. What happens if an injured party dies before the award is complete? The Model Act's basic answer is that damages which cease to accrue at death need not be paid beyond death. The major problem here, of course, lies with wrongful death actions. If one beneficiary dies from among a group of actual beneficiaries or possible beneficiaries, the Model Act provides rules for succession to the award due the deceased beneficiary.

The Model Act requires adequate security for a structured judgment. The expected security, in most cases, will be a contract of insurance with an established insurance company. However, other forms may be accepted by the court, if convinced of the solidity of the security offered. It is very possible, for example, that trust arrangements might be made to satisfy the requirement for adequate security.

The Model Act considers other problems and issues of the structured judgment, as well. But these listed examples indicate the comprehensive consideration of the issues by the drafters. For a relatively new concept, the Model Act contains a package of integrated and consistent provisions which will overcome the difficulties inherent in structured judgments.

UNIFORM LAW COMMISSIONERS' MODEL PERIODIC PAYMENT OF JUDGMENTS ACT

Historical Note

Where there is a demand for an Act covering the subject matter in a substantial number of the states, but where in the judgment of the National Conference of Commissioners on Uniform State Laws it is not a subject upon which uniformity between the states is necessary or desirable, but where it would be helpful to have legislation which would tend toward uniformity where enacted, acts on such subjects are promulgated as Model Acts.

The Model Periodic Payment of Judgments Act was approved by the National Conference of Commissioners on Uniform State Laws in 1980.

PREFATORY NOTE

The common law system of awarding damages in bodily injury cases is that of lump sum payment. The trier of fact must determine at the time of trial all damages, past and future, that are owing to a claimant. Perhaps this system is the only one the courts could realistically administer when the law regarding damages in bodily injury cases developed. Yet, it is not free from problems. There are a number of things that are relatively uncertain at the time of trial in serious injury cases. Even with the passage of time, we will never know, in many of these cases, what the claimant would have been like if he had not been injured. On the other hand, passage of time will reveal the answers to the question of what the seriously injured claimant actually will be like in the future. We will also know the answers to other questions such as the state of the economy that now looms as a serious question for the trier of fact in ascertaining large damage awards for losses that will accrue far into the future.

In addition to these inherent problems in the lump-sum system, other matters have developed that call for re-examination of how large awards of future damages in bodily injury cases are calculated and paid. First, half million and multi-million dollar awards have become so frequent in the last few years that they no longer represent the exceptional case. Such awards have a great impact on the availability and affordability of bodily injury liability insurance. The most acute problems have been experienced in the areas of products liability and medical malpractice, situations that give rise to some of the most serious injury cases.

Second, the income tax laws are such that it is to the benefit of claimants, and even their attorneys, to think about alternatives to the present system. Payment of damages as they accrue can provide substantial tax savings. Finally, the disposition of large lump-sum awards by successful claimants is not a matter that can be ignored when the public is demanding closer scrutiny of government spending, particularly in the welfare area.

Largely as a result of the availability and affordability problems in bodily injury liability insurance markets, but also because of the other factors mentioned above, a number of states have adopted legislation, mainly in the field of products liability, that permits judgments for damages for bodily injury to be paid in periodic instalments rather than in a lump sum. In the main, this legislation has not been thorough and creates more problems than it answers. The problems not only affect the litigants in the adopting states, but are exacerbated because of the national and international nature of products liability and similar litigation. Needless to say, the problems of affordability and availability of bodily injury liability insurance are not intrastate in nature either, but also transcend governmental boundary lines.

The Model Periodic Payment of Judgments Act provides an alternative to the lump-sum system of paying large awards of future damages arising from bodily injury by facilitating payment over the period which the losses will accrue. At the election of any party, subject to certain safeguards, a case involving large amounts of damages that will accrue in the future will be tried under this Act and, if appropriate, the court will fashion a periodic-instalment judgment. The Act answers the problems left untended in legislation passed to date and does it at the state level so that each state can tailor various parts of the legislation to its own needs.

There are advantages to both claimants and defendants, as well as to the public, in the Act. A claimant's award for bodily injury is not subject to the federal income tax. Under Section 104(a)(2) of the Internal Revenue Code 1954, a claimant may exclude from gross income the amount of any damages received on account of bodily injury. The same rule usually prevails with regard to state income taxes. However, any income earned on such an award is subject to income tax. Under the present lump-sum system, awards for future damages are discounted to present value to take into account the earning power of money. A claimant is paid an amount of money now which will generate income by investment and, in turn, produce the total amount of damages awardable to the claimant. Thus, a portion of the claimant's damages is taxable income under the lump-sum system.

Recently, casualty insurers have undertaken to settle very serious personal injury cases employing annuities and similar financial devices. The insurer of the tort defendant may offer to provide a series of payments to the tort victim extending over the victim's life or a period certain. By paying today's claims with tomorrow's dollars the insurer can offer an attractive package including cost-of-living escalator clauses and other features, at a lower cost than paying the claim in a lump sum. This type of settlement is being referred to in the insurance industry and literature as a "structured settlement." Annuities are often used to fund it. There are considerable income tax and other advantages to this type of settlement as compared to a lump-sum settlement.

In 1979, the Internal Revenue Service issued a ruling stating that the entire amount of the proceeds payable to the tort victim under a structured settlement is tax free where the victim has a right to receive only the periodic payments and does not have the actual or constructive receipt of the economic benefit of the lump-sum amount that is invested to yield that periodic payment. Rev. Rul. 79-220, 1979-2 C.B. 74. The Model Act is designed to provide the same favorable income tax consequences to the tort claimant who receives a periodic-payment judgment in which future damages are paid out as the losses accrue. In addition, if the claimant's attorney has a contingent fee contract and payment is to be made on a periodic basis under that contract, the attorney may be able to spread the income for tax purposes over the years in which the fee is paid. The Act facilitates such an arrangement. However, counsel would be well advised to consult with those who have special expertise in income taxation matters and structured settlements to ensure that the form of a periodic-instalment judgment and the method of securing it conform to Rev.Rul. 79-220 and subsequent rulings or modifications by the Internal Revenue Service.

Under the present accident loss system, the risk of investment of large lump-sum payments for future damages is forced on the accident victim. Many claimants lack the financial expertise to handle and invest large sums of money. Services of others can be obtained, but there is always the risk of improvident investments. Moreover, there is usually a fee involved for such services. Under the periodic-payment scheme in this Act, the defendant or the defendant's insurer will shoulder these burdens. Presumably, they will have easier access to sources of financial expertise and can better absorb the risks and costs involved. In short, the accident victim should not have to bear the risks and costs associated with the management of a large sum of money paid in a lump sum.

Defendants will also benefit by being permitted to pay large awards for future damages in periodic instalments as the losses accrue. Many defendants in the very serious cases are either large or, at least, solvent corporations, which carry liability insurance or act as self-insurers. These corporations, or their insurers, are often in a better position than a single claimant to secure the most advantageous arrangements. In addition, the Act contemplates that awards for certain damages which never accrue because the loss is never suffered shall terminate.

The Act also eliminates the guesswork and speculation involved in the lump-sum system where the trier of fact, usually a jury, is asked to discount awards of future damages to present value and, in an increasing number of jurisdictions, predict future rates of inflation. Since damages will be paid as losses accrue, there is no need for the trier of fact to discount to present value. The Act also provides for adjustments in the instalment payments so that the damages awards are not eroded by decreases in the purchasing power of the dollar.

Overall, the Act contemplates payment of claimants for the actual losses incurred through a system which should be more efficient, all to the benefit of the public. The Act provides the states a flexible framework to accomplish this by leaving it to the adopting state to tailor certain provisions to meet the needs of the citizens of that state. At present, the casualty insurance industry is very interested in the concept of paying large personal injury awards for future damages on a periodic basis, but some insurers are fearful that problems inherent in such a mandatory scheme have not been satisfactorily resolved. For example, the cost-of-living index factor which is employed in the Act is designed to fluctuate with economic conditions. Annuity underwriters are accustomed to a fixed index, the effect of which can be calculated with certainty when the annuity is issued. Some casualty insurers are fearful that there will be no market for the type of annuity needed to fund a periodic-instalment judgment which is adjusted yearly by a factor that is not known when the annuity is priced. The Drafting Committee, after hearing from representatives of the banking, as well as the insurance industry, believes that the scheme is workable and that a market will develop. The Act requires an annual adjustment keyed to the discount rate for a certain issue of 52-week U.S. treasury bills. It is believed that the investment portfolio of any prudent annuity company should be productive enough to permit this adjustment without loss.

Attachment 3

3. [Election for Act to Apply]

a) In order to invoke this Act, a party to an action for bodily injury must make an effective election in accordance with this section.

b) The election must be made [in accordance with rules of court] [by motion directed to the court with notice to all parties not less than 60 days before commencement of a trial involving issues of future damages unless leave of court is obtained]. Any objection to the election must be made [in accordance with rules of court] [by motion directed to the court with notice to all parties not less than 30 days after notice of the election].

c) An election is effective if:

1) all parties have consented;

2) no timely objection is filed by any party; or

3) a timely objection is filed; but

(i) the electing party is a claimant and shows there is a good faith claim that future damages will exceed [$100,000] or

(ii) the electing party is a party responding to a claim for future damages in excess of $100,000] and shows that security in the amount of the claim for past and future damages or [$500,000], whichever is less, can be provided under this Act.

d) If an objecting party shows that the purposes of this Act would not be served by conducting the trial of the claim affecting him under this Act, the court may determine not to try the claim under this Act even though the conditions of subparagraphs (i) or (ii) of subsection (c)(3) are satisfied. [Such determination must be made [in accordance with rules of court] [by the court at least 30 days prior to trial].]

e) If an effective election is on file at the commencement of trial, all actions, including third-party claims, counterclaims, and actions consolidated for trial, must be tried under this Act unless the court finds that the purposes of this Act would not be served by doing so or in the interest of justice a separate trial or proceeding should be held on some or all of the claims that are not the subject of the election.

f) An effective election can be withdrawn only by consent of all parties to the claim to which the election relates.

COMMENT

The policy underlying this Section is to permit a party to an action for bodily injury to elect to have the case be tried under the procedures set forth in this Act. If all parties consent or there is no objection filed by any party, the court will proceed to secure the necessary fact findings (Section 4) and determine the type of judgment to be entered (Section 6).

If a party objects to the invocation of the Act, further proceedings must be held by the court. Whenever an objection is lodged, the court should first determine whether the electing party is a claimant or a party responding to a claim. If the electing party is a claimant, the burden is on that party to show that a good faith claim for future damages exceeding the suggested figure of $100,000 exists. The Act contemplates that only serious cases involving substantial damages which will accrue after the time of trial should be subject to the Act unless all parties agree. The adopting state is free to choose a threshold figure more or less than the bracketed figure in (c)(3). The size and prevalence of serious injury cases in a particular jurisdiction should be considered in setting this figure. It should also be kept in mind that the dollar figure in this Section is merely a trigger for trying the case under the procedures of the Act and is not dispositive on the question of whether a periodic-installment judgment will actually be entered. Section 6 determines the type of judgment that will be entered.

If the electing party is a party responding to a claim for future damages in excess of the suggested figure of $100,000, that party has the burden of showing that adequate security can be posted. This will help prevent respondents from abusing the Act. There also is a sanction where a responding party makes the necessary showing as to the ability to post security and later fails to post security without good cause. See Section 9(c).

The suggested figure in brackets in subparagraph (i) and the first figure in subparagraph (ii) should be the same regardless of the amount finally adopted. There appears to be no justification for using a different triggering threshold depending upon whether the electing party is a claimant or a respondent.

Questions with regard to the type of evidence that is admissible, the burden of adducing evidence, and the burden of persuasion under subsection (c) are left to prevailing rules that govern similar pre-trial matters in the adopting state.

In any event, an objecting party has the opportunity to show under subsection (d) that the purposes of the Act will not be served by conducting the trial of the claim affecting that party under the Act. The court must refer back to the criteria stated in Section 1 in resolving this issue. For example, the objecting party may show that, even though the claimant's damages are in excess of the triggering threshold figure, the claim against him is so different in nature from other claims in the case that it should be tried separately, at least as to the damages issue. This could occur where future damages consist mainly of medical bills and pain and suffering that will accrue in less than one year from the date the judgment is entered.

Subsection (e) deals with multiple claim cases. The court will want to take into consideration the question of whether the trial of the objecting party's claim will somehow interfere with the trial of claims which clearly should be subject to the provisions of this Act. In a case in which there are multiple claimants who were injured in one accident, it may not be advisable to try in the same proceedings claims under the procedures of this Act with claims that are not being tried under the procedures of this Act. The Act prohibits expert testimony on future changes in the purchasing power of the dollar whereas such testimony might be admissible on a claim not subject to the procedures of this Act. See Section 5. Thus, instructions to the jury could differ as to the various claimants with regard to inflation. This same disparity would occur with regard to instructions on discounting to present value and on life expectancy. *Id.*

The confusion engendered by trying the claims with different jury instructions in the same proceeding would be a basis for the court to decide that there should be separate trials. The court could sever the damages issues and dispose of them in separate proceedings or try all the claims or none of them under the Act. It is a matter for the court to determine so that the purposes of the Act are served and no injustice is done to either the electing or objecting party after taking all interests into account. Assuming the interests are equal, however, the electing party prevails.

The bracketed language in subsections (b) and (d), dealing with the time periods within which an election or objection must by filed and when the court must rule, respectively, anticipates the problem in some states as to whether the legislature has the power to prescribe such rules or whether this is solely within the jurisdiction of the supreme court of the state. The adopting state should choose the appropriate language. Also, if the time period suggested is not appropriate, the adopting state should feel free to tailor the provision to its own situation. It should be kept in mind that the trial of a case under the procedures of this Act might entail different methods of preparation and should not give an undue advantage to, or work a hardship on, any party. Time periods should be determined accordingly.

The election to try the case under the procedures of this Act may be made for the first time after a mistrial is declared, a motion for new trial is granted, or a case is remanded on appeal for a new trial. A court may even permit an election to be filed after a severance. Leave of court may be granted at any time to file an election absent an abuse of discretion.

An election or attempted election is not to be taken as evidence that the claim is worth more or less than the figure that is finally adopted in subsection (c)(3), nor should any argument to the jury referring to such be allowed.

If an effective election is filed and the case is tried under this Act but the respondent is unable or refuses to post security under Section 9, the claimant has the option to have a periodic or a lump-sum judgment entered. Thus, the claimant can force the respondent to pay the judgment in periodic instalments regardless of whether security is posted. In many cases, the respondent will be covered by liability insurance and the insurance regulator is empowered under Section 17 to take appropriate action against any liability insurer that refuses to post security if it is capable of doing so. There are additional sanctions under Section 9(c).

Library References

Election of Remedies ⇐2
C.J.S. Election of Remedies § 2 et seq.

§ 4. [Special Damages Findings Required]

(a) If liability is found in a trial under this Act, the trier of fact, in addition to other appropriate findings, shall make separate findings for each claimant specifying the amount of:

(1) any pas[illegible]ges; and
any future damages and the periods over which they will accrue, on an annual
for each of the following types:
(i) medical and other costs of health care;
(ii) other economic loss; and
(iii) noneconomic loss.

) The calculation of future damages for types (i) and (iii) described in subsection (a)(2)
t be based on the costs and losses during the period of time the claimant will sustain
e costs and losses and the calculation for type (ii) must be based on the losses during
period of time the claimant would have lived but for the injury upon which the claim is
ed.

COMMENT

an effective election is made under Section
ction 4 requires that certain types of find-
he made by the trier of fact with regard to
ages. The purpose is to obtain the neces-
fact findings so that a periodic-instalment
ment can be fashioned. Both past and fu-
damages are defined in Section 2. Past
ages include any punitive or exemplary dam-
permitted and a court can require separate
ngs with regard to the latter. Only future
ages are subject to payment in periodic in-
ents so they must be separated from past
ages. The findings with regard to future
ages must be further delineated between
for medical and other health care costs,
economic loss, and noneconomic loss. The
d over which these three categories of fu-
damages will accrue and the amounts of
during these periods must be specified by
rier of fact. Special interrogatories to the
will provide the needed findings.

ubsection (b) brings into focus an issue re-
ng damages that has not been given thor-
attention by the common law. It is com-
y said that, in contrast with the English
the United States jurisdictions have denied
lamages for the reduced life expectancy of
ccident victim. To bring the issue into
er focus, the question is one of whether the
of fact should use the pre-injury or post-in-
life expectancy of the victim in calculating
e damages. There is, however, American
rity for the proposition that the pre-injury
expectancy is to be used in determining
iary losses such as loss of earnings. See
s, *Remedies*, 549 (1973). The Act recog-
this authority and provides that, in deter-
g loss of earnings, the trier of fact shall
late future damages on the working life
tancy that the claimant would have had but
he injury upon which the claim is based.
economic loss except medical type
governed by the pre-injury life

re does not seem to be any American au-
y for the proposition that medical bills or
health care costs should be calculated on
the basis of preinjury life expectancy. In fact, these damages are nonexistent because death will prevent their accrual. This same argument can be made for non-economic loss. The clearest case of non-accrual, though, is with regard to medical and other health care costs because the dependents of the victim, whose life has been shortened, would never receive any benefits from the awarding of these damages. Had the victim lived, the money would have been spent for the medical services.

The fact situation contemplated is anomalous only because the common law development with regard to wrongful death claims was truncated. Had there been a cause of action for wrongful death recognized at common law, perhaps the courts would have gone forward and recognized a claim for reduced life expectancy, at least for earnings loss. After all, by definition, the injury has reduced the life expectancy of the victim, and it would be a logical extension to permit the survivors to bring a cause of action which would cover the loss of earnings less the amount that would have been spent on the victim or persons other than the wrongful death claimants.

The common law probably would never have recognized the cause of action for any medical expenses beyond death since these will never accrue. The answer as to whether the common law would recognize a cause of action for pain and suffering after the victim has departed this veil of tears would probably have been in the negative too. One can look to the survival statutes and the wrongful death statutes for support for these conclusions. Under the orthodox survival acts, the deceased's cause of action ends upon death except to the extent that the statute permits the bringing of an action for those damages incurred prior to death. (Even then, in some jurisdictions, damages for such noneconomic loss as pain and suffering do not survive death.) The wrongful death statutes create a cause of action in the dependent survivors for their own losses. Weaving the two statutes together, it is clear that there is no cause of action for medical expenses or pain and suffering of the deceased beyond death. The Model

Periodic Payment of Judgments Act follows this scheme and dictates that postinjury life expectancy be used in calculating damages for health care and related expenses and noneconomic loss.

The trial court, where necessary, may require more detailed findings separating different types of damages and may require findings relative to apportionment or application among the parties. For example, additional findings may be needed to allocate damages among defendants because of rules with regard to contribution, indemnity or comparative fault. [illegible]tion of damages awards among wrongful death claimants or beneficiaries may be required. Also, more detailed findings with regard to the periods of losses and the amounts incurred during these periods could be required because there may be periods of maximum loss, periods of stabilized loss, requirements for one-time medical procedures or separate medical procedures at different points in the future. Whatever findings are necessary to fashion a periodic-instalment judgment, the court is empowered to obtain.

Library References

Damages ⇐219.
C.J.S. Damages § 189.

§ 5. [Calculation of Future Damages]

[(a)] In all trials under this Act, evidence of future damages must be expressed in current values and those damages must be calculated by the trier of fact without regard to future changes in the earning power or purchasing power of the dollar.

[(b)] In all jury trials in which special damages findings are required under this Act, the jury must be informed that with respect to future damages:

(1) the law provides for adjustments to be made later to take account of future changes in the purchasing power of the dollar;

(2) the law takes into account the fact that those payments may be made in the future rather than in one lump sum now; and

(3) the jury will make their findings on the assumption that appropriate adjustments for future changes in the purchasing power of the dollar will be made later]

COMMENT

One of the main purposes of the Act is to avoid as much speculation as possible with regard to the calculation of future damages and to more accurately tailor awards to actual losses. The thrust of this Section is to require the trier of fact to calculate future damages on the basis of present dollar value or purchasing power. This eliminates the need for expert testimony with regard to general economic fluctuations in the future. It does not eliminate the need for expert testimony with regard to the particular victim's future earning capacity which would take into account the attributes of the victim and any increases or decreases in productivity that might result from technology or other changes in a particular industry or trade. However, any statistical data relied on by an expert as the basis for this type of testimony must be adjusted to eliminate factors that reflect predictions as to fluctuations in the purchasing power of the dollar in the future.

Where future damages are paid in periodic instalments, a cost-of-living adjustment is required under Section 7.

The Section also contemplates elimination of speculation as to the earning power of money in the future, and this is accomplished by paying damages as the losses accrue. Thus, there is no occasion for the trier of fact to consider the earning power of money and thereby reduce to present value awards for losses accruing in the future. When future damages are paid in advance of the period to which they apply, they will be discounted in accordance with Section 16.

No reference is made to income tax consequences. This is left to prevailing rules in the adopting state.

The material dealing with instructions to the jury is bracketed, and an adopting state may include or exclude it. The choice may depend upon the respective jurisdictions of the court of last resort and the legislature as to who has the power to decide such matters. Nevertheless, there is concern that, if the jury is not so instructed, because of their familiarity with the lump-sum system or for some other reason, the jury might take the purchasing power of money and the earning power of money into account in their calculations of future damages. Thus, the jury should be instructed on these matters.

Library References

...ses ©=208(1).
...mages § 176.

[Basis for Determining Judgment to be Entered]

n order to determine what judgment is to be entered on a verdict requiring findings of ...cial damages under this Act, the court shall proceed as follows:

) The court shall apply to the findings of past and future damages any applicable ...s of law, including set-offs, credits, [comparative fault], additurs, and remittiturs, in ...ulating the respective amounts of past and future damages each claimant is entitled ...ecover and each party is obligated to pay.

) If the total amount of future damages recoverable by a claimant in an action for ...ily injury or by all of the beneficiaries in an action for wrongful death is less than ...0,000], the court, unless the claimant or beneficiaries elect to receive a judgment for ...odic instalments, shall reduce the amounts payable for future damages in accordance ... Section 10 to determine the equivalent lump-sum value and enter judgment for that ...unt plus the amounts found for past damages.

) If the total amount of future damages recoverable by a claimant in an action for ...ily injury or by all of the beneficiaries in an action for wrongful death is [$100,000] or ...e, or the claimant or beneficiaries so elect, the court shall enter judgment as follows:

(i) If a judgment for periodic instalments is entered, it must specify payment of ...ttorney's fees and litigation expenses in a manner separate from the periodic instal...ents payable to the claimant, either in lump sum or by periodic instalments, pursuant ... any agreement entered into between the claimant or beneficiary and his attorney. If ...ny portion of future damages is payable in advance of the period to which it applies in ...atisfaction of the agreement, the amount of the damages is subject to discount in ...ccordance with Section 10.

(ii) Upon election of a subrogee, including an employer or insurer who provides ...orkers' compensation, filed within [the time permitted by rule of court] [10 days after ...erdict], any part of future damages allocable to reimbursement of payments previous... made by the subrogee is payable in lump sum to the subrogee and the appropriate ...duction of future damages must be calculated in accordance with Section 10.

(iii) The court shall enter judgment in lump sum for past damages and for any ...amages payable in lump sum or otherwise under subparagraphs (i) and (ii). Any ...ump-sum payments for future damages reduce proportionately all periodic instalments ...r future damages.

(iv) After making any adjustments prescribed by the preceding subparagraphs, the ...ourt shall reduce the remaining amounts for future damages to present value in ...ccordance with Section 10 to determine the equivalent lump-sum value. If the ...quivalent lump-sum value is more than [$50,000] or the claimant or beneficiaries elect ... receive a judgment for periodic instalments, the court shall enter a judgment for the ...ayment of the remaining amounts of future damages, without reduction, in periodic ...stalments in accordance with Section 7; otherwise, the court shall enter a judgment ...r the equivalent lump-sum value.

(v) In an action for wrongful death, the calculation of the equivalent lump-sum value ...der subparagraph (iv) of the remaining amounts for future damages must be based ...n the total recovery for all beneficiaries of the action. If the lump-sum equivalent of ...he total is more than [$50,000], each beneficiary must be paid in periodic instalments in ...ccordance with Section 7.

... petition of a party before entry of judgment and a finding of incapacity to ... required security, the court, at the election of the claimant or beneficiaries in an ...on for wrongful death, shall:

(i) enter a judgment in accordance with subsection (3); or

(ii) reduce the amounts payable for future damages in accordance with Section 10, unless Section 9(c)(1) applies, to determine the equivalent lump-sum value and enter judgment for that amount plus the amounts found for past damages.

COMMENT

Even though an effective election to try the case under the provisions of this Act has been made, it may be that a judgment for periodic-instalment payments is not warranted. A policy decision has been made that, if the future damages recoverable by a claimant, after applying any setoffs, credits, comparative fault rules, additurs, and remittiturs, are less than the suggested figure of $100,000, the court shall enter a lump-sum judgment for future damages unless a claimant or the beneficiaries of a wrongful death action nevertheless prefer to take a periodic-instalment judgment. In other words, the defendant cannot force a claimant to take a periodic-instalment judgment even if the damages award for future losses is relatively small. Although the bracketed figure of $100,000 is a suggested figure, an adopting state should probably not use a lower figure, in view of the fact that the Section provides for some portions of the award for future damages to be paid in a lump sum. The Act has its greatest utility in the serious injury cases, and anything less than $100,000 as a threshold would probably result in marginal benefits to the parties and to the public.

If the total amount of future damages recoverable does not meet the suggested figure and the claimant or wrongful death beneficiaries do not elect otherwise, the court is to discount the future damages to present value in accordance with Section 10 and enter a lump-sum judgment for all damages recoverable in the action. This includes past and future damages and any other awards such as punitive damages and costs.

If the total amount of future damages recoverable meets or exceeds the suggested figure or the claimant or wrongful death beneficiaries so elect, the court is directed to enter a judgment for that portion of the damages award representing attorneys' fees and litigation expenses as set out in subparagraph (i) of paragraph (3). The Act, however, does not dictate how the attorney is to be paid. This is left, as it is today, to contractual agreement between the attorney and client and the attorney may be paid in a lump sum or in periodic instalments.

It would serve no purpose not to permit a subrogee to enforce a subrogation claim in lump sum, and the Act gives a subrogee that election in subparagraph (ii) of paragraph (3).

A lump-sum judgment is required for past damages and any other awards so determined under subparagraphs (i) and (ii) of paragraph (3). If punitive damages are awarded, they should also be entered as a lump sum.

Any amounts of future damages which are paid in advance of the period in which the trier of fact has determined that they will accrue must be discounted. See Section 10 and the comment thereto. This applies to any future damages that are used to pay attorney fees, litigation expenses, or a subrogee in lump sum. The remaining future damages that are to be paid periodically must be reduced, and the Act requires that this be done on a proportionate basis. For example, assume that an attorney and client agree to a lump-sum contingent fee contract that, in part, results in a $30,000 attorney fee when the percentage figure in the contract is applied to the future damages findings. Assuming further that the future damages findings consist of $10,000 per year for thirty years, the $30,000 fee would be applied at the rate of $1,000 per year to the instalments of future damages. Thus, the judgment should specify that the attorney receive an amount which represents $30,000 discounted to present value in accordance with Section 10 and that the tort victim receive $9,000 per year for thirty years. It should be noted that the full amount of the attorney's fee is offset against future damages even though the attorney would receive less than $30,000 once this figure is reduced to present value. If the attorney had contracted for a dollar fee of $30,000 rather than a contingent fee, it would take more than $30,000 of future damages to produce that amount because of the discount factor.

After the adjustments discussed above are made, the court shall reduce the remaining amounts for future damages to present value in accordance with Section 10 to determine the lump-sum value of these damages. If this lump-sum figure is equal to or less than the suggested figure of $50,000, the utility of paying the award in periodic instalments as the losses accrue is marginal as far as serving the purposes of the Act. However, the claimant or beneficiaries of a wrongful death action are given the benefit of the doubt and are permitted to elect a periodic-instalment judgment even if the threshold figure is not met. Otherwise, the Act requires that a lump-sum judgment be entered. If the lump-sum value exceeds the suggested figure, the court is directed to enter a periodic-instalment judgment for future damages.

There should be but one judgment entered, and it should contain the lump-sum amounts entered under subparagraphs (i) through (iii) and the periodic instalments entered under subparagraph (iv), all of paragraph (3). The judgment should also contain any costs, prejudgment inter-

...d other ite... awarded in the case and ...form to the requirements of Section 7.

...ever future damages are to be paid in ...odic instalments as the losses accrue, it be...es imperative that these payments be as...d insofar as possible. The form of security ...et out in Section 8, and the requirement for ...ng and maintaining security is covered in ...ion 9. If the required security cannot be ...ed, there is no point in delaying the entry of a lump-sum judgment if that is what a claimant desires. Paragraph (4) permits a party to show an incapacity to post security so that a lump-sum judgment may be entered immediately. However, a claimant may want to have an instalment judgment entered even though there is an incapacity to post security and has that right. If this is the case, a claimant may have the instalment judgment reduced to a lump-sum judgment at a later date under the provisions of Section 9(b).

. [Adjustment of Periodic-Instalment Obligations]

a) A judgment for periodic instalments must set out:

(1) the findings of the future damages for each calendar year; and

(2) a schedule of the base figure for each calendar year to be used in calculating uture payments. The base figure is determined by discounting the findings for each alendar year in accordance with Section 10.

b) As of the first day of each calendar year after a judgment for periodic instalments ntered, the schedule of all instalments not previously due must be adjusted by adding the base figure for each instalment, in the most recently modified schedule, a sum ermined by multiplying the base figure by the index factor defined in subsection (c).

c) If a judgment for periodic instalments has been in effect for

[(1)] one year or more at the time of adjustment, the index factor is the rate of iscount per annum for the last issue of 52-week United States treasury bills in the ear before the year immediately preceding the year of adjustment [;][.]

[(2) less than one year but more than 6 months at the time of adjustment, the index actor is one-half of the index factor defined in paragraph (1); and

(3) less than 6 months but more than 3 months at the time of adjustment, the index actor is one-fourth of the index factor defined in paragraph (1).]

d) In all other cases, no adjustment may be made.

e) Unless the court directs otherwise or the parties otherwise agree, payments must be eduled at one-month intervals. Payments for damages accruing during the scheduled ervals are due at the beginning of the intervals.

COMMENT

...however a periodic-instalment judgment for ...re damages is entered, there must be some ...hod of adjusting the payments that do not ...me due until a date certain in the future to ... into account fluctuations in the purchasing ...er of the dollar. This Section deals with that ...ject.

...fter considerable experimentation with vari... indexes and formulas and consultation with ...de knowledgeable about these matters, the ...ent approach was developed.

...he index factor utilized for adjusting for fluc...ions in the purchasing power of the dollar is ... the rate of discount for the 52-week ... bills issued by the United States ...t. Any judgment debtor or other ...on required to secure a periodic instalment ...ment, such as a casualty insurance company ...rporation can invest the funds necessary to ...treasury bill specified to produce the income ...ake the required yearly adjustments. The treasury bills chosen provide the maximum accommodation between security and liquidity.

The Section does not require, however, that the judgment be secured by investing in such instruments. It merely requires that the periodic instalments be adjusted on the basis of the specified per annum rate of discount. If the judgment debtor chooses to secure the judgment through investments in other instruments, this may be accomplished if the provisions of Section 8 dealing with the form of security are met.

At present, there does not appear to be a market for the type of annuity that would best secure the periodic-instalment judgment contemplated in this Act. It is probable, however, that a market will develop to meet the needs of the casualty insurers and corporations required to secure periodic-instalment judgments.

Institutional investors, such as large corporations and insurance companies, are able to make investments providing a greater return than the treasury bills specified and will, in all likelihood, do so. This should provide the profit incentive for the life insurance industry to market an annuity that will allow the judgment debtor to secure the judgment as required under the Act. In the meantime, a judgment debtor is not left to the mercy of the insurance industry in providing a market and can secure the judgment and the adjustments required under this Section by investing in the treasury bill specified.

At least one large commercial bank has expressed an interest in the Act and indicated that the investment of the sums needed to produce the instalment payments and adjustments could be handled through a trust. Thus, it is felt that the fluctuating index factor employed in this Section is not only the most accurate and, therefore, the fairest approach for all concerned, but that it is a feasible system. On the other hand, it is recognized that a fluctuating index factor is of great concern to some insurers and that some experimentation may need to take place in the settlement arena before such a scheme is mandated by statute.

A state could adopt a fixed index factor initially by simply substituting the following language for that contained in paragraph [(1)] of subsection (c): "[(1)] one year or more at the time of adjustment, the index factor is 8 percent." This suggested substitute language employs a figure of 8 percent which is a realistic, if not low, figure for the present economic conditions. This points up the difficulty in reaching a decision on what figure should be used and the unfairness involved if the figure is not an accurate prediction of future fluctuations or, at least, the average of the fluctuations over time. This is why preference is given in the Act to a fluctuating index factor that is based on actual economic conditions. If the above language utilizing a fixed index factor is substituted, paragraph (2) of Section 17 is no longer needed and should be deleted.

Adjustments for fluctuations in the purchasing power of the dollar are to be made on the first day of each calendar year after a periodic-instalment judgment is entered. The Section provides alternative language in subsection (c) to give the adopting state a choice as to whether it will adjust only after a judgment has been in effect for a full year or whether it will adjust for initial partial year periods. This is a matter that will arise only on the occasion of the first adjustment. For example, if a periodic-instalment judgment is entered on May 1, 1982, should it be adjusted for the first time on January 1, 1983 or January 1, 1984? The adopting state can choose the appropriate language to implement whatever decision is reached on this question.

The Section requires the court to include certain findings in the judgment so that the exact amount due, either in a lump sum or periodic instalments, can be easily ascertained. The court is required to include in findings for future damages for each calendar year that losses will accrue. It is also required to include a schedule of the base figures for each calendar year for calculating future payments. The base figures are determined by applying to the findings of future damages for each calendar year the discount factor in Section 10. It is necessary to adjust the findings for future damages in accordance with Section 10 before the index factor in Section 7 is applied. This is so because the index factor in Section 7 is based on the discount rate for 52-week United States treasury bills. The discount factor on the treasury bills represents two predictions by investors about the future: (1) the purchasing power of money and (2) the earning power of money. (The risk of nonpayment is nil for all practical purposes. See Comment to Section 10.) The two together constitute the amount of the discount bid by investors on the treasury bills. An adjustment for fluctuations in the purchasing power of money is all that is required because the damages will be paid as losses accrue, rather than in advance of the period they accrue. Thus, that portion of the discount rate that represents the earning power of money must be eliminated. Otherwise, the judgment creditor will be overpaid just as would be the case of a lump-sum judgment were not discounted to present value.

It would be possible to adjust the discount rate on the United States treasury bills so that one could simply multiply the adjusted discount rate times the unpaid instalments at the beginning of every year. However, the illustration below will show that it will be more advantageous to discount the instalment payments in accordance with Section 10 first and then multiply by an unadjusted index factor based on the treasury bills. By doing this, the schedule, as illustrated below, will always show the amount of money due at any one time on a periodic-instalment judgment on a lump-sum basis, as well as on a periodic-instalment basis.

Illustration

Assume a jury verdict is returned and judgment is entered on January 1, 1982, awarding future damages of $20,000 in 1982 and $10,000 in each year for the years 1983 through 1986. Assume that the index factor defined in subsection (b) of Section 7 and the discount rate of Section 10 are as indicated. As time passes, and adjustments are made, the amounts due can be easily determined. The first step is to divide the findings for future damages by the discount factor to obtain the base figures. Assuming the discount factor is 3% and adjustments are to be made only where the judgment has been in effect one year or more, the amount of $10,000 to be paid in 1983 is divided by 1.03, the amount of

:0,000 to be p 1984 is divided by (1.03)⁶.
c. The secon s to apply the inflation or
dex factor.

	Base Figure Schedule (3% discount) 1/1/82	Adjusted for 1982 (Factor 9%) 1/1/83	Adjusted for 1983 (Factor 10%) 1/1/84	Adjusted for 1984 (Factor 8%) 1/1/85	Adjusted for 1985 (Factor 7%) 1/1/86
82	$20,000				
83	9,709	$10,583			
84	9,426	10,274	$11,301		
85	9,151	9,975	10,973	$11,851	
86	8,885	9,685	10,654	11,508	$12,311
mp Sum	$57,171	$40,517	$32,928	$23,359	$12,311

By examining the illustration, it can be seen at, if security is not posted on January 1, 1982, e judgment creditor can move the court to ter a lump-sum judgment and that amount is 7,171. If security is posted but, by the end of 82, the security should fail and the judgment itor moves to have a lump-sum judgment en- ed, it can be easily determined that the ount is $32,928. On the other hand, the edule also shows the amount that is due each ar once the adjustment is made on the basis of periodic-instalment scheme. Thus, the utility using this type of schedule that employs a edule of base figures calculated in accordance h Section 10 and then adjusting on the basis the index factor in Section 7(b) is demonstrat-

ven though subsection (b) speaks in terms of ding to the base figure", this does not mean there will not be any adjustments down- rd if we experience a period of deflation in the future in the economy. It is highly improbable that people would want to pay more than the face value of a United States treasury bill. To do so would mean that one must believe that the earning power of a dollar will be more when the treasury bill comes due than at the date of purchase. One would be better advised to merely retain the money and not invest it at all under these circumstances. Thus the discount rate for treasury bills will be zero.

However, the instalments for future damages will continue to be paid as losses accrue. These instalments have been discounted in accordance with Section 10 to arrive at the base figures under subsection (a)(2). Since the index factor will be zero in periods of deflation, there will be no adjustment under subsection (b). Thus, there has been a downward adjustment in the periodic instalments because the instalments were discounted under Section 10 and will not be adjusted upwards during periods of deflation.

Library References

Judgment ⇐713(1)
C.J.S. Judgments § 56

[Form of Security]

a) Security authorized or required for payment of a judgment for periodic instalments ered in accordance with this Act must be in one or more of the following forms and roved by the court:

(1) bond executed by a qualified insurer;

(2) annuity contract executed by a qualified insurer;

(3) evidence of applicable and collectible liability insurance with one or more qualified nsurers;

(4) an agreement by one or more qualified insurers to guarantee payment of the dgment, or

(5) any other satisfactory form of security.

) Security complying with this section serves also as a required supersedeas bond.

COMMENT

...ations where obligations are to be ...over a period of time it becomes ...ssary to use reasonable devices to assure ...the means for discharging the obligations continues to exist during the time in question. Under a system of paying future damages over the period the losses will accrue, particularly if the judgment debtor is empowered to make this

election, it is crucial to the system that the judgment obligation be secured. Section 9 requires that a periodic-instalment judgment be secured by each party liable for all or a portion of the judgment. Section 8 details the form of the security.

A variety of ways are available to a judgment debtor to secure a periodic-instalment judgment, but it should be noted that the court must approve the form of security. The judgment debtor does not have an unfettered choice in the matter. Four different types of security are explicitly mentioned and will suffice as long as the obligor on the security is a qualified insurer and the court approval is obtained. The insurance regulator in the adopting state is required to establish rules and procedures for determining which insurers, self insurers, plans or arrangements are financially qualified to provide the four types of security mentioned in this Section. See Section 17. Subsection (5)(a) gives some discretion to the trial court to approve other forms of security so long as they are satisfactory in the judgment of the court to provide the requisite financial stability.

A bank might provide the requisite security through a trust. For example, the Act contemplates that U.S. treasury bills can be used to secure a periodic-instalment judgment both as to the lump-sum equivalent of the instalments and as to the amount needed to make adjustments for future inflation. A judgment debtor could establish a trust with a bank whereby the bank would invest the lump-sum equivalent in U.S. treasury bills thereby providing the security and the instalment payments. As pointed out in Section 7 and the comment thereto, other types of investments can be utilized to produce the income necessary to make the cost-of-living adjustments required by the Act. Thus, the trust might invest in other quality instruments. As long as the court is satisfied that the security is adequate, it could approve such an arrangement.

It should be kept in mind, however, that the security must meet the conditions set out in Rev.Rul. 79-220, 1979-2 C.B. 74 in order for the judgment creditor to receive the instalment payments on a tax-free basis. The ruling dealt with a situation where an insurance company purchased and retained exclusive ownership in a single premium annuity contract to fund annually payments stipulated in settlement of a damage suit. It was held that the exclusion from gross income by Section 104(a)(2) of the Internal Revenue Code of 1954 applies to the full amount of the monthly payments received by the victim in settlement of the damage suit because the victim had a right to receive only the monthly payments and did not have the actual or constructive receipt or the economic benefit of the lump-sum amount that was invested to yield the monthly payment. If the victim were to die before the end of the period over which the payments were to be made, the payments made to the victim's estate under the settlement agreement would also be excludable from income under Section 104. See also Rev.Rul. 79-313 1979-2 C.B. 75.

Subsection (b) simply provides that any security complying with this Section serves also as a required supersedeas bond since it would be wasteful to require both security and a supersedeas bond if the case is on appeal. If the judgment debtor chooses not to secure the periodic instalment judgment pending an appeal in a manner that qualifies under this Section, the regular rules with regard to supersedeas bonds in the adopting jurisdiction will still apply.

Library References

Judgment ⇐675
C.J.S. Judgments § 782

§ 9. [Posting and Maintaining Security]

(a) If the court enters a judgment for periodic instalments, each party liable for all or a portion of the judgment, unless found to be incapable of doing so under Section 6(d), shall separately or jointly with one or more others post security in an amount equal to the present lump-sum equivalent of the unpaid judgment, including past damages, in a form prescribed in Section 8, within 30 days after the date the judgment is subject to execution. A liability insurer having a contractual obligation and any other person adjudged to have an obligation to pay all or part of a judgment for periodic instalments on behalf of a judgment debtor is obligated to post security to the extent of its contractual or adjudged obligation if the judgment debtor has not done so.

(b) A judgment creditor or successor in interest and any party having rights under subsection (c) may move that the court find that security has not been posted and maintained with regard to a judgment obligation owing to the moving party. Upon so finding, the court shall order that security complying with this Act be posted within 30 days. If security is not posted within that time and subsection (c) does not apply, the

urt shall calcu[illegible] lump-sum equivalent of the obligation under Section 10 and enter udgment for [illegible] mount in favor of the moving party.

on motion by the claimant, or the beneficiaries in an action for wrongful death, , in the absence of a showing of good cause, shall enter a lump-sum judgment hout applying the discount factor in Section 10 if:

(1) a responding party elects to have this Act apply and makes the required showing s to security under Section 2(c)(2)(ii), but thereafter fails to post security; or

(2) a party fails to maintain security.

) If a judgment debtor who is the only person liable for a portion of a judgment for odic instalments fails to post and maintain security, the right to lump-sum payment cribed in subsection (b) applies only against that judgment debtor and the portion of judgment so owed.

) If more than one party is liable for all or a portion of a judgment requiring security er this Act and the required security is posted by one or more but fewer than all of parties liable, the security requirements are satisfied and those posting security may oved under subsection (b) to enforce rights for security or lump-sum payment to sfy or protect rights of reimbursement from a party not posting security.

COMMENT

large awards of future damages are to be periodically in the future rather than in p sum, it is important that the judgment be ired to assure the payments. This Section ures that a periodic-instalment judgment be ired. Section 8 prescribes the form of securi- hat will suffice under this Act.

ach party liable for all or any part of a odic-instalment judgment is required to post rity within 20 days after the date the judg- t is subject to execution. A party may post rity even though an appeal is contemplated have the security suffice as a supersedeas : See Section 8(b). In this event, the secur- must be posted in the time required in the ing state for a supersedeas bond. Other- then Section merely requires that the secur- e posted within 20 days after the date the ment is subject to execution. This will give rties sufficient time to arrange for securi- ter the judgment becomes final.

a defendant is incapable of posting security, r the claimant or defendant may petition the before entry of judgment for a finding of acity to post security required in this Sec- See Section 6(d). If the court finds that efendant is incapable, the court may, at the est of the claimant, enter a lump-sum judg without regard to any waiting period in ion 9. Unless a party can show incapacity to security, the judgment debtor is given 20 to post the security.

e security required must meet the form ria in Section 8 and must be in an t to the present lump-sum equiva- quired judgment, including past dam- The latter requirement contemplates that outstanding judgment obligation must al- be secured even though diminishing over a period of time. Section 7(a)(2) requires that a periodic-instalment judgment set out a schedule of the base figures for calculating future pay- ments. The base figures are determined by applying the discount factor in Section 10. The base figures are adjusted periodically and, when totalled for a particular year, equal the present lump-sum equivalent of the unpaid judgment. Thus, by requiring the base figures to be set out in the judgment, the total amount of the lump- sum equivalent of the unpaid judgment is readily identifiable at any particular time. Even though the individual instalments may increase over time due to the adjustment required in Section 7, the total amount of unpaid instalments will de- crease. (See the illustration in the Comment to Section 7.) It is the total of the unpaid base figures, including any adjustments, that must be secured to satisfy this Section.

The last line in subsection (a) requires a liability insurer or anyone else who has been adjudged liable to pay all or part of the judgment on behalf of a judgment debtor to post security if the judgment debtor does not. This covers the situation, in addition to that of a liability insurer, in which a manufacturer, or someone else in the marketing chain, enters into an agreement to indemnify or otherwise discharge all or part of the obligation of a party adjudged liable, but limits it to situations in which there has been a court determination of liability.

Subsection (b) deals with the situation in which security is not posted during the 30 day period set out in subsection (a) and the situation in which, regardless of when security is posted, the security proves inadequate. The security may prove inadequate because it is not in the proper sum or amount or, although in the required amount, the obligor on the security is no longer qualified

to provide security. There may be other situations in addition to these. In the event security is not posted and maintained, the court is required to order that it be posted within 20 days. If security is not posted within that time, a lump-sum judgment shall be entered if the judgment creditor so moves. There may be circumstances, however, in which the judgment creditor prefers to retain the periodic-instalment judgment even though unsecured. Appeals from any rulings with regard to adequacy of security are left to prevailing rules in the adopting jurisdiction.

Subsection (c) provides for a penalty in some of the situations in which there is a capricious failure to post or maintain security. For example, where a defendant elects to try the case under Section 2(c)(2)(ii) and prevails over the claimant's objection by showing that adequate security can be posted but later refuses to post security without good cause, the claimant can elect to receive a lump-sum judgment without having the discount factor in Section 10 applied. Using the illustration in the comment to Section 7 as a hypothetical case, the claimant would be entitled to a lump-sum judgment of $68,088. Thus, a penalty of $2,825 would be imposed. Where the election to try the case under the Act is made by the claimant and there is a subsequent capricious failure to post security, no penalty is imposed. However, the claimant can still count on a periodic-instalment judgment and, if the refusal is by an insurance company, the insurance regulator has power to take action against the company. See Section 17(2). The penalty in subsection (c) applies to all failures to maintain security where there is not good cause for the failure.

The penalty in subsection (c) only applies where there is an absence of good cause. It could happen that the failure to post security in the example given in the preceding paragraph occurred when the verdict exceeded the amount specified for an adequate showing under Section 2(c)(2)(ii) and the defendant was financially unable to post the security required for the jury award under Section 9. This would constitute good cause. Other examples can be posited, but in the final analysis the burden is on the defendant or judgment debtor to convince the court that good cause exists.

The last two subsections deal with situations in which there are multiple obligors under a periodic-instalment judgment. Subsection (e) deals with the situations in which one of the obligors is solely liable for a portion of a judgment. In this case, the right to a lump-sum judgment for failure to post and maintain security by this obligor is limited to the amount owed by the obligor. The balance of the judgment which is owed by one or more other judgment debtors is unaffected.

Subsection (e) deals with a variety of situations involving multiple obligors under a periodic-instalment judgment where one or more of the obligors fails to post and maintain security in accordance with this Section. Situations contemplated include those of joint and several liability in which contribution or indemnity is owed, where there is no joint and several liability, but a right of indemnity is owed as in the case in which a manufacturer owes indemnity to a retailer who has sold a defective product originating with the manufacturer, or in which an employer is vicariously responsible for the acts of an employee, and the employee, as a third party defendant, owes indemnity to the employer. This subsection provides that any party who is obligated to pay part or all of the judgment, whether primarily or secondarily liable, may post security to satisfy the requirements of this Section. Once having posted security, the posting party is entitled to protect any rights that party has against a defaulting party by requesting that security be posted under subsection (b). If the defaulting party persists in failing to post or maintain security, the posting party can obtain a lump-sum judgment. This provides the maximum accommodation in that the judgment creditor is not deprived of the benefits of a periodic-instalment judgment merely because one among several judgment debtors fails to post or maintain security. At the same time, it provides protection to those judgment debtors who do post and maintain security. It prevents one judgment debtor from depriving the other parties to the judgment, be they creditors or debtors, of the benefits of this Act.

Library References

[illegible]

C.J.S. [illegible] § 181 et seq.

§ 10. [Discounting Future Damages to Present Value]

If (1) future damages are determined in accordance with Section 5 but are ordered to be paid in advance of the period to which they apply, or (2) base figures are required under Section 7, the court shall apply a discount factor of [3] percent, compounded annually

COMMENT

Under the comm[illegible]w system, damages for bodily injury are [illegible]d in a lump sum. In most jurisdictions, [illegible]er of fact is required to red[illegible] future damages to present value. A cl[illegible] would be overcompensated if the earning [illegible] of money were not taken into account.

Whenever an effective election is made to try a case under this Act, the trier of fact is told to disregard the earning power of money because the Act contemplates paying future damages as the losses accrue, rather than in advance of the period when the losses accrue. However, in some cases, awards for future damages so determined may not be paid in periodic instalments in the future for a variety of reasons. After taking into account any set-offs, credits, comparative fault rules, addtuirs or remittiurs, or other portions of future damages that are to be paid in lump sum, such as litigation costs and attorneys' fees and amounts to which others may be subrogated the final amount of future damages subject to payment in periodic instalments may not meet the threshold monetary figures prescribed in Section 6. Moreover, even though the thresholds are met, security may not be posted or maintained and a lump-sum judgment may be entered. Whenever the award for future damage is calculated without regard to the earning power of money and is subsequently required to be paid in a lump sum, it is subject to discount under this Section.

As explained in the Comment to Section 9, the discount factor is also used in arriving at the base figures required to be set out in a periodic-instalment judgment.

The discount factor suggested in this Section represents the real rate of interest. Market interest rates reflect two basic components. One component is based upon predictions about increases or decreases in the purchasing power of money over the period the interest rate will be in effect. The second element reflects what the waiting party demands in return for the use of the money and the risk that it will not be returned. The following explanation by Frederick C. Kirby, appearing at pages 449–50 in the August 1976 issue of the *Insurance Law Journal*, is instructive:

> It has long been observed that interest rates tend to be 'high' when prices are rising and 'low' when prices are falling, and that interest rate movements lag behind price level changes. Economic reasoning recognizes inflation as a cost of lending money. Similarly, the borrower recognizes inflation as a gain in borrowing money through repayment of less valuable dollars. The dollars of principal received by the lender upon maturity of a loan will purchase less than the [illegible]number of dollars would have pur[illegible] the time of the loan. This purchasing [illegible] reduction must be compensated for in the price (interest rate) charged for lending money. Thus, inflation is a cost of lending that is included in the price of lending (market rate of interest) according to anticipation of its rate.
>
> Measures of past rates of inflation and relating this to current market rates of interest explains 70 to over 90 percent of the variation in the market rates of interest.
>
> However, the well-known inflationary element of the market rate of interest does not account for the whole market rate of interest nor does the variation in the inflationary element account for the entire change in the market rate of interest. The economically rational person prefers present cash or liquidity to future cash. A borrower must pay a lender a rate of interest, absent inflation, sufficient to induce the lender to part with present cash (liquidity). Additionally, all borrowers (except perhaps the U.S. Government) have some probability of not being able to repay the loan when due. The probability of default is the risk element of the market rate of interest and, absent inflation, a borrower must pay a lender a rate of interest sufficient to induce the lender to accept the risk of default. The time preference element plus the risk element is what economists refer to as the real rate of interest or that rate of interest which would prevail if investors' inflationary expectations were zero. To assume the market rate of interest is offset by the rate of depreciation of real value caused by inflation is to assume, incorrectly, that the real rate of interest (time preference and risk elements) is zero.

Dr. Kirby estimates that the real rate of interest (which includes the time preference element plus the risk element of the market rate of interest) has been approximately 2.56% over the seven years preceding the publication of his article. His estimate is based on a formula that uses the market rates of interest for corporate and U.S. treasury bonds and adjusts them to arrive at a figure for the real rate of interest.

In a study for the Special Committee drafting this Act, Dr. William B. Fairley concluded that the real rate of interest, on the average, has been 1% over the period from 1960 to 1978. Dr. Fairley used one-year government bonds and 52 week treasury bills as the basis for his study. The difference between the two studies can be attributed to the main to three factors. (1) the different time periods involved in the two studies, (2) the fact that corporate bonds have maturity dates far in excess of one year and (3) the fact that corporate bonds have a greater risk of nonpayment.

The suggested figure of 3% in the Act is probably the highest figure that should be accepted, and there is substantial evidence that it should be lower.

Library References

Damages ⇨95
C.J.S. Damages § 71 et seq.

§ 11. [Effect of Death]

(a) In all cases covered by this Act in which future damages are payable in periodic instalments, the liability for payment of any instalments for medical or other cost of health care or noneconomic loss not yet due at the death of a person entitled to receive these benefits terminates upon the death of that person. The liability for payment of other instalments or portions thereof not yet due at the death of the person entitled to receive them likewise terminates except as provided in subsections (b) and (c).

(b) If, in an action for wrongful death, a judgment for periodic instalments provides payments to more than one person entitled to receive benefits for losses that do not terminate under subsection (a) and one or more but fewer than all of them die, the surviving beneficiaries are entitled to shares proportionate to their shares in the periodic instalments not yet paid, but they are not entitled to receive payments beyond the respective periods specified for them in the judgment.

(c) If, in an action other than one for wrongful death, a judgment for periodic instalments is entered and a person entitled to receive benefits for losses that do not terminate under subsection (a) under the judgment dies and is survived by one or more qualifying survivors, any periodic instalments not yet due at the death must be shared equitably by those survivors. Amounts due each survivor may not exceed the survivor's economic loss resulting from the death.

(d) "Qualifying survivor" means a person who, had the death been caused under circumstances giving rise to a [claim for relief] [cause of action] for wrongful death, would have qualified as a beneficiary at the time of the death according to the law that would be applied in an action for wrongful death by the jurisdiction under which the source of liability was resolved in entering the judgment for periodic instalments.

COMMENT

In ascertaining damages under the common law lump-sum system, the trier of fact is ill-informed as to two matters. One of these matters can be ascertained with the passage of time and the other will never be known. In permanent injury cases, it will never be known what the victim would have been like had he or she not been injured. Mere passage of time, however, will reveal what the victim will be like. The Act does not attempt to modify the damages award based on revelations with the passage of time, with one exception.

A policy decision was made to terminate any instalments not yet due upon death when representing medical or other health care costs and noneconomic loss such as pain and suffering. Even though the trier of fact is instructed to use the post injury life expectancy of the victim for these items of damages (see Section 4(b)), death may result prematurely from causes having no relation to the original injury. Since death precludes the accrual of losses for such items of damage, it was felt that these items would be a windfall to the recipient. Thus, subsection (a) provides that any instalments representing these items not yet due at death terminate.

Attorney's fees do not terminate, even though based on a contingent fee contract and paid periodically. Those fees are to be set out separately in the instalment judgment under Section 6(2)(ii) and do not represent amounts owed to the tort victim. This recognizes the common understanding that the attorney is entitled to fees when the judgment is obtained. Because the fees are owed to the attorney and does not represent damages owed to the tort victim, it does not fall within the operative provisions of this section.

As to economic loss, the trier of fact is to use the pre-injury life expectancy of the victim (see Section 4(b)). The Section provides that instalments representing these aspects of damages shall continue to be paid to certain beneficiaries with certain limitations. Subsection (b) deals with the wrongful death case. If a periodic instalment judgment provides payments to more than one beneficiary of a wrongful death cla-

and one or more, but fewer than all, of the beneficiaries die, t' viving beneficiaries succeed to the share deceased beneficiaries. The surviving ben. ies are to divide the decer 'eneficiaries' shares proportionately. H. the surviving beneficiaries are not entith receive the deceased's shares for any period longer than they are entitled to receive benefits in their own right.

Subsection (c) deals with cases other than wrongful death in which a person receives a periodic-instalment judgment, but the person subsequently dies. If there are qualifying survivors, any periodic instalments representing economic loss not yet due at the death must be shared equitably between the survivors. The survivors are not entitled to receive benefits in excess of their losses which result from the death of the judgment creditor.

The term "qualified survivors" is used to designate the recipients of these benefits under subsection (c). The wrongful death act or law of the jurisdiction whose law is dispositive of the liability issue in the action giving rise to the periodic-instalment judgment is employed to define the recipients. Thus, if the action giving rise to the periodic-instalment judgment is filed in State X, but the law of State Y governs the disposition of the liability issue, the wrongful death act or law of State Y also determines who is a "qualified survivor." This technique avoids the necessity of each state having to define the eligible recipients and adopts what would more than likely be the outcome in most states in any event under conflict of law principles. If litigation arises over eligibility to receive benefits or the amounts of benefits to be received, rights will be enforced as they otherwise would be in a wrongful death action.

The survivors described in subsection (c) also may have a cause of action under a wrongful death act or law separate and apart from the rights given to them by this Act. See Sea-Land Services, Inc. v. Gaudet, 414 U.S. 573 (1974). In this case, the Supreme Court held that the fact that the decedent had previously recovered damages for loss of wages, pain and suffering and medical expenses would not interfere with the independent cause of action for wrongful death in the survivors resulting from the same injury. The wrongful death action was not precluded by the prior recovery under the doctrine of res judicata. The potential for double liability coming from the awards to the decedent for loss of future wages and to the survivors for loss of support was held to be controlled by the law of collateral estoppel. The Act does not attempt to deal with this matter, but leaves it to be resolved und law of the adopting state regarding res a and collateral estoppel.

S consideration was given to including provisions for modifying an instalment judgment when it is learned after the verdict that the tort victim's damages are greater or worse than found at the trial. A suggested section in an early draft would have permitted a court to hold a limited number of additional hearings after a trial and to modify a judgment for future damages based upon later events affecting the judgment creditor's damages. This proposed section was eliminated from the Fifth Tentative Draft by a vote of the Committee of the Whole at the annual meeting of the Conference in 1978. It was argued there that the insurance industry could not cost its product if liability was open-ended, court congestion would be worsened, and some injured persons might be motivated to resist rehabilitation and recovery. Difficulty in determining the cause of subsequent medical and other change in the tort victim were also cited. In short, the Conference voted to abandon the suggestion because of the seemingly intractable practical problems involved.

Under the present system, the trier of fact predicts the dollar value of all future damages, reduces them to present value, and awards a verdict in a lump sum. If the victim's injuries prove to be different than as predicted, there is no remedy for either the tort victim or the judgment debtor. The undercompensated victim may have a partial remedy through resort to social programs provided for the needy which are paid for by taxpayers. On the other hand, damages paid for losses that are never suffered are clearly a windfall to someone. The cost of this windfall is generally spread among those who pay insurance premiums. In products liability cases, this cost is usually passed on to consumers. The Drafting Committee has concluded that the elimination of this windfall, which has the potential for reducing liability insurance premiums, is not unjust even though a viable solution to the problems of the undercompensated victim cannot be woven into this Act. It must not be overlooked in Section 11 that only liability for unsuffered noneconomic damages and unincurred medical and other health care costs is totally eliminated upon the premature death of a judgment creditor. Survivors may still recover portions of the unpaid future instalments to which they have a rightful claim. Moreover, the tort victim is advantaged by tax savings, inflationary adjustments, and other features of the Act. It is believed that the Act is balanced and that it fairly addresses those problems that are subject to solution without completely reforming the method by which tort victims are compensated. See *Variable Periodic Payments of Damages: An Alternative to Lump Sum Awards*, 64 Iowa Law Review 138 (1978).

If a state decides to eliminate Section 11 on the basis that neither problem should be resolved unless solutions are offered to the undercompensated victim as well as those who pay

damages that are never suffered, then it would appear that all unpaid future damages should be lump-summed and paid to survivors upon the death of each judgment creditor. To continue paying the decedent's unincurred medical expenses and noneconomic damages to survivors instalments merely ... fers the windfall ture of the payments ... carries out no d able policy.

Library References

Abatement and Revival ⇔52
C.J.S. Abatement and Revival §§ 117, 132 et seq.

§ 12. [Liability Insurance Policy Limits]

(a) In determining whether or to what extent a judgment for periodic instalm exceeds limits under a liability insurance policy, the total of the base figures calculate accordance with Section 7(a)(2) must be added to the lump-sum damages in the judgm The sum so calculated must be compared to applicable limits under the policy.

(b) If the sum calculated under subsection (a) does not exceed applicable policy lin when the judgment is entered, amounts due by reason of the adjustments required un Section 7 are entirely within those limits.

(c) If the sum calculated under subsection (a) exceeds applicable policy limits when judgment is entered, the adjustments required under Section 7 must be allocated pro tionately to amounts within and amounts in excess of those limits.

COMMENT

This Section determines how adjustments in periodic-instalment payments under Section 7 are to be applied towards liability insurance limits. It was thought best to spell this out in the Act, rather than leaving it to the insurance industry to draft policy language which may not be in the best interest of the insured or the victim, or to leave it to litigation under present policy language.

Under subsection (a), the total amount of the judgment is reduced to a lump-sum basis. This is done by taking the total of the base figures as calculated in Section 7(a)(2) and adding this figure to the amount of lump-sum damages in the judgment. The base figures are determined discounting the instalment payments in ac ance with Section 10. The sum of the discou instalment payments or base figures and lump sum damages is then compared wit policy limits. If the sum does not exceed policy limits when the judgment is entered section (b) states that all the adjustments quired under Section 7 are contained within limits. If the sum exceeds the policy limit the time the judgment is entered subsection states that the adjustments are allocated pro tionately to amounts within and amounts in cess of the limits.

Library References

Insurance ⇔512(1)
C.J.S. Insurance § 923 et seq.

ALTERNATIVE A

§ 13. [Assignment of Periodic Instalments]

An assignment of or an agreement to assign any right to periodic instalments future damages contained in a judgment entered under this Act is enforceable only as amounts

(1) to secure payment of alimony, maintenance, or child support,

(2) for the costs of products, services, or accommodations provided or to be provi by the assignee for medical or other health care, or

(3) for attorney's fees and other expenses of litigation incurred in securing judgment.

ALTERNATIVE B

§ 13. [Assig of Periodic Instalments for Costs of Medical and Other Heal Care.

ssignment of or an agreement to assign any right to periodic instalments for costs lical or other health care is enforceable only to the extent the assignment or agreement is for the costs of products, services, or accommodations provided or to be provided by the assignee for medical or other health care.

COMMENT

One of the purposes of the Act is to pay out losses periodically in the future to assure that the awards serve the purposes for which they are made. In furtherance of this purpose, this Section places limitations on the assignability of periodic instalments. Two versions are presented, both bracketed to indicate that the jurisdiction should consider adopting one or neither of the versions.

Alternative A is the most restrictive and, under it, assignments may be made only to secure familial obligations of support; to secure needed medical and related services; and to obtain legal services and pay for litigation expenses in securing the periodic-instalment judgment in question. Alternative B freely permits assignments with one exception—periodic payments for future medical expenses may not be assigned unless the assignment is for the purpose of securing medical and related services. The medical services do not have to relate to the injury, however, which produced the periodic-instalment judgment.

This Section is not meant to affect a workers' compensation insurer's right of subrogation or other similar subrogation rights whether created by a statute, contract or under the common law.

Library References

Assignments ⇐28
C J S Assignments § 41

§ 14. [Exemption of Benefits]

Periodic instalments for future damages contained in a judgment entered under this Act for loss of earnings are exempt from garnishment, attachment, execution, and any other process or claim to the extent that wages or earnings are exempt under any applicable law. [Except to the extent that they may be assigned under Section 13, periodic installments for all other future damages are exempt from garnishment, attachment, execution, and any other process or claim.]

COMMENT

This Section complements Section 13 and is based on the same policy grounds. Periodic instalments representing loss of earnings are treated as earnings are otherwise treated in the adopting state.

If Alternative A of Section 13 is adopted, periodic installments for medical and other health care costs and noneconomic losses are exempt except to the extent that they may be assigned under Section 13.

If Alternative B of Section 13 is adopted, the last sentence of Section 14 should be changed to read: "Periodic installments for medical and other costs of health care are exempt from garnishment, attachment, execution, and any other process or claim except to the extent that they may be assigned under Section 13."

If no limitation is placed on the ability to assign periodic installments for future damages, the last sentence of Section 14 should be deleted.

Library References

Exemptions ⇐33
C J S Exemptions § 27 et seq

§ 15. [Settlement Agreements and Consent Judgments]

(a) Parties to an action on a claim for bodily injury may file with the clerk of the court ich the action is pending or, if none is pending, with the clerk of a court of tent jurisdiction over the claim, a settlement agreement for future damages payable periodic installments. The settlement agreement may provide that one or more sections of this Act apply to it.

(b) Upon petition of the parties, a court of competent jurisdiction may enter a consent judgment adopting one or more of the sections of this Act.

COMMENT

This Section merely makes clear that the provisions of the Act are available to parties in fashioning settlement agreements and consent judgments. Such agreements and judgments may incorporate the provisions of this Act or adopt them by reference.

Library References

Compromise and Settlement ⇐1
Judgment ⇐72
C J S Compromise and Settlement § 1
C J S Judgments §§ 174, 175

§ 16. [Satisfaction of Judgments]

If security is posted in accordance with Section 9 and approved under a final judgment entered under this Act, the judgment is satisfied and the judgment debtor on whose behalf the security is posted is discharged.

COMMENT

In many states, a judgment when entered creates a lien on the judgment debtor's property. The Act, however, requires that security be posted under Section 9 for all the damages, past and future, due under the judgment. The security serves the same purpose as the lien and is a more suitable method of assuring payment than type of judgment. Accordingly, this Section provides that the judgment is satisfied when adequate security is posted. Since the judgment is satisfied, there is no lien created under laws of the adopting state.

Library References

Judgment ⇐690
C J S Judgment § 573

§ 17. [Duties of [Commissioner] of Insurance]

The [commissioner] of insurance shall establish rules and procedures:

(1) for determining which insurers, self-insurers, plans, or arrangements are financially qualified to provide the security required under this Act and to be designated as qualified insurers;

(2) to require insurers to post security under Section 9 if found by the court to be obligated and capable of posting security; and

(3) for publishing prior to January 1 of each year the rate of discount per annum set out in Section 7(c).

COMMENT

This Section establishes certain obligations on behalf of the insurance regulator in the adopting state. Since securing a periodic-installment judgment is crucial under this Act, the insurance regulator in the adopting jurisdiction is required to establish rules and procedures to facilitate the provision of such security and to make sure the entities providing the security are financially responsible. The insurance regulator in the adopting state is the most logical person to discharge this responsibility.

It is also the obligation of the insurance regulator to establish rules and procedures to assure that liability insurers admitted to do business in the state post security on behalf of their insureds when they are capable of doing so should not be within the power of the liability insurer to defeat the purpose of the Act and thwart the benefits under the periodic-installment judgment system flowing to the judgment creditor and judgment debtor. The insurance regulator is the best position to adopt rules and procedures to prevent abuses by liability insurers.

Finally, the insurance regulator is responsible for publishing the index factor to be used under Section 7 in making cost-of-living adjustments to unpaid installment obligations. This will facilitate the making of the adjustments by those who are obligated to do so. If a fixed cost-of-li

adjustment factor were to be adopted as explained in the Comment to Section 7, there would be no need for paragraph (3) and, in such event, it should be deleted.

Library References

Insurance ⇐4.2.
C.J.S. Insurance § 57.

§ 18. [Severability]

If any provision of this Act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of this Act which can be given effect without the invalid provision or application, and to this end the provisions of this Act are severable.

Library References

Statutes ⇐64(7).
C.J.S. Statutes § 96 et seq.

§ 19. [Repeal]

The following acts and parts of acts are repealed:

(1)

(2)

(3)

§ 20. [Time of Taking Effect]

This Act takes effect _____ and applies to actions commenced after that date.

UNIFORM PERPETUATION OF TESTIMONY

Table of Jurisdictions Wherein Act Has Been Adopted

Jurisdiction	Laws	Effective Date	Statutory Citation
Oregon		12-2-1978*	ORCP, Rule 37.

* Date of approval.

General Statutory Notes

Mississippi. The Mississippi act (Code 1972, § 13-1-227) bears some similarity to rule 27 of the Federal Rules of Civil Procedure, 28 U.S.C.A., but cannot be considered a substantial adoption of the major provisions of the uniform act.

Oklahoma. Repealed the Uniform Perpetuation of Testimony Act (12 Okl.St.Ann. §§ 538.1 to 538.13) by L.1982, c. 198, § 16.

Oregon. The Oregon Act is a substantial Uniform Act. However, it contains no comments and additional matter which is indicated by statutory notes.

UNIFORM PERPETUATION OF TESTIMONY ACT

§ 1. [Depositions Before Action]

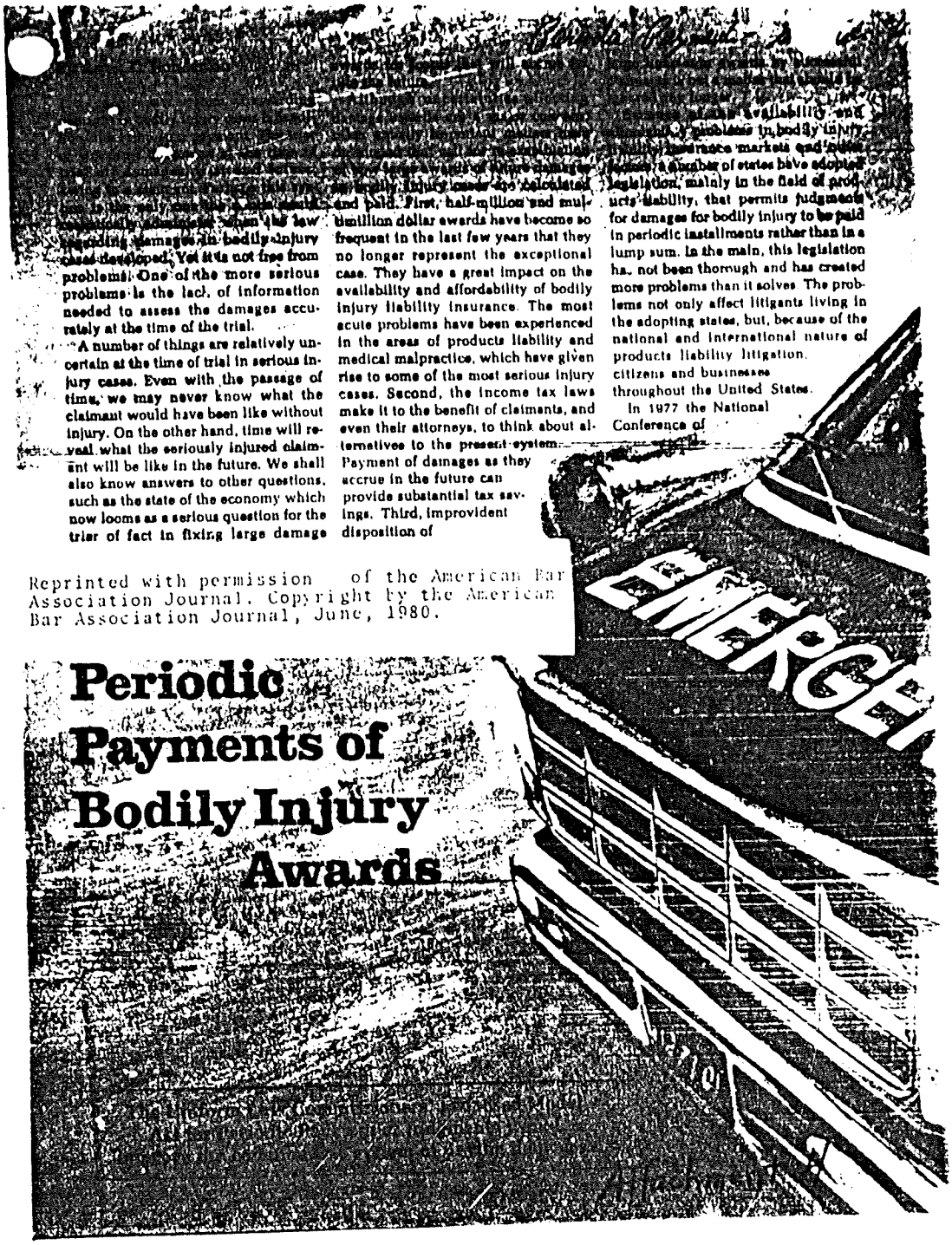
Notes of Decisions

As noted in the Commissioners' Comment in the main volume, this basically follows section (a)(1) of Rule 27 of the Federal Rules Procedure. For cases construing said rule, see Notes of Decisions under 27, Federal Rules of Civil Procedure, 28 U.S.C.A.

§ 2. [Petition, Notice and Service]

Notes of Decisions

As noted in the Commissioners' Comment in the main volume, this basically follows section (a)(2) of Rule 27 of the Federal Rules Procedure. For cases construing said rule, see Notes of Decisions under 27, Federal Rules of Civil Procedure, 28 U.S.C.A.



Periodic Payments of Bodily Injury Awards

...damages in bodily injury cases developed. Yet it is not free from problems. One of the more serious problems is the lack of information needed to assess the damages accurately at the time of the trial.

A number of things are relatively uncertain at the time of trial in serious injury cases. Even with the passage of time, we may never know what the claimant would have been like without injury. On the other hand, time will reveal what the seriously injured claimant will be like in the future. We shall also know answers to other questions, such as the state of the economy which now looms as a serious question for the trier of fact in fixing large damage ... and paid. First, half-million and multimillion dollar awards have become so frequent in the last few years that they no longer represent the exceptional case. They have a great impact on the availability and affordability of bodily injury liability insurance. The most acute problems have been experienced in the areas of products liability and medical malpractice, which have given rise to some of the most serious injury cases. Second, the income tax laws make it to the benefit of claimants, and even their attorneys, to think about alternatives to the present system. Payment of damages as they accrue in the future can provide substantial tax savings. Third, improvident disposition of ... availability and ... problems in bodily injury ... insurance markets and ... a number of states have adopted ... legislation, mainly in the field of products liability, that permits judgments for damages for bodily injury to be paid in periodic installments rather than in a lump sum. In the main, this legislation has not been thorough and has created more problems than it solves. The problems not only affect litigants living in the adopting states, but, because of the national and international nature of products liability litigation, citizens and businesses throughout the United States.

In 1977 the National Conference of ...

Commissioners on Uniform State Laws established a special committee to consider drafting an act that would change the common law system of paying damages. The committee is now in the final stage of completing the Model Act for Periodic Payment of Judgments, which provides an alternative to the system of lump-sum payment of future damages arising from bodily injury by facilitating payment over the period when the losses will accrue. At the election of any party, subject to certain safeguards, a case involving large amounts of damages to accrue in the future will be tried under this act, and when appropriate, the court will fashion a periodic installment judgment. The trier of fact, usually a jury, will fix the amount of damages under current tort law. There must be special fact findings, however, with regard to the amount of damages that will be incurred and payable in each future year. The periodic installment judgment should be fashioned accordingly. The act answers the problems left untended in legislation passed to date at the state level so that each state can tailor various parts of the legislation to its own needs.

There are advantages to both claimants and defendants, as well as to the public, in the act. A claimant's award for bodily injury is not subject to federal income tax under Section 104(a)(2) of the Internal Revenue Code, and the same rule usually prevails with regard to state income taxes. But any income earned on the award is subject to income tax. Under the present lump-sum system, awards for future damages are discounted to present value to take into account the earning power of money. A claimant is paid an amount of money now that will generate income by investment and, in turn, produce the total amount of damages awardable to the claimant. A portion of the claimant's damages thus is taxable under the lump-sum system.

Under the uniform act the entire amount of future damages owing to a claimant will be free from federal income taxation because there will be no occasion to discount to present value. In addition, if the fee of the claimant's attorney is contingent on the payment of damages for losses accruing in the future, the attorney arguably should be able to spread the income over the years in which the fees are paid. The act facilitates but does not mandate that arrangement. The attorney and client are free to contract as they choose.

Under the present system the risk of investment of large lump-sum payments for future damages is forced on the accident victim. Many claimants lack the financial expertise to handle and invest large sums of money. Services of others can be obtained, but there is always a risk of improvident investments and usually a fee is involved. Under the periodic payment scheme of this act, the defendant or the defendant's insurer will shoulder these burdens. They presumably will have easier access to sources of financial expertise and can better absorb the risks and costs involved.

Defendants also will benefit by being permitted to pay awards for future damages in periodic installments. Many defendants in personal injury cases are either large well-insured or solvent corporations or carry liability insurance. The use of annuities or similar financial arrangements to secure and pay the installments could afford savings because they are in a better position than a single claimant to secure the most advantageous arrangements. In addition, the act as now drafted contemplates that periodic installments for certain damages that never accrue will terminate on premature death of the tort victim.

The act also eliminates the guesswork and speculation involved in the lump sum system when the jury is asked to discount awards of future damages to present value and, in an increasing number of jurisdictions, predict future rates of inflation. Since damages will be paid as losses accrue, there is no need to discount to present value. With regard to inflation, the act provides for adjustments in the unpaid installments so that the damages award is not eroded by inflation.

The act leaves it to the adopting state to tailor certain provisions to meet the needs of that state. On the other hand, the problems that give rise to the need for this type of legislation in many instances are national. A model act should be the best vehicle by which to accomplish the changes contemplated. This certainly seems preferable to a solution mandated at the national level with all of its attendant problems.

Although the attempt to avoid much of the uncertainty at the trial in the lump-sum system is a goal of a periodic payment scheme, a number of the problems that plague the jury are shifted to another forum — the legislature. These problems must be addressed in drafting a statutory scheme. Several of the more difficult, not to mention controversial, problems follow.

Through the passage of time we can learn if the victim is hurt as seriously as the evidence indicates to the trier of fact at the time of trial. This would seem to call for a system that would allow for adjustments in the damages award in the future based on new information. Although the range of adjustments and the occasions can be limited to avoid an undue burden on the courts and parties, the dissipation of evidence and impinging extraneous factors on the health of the victim raise a horrible specter to the insurance industry. Placing the victim under the constant surveillance of an insurance company to determine whether there has been a change does not find favor with the plaintiffs' bar, either, not to mention the psychological aspects of rehabilitation. The insurance industry asserts that there is no way to cost the liability insurance coverage if the insurance carrier's exposure is open ended. Suggestions for limiting the number of times that a case can be reopened or

placing outside limits on the range of the modifications a court can make do not placate the insurance industry.

A similar problem arises with the premature death of the victim. Although the jury will assess damages under present tort law by using life expectancy tables, the victim may die early from a cause unrelated to the accident that gave rise to a periodic payment judgment. The insurance industry favors terminating all periodic payments not accrued, while the plaintiffs' bar is adamantly opposed. It is clear, however, that some, if not all, of the unaccrued award—for instance, future medical expenses—is a windfall to the victim's heirs if there is premature death.

For better or worse, the present draft of the model act does not allow reopening the case to permit modifying the damages award based on new information, with one exception. That exception involves the premature death of the victim. In that event any awards for medical expenses or pain and suffering that have not accrued terminate. Awards for earnings loss, however, do not necessarily terminate.

Another controversy lies in the issues with regard to inflation and discounting to present value. Courts today are being persuaded that the jury should be able to take into account fluctuations in purchasing power in the future, as difficult as that is to predict. The act contemplates that the jury will assess damages in terms of present dollar value, not taking into account inflation at the time the damages award is calculated. By paying the judgment in periodic installments in the future, there is no occasion for the jury to discount to present value either.

It is still necessary, however, if inflation is to be considered, to have some scheme for adjusting the periodic payments in the future so that the purchasing power of these payments is not diluted. Everyone agrees that adjustments for inflation must be dealt with in the act, but there is less agreement on the method. Does one use a fixed percentage or index factor or a formula that will cause the percentage to change as the economy fluctuates? The latter method has been adopted.

The act adjusts for inflation by utilizing an index factor based on the 52-week United States Treasury bill rate. This is a "floating" index factor much like the consumer price index, because interest rates reflect market expectations or predictions about inflation. When inflation is high, interest rates are high and vice versa. The reason for adopting this index factor instead of the consumer price index or some other index is that there is no annuity marketed that will take into account inflation on a fluctuating basis and guarantee the principal sum invested. Yet, it will be necessary to secure a periodic payment judgment, or the "principal," with some type of instrument such as an annuity. If this cannot be done, there is a new risk that the victim may not be paid the damage award (or principal) because the judgment debtor or liability insurer obligated to pay the judgment may become insolvent over the period in which the periodic payments are to be paid. The new type of judgment must be secured, but what will suffice?

If a fixed factor were used to adjust the payments for inflation, a standard annuity could be used as security, but a fixed factor in volatile times such as ours would not be fair to either party. In the face of the protests by the insurance industry that an annuity that would guarantee the damages award and also vary according to inflation cannot and will not be marketed, the committee adopted the rate of return for 52-week Treasury bills as the index factor. This would permit a judgment debtor or insurance company to invest in Treasury bills, thereby providing not only the security needed for the judgment but also the income needed to make the adjustments for inflation, since the rate of return on the treasury bills mirrors economic conditions.

Security against inflation is a must

While the security aspect is excellent there is a question whether this index is too conservative. At the present time the rate of inflation is exceeding interest rates in general, so that there is a negative real rate of interest. Is there a better solution to the problem? If security that will protect the victim's award and also protect against decreases in the purchasing power of the dollar cannot be provided, the periodic payment concept is in serious jeopardy.

Under the act there will be situations in which a periodic payment judgment will be commuted or "lump summed." For example, if this security should fail, the victim or judgment creditor may move the court to calculate the equivalent lump-sum value of the periodic payments and order that the judgment be paid in lump sum. In some jurisdictions the jury is not told to use a specific discount figure. Unless this leeway is to be left with the court (the jury trial already having been concluded), the act must specify a rate or, at least, a method for determining the rate. This decision could depend on the type of investment one believes is readily available to the victim. Based on economic data since World War II, the act suggests adoption of a real rate of interest of 3 per cent.

Another problem centers around whether the act should be mandatory, for example, by making it applicable to any case involving bodily injury damages in excess of a certain figure. It would serve little purpose to make the act applicable to small cases unless the parties consent, but at what level should it be mandatory for some class of cases? In lieu of a mandatory feature, would it be better to set up the framework or procedures by statute or rule of court to permit only voluntary invocation by the parties? The drafters think not and suggest that the act apply only, absent consent of all parties, to cases in which future damages for bodily injury exceed $100,000.

The Uniform Laws Commissioners debated the provisions of the act at its 1979 annual meeting in San Diego. At the urging of those who felt there needed to be more discussion and interchange with the trial bar and insurance industry, it voted to delay action until the annual meeting in 1980. The purpose of this article is to further debate.

The insurance industry says that it embraces the "concept" in the act, but not this particular act. They say the inflation factor is not workable and the discount rate is too low. The plaintiffs' bar has voiced strong opposition to the provision terminating unpaid installments on premature death, if not to the whole act, but has appeared intrigued over the idea of being able to elect such a method of payment. The drafting committee would still mean to construct [illegible] that the act is workable and that its [illegible]

(Roger C. Henderson is dean of the University of Arizona College of Law. He also is a commissioner of the National Conference of Commissioners on Uniform State Laws and was reporter to the conference's Special Committee on the Periodic Payment of Judgments Act.)

KANSAS TRIAL LAWYERS ASSOCIATION POSITION ON STRUCTURED SETTLEMENTS UNDER H.B. 2661, SECTIONS 13, 14, 15 AND 16

Background

"Structured settlements" have been utilized for a good number of years in connection with the settlement of bodily injury litigation, including actions involving medical malpractice. Ideally, this tool has worked to the advantage of claimants and/or their estates and/or heirs (by providing for receipt of future "tax free" benefits, purportedly "guaranteed", with built-in "spendthrift" protection) and defendants' liability insurance carriers (minimization of current "runaway" exposure coupled with assignment of future obligations by purchase of future benefits for a lower present premium payment). In fact, "good" structured settlements have been mutually advantageous to both sides. For example, how can an ethical plaintiff's attorney charge an "ethical fee" in a case involving structured features without knowing the cost or present value of his client's future benefits? Remember the familiar argument that knowing the premium cost will void tax-free treatment because disclosure results in "constructive receipt"? To the best of our knowledge, all Kansas "structured settlements" have been voluntary, as opposed to mandatory.

The "New Law"

House Bill No. 2661, effective July 1, 1986, however, mandates, literally and figuratively, the "structured judgment" under circumstances to be outlined below. As we will see, the law leaves much to be desired, legislatively, and fails to answer at least as many questions as it answers. Thankfully, the judgment annuity law affects only causes accruing on or after 7/1/86.

"New Sec. 13" (H.B. No. 2661, p. 8)

Preliminarily, "noneconomic loss" of each party in a medical malpractice liability action has a "cap" (upper limit) of $250,000 regardless of the number of defendants. Subject to Sec. 28, there is a further "cap" of $1,000,000 upon the total amount recoverable by each party in these cases, again regardless of the number of defendants. The jury is not to be told about these financial limitations. Comparative fault (K.S.A. 60-258a) still applies. Should the verdict be for more than $250,000 for noneconomic loss, the court enters judgment for $250,000 for all such claims.

If the verdict for "current economic loss" exceeds the difference between $1,000,000 and the award for noneconomic loss, no judgment can be entered for "future economic loss." Finally,

Attachment 5

we reach the first provision which mandates entry of judgment for the cost of an annuity contract; combining separate sentences in Sub-section (c)(3) of "New Sec. 13", we reach the

RULE: IF THE SUM OF (THE AMOUNTS AWARDED BY THE COURT FOR NONECONOMIC LOSS AND FOR CURRENT ECONOMIC LOSS) IS LESS THAN $1,000,000 AND THE VERDICT RESULTS IN AN AWARD FOR FUTURE ECONOMIC LOSS WHICH EXCEEDS THE DIFFERENCE BETWEEN $1,000,000 AND THE SUM OF (THE AMOUNTS AWARDED BY THE COURT FOR NONECONOMIC LOSS AND CURRENT ECONOMIC LOSS), THE COURT SHALL ENTER JUDGMENT FOR THE COST OF AN ANNUITY CONTRACT WHICH, TO THE GREATEST EXTENT POSSIBLE, WILL PROVIDE FOR THE PAYMENT OF BENEFITS OVER THE PERIOD OF TIME SPECIFIED IN THE VERDICT IN THE AMOUNT AWARDED BY THE VERDICT FOR FUTURE ECONOMIC LOSS, THE COST OF SUCH ANNUITY NOT TO EXCEED THE DIFFERENCE BETWEEN $1,000,000 AND THE SUM OF THE AMOUNTS AWARDED BY THE COURT FOR NONECONOMIC LOSS AND CURRENT ECONOMIC LOSS.

For some reason, damages recoverable for noneconomic loss under this section will be annually adjusted by Supreme Court Rule based upon the consumer proce index such that, in times of inflation, suffering may be worth more while the "cap" may have the effect of reducing compensation for actual economic losses, current and future, which would seem to have more to do with the consumer price index. In the alternative, will suffering be worth less (adjusted down) to attempt to fund economic losses during times of inflation? In other words, in which direction, up or down, are noneconomic loss damages going to be adjusted?

"New Sec. 13" expires on July 1, 1993, which might be the best thing which can be said for it.

"New Sec. 14" and "New Sec. 15" are not subject to the "sunset" provision found in "New Sec. 13." For reference, "New Sec. 11" through "New Sec. 16" are attached as the last page of this paper.

"New Sec. 14" (H.B. No. 2661, p. 9)

Basically, Sec. 14 requires verdict itemization of "economic loss" and "noneconomic loss." Further, "economic loss" is to be itemized to show "current economic losses" and "future economic losses." As if that is not enough, "future economic loss" must be further itemized to indicate amounts necessary for "future medical care and related benefits." If there are any "future economic losses," the verdict is to specify the period of time over which payment of such losses will be needed, apparently disregarding the fact that future loss of earnings might require an entirely different period of time than that which might pertain to the time over which "future medical care and related benefits" might be needed.

"New Sec. 15" (H.B. No. 2661, p.9)

The jury is to be told that, in reaching any verdict for "future economic loss," the verdict shall not reduce such damages to present value. As to FUTURE ECONOMIC LOSS, which is to have been broken down to show such amounts as might be necessary for "future medical care and related benefits," we reach another

RULE: THE COURT SHALL REDUCE (DAMAGES FOR FUTURE ECONOMIC LOSS) TO THEIR PRESENT VALUE AND, EXCEPT AS PROVIDED BY SECTION 13, THE COURT SHALL ENTER JUDGMENT, WITH RESPECT TO SUCH DAMAGES, FOR AN ANNUITY CONTRACT WHICH, TO THE GREATEST EXTENT POSSIBLE, WILL PROVIDE FOR THE PAYMENT OF BENEFITS OVER THE PERIOD OF TIME SPECIFIED IN THE VERDICT IN THE AMOUNT AWARDED BY THE VERDICT FOR FUTURE ECONOMIC LOSS. THE JUDGMENT SHALL INCORPORATE THE INTERVALS OF THE ANNUITY PAYMENTS, WHICH SHALL BE FIXED AND DETERMINABLE AS TO AMOUNTS AND DATES OF PAYMENTS.

Observe, if you please, that this second RULE, under Sec. 15, calls for entry of judgment "for an annuity contract," unlike the first RULE, under Sec. 13, which required entry of judgment "for the cost of an annuity contract." There is a world of difference when it comes to attempting to apply these clearly different coexisting statutes, particularly when either side might appeal the verdict, entry of judgment or both. As is well known to anyone who knows anything about structured features, the current cost of an annuity contract is influenced, often constantly, by fluctuation of interest rates and annuity premium amounts (for given future benefits) are seldom "guaranteed" to the prospective purchaser for any significant length of time.

Presumably, the trial judge certainly will require an evidentiary hearing after the verdict to enter judgment for an "annuity contract which, to the greatest extent possible, will provide for the payment of benefits...," but the truth is that the cost of such an annuity contract well might go up or down prior to the time of post-trial motions and almost certainly will go up or down, perhaps drastically, during the time required for any appeal by either side on any issue.

Sub-section (b) provides another

RULE: THE HEALTH CARE STABILIZATION FUND OR INSURER SHALL PURCHASE THE ANNUITY PROVIDED FOR IN SECTION 13 OR (SECTION 15) UPON APPROVAL OF THE COURT AND, UPON PAYMENT BY THE FUND OR INSURER OF THE COST OF SUCH ANNUITY, THE JUDGMENT WILL BE SATISFIED AS TO SUCH ANNUITY.

This third RULE is really no help, at least in my opinion, for numerous reasons. How is interest computed with regard

to an annuity contract which was never purchased because an appeal was taken? If an annuity contract was purchased which should not have been purchased as a result of determination upon appeal, what happens to it if the judgment is reversed? If, under Sec. 15, the Court enters judgment for "an annuity contract" providing specific benefits and the defense appeals and loses, is the defense obligated to provide the benefits at any cost, obligated to pay all benefits which would have accrued during the appeal time, entitled to benefit by cheaper premiums consequential to rising interest rates, or destined to suffer by higher premiums resultant from falling interest rates? Suffice to say that this limited presentation cannot pretend to answer these questions and will not attempt even to ask all the man other questions which appear obvious; the law simply ignores the fact that annuity cost is constantly variable.

Conclusion

Jointly and severally the "annuity judgment" sections of H.B. 2661 cannot be applied logically and they illogically discriminate between claimants in differing circumstances. In general, structured settlements have been and will continue to be of benefit to both injured claimants and insurance companies in the termination of medical malpractice and other kinds of negligence litigation, but these particular statutes may create more problems than they correct. It will probably be years before the Supreme Court will interpret questionable areas of the new law, and thus place both claimants lawyers and insurance defense lawyers in a position of not knowing for some time the parameters of insurance company exposure. This then in turn will greatly affect settlements on all kinds of cases that normally take place within the tort system in the malpractice area. Additionally, the Kansas Wrongful Death Statute, KSA 60-1903 with the $100,000 limit on nonpecuniary loss, also will need to be judicially interpreted along with the new sections of H.B. 2661, which seems in conflict.

Most importantly, the difference between "New Sec. 13" and "New Sec. 15" regarding the difference between the cost of an annuity contract ("New Sec. 13") ...and the extent possible will provide for the payment of benefits over the period of time specified in the verdict in the amount awarded by the verdict for future economic loss can result into differing costs for the annuity in the area of hundreds of thousands of dollars and differing benefits to the injured party in the amount of several hundreds of thousands of dollars.

Finally, the tying of Consumer Price Index as a basis for changing the allowable "cap" for pain and suffering to economic loss, while at the same time not using the Consumer Price Index for determining inflation or deflation as it

relates to economic loss, is exactly contrary to the basic economic facts in that pain and suffering by an injured person should in no way be related to inflation or deflation, but economic losses, present or future, are most certainly related to inflation and deflation.

The annuity statutes, "New Sec. 13" through "New Sec. 16" ought to be rewritten by the Legislature in H.B. 2661 and any other intended legislation to make them more understandable and more logical in their application for the benefit of all the parties.

New Sec. 11. The provisions of sections 2 through 10 shall be supplemental to K.S.A. 65-28,121, 65-28,122 and 65-4900, and amendments thereto, and shall not be construed to repeal or modify those sections.

New Sec. 12. As used in sections 12 through 16:

(a) The words and phrases defined by K.S.A. 1985 Supp. 60-3403 and amendments thereto shall have the meanings provided by that section.

(b) "Current economic loss" means costs of medical care and related benefits, lost wages and other economic losses incurred prior to the verdict.

(c) "Future economic loss" means costs of medical care and related benefits, lost wages, loss of earning capacity or other economic losses to be incurred after the verdict.

(d) "Medical care and related benefits" means all reasonable medical, surgical, hospitalization, physical rehabilitation and custodial services, including drugs, prosthetic devices and other similar materials reasonably necessary to provide medical services required due to the negligent rendering of or failure to render professional services by the liable health care provider.

New Sec. 13. (a) In any medical malpractice liability action:

(1) The total amount recoverable by each party from all defendants for all claims for noneconomic loss shall not exceed a sum total of $250,000; and

(2) subject to section 28, the total amount recoverable by each party from all defendants for all claims shall not exceed a sum total of $1,000,000.

(b) If a medical malpractice liability action is tried to a jury, the court shall not instruct the jury on the limitations imposed by this section or on the ability of the claimant to obtain supplemental benefits under section 28.

(c) In a medical malpractice liability action, subject to apportionment of fault pursuant to K.S.A. 60-258a and amendments thereto:

(1) If the verdict results in an award for noneconomic loss which exceeds $250,000, the court shall enter judgment for $250,000 for all the party's claims for noneconomic loss.

(2) If the verdict results in an award for current economic loss which exceeds the difference between $1,000,000 and the amount awarded by the court for damages for noneconomic loss, the court shall enter judgment for an amount equal to such difference for all the party's claims for current economic loss.

(3) If the sum of the amounts awarded by the court for noneconomic loss and for current economic loss is $1,000,000 or more, no judgment shall be entered for future economic loss. If the sum of such amounts is less than $1,000,000 and the verdict results in an award for future economic loss which exceeds the difference between $1,000,000 and the sum of such amounts, the court shall enter judgment for the cost of an annuity contract which, to the greatest extent possible, will provide for the payment of benefits over the period of time specified in the verdict a the amount awarded by the verdict for future economic loss, he cost of such annuity not to exceed the difference between 1,000,000 and the sum of the amounts awarded by the court for oneconomic loss and current economic loss.

(d) The limitations on the amount of damages recoverable for oneconomic loss under this section shall be adjusted annually n July 1 by rule of the supreme court in proportion to the net ange in the United States city average consumer price index r all urban consumers during the preceding 12 months.

(e) The provisions of this section shall not be construed to peal or modify the limitation provided by K.S.A. 60-1903 and endments thereto in wrongful death actions.

(f) The provisions of this section shall expire on July 1, 1993.

New Sec. 14. (a) In every medical malpractice liability action in which the verdict awards compensatory damages, the verdict shall be itemized to reflect the amounts awarded for economic loss and noneconomic loss. The amount awarded for economic loss shall be further itemized to show current economic losses and future economic losses. The amount awarded for future economic loss shall be further itemized to show amounts found necessary for future medical care and related benefits.

(b) In every medical malpractice liability action in which the verdict awards damages for future economic losses, the verdict shall specify the period of time over which payment for such losses will be needed.

New Sec. 15. (a) In any medical malpractice liability action in which the verdict awards damages for future economic loss, the verdict shall not reduce such damages to their present value and the jury shall be instructed to that effect. The court shall reduce such damages to their present value and, except as provided by section 13, the court shall enter judgment, with respect to such damages, for an annuity contract which, to the greatest extent possible, will provide for the payment of benefits over the period of time specified in the verdict in the amount awarded by the verdict for future economic loss. The judgment shall incorporate the intervals of the annuity payments, which shall be fixed and determinable as to amounts and dates of payments.

(b) The health care stabilization fund or insurer shall purchase the annuity provided for in section 13 or this section upon approval of the court and, upon payment by the fund or insurer of the cost of such annuity, the judgment will be satisfied as to such annuity.

(c) If an annuity is purchased pursuant to section 13 or this section, the annuitant shall not own, receive by assignment or otherwise have any interest in the ownership or purchase of the annuity and periodic payments made through such annuity shall not be accelerated, deferred, increased or decreased by the annuitant. If the fund or insurer assigns the annuity, the assignee shall not provide to the annuitant rights against the assignee which are greater than those of a general creditor and the assignee's obligation shall be no greater than the obligation of the assignor.

(d) Benefits paid under an annuity contrac awarded pursuant to this section or section 13 shall not be assignable or subject to levy, execution, attachment, garnishment or any other remedy or procedure for the recovery or collection of a debt, and this exemption cannot be waived.

New Sec. 16. The provisions of sections 12 through 15 shall apply only to medical malpractice liability actions which are based on causes of action accruing on or after July 1, 1986.

Sec. 28.

STATE HISTORICAL SOCIETY

(a) There is appropriated for the above agency from the state general fund for the fiscal years specified, the following:

	Fiscal Year 1986	Fiscal Year 1987
Memorial building air conditioning replacement	$3,476	
Grant to the First Black Historical Society, Wichita, Kansas		$2,000
Provided, That the state historical society shall administer and provide for the disbursement of this grant to the First Black Historical Society, Wichita, Kansas.		
Historic properties maintenance and repairs		100,000
Total	$3,476	$102,000

(b) On July 1, 1986, of the $489,957 appropriated for the above agency by section 7(a) of 1986 House Bill No. 2776 from the state general fund in the historic properties account, the sum of $2,700 is hereby lapsed.

Sec. 29.

STATE FIRE MARSHAL

(a) On July 1, 1986, the expenditure limitation established by section 3(b) of 1986 House Bill No. 2799 on the fire inspection—social security act—federal fund is hereby increased from $80,491 to No limit.

Sec. 30.

JUDICIAL BRANCH

(a) There is appropriated for the above agency from the state general fund for the fiscal year specified, the following:

	Fiscal Year 1986	Fiscal Year 1987
Administration of justice—appellate operations		$29,588
Administration of justice—district courts		424,690

[†]

(b) Expenditures shall be made by the above agency from the administration of justice—appellate operations account of the state general fund for the collection of information relating to personal injury civil litigation: *Provided*, That such information shall be disseminated as part of the annual statistical report of the supreme court in a manner which does not identify individuals involved in such litigation.

Sec. 31.

JUDICIAL COUNCIL

[†]

Attachment 6

IN THE SUPREME COURT OF THE STATE OF KANSAS

FILED
JUL 22 3 17 PM '86
CLERK APPELLATE COURTS

ORDER

As required by the Legislature (Chapter 33, Section 10(b), 1986 Session Laws of Kansas) and upon request of the Kansas Bar Association, from and after January 1, 1987 every plaintiff's attorney and every plaintiff unrepresented by counsel filing a civil action in tort in a Kansas District Court shall provide at the time of case filing and termination on forms developed for that purpose such information about the litigation as may be required by the Judicial Administrator.

Commencing with the Annual Report of the Courts of Kansas for the 1986-1987 fiscal year, the Judicial Administrator shall include as a part of each such annual report a separate section containing information on civil tort litigation in Kansas during the fiscal year in a manner which does not identify individuals involved in such litigation.

The Reporter is directed to publish this order in the July and November 1986 advance sheets of the Kansas Reports.

BY ORDER OF THE COURT this 17th day of July 1986.

ALFRED G. SCHROEDER
Chief Justice

Attachment 7

4361

Speed

COMMENTARY ON THE DOCTRINE OF PUNITIVE DAMAGES

HISTORY

The origins of the doctrine of punitive damages are deeply rooted in the history of the English common law. The purposes behind awarding such damages cannot, however, be as readily discerned. One theory asserts that the concept of punitive damages arose from a judicially perceived need to justify compensation to injured parties in cases where the courts refused to grant new trials, yet the verdict was greatly in excess of any possible monetary losses suffered. Judges, extremely reluctant to overturn a jury's verdict, began to instruct juries to utilize their collective conscience and discretion in awarding punitive damages.

With the advent of courts of equity and the Chancellor's power to grant new trials, law courts were forced to come to terms with the concept of developing standards by which to measure compensatory damages in civil actions. Yet another theory regarding the evolution of punitive damages suggests they were used to facilitate placing an injured party in the position enjoyed prior to the happening of the event which caused his injury. The premise was designed to make the plaintiff entirely whole again by reimbursement for those injuries not previously compensable under traditional theories of recovery for actual damages,

Attachment 8

such as embarrassment, hurt feelings, and other dignitary torts.

Whatever the origins of the doctrine of punitive damages, it has become equally well entrenched in the American common law. The doctrine is now embraced in all but four states: Louisiana, Massachusetts, Nebraska, and Washington.[1] Born of the idea that the same act might be both a wrong against the citizens of the state as well as a wrong against an individual, the question arose as to under what circumstances the concept of punishing a wrongdoer should enter the arena of civil actions for damages. The prevailing justification in this country has been to construe the language of punitive damages literally, and to impose them for malicious or vindictive acts, or in cases of conscious and deliberate disregard of the interests of others. The motive and conduct of the defendant in committing a wrongful act are central to the determination of whether punitive damages should attach.

It follows that the type of conduct which the awarding of punitive damages seeks to deter is actually that conduct from which society in general demands protection. Obviously, society does not demand punitive treatment for mere negligence; rather, it seeks to punish only those acts which warrant deterrence due to their outrageous nature. The Supreme Court of the State of Kansas has stated:

> Punitive damages are allowed not because of any special merit in the injured

> party's case, but are imposed to punish the wrongdoer for malicious, vindictive or willful and wanton invasion of the injured party's rights, the purpose being to restrain and deter others from the commission of like wrongs.

Woodersen v. Ortho Pharmaceutical Corp., 235 Kan. 387, 689 P.2d 1038 (1984). The rationale behind such a holding would seem to be that the damages awarded to an injured party should be commensurate with the extent of the party's injuries, and that a plaintiff should not profit from a fortuitous event. It is submitted that this is an entirely reasonable view.

THE PROBLEM

Presently virtually every tort action brought seeks punitive awards against defendants; both large and small, corporate entities as well as small enterprises and individuals. Cloaked behind the pretext of a shield, punitive damages are being wielded like a mighty sword to extract unwarranted bounty. The goal of punitive damages is to punish a defendant in much the same way as he would be in a criminal proceeding. Here, however, the resemblance ceases as the civil defendant is afforded far fewer protections than his counterpart who has been charged with a crime. In short, the civil defendant is denied the benefit of even those basic safeguards guaranteed to one facing criminal prosecution. The civil defendant may be forced to incriminate himself by testifying about his financial status so that a jury might

consider this evidence before reaching its verdict. In addition, the standard of proof necessary for imposition of punitive sanctions does not require the proving of the civil defendant's evil intent beyond a reasonable doubt. The law in Kansas provides that punitive damages may be assessed when the elements of fraud, malice, gross negligence or oppression accompany the wrongful act.[2] The law in this state, however, does not require that the burden of proof in punitive damage actions meet the evidentiary standard of beyond a reasonable doubt.[3] The standard of proof does not even meet the less stringent requirement of proof by clear and convincing evidence.

In cases involving wealthy defendants where a "deep pocket" theory of recovery is advanced, jurors are prone to consider the situation as one of risk bearing economics. The rationale is that such a defendant is better suited to bear the loss, and in the case of corporations such losses are often passed off as merely attendant to the costs of doing business. Clearly, such an attitude is likely to produce biased results in a jury's decision.

Excessive punitive damages serve no logical purpose since it is well established that punitive sanctions are only designed to deter and make an example of the wrongdoer's conduct, not to drive him into bankruptcy. As a practical matter, compensatory damages serve the purpose of restoring an injured party to his original position while causing the

wrongdoer to atone for whatever damages the fact finder recognizes as compensable.

Apparent as these criticisms may be, judges and juries are notorious for erring on the side of plaintiffs. This is especially true where they are convinced that the civil defendant is financially able to bear the loss and that an unfavorable verdict for the defendant will not cause him to suffer the stigma associated with a criminal conviction. Negative repercussions for the defendant, should he lose, are clear when taking into account the fact that many defendants rely on insurance policies to cover their liability. The problems facing businesses vis-a-vis insurability become more apparent in light of cases in which a plaintiff proceeds under a theory of vicarious liability, commonly known as the doctrine of respondeat superior. Here, the employer sits as an attractive target to bear the consequences occasioned by the tortious acts of an employee. Such a state of affairs offends traditional notions of fair play; that one should be punished excessively for the actions of another, which were neither condoned nor approved of, doubtless seems unreasonable.

SUGGESTED SOLUTIONS

At the crux of many valid criticisms of punitive damages is an inherent inertia which resists modification of doctrines though they no longer meet the ends they were

implemented to achieve. What is called for is not the abrogation of punitive damages; rather, changes in comity with current social needs and the canons of public policy. Many jurists and commentators advocate that such change is best left to the state's legislative body and not to the judiciary on a case-by-case basis. Keeping in mind that the doctrine of punitive damages, like any doctrine, is nothing more and nothing less than a tool by which to resolve problems, it should be evident that the time for change in the area of punitive damages has arrived.

If the legislature is to be the vehicle by which such reformation is to take place, we are not without the valuable assistance of some guidelines in undertaking such a task. As previously noted, five states have already taken the lead in confronting the problems presented in awarding punitive damages by rejecting the doctrine entirely.[4] Other states have sought to curb punitive damage awards by enacting statutes drafted to serve as a yardstick by which the courts may measure out reasonable punitive damage awards. Minnesota is one such state which may be looked to for guidance, the text of which is attached.[5] Section 549.20 of that state's statutes provides a workable guideline which is calculated to insure that punitive damages are awarded only in deserving cases.

Ideally, a comprehensive punitive damages statute designed to address the aforementioned problems should

contain certain elements which will provide incisive direction for the courts to follow and administer.[6] Responding to the jury's inclination to succumb to the emotional appeal of an injured plaintiff in any case involving punitive damages, a bifurcated trial should be utilized.[7] Such a trial is divided into two component parts. The first phase retains the jury as a fact finder to determine what, if any, liability should be imposed on the defendant, as well as whether punitive damages should be assessed. This approach does not deprive the jury of its basic function, but merely places restraints on a potential "runaway" jury by proceeding to a second phase of the trial should punitive damages be warranted. In this second phase, the judge would then assess the amount of the punitive damages to be awarded. This step is logical since the judge is able to call upon his experience and expertise in fixing the assessment of punitive damages.

In order to afford the civil defendant facing a punitive damage claim evidentiary safeguards against self-incrimination, no evidence of the defendant's financial status should be admissible during the first phase of the trial.[8] To further insure that the objections of awarding punitive damages are fulfilled, the reasonable doubt standard as applied in criminal proceedings should be used to create the same evidentiary burden as would be required of a prosecutor with respect to a defendant in such a proceeding.[9]

The upshot of this provision would be to require that each element in a punitive damages liability case be founded on facts proved beyond a reasonable doubt. In the alternative, even a less stringent standard of proof by clear and convincing evidence would afford the safeguard of more careful deliberation by the jury in reaching its verdict.

In keeping with the idea that a plaintiff should not prosper at the expense of a defendant found liable for punitive damages, and that such punishable conduct is in reality that from which society demands protection, the sum of the assessment of punitive damages could be divided between the state and the plaintiff.[10] It is submitted that a ratio distribution with ninety-five percent of the punitive damage award proceeds being deposited into the state's general fund and the remaining five percent awarded to the plaintiff is a reasonable distribution, best suited to carry out the objectives of punitive damages.[11] However, it has been suggested in some jurisdictions that alternative means of award distribution might be looked to. One possibility is to allow the litigants to reach an agreement as to what agencies should be recipients of punitive damage awards in lieu of the state. Another might be to present the awards to schools or noteworthy charitable organizations. In any event, some compromise can be reached while insuring that the funds are equitably disbursed in a manner consistent with good public interests.

To protect the interests of employers and their economic well being, which is greatly favored by public policy, punitive damages should not be allowed to be assessed against an employer for the acts of its employees or agents unless such acts were ratified or authorized by the employer or by a person expressly empowered to do so on the employer's behalf.[12]

CONCLUSION

It has become apparent that the role played by the doctrine of punitive damages in our legal system has evolved to a point that can scarcely be restrained. Its proliferation has progressed to such an extent that immediate intervention is warranted to preserve the vitality of its purpose. Allowed to continue on its present course, punitive damages will run roughshod over individuals and businesses alike, leaving in its wake serious economic hardships for everyone. It is respectfully urged that swift, yet thoughtful, consideration be given to reformation of the doctrine of punitive damages.

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1. Duffy, Punitive Damages: A Doctrine Which Should be Abolished, Defense Research Institute Journal, 6, (Aug. 1978).

2. Kline v. Multi-Media Cablevision, Inc., 233 Kan. 988, 666 P.2d 711 (1983).

3. PIK 2d 9.44

4. Ibid, Footnote 1.

5. Minn. Stat. §549.20 (1978).

6. H.B. 2457, 1985 Sess. (Unenacted bill).

7. H.B. 2456, 1985 Sess., §1(a).

8. H.B. 2457, 1985 Sess., §1(d).

9. H.B. 2457, 1985 Sess., §2(b).

10. H.B. 2457, 1985 Sess., §5.

11. H.B. 2457, 1985 Sess., §5.

12. H.B. 2457, 1985 Sess., §7.

Minnesota law

549.18 SECURITY FOR COSTS.

When an action is begun in the district court by a plaintiff who is committed for a crime, or is a non-resident or a foreign corporation, or when such action is brought into the district court on appeal by defendant, such plaintiff shall file a bond to the clerk, before service of summons, or in case of appeal within five days after perfecting the same, in the sum of at least $75, conditioned for the payment of all costs and disbursements that may be adjudged against him. If, after the commencement of the action or the taking of an appeal, all parties plaintiff therein become non-residents, or the sureties on the bond remove from the state or become insolvent, the court, on motion, may require such bond, or an additional bond, to be filed, conditioned as aforesaid. This section shall not apply to any action brought for the recovery of wages or claims for personal services.

History: *RL s 4355 (9488)*

549.19 NEGLECT TO FILE SECURITY; PROSECUTION OF BOND.

When any party shall commence an action without filing a bond, or fail to provide an additional bond when so required, the court, on motion of defendant, may order a stay of all proceedings in such action, or a dismissal thereof at the cost of the attorney commencing the same. When judgment is entered against any party who has given security as required, and the costs and disbursements adjudged against him remain unpaid in whole or in part for ten days, such bond may be put in suit and prosecuted to final judgment.

History: *RL s 4356 (9489)*

549.20 PUNITIVE DAMAGES.

Subdivision 1. Punitive damages shall be allowed in civil actions only upon clear and convincing evidence that the acts of the defendant show a willful indifference to the rights or safety of others.

Subd. 2. Punitive damages can properly be awarded against a master or principal because of an act done by an agent only if:

(a) the principal authorized the doing and the manner of the act, or

(b) the agent was unfit and the principal was reckless in employing him, or

(c) the agent was employed in a managerial capacity and was acting in the scope of employment, or

(d) the principal or a managerial agent of the principal ratified or approved the act.

Subd. 3. Any award of punitive damages shall be measured by those factors which justly bear upon the purpose of punitive damages, including the seriousness of hazard to the public arising from the defendant's misconduct, the profitability of the misconduct to the defendant, the duration of the misconduct and any concealment of it, the degree of the defendant's awareness of the hazard and of its excessiveness, the attitude and conduct of the defendant upon discovery of the misconduct, the number and level of employees involved in causing or concealing the misconduct, the financial condition of the defendant, and the total effect of other punishment likely to be imposed upon the defendant as a result of the misconduct, including compensatory and punitive damage awards to the plaintiff and other similarly situated persons, and the severity of any criminal penalty to which the defendant may be subject.

History: *1978 c 738 s 4*

Attachment 9

Punitive Damages:

BY STEPHEN DANIELS

The preliminary findings of the American Bar Foundation's research indicate that punitive damage awards are not routine. They are not, typically, given in amounts that boggle the mind. Table 1 reports some of the preliminary findings. It presents the total number of reported verdicts and the number and percentage of cases in which the plaintiff won money. It also shows the number and percentage of verdicts in which a money award included a punitive award.

In none of the jurisdictions studied did even one-quarter of the cases in which the plaintiff was successful include an award for punitive damages. In the 32 sites reported on Table 1, the percentage of verdicts with money awards that included punitive damages ranged from 0 percent in four sites to 21.6 percent in Cobb County, Ga. (near Atlanta). For two-thirds of the sites, less than 10 percent of the awards included punitive damages.

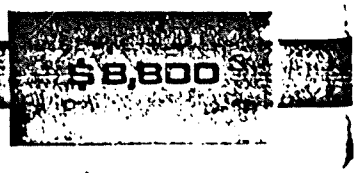
The highest percentages of punitive awards were in Fulton, DeKalb and Cobb counties (metropolitan Atlanta); Maricopa County (Phoenix, Ariz.); Harris County (Houston); and Brown County (Green Bay, Wis.). More than 13 percent of the money awards in each of these jurisdictions included a punitive award.

Four other sites had percentages higher than 10 percent: Dane (Madison) and Racine counties in Wisconsin; and Alameda (Oakland) and Sacramento counties in California. Interestingly, the punitive damages percentages for the jurisdictions with the three largest cities in the country were relatively low: 1.6 percent in New York City, 2.2 percent in Cook County, Ill., and 8.6 percent in Los Angeles County, Calif.

CAUSES OF ACTION

A more important question deals with the incidence of punitive damages in different causes of action. As a part of the research now underway, a detailed analysis has been done on seven of the sites: Cook County, New York City, Los Angeles County, San Diego County, Fulton County, Harris County and Maricopa County.

Among other things, this analysis shows that product liability and medical malpractice, which figure so prominently in discussions of the crisis, did not make up particularly large proportions of the reported verdicts at any of



Median Awards for Reported Money Verdicts

Stephen Daniels is a project director for the American Bar Foundation. He has a doctorate in political science.

Attachment 10

The Real Story

the sites. Product liability cases accounted for less than 5 percent of all reported verdicts at all sites except Los Angeles County, where the percentage was 9.6 percent. Medical malpractice cases accounted for less than 10 percent of reported verdicts in all sites except Los Angeles County (10.9 percent) and New York City (16.1 percent).

Punitive damages were not routine across all causes of action. The higher percentages of punitive awards were clustered, typically, in a small set of causes of action: personal violence, fraud, false arrest and insurance bad faith. For each of these causes of action, at least 20 percent of the dollar awards in four of the seven jurisdictions included a punitive award.

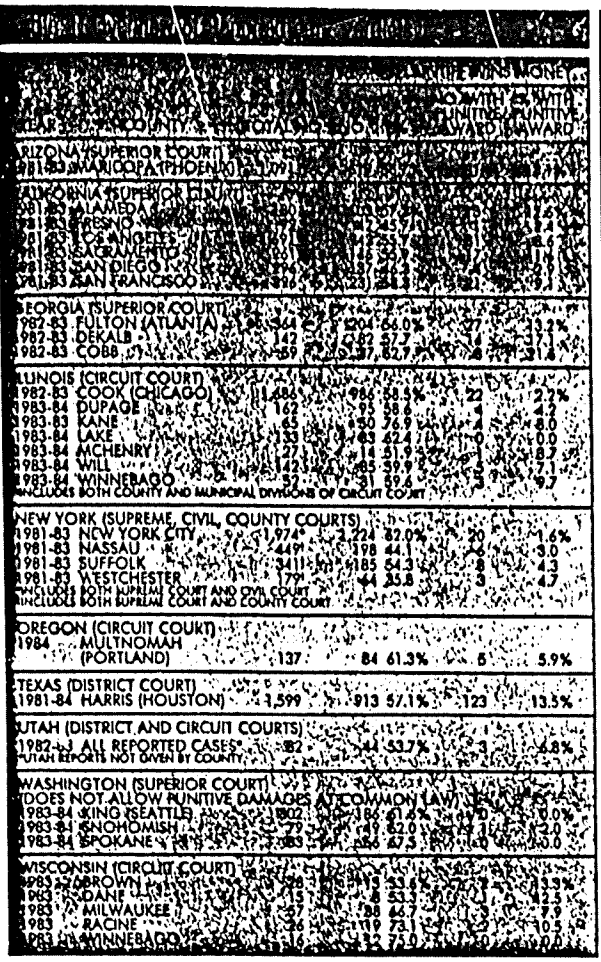
Cases in which fraud or false arrest were proven were the most likely to result in a punitive award. For each of these two categories, at least 20 percent of the dollar awards in five of the sites included a punitive award, and fraud cases accounted for the largest number of punitive awards overall.

These four causes of action—personal violence, fraud, false arrest and insurance bad faith—are ones in which we might logically expect to find higher percentages of punitive awards. Most states require that bad faith, fraud, willful misconduct, malice, oppression, or the like be proven before an award of punitive damages is allowed.

Punitive damages appeared more sporadically in other types of cases, as we also might expect. Interestingly, punitive damages were not often awarded in product liability or medical malpractice cases. In fact, it was relatively rare for plaintiffs to win any kind of award in those two areas.

SIZE OF AWARDS

Table 2 presents medians for all dollar awards as well as medians for punitive awards. I intentionally have not used averages as a measure for awards because averages are strongly influenced by the small number of high awards, which makes them a poor measure of central tendencies. A "median award" means that half the



cases had lower awards than the median and that half had higher awards.

To illustrate the distortion introduced by using averages, we need look only at Cook County. The average award for the reported verdicts in which the plaintiff won money was $137,350, but 87.7 percent of the cases had awards lower than the average. The median award was $8,800.

Median awards for reported money verdicts ranged from $8,800 in Cook County to $100,000 in New York City. Only New York City and Los Angeles County ($69,000) had medians in excess of $50,000, while San Diego County's was $50,000. For the two California counties, however, only verdicts from the superior court are covered. In the years covered by the study, this court generally heard only cases in which the amount in controversy was in excess of $15,000.

Cases involving lower amounts typically went to the municipal court, and data from that court are not presently available. In addition, superior court cases under $25,000 may well have gone to arbitration, especially in Los Angeles County. The New York City data, on the other hand, include both the supreme court (the rough equivalent of the California superior court) and the civil court (the rough equivalent of California municipal courts).

Consequently, the California medians are likely to be higher than they would be if both the superior and municipal courts were included. And, since the New York City median does include the lower civil court, it is high, relative to the others. The remaining four sites each had medians below $20,000.

Median punitive damages awards also varied considerably, but were not uniformly high. They ranged from $14,000 in Cook County to $244,050 in San Diego County, although there were only four punitive damage cases in San Diego. The next highest median was $87,500 in Los Angeles County, and again we must assume that this figure would be lower if the municipal courts were included.

No other site had a median punitive damage award higher than

$25,000, and only two were higher than $20,000: New York City ($25,000) and Harris County ($24,100). The remaining two sites had medians below $20,000: Maricopa County ($16,200) and Fulton County ($16,000).

Generally speaking, huge jury awards are not a single, ominous storm engulfing the entire country. The variation in medians, however, suggests that there may be some inclement weather on the map—around New York City for awards generally but not for punitive awards specifically; and around Los Angeles for awards generally and for punitive awards.

But in other sites, particularly Cook, Harris, Fulton and Maricopa counties, the medians for all dollar awards as well as for punitive awards certainly were not of the magnitude that boggles the mind. Interestingly, the three sites with the highest percentages of punitive damage awards—Harris, Fulton and Maricopa counties—had three of the four lowest medians for punitive awards, and all were below $25,000.

PATTERNS

As different types of cases had different patterns with regard to the incidence of punitive awards, they also had different patterns with regard to the size of punitive awards. For instance, product liability cases were not, relatively speaking, that likely to lead to punitive awards.

In fact, plaintiffs were not likely to win at all in these cases (in only one site, New York City, did plaintiffs win even half of these cases—56.3 percent). But when a plaintiff did win and received a punitive damage award, he or she was likely to win a large amount of money.

In the seven sites there were a total of 11 reported product l. bility cases with punitive damage awards, and eight had total awards (compensatory, punitive and specials) of $1 million or more. A similar pattern was found with medical malpractice. In none of the seven sites did even half of the medical malpractice plaintiffs win, and those who did rarely received punitive damages. When punitive damages were awarded, however, half had total awards of $1 million or more.

Fraud cases, on the other hand, tended to have high percentages of reported verdicts in which plaintiffs won. As might be expected, they also resulted in a much higher percentage of punitive awards. But these cases were not likely to receive very high awards. Overall, fraud cases represented the largest total number of punitive damage cases in the seven sites. There were 65, but only eight (12.3 percent) had awards of $1 million or more.

This suggests that the kinds of cases drawing the most attention because of the size of their awards did not constitute large percentages of all reported verdicts. They were less likely to result in awards for plaintiffs, and they were less likely to include punitive awards. The causes of action that were likely to see higher percentages of plaintiffs' verdicts or higher percentages of punitive awards also were more likely to have fewer big awards and lower awards generally. Hence, they draw less attention.

In other words, there may be two punitive damage systems at work. One for the few highly visible mega-cases in areas like malpractice or product liability, and another for the more common and less visible areas that are more likely to see plaintiffs win money and receive punitive awards, but in much lower amounts.

Much discussion, of course, has been based on the highly visible but highly unusual mega-cases rather than on the more typical cases. Consequently, that discussion has been somewhat distorted, and we should be skeptical of the demands for sweeping reforms emanating from it.

The material presented here is from a large-scale research project still very much in progress. Nonetheless, these preliminary findings are sufficient to call into question many of the claims about the incidence and magnitude of punitive damages. Punitive damages are not, at least in the sites examined, routine. Nor are they awarded in amounts that boggle the mind. Higher percentages of verdicts with punitive awards appeared in only a few sites, and even there the median punitive awards were relatively low.

Punitive damages appear to be clustered in certain types of cases, as might be expected given the purposes of and requirements for punitive damages. Extremely high awards do not appear to be the norm, and the few high awards that do occur tend to appear in only a handful of causes of action in which plaintiffs are not likely to be successful.

When we think of problems in the civil justice system, it is perhaps more sensible to think not of a single, massive storm about to engulf the entire country, but of a weather map depicting different climatic conditions and meteorological events. Some conditions may be inclement, but others may be quite comfortable. If there are problems, they are likely to be in particular types of cases in particular locales, and any reforms or changes in the civil system should reflect this. ■

Table 2: Median Awards for Selected Sites

YEAR	COUNTY	OVERALL MEDIAN	PUNITIVE MEDIAN
1982-83	COOK, IL	$ 8,800 (N=986)	$ 14,000 (n=32)
1981-84	HARRIS, TX	$ 33,000 (N=213)	$ 24,100 (n=123)
1982-83	FULTON, GA	$ 17,500 (N=204)	$ 16,000 (n=27)
1981-83	MARICOPA, AZ	$ 17,000 (N=619)	$ 16,200 (n=81)
1981-83	NEW YORK CITY, NY	$100,000 (N=1,924)	$ 25,000 (n=20)
1981-83	SAN DIEGO, CA	$ 80,000 (N=137)	$ 244,050 (n=4)

N=TOTAL NUMBER OF VERDICTS WHERE PLAINTIFF WINS MONEY
n=TOTAL NUMBER OF VERDICTS WHERE PLAINTIFF WINS PUNITIVE AWARD

Hointaber.

KANSAS TRIAL LAWYERS ASSOCIATION POSITION PAPER

PUNITIVE DAMAGES

Mr. Chairman, Members of the Committee:

The subject of punitive damages produces controversy and an interesting tension between the association of lawyers representing defendants on one side and lawyers representing plaintiffs on the other. In 1976 the Kansas Association of Commerce and Industry spearheaded a five year drive to restrict product liability claims, with curtailment of punitive damages, an important theme in its legislative proposal. The Legislature did adopt a products liability bill effective July 1981 and in doing so, rejected the proposed restriction on punitive damages. Therefore, clearly, punitive damages must be viewed as a part of a continuum and not as a new idea whose time has come. A couple of years ago Farmers Insurance Group, a large insurance company based primarily in Los Angeles, California, with offices nationwide, decided to "target" 24 states and wrote a "model statute" which was disseminated to

Attachment II

favorable organizations and parties in the 24 states. Kansas was one of those states and the bill was introduced into the Kansas Legislature basically in its original form as written by Farmers Insurance Group in 1984. The highlights of the bill, as I am sure all recall, limited punitive damages, shifted the burden of proof, required that the plaintiff prove the facts upon which punitive damages verdict is granted beyond a reasonable doubt, limiting the amount of punitive damages award that the plaintiff receives and instead channeling them to the State and other limits.

In response to that proposed bill, the Kansas Bar Association established a panel to look into the punitive damage issue. This panel carefully examined punitive damages in the State of Kansas and as a result of the panel recommendation, the Kansas Bar Association, made up of all members of the Kansas Bar, plaintiff and defense attorney alike, voted to recommend no change in the Kansas law relative to punitive damages.

Punitive damages in the State of Kansas may only be assessed when a party's conduct is found by a jury or other trier of fact to be willful, intentional or reckless. If punitive damages in the State of Kansas were abolished or greatly restricted, the only real winner would be persons or corporations or other wrong doers who commit intentional, willful or reckless acts, thereby injuring another party. It has been argued and suggested that awards threathen the financial health of certain corporations. However, this fear is more imagined than real. A recent issue of the American Bar Association Journal relates the experience with a defective drug produced by Merrell Dow known as MER-29. Apparently the corporation knew the drug caused cataracts and marketed it anyway deciding that the cost of paying victims and defending suits would be less than the amount of money they could make by selling the drug. Of the thousand cases only 11 went to trial, 7 of which were won by plaintiffs. Of the 7, 3 juries awarded punitive damages. One of those was reversed on appeal and two others were upheld

after the trial court reduced the amount of punitive damages by a court ordered remitter. In total the company paid one million dollars in punitive damages for conduct found to be reckless.

I think it goes without saying that corporations are motivated by profit. Some manufacturers may well decide to market defective products if the down side risk for doing so is eliminated. As an example, the asbestos industry knew of the risks of inhalation of asbestos for many years, and, in fact, that risk has been known since the turn of the century and yet the substance was marketed, produced and placed in buildings all over the country without proper warning of the risk and further the asbestos workers worked in factories without proper venilation or masking even though the companies knew of the risks of asbestosis and eventual death by cancer. Perhaps the greatest example of companies deciding to market products knowing their defective nature is the Ford Pinto. In that case the Ford Motor Company had an internal memo clearly indicating the position of the gas tank on the Pinto

created an unreasonable risk in the case of a rear end collision. The company made a conscious decision to continue to market the car because they figured the cost of paying victims of horrible burn injuries and death would be less than the money they could make by selling the pinto. This was evidenced by the famous "let them burn" letter introduced in litigation against the Pinto.

So, the premise can be made that punitive damages serve society as a deterrent against companies placing on the market products which they know are dangerous and defective and nevertheless decide to market the product with the profit motive in mind rather than safety of the consuming public.

Kansas law already provides for many safeguards against the award of excessive punitive damages and against the filing of claims for punitive damages without "probable cause". The Judge, of course, always has the opportunity to review a punitive damages award and order a remitter or grant judgment NOV (not withstanding the verdict) in favor

of a person against whom punitive damages have been awarded. Kansas law provides for an award of attorney fees and costs for an attorney filing a frivolous lawsuit without probable cause and further, the Disciplinary Administrator of the State of Kansas may act against an attorney who files frivolous lawsuits on a regular basis. Such action may take the form of suspension by censure or disbarment. Kansas law provides that punitive damages may not be awarded unless the plaintiff is also awarded concurrently therewith, compensatory or actual damages. Punitive damages may not be awarded in a wrongful death action nor may they be awarded in a contract case unless there is an independent tort proven and found by the jury or unless fraud is shown. Further, under Kansas law there is no cause of action recognized in the State of Kansas for the tort of "bad faith" by an insurance company and therefore insurance companies are not subject to some of the problems they have had in other states for bad faith failure to pay claims or bad faith failure to settle a case.

Questions have been raised as to whether or not punitive damage awards should go to the "victim" or to a state fund. The argument is made that inasmuch as punitive damages are not intended to compensate a victim but rather act as a deterrent to the defendant and others from continuing with their reckless or willful misconduct. Unfortunately, this argument was carried to its extreme by the proposed legislation drafted by Farmers Insurance Group limiting the amount of recovery to a "victim" of punitive damages awards to 5%. Clearly, the intent of the proposed legislation was to emasculate the system by making it economically impossible for a plaintiff and his or her attorney to prosecute the punitive damage portion of the case. If the basic premise that punitive damages deter willful and reckless misconduct is correct, then a law which restricts recovery to a plaintiff of 5% of the award totally undermines that proposition. Furthermore, one cannot logically equate a criminal fine with a punitive damages award. To do so mixes the two areas of law (civil and criminal) together which was never the

intent of the common law. In a criminal case the state or political subdivision is in fact the "victim" from a strictly legal perspective. The victim of a civil wrong is in fact the plaintiff and the plaintiff is entitled to recover for negligence and willful and reckless wrongdoings by a defendant just as the state is entitled to recover a fine in a criminal case as the technical victim of the crime. By making it absolutely economically unsound for a plaintiff and plaintiff's attorney to bring a lawsuit for punitive damages, the proponents of legislation which would limit the amount of punitive damages recovered by the plaintiff to a small percentage, effectively seek to undermine the entire system. Surely no plaintiff or plaintiff's attorney is going to bring a punitive damage action when all the recovery goes into a state fund with nothing to pay the costs of the lawsuit, court costs and attorney fees.

The potential for over-punishment of a defendant has been reduced by responsible and effective judicial control. Although an occasional

case may arise in which excessive damages are awarded, the benefits of the present system clearly outweigh the risk.

The discretion of the jury to award punitive damages in certain cases is firmly established in our common law and should not be tampered with.

STATE BY STATE ANALYSIS: PUNITIVE DAMAGES
(2/08/84)

STATE	COMMON LAW?	STATUTE ONLY?	PURPOSES	CITATIONS AND COMMENTS
AL	Yes	No	Punishment, deterrence (of def. & others)	Trahan v. Cook, 288 Ala. 704, 265 So.2d 1256 (1972). Allowed in wrongful death actions, General Tel. Co. of Alabama v. Cornish, 291 Ala. 293, 280 So.2d 541 (1973).
AK	Yes	No	Deterrence of others	Alaska Placer Co. v. Lee, 553 P.2d 54 (Alaska 1976). Not allowed in wrongful death actions, Linge's Administrator v. Alaska Treadwell Co., 3 Alaska 9 (1906).
AZ	Yes	No	Punishment, deterrence of others	Nielson v. Flashberg, 104 Ariz. 335, 419 P.2d 514 (1966). Allowed in wrongful death actions, Boies v. Cole, 99 Ariz. 198, 407 P.2d 917 (1965).
AR	Yes	No	Punishment, deterrence (of def. and others)	Ray Dodge, Inc. v. Moore, 251 Ark. 1036, 479 S.W.2d 518 (1972). Allowed in wrongful death actions, Mode v. Barnett, 235 Ark. 641 361 S.W.2d 525 (1962).
CA	Yes	No	Punishment, deterrence (of def. and others)	Beebe v. Pierce, 185 Cal. 34, 521 P.2d 1263 (1974). Not allowed in wrongful death actions, Doak v. Superior Court of Los Angeles, 257 Cal. App. 2d 825, 65 Cal. Rptr. 193 (1968).
CO	Yes	No	Punishment, deterrence (of def. and others)	Colo. Rev. Stat. 13-21-102. Not allowed in wrongful death actions, Mangus v. Miller, 35 35 Colo. App. 335, 535 P.2d 219 (1975).
CT	Yes	No	Compensation	Collend v. New Canaan Water Co., 155 Conn. 477, 234 A.2d 825 (1967).

STATE BY STATE ANALYSIS: PUNITIVE DAMAGES
(2/08/84)

DE	Yes	No	Punishment	Riegl v. Aastad, 272 A.2d 715 (Del. 1970). Not allowed in wrongful death actions, Mayer v. Rose, 405 A.2d 143 (Del. Super. 1979).
DC	Yes	No	Punishment, deterrence (of def. and others)	Harris v. Wagshal, 343 A.2d 283 (D.C. App. 1975); Huber v. Teuber, 3 MacArth. 484 (D.C. 1879). Not allowed if subject to criminal prosecution. Not allowed in wrongful death actions, Runion v. District of Columbia, 463 F.2d 1319 (D.C. Cir. 1972).
FL	Yes	No	Punishment, deterrence (of def. and others)	Campbell v. Government Employees Ins. Co., 306 So.2d 525 (Fla. 1975). Allowed in wrongful death actions, Martin v. United States Security Services, Inc., 314 So.2d 765 (Fla. 1975).
GA	Yes	No	Compensation or deterrence of def.	Johnson v. Morris, 158 Ga. 403, 123 S.E. 707 (1924); Westview Cemetery, Inc. v. Blanchard, 234 Ga. 540, 216 S.E.2d 776 (1975). Not allowed in wrongful death actions, Foescher v. Lehigh Acres Development, Inc., 125 Ga. App. 420, 188 S.E.2d 154 (1972).
HI	Yes	No	Punishment	Lauer v. Young Men's Christian Ass'n of Honolulu, 57 Haw. 390, 557 P.2d 1334 (1976). Not allowed in wrongful death actions, Greene v. Texeira, 54 Haw. 231, 505 P.2d 1169 (1973).
ID	Yes	No	Deterrence (of def. and others)	Jolley v. Puregro Co., 94 Idaho 712, 496 P.2d 939 (1972). Allowed in wrongful death actions, Gavica v. Hanson, 101 Idaho 58, 608 P.2d 861 (1980).
IL	Yes		Punishment, deterrence (of def. and others)	Mattyasovszky v. West Town Bus Co., 61 Ill.2d 31, 33 N.E.2d 509 (1975). Not allowed in wrongful death actions, id.

STATE BY STATE ANALYSIS: PUNITIVE DAMAGES
(2/08/84)

IN	Yes	No	Compensation	Hibschman Pontiac, Inc. v. Batchelor, 266 Ind. 310, 362 N.E.2d 845 (1977); Taber v. Hutson, 5 Ind. 322 (1854). Not allowed if subject to criminal prosecution, unless (1) the conduct of the def. indicates a heedless disregard of the consequences, (2) the statute of limitations on the criminal charge has run, or (3) in an action against a corporation, the corporation can not be criminally prosecuted for the act of the agent.
IA	Yes	No	Punishment, deterence of others	Pringle Tax Service, Inc. v. Knoblauch, 282 N.W.2d 151 (Iowa 1979). Allowed in wrongful death actions, Koppinger v. Cullen-Schlitz & Associates, 513 F.2d 901 (8th Cir. 1975).
KS	Yes	No	Punishment, deterrence (of def. and others)	Newton v. Hornblower, Inc., 224 Kan. 506, 582 P.2d 1136 (1978); Henderson v. Hassur, 225 Kan. 678, 594 P.2d 650 (1979). Not allowed in wrongful death actions, Atchison T. & S.F. Ry. Co. v. Townsend, 71 Kan. 524, 81 P. 205 (1905).
KY	Yes	No	Punishment, deterrence (of def. and others)	Bisset v. Goss, 482 S.W.2d 71 (Ky. 1972). Allowed in wrongful death actions, Ky. Rev. Stat. Ann., 411.130, 411.150.
LA	No	Yes		McCoy v. Arkansas Natural Gas Co., 175 La. 487, 143 So. 383 (1932), cert. den. 287 U.S. 661 (1932).
ME	Yes	No	Deterrence	Foss v. Maine Turnpike Authority, 309 A.2d 339 (Me. 1973). Not allowed in wrongful death actions, Dostie v. Leviston Crushed Stone Co., 136 Me. 284, 8 A.2d 393 (1939).

STATE BY STATE ANALYSIS: PUNITIVE DAMAGES
(2/08/84)

MD	Yes	No	Punishment, deterrence (of def. and others)	Wedeman v. City Chevrolet Co., 278 Md. 524, 366 A.2d 7 (1976). Not allowed in wrongful death actions, Smith v. Gray Concrete Pipe Co., Inc., 267 Md. 149, 297 A.2d 721 (1972).
MA	No	Yes		City of Lowell v. Massachusetts Bonding & Insurance Co., 313 Mass. 257, 47 N.E.2d 265 (1943). Allowed in wrongful death actions, Mass. Gen. Laws Ann. ch 229, sect. 2.
MI	Yes	No	Compensation	Wise v. Daniel, 221 Mich. 229, 190 N.W. 746 (1922). Not allowed in wrongful death actions, Currie v. Fiting, 375 Mich. 440, 134 N.W.2d 611 (1965).
MN	Yes	No	Punishment, deterrence	Kirschbaum v. Lowrey, 171 Minn. 233, 206 N.W. 171 (1925). Not allowed in wrongful death cases, Hutchins v. St. Paul M. & M. Ry. Co., 44 Minn. 5, 46 N.W. 79 (1890).
MS	Yes	No	Punishment, deterrence of others	Standard Life Ins. Co. of Indiana v. Veal, 354 So.2d 239 (Miss. 1979). Allowed in wrongful death actions, Sandifer Oil Co. v. Drew, 220 Miss. 609, 71 So.2d 752 (1954).
MO	Yes	No		State ex rel. Smith v. Greene, 494 S.W.2d 55 (Mo. 1973). Allowed in wrongful death actions, Glick v. Ballantine Produce, Inc., 396 S.W.2d 609 (Mo. 1965).
MT	Yes	No	Punishment, deterrence (of def. and others)	Mont. Rev. Codes Ann. 27-1-221. Allowed in wrongful death actions, Gagnier v. Curran Const. Co., 151 Mont. 468, 443 P.2d 894 (1968).
NE	No	No		Abel v. Conover, 170 Neb. 926, 104 N.W.2d 684 (1960). It

				seems likely that any statutory attempt to provide for punitive damages would be struck down as in violation of the Nebraska state constitution. Neb. Const. art. VII, sect. 5. Not allowed in wrongful death actions, Miller v. Kingsley, 194 Neb. 123, 230 N.W.2d 472 (1975).
NV	Yes	No	Punishment, deterrence (of def. and others)	Nev. Rev. Stat. 42.010 Allowed in wrongful death actions, Porter v. Funkhouser, 79 Nev. 273, 382 P.2d 216 (1963).
NH	Yes	No	Compensation	Fay v. Parker, 53 N.H. 342 (1872). Not allowed if subject to criminal prosecution. Not allowed in wrongful death actions, Kennett v. Delta Airlines, Inc., 560 F.2d 456 (1st Cir. 1977).
NJ	Yes	No	Punishment, deterrence of def.	Sandler v. Lawn-A-Mat Chemical & Equipment Corp., 141 N.J. Super 437, 358 A.2d 805 (1976). Not allowed in wrongful death actions, Kern v. Kogan, 93 N.J. Super. 459, 226 A.2d 186 (1967).
NM	Yes	No	Punishment, deterrence (of def. and others)	Christmas v. Voyer, 92 N.M. 772, 595 P.2d 410 (1979). Allowed in wrongful death actions, N.M. Stat. Ann. 41-2-1, 41-2-3.
NY	Yes	No	Punishment, deterrence (of def. and others)	Garrity v. Lyle Stuart, Inc., 40 N.Y.2d 354, 386 N.Y.S.2d 831, 353 N.E.2d 793 (1976). Not allowed in wrongful death actions, Kollin v. Shaff, 79 Misc.2d 49, 359 N.Y.S.2d 515 (1974).
NC	Yes	No	Punishment, deterrence of others	Newton v. Standard Fire Ins. Co., 291 N.C. 105, 229 S.E.2d 297 (1976). Allowed in wrongful death actions, N.C. Gen. Stat. 28A-18-2(b)(5).

ND	Yes	No	Punishment, deterrence (of def. and others	N.D. Cent Code 32-03-07. Not allowed in wrongful death actions, Hyyti v. Smith, 67 N.D. 425, 272 N.W. 747 (1937).
OH	Yes	No	Punishment, deterrence of others	Arnold v. Wylie, 25 Ohio App. 10, 157 N.E. 571 (1927). Not allowed in wrongful death actions, Rubeck v. Huffman, 54 Ohio St. 2d 20, 374 N.E.2d 411 (1978).
OK	Yes	No	Punishment, deterrence (of def. and others)	Okla. Stat. Ann. tit. 23, sect. 9. Allowed in wrongful death actions, O.S.A. tit. 12, sect. 1053(c).
OR	Yes	No	Deterrence	Lewis v. Devil's Lake Rock Crushing Co., 274 Ore. 293, 545 P.2d 1374 (1976). Allowed in wrongful death actions, Ore. Rev. Stat 30.020(2)(e).
PA	Yes	No	Punishment, deterrence (of def. and others)	Esmond v. Liscio, 209 Pa. Super. Ct. 200, 224 A.2d 793 (1966). Not allowed in wrongful death actions, Palmer v. Philadelphia, B. & W.R. Co., 218 Pa. 114, 66 A. 1127 (1907).
RI	Yes	No	Deterrence	Norel v. Gorchowski, 51 R.I. 376, 155 A. 357 (1931).
SC	Yes	No	Punishment, deterrence (of def. and others)	Hicks v. Herring, 246 S.C. 429, 144 S.E.2d 151 (1965). Allowed in wrongful death actions, section 15-51-40, Adams v. Hunter, 343 F. Supp. 1284 (D. S.C. 1972).
SD	Yes	No	Punishment, deterrence (of def. and others)	S.D. Comp. Laws Ann. 21-3-2. Not allowed in wrongful death actions, Anderson v. Lale, 88 S.D. 111, 216 N.W.2d 562 (1974).
TN	Yes	No	Punishment, deterrence (of def and others)	Huckeby v. Spangler, 563 S.W.2d 555 (Tenn. 1978). Allowed in wrongful death actions, Pratt v. Duck, 28 Tenn. App. 502, 191 S.W.2d 562 (1945).

STATE BY STATE ANALYSIS: PUNITIVE DAMAGES
(2/08/84)

TX	Yes	No	Punishment, deterrence of others	Sheffield Div. Armco Steel Corp. v. Jones, 376 S.W.2d 825 (Texas 1964). Allowed in wrongful death actions, Tex. Const. art. 16, sect. 26; Tex Stat. Ann. art. 4673.
UT	Yes	No	Deterrence (of def. and others)	Nash v. Craigco, Inc., 585 P.2d 775 (Utah 1978). Not allowed in wrongful death actions, Platis v. United States, 288 F. Supp. 254 (D. Utah 1968).
VT	Yes	No	Punishment, deterrence (of def. and others)	Goldsmith's Administrator v. Joy, 61 Vt. 488, 17 A. 1010 (1889).
VA	Yes	No	Punishment, deterrence of others	FBC Stores, Inc. v. Duncan, 214 Va. 246, 198 S.E.2d 595 (1973) Allowed in wrongful death cases, HB 135, eff. 7/1/82.
WA	No	Yes		Spokane Truck & Dray Co. v. Hoefer, 2 Wash. 45, 25 P. 1072 (1891). Not allowed in wrongful death cases, Skidmore v. City of Seattle, 128 Wash. 340, 244 P. 545 (1926).
WV	Yes	No	Punishment, deterrence of others	Spencer v. Steinbrecher, 152 W.Va. 490, 164 S.E.2d 710 (1968). Allowed in wrongful death cases, Kelley v. Ohio River R. Co., 58 W. Va. 216, 52 S.E. 520 (1905).
WI	Yes	No	Punishment, deterrence (of def. and others)	John Mohr & Sons, Inc. v. Jahnke, 55 Wis.2d 402, 198 N.W.2d 363 (1972). Not allowed in wrongful death actions, Wangen v. Ford Motor Co., 97 Wis.2d 260, 294 N.W.2d 437 (1980).
WY	Yes	No	Punishment, deterrence (of def. and others)	Danculovich v. Brown, 593 P.2d 187 (Wyo. 1979). Allowed in wrongful death actions, id.

Washington, D.C. -- Rep. Peter W. Rodino, Jr. (D-NJ), Chairman of the House Judiciary Committee, announced today that his subcommittee investigation into the insurance crisis has revealed that the liability insurance industry actually paid out far less in claims than it received in premiums over the past decade. Rodino added that this revelation was "extremely significant" as policymakers consider the crisis, because it "undermines the companies' claims of massive losses and raises the specter of price-gouging and bloated profits." Rodino also noted that his subcommittee investigation would be continuing in light of the seriousness of the crisis.

In releasing information on losses paid and loss adjustment expenses that the Subcommittee on Monopolies and Commercial Law obtained, Rodino asserted, "The companies say they are losing money on underwriting. But the facts reveal that, over the past decade, they have paid out only 29 cents to 57 cents in claims and allocated loss adjustment expenses, such as defense costs, on every premium dollar they have taken in. Actually, the cash picture is much more favorable to the industry than this because investment income has not been added in. Moreover, the pay out to policyholders is lower than these figures indicate because the loss figures include some loss adjustment expenses. The so-called 'losses' are really paper losses, calculated by deducting reserve amounts that the companies retain and invest. Even in the troubled lines, such as day care, the companies are taking in twice as much as they are paying out in claims. At a minimum, what this shows is that the claims of losses are almost wholly speculative."

Rodino cited a number of examples. He said that for day nurseries, figures showed that over the past ten years the companies had paid out only 49 cents per dollar taken in, and over the past five years the pay out figure was 48 cents. For product liability bodily injury claims, the companies had paid out 45 cents per dollar in the past ten years, and only 29 cents per dollar over the past five years. For product liability (including both bodily injury and property damage), of the premium dollars taken in over the past ten years, less than half have been paid out for claims and allocated adjustment expenses -- the companies have paid out just $1.7 billion on a premium volume of $4.3 billion. "That's a positive cash flow of $2.6 billion, not including investment income. In view of figures like these," Rodino added, "I question how the companies can claim they are losing money. The burden has to be on them to show they will lose money."

Rodino stated that he had sent out letter requests about six weeks ago for financial information and actual loss data. "We did this because no one seemed to know whether the industry had actually lost money or how much it was paying in claims." Rodino noted that a number of insurance organizations that his subcommittee had requested to submit information had supplied incomplete responses. "We'll be pressing ahead for more and better information," he stated. Rodino's subcommittee is reviewing the McCarran-Ferguson Act, which affords a broad antitrust immunity to the business of insurance.

Rodino stated that his investigation showed how difficult it was to obtain information about the industry. "Information about insurance is almost exclusively in the hands of the industry," he stated. He noted that the National Association of Insurance Commissioners and A.M. Best Company, the noted statistical reporting agency for insurance, had been unable to supply even the most basic financial information on cash flow to the subcommittee.

"The lack of information is astounding. In light of the claims of the industry about losses and their requests for federal legislative action, the need for the federal government to play a more active role in collecting information and monitoring the industry is clear," Rodino said.

Copies of the investigative materials released by the subcommittee are available in the office of the Subcommittee on Monopolies and Commercial Law, Room B353 Rayburn House Building (tel. - 202-225-2825).

# # #

1984* REVENUES, EXPENDITURES & PAY OUT RATIOS
(REVENUES & EXPENDITURES SHOWN IN THOUSANDS)

Line	Revenues**	Expenditures***	Pay Out Ratios****
Day Nurseries	4,581	1,126	.25
Owners, Landlords & Tenants Bodily Injury Liability	764,850	210,581	.28
Manufacturers & Contractors Bodily Injury Liability	478,278	55,726	.12
Manufacturers & Contractors Property Damage Liability	270,646	143,695	.53
All Products & Completed Operations Bodily Injury Liability	311,540	21,938	.07
All Products & Completed Operations Property Damage Liability	214,569	32,816	.15
Municipal Classes	67,716	19,087	.28
Liquor Liability	10,798	504	.05
Governmental Sudivision	25,970	5,694	.22

* Because ISO data was on an accrual basis, expenditures are matche against the policy year in which the occurrence insured against happened.

** Revenues = Earned premiums. It does not include investment inco

*** Expenditures = paid losses + loss adjustment expenses allocated to losses, both through 3/31/85. It does not include reserves o unallocated loss adjustment expenses.

**** Pay Out Ratio = Expenditures/revenues, rounded to nearest cent.

[Prepared by Subcommittee on Monopolies and Commercial Law staff fro data supplied by the Insurance Services Office (ISO)]

1978* REVENUES, EXPENDITURES & PAY OUT RATIOS
(REVENUES & EXPENDITURES SHOWN IN THOUSANDS)

Line	Revenues**	Expenditures***	Pay out Ratios****
Day Nurseries	1,115	571	.51
Owners, Landlords & Tenants Bodily Injury Liability	459,430	231,763	.50
Manufacturers & Contractors Bodily Injury Liability	381,654	192,283	.50
Manufacturers & Contractors Property Damage Liability	222,903	99,118	.44
All Products & Completed Operations Bodily Injury Liability	283,382	132,640	.47
All Products & Completed Operations Property Damage Liability	147,518	60,990	.41
Municipal Classes	1980 was first year for which statistics were suppli		
Liquor Liability	13,758	5,529	.40
Governmental Sudivision	1980 was first year for which statistics were suppl:		

* Because ISO data was on an accrual basis, expenditures are matched against the policy year in which the occurrence insured against happened.

** Revenues = Earned premiums. It does not include investment income

*** Expenditures = paid losses + loss adjustment expenses allocated to losses, both through 3/31/85. It does not include reserves or unallocated loss adjustment expenses.

**** Pay Out Ratio = Expenditures/revenues, rounded to nearest cent.

[Prepared by Subcommittee on Monopolies and Commercial Law staff from data supplied by the Insurance Services Office (ISO)]

TEN-YEAR REVENUES, EXPENDITURES & PAY OUT RATIOS (1975-1984)
(REVENUES AND EXPENDITURES SHOWN IN THOUSANDS)

Line	Revenues*	Expenditures**	No. of Years for which pay outs exceed Revenues	Pay out Ratio***
Day Nurseries	21,335	10,395	1	.49
Owners, Landlords & Tenants Bodily Injury Liability	5,380,568	3,057,922	0	.57
Manufacturers & Contractors Bodily Injury Liability	4,220,972	1,796,602	0	.43
Manufacturers & Contractors Property Damage Liability	2,414,623	1,227,437	0	.51
All Products & Completed Operations Bodily Injury Liability	2,666,001	1,204,514	2	.45
All Products & Completed Operations Property Damage Liability	1,640,536	478,356	0	.29
Municipal Classes	5-year statistics only		--	--
Liquor Liability	115,225	46,346	1	.40
Governmental Subdivision	5-year statistics only		--	--

* Revenues = Earned premiums. It does not include investment income

** Expenditures = paid losses + loss adjustment expenses allocated to losses, both through 3/31/85. It does not include reserves or unallocated loss adjustment expenses.

*** Pay Out Ratio = Expenditures/revenues, rounded to nearest cent.

[Prepared by Subcommittee on Monopolies and Commercial Law staff from data supplied by the Insurance Services Office (ISO)]

FIVE YEAR REVENUES, EXPENDITURES & PAY OUT RATIOS (1980-1984) (REVENUES & EXPENDITURES SHOWN IN THOUSANDS)

Line	Revenues*	Expenditures**	No. of Years for which pay outs exceed Revenues	Pay out Ratios***
Day Nurseries	16,633	7,906	0	.48
Owners, Landlords & Tenants Bodily Injury Liability	3,628,980	1,956,543	0	.54
Manufacturers & Contractors Bodily Injury Liability	2,706,699	918,466	0	.34
Manufacturers & Contractors Property Damage Liability	1,495,732	775,956	0	.52
All Products & Completed Operations Bodily Injury Liability	1,732,000	497,928	0	.29
All Products & Completed Operations Property Damage Liability	1,127,591	270,758	0	.24
Municipal Classes	308,321	204,015	1	.66
Liquor Liability	75,797	20,976	0	.28
Governmental Sudivision	95,756	39,852	1	.42

* Revenues = Earned premiums. It does not include investment incoc

** Expenditures = paid losses + loss adjustment expenses allocated to losses, both through 3/31/85. It does not include reserves or unallocated loss adjustment expenses.

*** Pay Out Ratio = Expenditures/revenues, rounded to nearest cent.

[Prepared by Subcommittee on Monopolies and Commercial Law staff from data supplied by the Insurance Services Office (ISO)]

Bill No. _____

AN ACT relating to punitive damage awards in civil actions.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) In any civil action, except medical malpractice liability actions pursuant to K.S.A. 60-3402, in which exemplary or punitive damages are recoverable, the trier of fact shall determine, concurrent with all other issues presented, whether such damages shall be allowed. If such damages are allowed, a separate proceeding shall be conducted to the court to determine the amount of such damages to be awarded.

(b) At a proceeding to determine the amount of exemplary or punitive damages to be awarded under this section, the court shall hear evidence of the financial condition of any party against whom such damages have been allowed. At the conclusion of the proceeding, the court shall determine the amount of exemplary or punitive damages to be awarded, but not exceeding the amount provided by subsection (d), and shall enter judgment for that amount.

(c) In any civil action where claims for punitive damages are included, the plaintiff shall have the burden of proving by clear and convincing evidence in the initial phase of the trial, that the defendant acted toward the plaintiff with willful conduct, wanton conduct, fraud or malice.

(d) No award of exemplary or punitive damages shall exceed the lesser of: (1) Twenty-five percent of the annual gross income earned by the party against whom the damages are awarded as determined by the court based upon the party's highest gross annual income earned for any one of the five years immediately before the act for which such damages are awarded; or (2) three million dollars.

(e) If exemplary or punitive damages are awarded pursuant to this section, 50% of such damages recovered and collected shall be paid to the party awarded them and 50% shall be paid to the state treasurer for deposit in the state treasury.

(f) In no case shall punitive damages be assessed pursuant to this section against:

(1) A principal or employer for the acts of an agent or employee unless the questioned conduct was authorized or ratified by a person expressly empowered to do so on behalf of the principal or employer; or

(2) a professional corporation for the acts of a shareholder of that corporation unless such professional corporation authorized or ratified the questioned conduct.

Attachment 12

(g) The provisions of this section shall apply only to an action based upon a cause of action accruing on or after July 1, 1987.

An Act

HOUSE BILL NO. 1197.

BY REPRESENTATIVES Grant, Strahle, Minahan, Owens, Underwood, Grampsas, Shoemaker, Fish, Carpenter, Armstrong, Berry, M.L. Bird, Bledsoe, Bryan, Paulson, Philips, Schauer, Singer, Taylor-Little, Tobedo, K. Williams, and Younglund;
also SENATORS Durham, Rizzuto, Strickland, Traylor, Glass, Brandon, Donley, Fowler, McCormick, P. Powers, and R. Powers.

CONCERNING THE AWARD OF DAMAGES, AND PROVIDING FOR LIMITATIONS THEREON AND FOR THE DISPOSITION THEREOF.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. 13-21-102, Colorado Revised Statutes, is amended to read:

13-21-102. Exemplary damages. (1) (a) In all civil actions in which damages are assessed by a jury for a wrong done to the person or to personal or real property, and the injury complained of is attended by circumstances of fraud, malice, or insult, or a wanton and reckless disregard of the injured party's rights and feelings OR WILLFUL AND WANTON CONDUCT, the jury, in addition to the actual damages sustained by such party, may award him reasonable exemplary damages. THE AMOUNT OF SUCH REASONABLE EXEMPLARY DAMAGES SHALL NOT EXCEED AN AMOUNT WHICH IS EQUAL TO THE AMOUNT OF THE ACTUAL DAMAGES AWARDED TO THE INJURED PARTY.

(b) AS USED IN THIS SECTION, "WILLFUL AND WANTON CONDUCT" MEANS CONDUCT PURPOSEFULLY COMMITTED WHICH THE ACTOR MUST HAVE REALIZED AS DANGEROUS, DONE HEEDLESSLY AND RECKLESSLY, WITHOUT REGARD TO CONSEQUENCES, OR OF THE RIGHTS AND SAFETY OF OTHERS, PARTICULARLY THE PLAINTIFF.

(2) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (1) OF THIS SECTION, THE COURT MAY REDUCE OR DISALLOW THE AWARD OF

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

EXEMPLARY DAMAGES TO THE EXTENT THAT:

(a) THE DETERRENT EFFECT OF THE DAMAGES HAS BEEN ACCOMPLISHED; OR

(b) THE CONDUCT WHICH RESULTED IN THE AWARD HAS CEASED; OR

(c) THE PURPOSE OF SUCH DAMAGES HAS OTHERWISE BEEN SERVED.

(3) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (1) OF THIS SECTION, THE COURT MAY INCREASE ANY AWARD OF EXEMPLARY DAMAGES, TO A SUM NOT TO EXCEED THREE TIMES THE AMOUNT OF ACTUAL DAMAGES, IF IT IS SHOWN THAT:

(a) THE DEFENDANT HAS CONTINUED THE BEHAVIOR OR REPEATED THE ACTION WHICH IS THE SUBJECT OF THE CLAIM AGAINST THE DEFENDANT IN A WILLFULL AND WANTON MANNER, EITHER AGAINST THE PLAINTIFF OR ANOTHER PERSON OR PERSONS, DURING THE PENDENCY OF THE CASE; OR

(b) THE DEFENDANT HAS ACTED IN A WILLFULL AND WANTON MANNER DURING THE PENDENCY OF THE ACTION IN A MANNER WHICH HAS FURTHER AGGRAVATED THE DAMAGES OF THE PLAINTIFF WHEN THE DEFENDANT KNEW OR SHOULD HAVE KNOWN SUCH ACTION WOULD PRODUCE AGGRAVATION.

(4) ONE-THIRD OF ALL REASONABLE DAMAGES COLLECTED PURSUANT TO THIS SECTION SHALL BE PAID INTO THE STATE GENERAL FUND. THE REMAINING TWO-THIRDS OF SUCH DAMAGES COLLECTED SHALL BE PAID TO THE INJURED PARTY. NOTHING IN THIS SUBSECTION (4) SHALL BE CONSTRUED TO GIVE THE GENERAL FUND ANY INTEREST IN THE CLAIM FOR EXEMPLARY DAMAGES OR IN THE LITIGATION ITSELF AT ANY TIME PRIOR TO PAYMENT BECOMING DUE.

(5) UNLESS OTHERWISE PROVIDED BY LAW, EXEMPLARY DAMAGES SHALL NOT BE AWARDED IN ADMINISTRATIVE OR ARBITRATION PROCEEDINGS, EVEN IF THE AWARD OR DECISION IS ENFORCED OR APPROVED IN AN ACTION COMMENCED IN A COURT.

(6) IN ANY CIVIL ACTION IN WHICH EXEMPLARY DAMAGES MAY BE AWARDED, EVIDENCE OF THE INCOME OR NET WORTH OF A PARTY SHALL NOT BE CONSIDERED IN DETERMINING THE APPROPRIATENESS OR AMOUNT OF SUCH DAMAGES.

SECTION 2. Effective date - applicability. This act shall take effect July 1, 1986, and shall apply to civil actions accruing on or after said date.

SECTION 3. Safety clause. The general assembly hereby

finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.

Carl B. Bledsoe
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Ted L. Strickland
PRESIDENT OF
THE SENATE

Lee C. Bahrych
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Marjorie L. Nielson
SECRETARY OF
THE SENATE

APPROVED May 16, 1986 8:57 pm

Richard D. Lamm
GOVERNOR OF THE STATE OF COLORADO

Litwin

Collateral Source

Bill No. _____

AN ACT relating to the admissibility of evidence of payments received by an injured party from sources collateral to the defendant in all civil actions; repealing K.S.A. 1985 Supp. 60-3403.

Be it enacted by the Legislature of the State of Kansas:

New Sec. 1. (a) In any action for damages for personal injury, including bodily harm, sickness, disease or death; or for property damage, the court shall admit into evidence the total amount of all compensation or benefits received or entitled to be received by the claimant from any collateral source, except compensation or benefits from life insurance coverage.
(b) If a party elects to introduce evidence of compensation or benefits from any collateral source, the court shall admit evidence of any amounts paid or contributed to secure the right to any compensation or benefits concerning which evidence of collateral source compensation or benefits has been admitted; and the extent to which the right to recover is subject to a lien or subrogation right.
(c) The provisions of this section shall apply to any action pending or brought on or after July 1, 1987, regardless of when the cause of action accrued.

New Sec. 2. This act replaces K.S.A. 1985 Supp. 60-3403 and shall be applied to all actions pending under that statute. K.S.A. 1985 Supp. 60-3403 is hereby repealed.

Attachment 13

Litwin

Verdicts

Bill No. _____

AN ACT providing for the itemization of verdicts when damages are assessed for personal injury and repealing 1986 Kan. Sess. Laws Ch. 229, Section 14(a).

Be it enacted by the Legislature of the State of Kansas:

New Sec. 1. In any action for personal injury, any damages found shall be itemized by the trier of fact as follows:
(a) Past economic damages;
(b) Past noneconomic damages;
(c) Future medical damages;
(d) Future economic damages excluding future medical damages;
(e) Future noneconomic damages; and
(f) The interval over which future damages are to be paid.

New Sec. 2. 1986 Kan. Sess. Laws Ch. 229 Section 14(a) is hereby repealed.

Attachment 14

Litwin

Tax

Bill No. _____

AN ACT regarding jury instructions on the taxibility of awards for bodily injuries.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. In any action where damages are awarded for bodily injuries, the court if requested by either party shall instruct the jury whether the award is subject to taxation under state or federal laws.

Attachment 15

Litwin?

DATE: August 15, 1986

TO: MEMBERS - SPECIAL COMMITTEE ON TORT REFORM
AND INSURANCE LIABILITY

FROM: Kansas Coalition for Tort Reform

RE: Tort Reform Issues

The Kansas Coalition for Tort Reform met July 31 to consider all the various items that had been suggested as tort reform proposals for the purpose of distilling the list down to specific topics to submit to your committee. Some of the items were presented as draft legislation to you yesterday (8-14-86) by the coalition spokesperson, David Litwin.

He presented the proposals because they were on your agenda. They were:

- Elimination of the collateral source rule
- Limitations of punitive damage awards
- Itemized jury verdicts
- Instructing the jury about taxibility of awards
- Mandatory structuring of awards

However, there are other important tort reform topics that the coalition has identified as follows:

- Limitation on noneconomic damages
- Establishment of specific criteria for qualifying expert witnesses
- Exemption from liability for negligent acts of directors and officers of non-profit organizations, i.e., "No director or officer of a non-profit corporation shall be liable for actions taken, or omissions made, in the performance of their duties as a board member except for wanton or willful acts or omissions."
- Consider the Delaware corporate code amendment to allow shareholders of a corporation to amend its charter to cap or eliminate awards against directors or officers in shareholder derivative suits

The coalition would be pleased to provide any additional information on any or all of these matters.

Attachment 16

4407

United States General Accounting Office

GAO

Fact Sheet for the Chairman,
House Committee on
Ways and Means

April 1986

TAX POLICY

Financial Cycles in the Property/Casualty Industry

GAO/GGD-86-56FS

Attachment 17

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

GENERAL GOVERNMENT
DIVISION

April 9, 1986

B-220675

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

During our testimony on insurance taxation before the House Committee on Ways and Means, Congressman Richard T. Schulze asked that we provide information about past financial cycles in the property/casualty (p/c) insurance industry. The enclosed four figures illustrate the financial cycles that p/c insurance companies experienced over the past several decades.

To identify past cyclicity, we plotted the p/c insurance industry's underwriting gains or losses over time. Basically, underwriting gains or losses are the differences between the amount of a company's premiums received and the amount of its claims, expenses, and policyholder dividends paid. For our purposes, we expressed underwriting gains or losses in two ways: (1) a ratio of the claims, expenses, and policyholder dividends paid to the premium income (combined ratio) and (2) the difference (plus or minus) between the amount of premium income and the amount of claims, expenses, and policyholder dividends. The enclosed figures illustrate the cyclicity in the p/c industry expressed in these terms.

The data we used to develop these figures came entirely from publicly available information contained in Best's Aggregates and Averages published by the A.M. Best Company. Data on the overall p/c insurance industry was available for the period 1967 through 1985; data on the stock company segment of the industry was available for a longer period, 1945 through 1984.

B-220675

As arranged with your office, we are making this information available to Congressman Schulze and other interested parties. We trust that you will find this information useful. If you have questions, please contact Mr. Natwar Gandhi of my staff on 376-0023.

Sincerely yours,

Johnny C. Finch

Johnny C. Finch
Senior Associate Director

[redacted]

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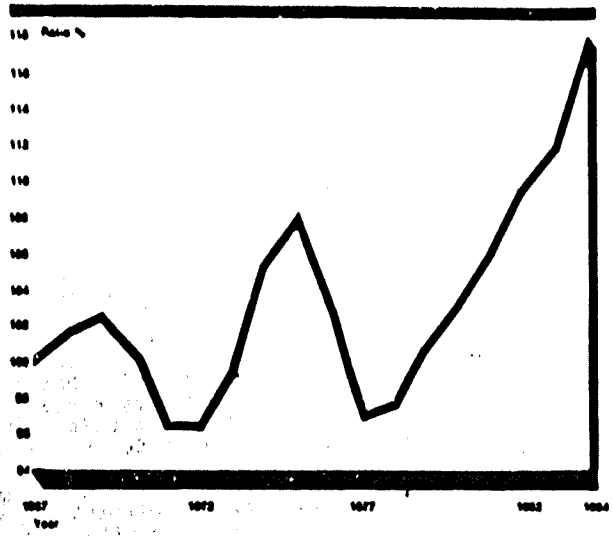
Figure 1 illustrates the cycles derived by plotting the annual combined ratios (the ratio of claims, expenses, and policyholder dividends paid to the premium income) of the p/c industry for the period 1967 through 1984. From 1969 through 1977 the cycles (the periods between peaks or troughs) appear to span 5 to 6 years in duration. This, however, has not been the case since 1977. The continuation of the upward cycle that began in 1977 has been due in large part to the industry's use of a technique known as "cash flow underwriting." Using this technique, companies undercharge for premiums in order to encourage sales and obtain funds. Premium proceeds are then used to take advantage of investment [redacted] afford to have ratios in excess of 100 percent (which represent an underwriting loss) if such losses are offset by investment earnings. The majority of the industry's investment earnings come from tax-exempt investments.

Figure 1: Combined Underwriting Ratios of the Property/ Casualty Industry For the Years 1967-84[a]



Year	Ratio
1967	100.2
1968	101.5
1969	102.5
1970	100.1
1971	96.4
1972	96.2
1973	99.2
1974	105.4
1975	107.9
1976	102.4
1977	97.2
1978	97.5
1979	100.6
1980	103.1
1981	106.0
1982	109.6
1983	112.0
1984	118.0

[a]Ratios below 100 represent underwriting gains and those above 100 represent losses.

APPENDIX

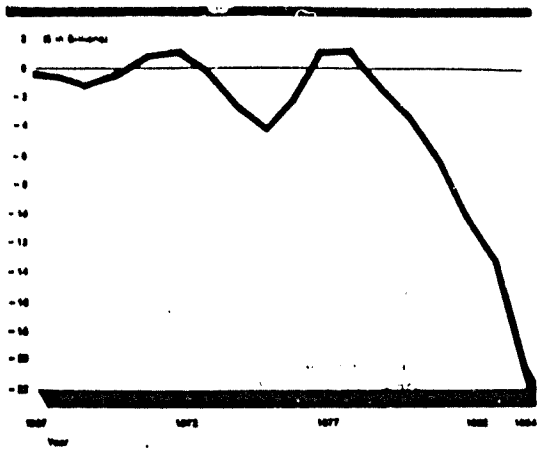
APPENDIX

Figure 2 shows the cycles of the underwriting gains and losses in billions of dollars for the p/c insurance industry between 1967 and 1984. These gains and losses represent the difference between the industry's claims, expenses, and policyholder dividends paid and the premiums it collected. These figures show the same cyclical trend as Figure 1 showed for the combined ratios.

APPENDIX

APPENDI.

Figure 2: Underwriting Gains or Losses For the Property/ Casualty Industry For the Years 1967-84 (in billions)



Year	Total
1967	$ -0.3
1968	-0.6
1969	-1.0
1970	-0.4
1971	0.8
1972	1.1
1973	0.0
1974	-2.6
1975	-4.2
1976	-2.2
1977	1.1
1978	1.3
1979	-1.3
1980	-3.3
1981	-6.3
1982	-10.3
1983	-13.3
1984	-21.5

APPENDIX

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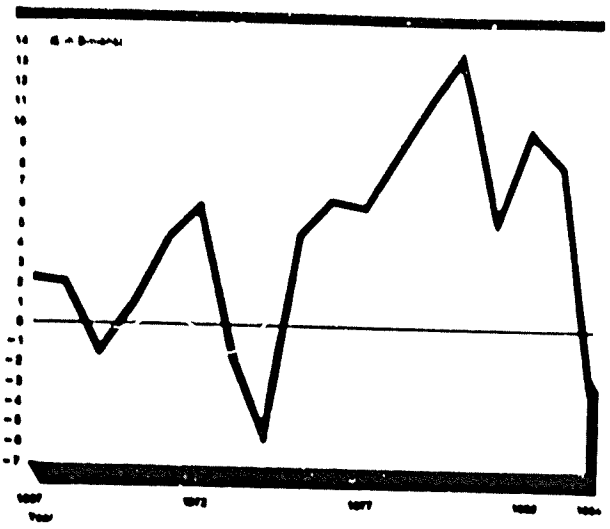
While Figures 1 and 2 illustrate the underwriting portion of the p/c insurance industry operations, Figure 3 shows how the cyclical nature of the industry has been affected when companies' investment income is added to their underwriting gains and losses. With both revenue sources combined, the p/c industry has usually shown a positive net income after taxes.

Figure 3: Combined Underwriting and Investment Gains or Losses For the Property/Casualty Industry For the Years 1967-84[a]

(in billions)

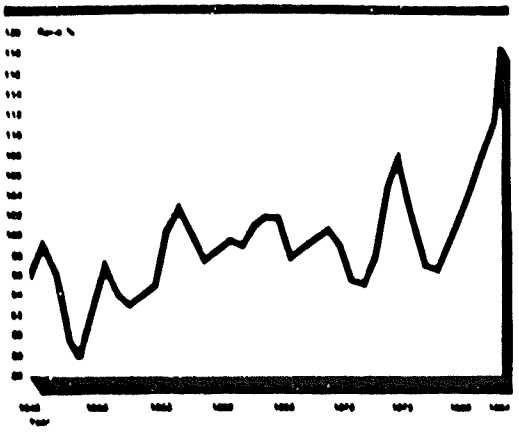


Year	Total	Year	Total
1967	$ 2.3	1976	$ 6.4
1968	2.1	1977	6.0
1969	-1.4	1978	8.9
1970	1.2	1979	11.6
1971	4.4	1980	13.7
1972	6.0	1981	5.3
1973	-1.7	1982	10.0
1974	-5.6	1983	8.3
1975	4.6	1984	-2.4

[a]These figures are aggregate stock and mutual company totals. We used aggregate totals because annual consolidated totals for the p/c industry, while available for some years, are not available for the entire period shown. Consolidated totals are usually lower since they do not include intercompany transactions. For the period 1975 through 1984, the aggregate stock and mutual totals shown above amounted to $72.4 billion while the corresponding consolidated totals amounted to $62.6 billion.

Figure 4 shows the cycles of the combined ratios for the industry's stock companies for the years 1945 through 1984. Except for the latest upswing beginning in 1978, Figure 4 shows that 5- to 6-year cycles were generally maintained throughout this period. This exception, as we noted in our explanation of figure 1, is in large part due to the effects of "cash flow underwriting."

Figure 4: Combined Underwriting Ratios For Property/Casualty Stock Companies For the Years 1945-84[a]



Year	Ratio %	Year	Ratio %
1945	95.8	1965	101.9
1946	98.8	1966	98.1
1947	96.3	1967	98.9
1948	91.2	1968	100.0
1949	87.6	1969	100.6
1950	93.0	1970	99.3
1951	97.1	1971	95.8
1952	94.4	1972	95.4
1953	93.1	1973	98.2
1954	93.6	1974	105.0
1955	94.9	1975	107.5
1956	100.5	1976	102.0
1957	102.9	1977	97.0
1958	100.0	1978	96.6
1959	97.8	1979	99.6
1960	98.4	1980	102.4
1961	99.4	1981	104.9
1962	99.0	1982	108.7
1963	101.0	1983	111.8
1964	101.9	1984	119.0

[a]Ratios below 100 represent underwriting gains and those above 100 represent losses.

(268237)

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NEWS RELEASE - - -

PETER W. RODINO
[illegible] District, New Jersey
Chairman
Committee on the Judiciary
U.S. House of Representatives

FOR IMMEDIATE RELEASE: June 9, 1986
Contact: M. Elaine Mielke (202) 225-6086

RODINO STATES JUDICIARY SUBCOMMITTEE INVESTIGATION SHOWS PROPERTY/CASUALTY INDUSTRY HAS POSITIVE CASH FLOW ON UNDERWRITING

Washington, D.C. -- Rep. Peter W. Rodino, Jr. (D-NJ), Chairman of the House Judiciary Committee, announced today that his subcommittee investigation into the insurance crisis has revealed that the liability insurance industry actually paid out far less in claims than it received in premiums over the past decade. Rodino added that this revelation was "extremely significant" as policymakers consider the crisis, because it "undermines the companies' claims of massive losses and raises the specter of price-gouging and bloated profits." Rodino also noted that his subcommittee investigation would be continuing in light of the seriousness of the crisis.

In releasing information on losses paid and loss adjustment expenses that the Subcommittee on Monopolies and Commercial Law obtained, Rodino asserted, "The companies say they are losing money on underwriting. But the facts reveal that, over the past decade, they have paid out only 29 cents to 57 cents in claims and allocated loss adjustment expenses, such as defense costs, on every premium dollar they have taken in. Actually, the cash picture is much more favorable to the industry than this because investment income has not been added in. Moreover, the pay out to policyholders is lower than these figures indicate because the loss figures include some loss adjustment expenses. The so-called 'losses' are really paper losses, calculated by deducting reserve amounts that the companies retain and invest. Even in the troubled lines, such as day care, the companies are taking in twice as much as they are paying out in claims. At a minimum, what this shows is that the claims of losses are almost wholly speculative."

Rodino cited a number of examples. He said that for day nurseries, figures showed that over the past ten years the companies had paid out only 49 cents per dollar taken in, and over the past five years the pay out figure was 48 cents. For product liability bodily injury claims, the companies had paid out 45 cents per dollar in the past ten years, and only 29 cents per dollar over the past five years. For product liability (including both bodily injury and property damage), of the premium dollars taken in over the past ten years, less than half have been paid out for claims and allocated adjustment expenses -- the companies have paid out just $1.7 billion on a premium volume of $4.3 billion. "That's a positive cash flow of $2.6 billion, not including investment income. In view of figures like these," Rodino added, "I question how the companies can claim they are losing money. The burden has to be on them to show they will lose money."

Attachment 18

Rodino stated that he had sent out letter requests about six weeks ago for financial information and actual loss data. "We did this because no one seemed to know whether the industry had actually lost money or how much it was paying in claims." Rodino noted that a number of insurance organizations that his subcommittee had requested to submit information had supplied incomplete responses. "We'll be pressing ahead for more and better information," he stated. Rodino's subcommittee is reviewing the McCarran-Ferguson Act, which affords a broad antitrust immunity to the business of insurance.

Rodino stated that his investigation showed how difficult it was to obtain information about the industry. "Information about insurance is almost exclusively in the hands of the industry," he stated. He noted that the National Association of Insurance Commissioners and A.M. Best Company, the noted statistical reporting agency for insurance, had been unable to supply even the most basic financial information on cash flow to the subcommittee.

"The lack of information is astounding. In light of the claims of the industry about losses and their requests for federal legislative action, the need for the federal government to play a more active role in collecting information and monitoring the industry is clear," Rodino said.

Copies of the investigative materials released by the subcommittee are available in the office of the Subcommittee on Monopolies and Commercial Law, Room B353 Rayburn House Building (tel. - 202-225-2825).

• • •

TEN-YEAR REVENUES, EXPENDITURES
& PAY OUT RATIOS (1975-1984)
(REVENUES AND EXPENDITURES SHOWN IN THOUSANDS)

Line	Revenues*	Expenditures**	No. of Years for which pay outs exceed Revenues	Pay out Ratios***
Day Nurseries	21,335	10,395	1	.49
Owners, Landlords & Tenants Bodily Injury Liability	5,380,568	3,057,922	0	.57
Manufacturers & Contractors Bodily Injury Liability	4,220,972	1,796,602	0	.43
Manufacturers & Contractors Property Damage Liability	2,414,623	1,227,437	0	.51
All Products & Completed Operations Bodily Injury Liability	2,666,001	1,204,514	2	.45
All Products & Completed Operations Property Damage Liability	1,640,536	478,356	0	.29
Municipal Classes	5-year statistics only		--	--
Liquor Liability	115,225	46,346	1	.40
Governmental Subdivision	5-year statistics only		--	--

* Revenues = Earned premiums. It does not include investment income.

** Expenditures = paid losses + loss adjustment expenses allocated to losses, both through 3/31/85. It does not include reserves or unallocated loss adjustment expenses.

*** Pay Out Ratio = Expenditures/revenues, rounded to nearest cent.

[Prepared by Subcommittee on Monopolies and Commercial Law staff from data supplied by the Insurance Services Office (ISO)]

FIVE YEAR REVENUES, EXPENDITURES & PAY OUT RATIOS (1980-1984)
(REVENUES & EXPENDITURES SHOWN IN THOUSANDS)

Line	Revenues*	Expenditures**	No. of Years for which pay outs exceed Revenues	Pay out Ratios***
Day Nurseries	16,633	7,906	0	.48
Owners, Landlords & Tenants Bodily Injury Liability	3,628,980	1,956,543	0	.54
Manufacturers & Contractors Bodily Injury Liability	2,706,699	918,466	0	.34
Manufacturers & Contractors Property Damage Liability	1,495,732	775,956	0	.52
All Products & Completed Operations Bodily Injury Liability	1,732,000	497,928	0	.29
All Products & Completed Operations Property Damage Liability	1,127,591	270,758	0	.24
Municipal Classes	308,321	204,015	1	.66
Liquor Liability	75,797	20,976	0	.28
Governmental Sudivision	95,756	39,852	1	.42

* Revenues = Earned premiums. It does not include investment income

** Expenditures = paid losses + loss adjustment expenses allocated to losses, both through 3/31/85. It does not include reserves or unallocated loss adjustment expenses.

*** Pay Out Ratio = Expenditures/revenues, rounded to nearest cent.

[Prepared by Subcommittee on Monopolies and Commercial Law staff from data supplied by the Insurance Services Office (ISO)]

1984* REVENUES, EXPENDITURES & PAY OUT RATIOS
(REVENUES & EXPENDITURES SHOWN IN THOUSANDS)

Line	Revenues**	Expenditures***	Pay Out Ratios****
Day Nurseries	4,588	1,126	.25
Owners, Landlords & Tenants Bodily Injury Liability	764,850	210,581	.28
Manufacturers & Contractors Bodily Injury Liability	478,278	55,726	.12
Manufacturers & Contractors Property Damage Liability	270,646	143,695	.53
All Products & Completed Operations Bodily Injury Liability	311,540	21,938	.07
All Products & Completed Operations Property Damage Liability	214,569	32,816	.15
Municipal Classes	67,716	19,087	.28
Liquor Liability	10,798	504	.05
Governmental Sudivision	25,970	5,694	.22

* Because ISO data was on an accrual basis, expenditures are matche against the policy year in which the occurrence insured against happened.

** Revenues = Earned premiums. It does not include investment incom

*** Expenditures = paid losses + loss adjustment expenses allocated to losses, both through 3/31/85. It does not include reserves or unallocated loss adjustment expenses.

**** Pay Out Ratio = Expenditures/revenues, rounded to nearest cent.

[Prepared by Subcommittee on Monopolies and Commercial Law staff from data supplied by the Insurance Services Office (ISO)]

1978* REVENUES, EXPENDITURES & PAY OUT RATIOS
(REVENUES & EXPENDITURES SHOWN IN THOUSANDS)

Line	Revenues**	Expenditures***	Pay out Ratios****
Day Nurseries	1,115	571	.51
Owners, Landlords & Tenants Bodily Injury Liability	459,430	231,761	.50
Manufacturers & Contractors Bodily Injury Liability	381,654	192,283	.50
Manufacturers & Contractors Property Damage Liability	222,903	99,118	.44
All Products & Completed Operations Bodily Injury Liability	283,382	132,640	.47
All Products & Completed Operations Property Damage Liability	147,518	60,990	.4
Municipal Classes	1980 was first year for which statistics were suppli		
Liquor Liability	13,758	5,529	.40
Governmental Sudivision	1980 was first year for which statistics were suppli		

* Because ISO data was on an accrual basis, expenditures are matched against the policy year in which the occurrence insured against happened.

** Revenues = Earned premiums. It does not include investment income.

*** Expenditures = paid losses + loss adjustment expenses allocated to losses, both through 3/31/85. It does not include reserves or unallocated loss adjustment expenses.

**** Pay Out Ratio = Expenditures/revenues, rounded to nearest cent.

[Prepared by Subcommittee on Monopolies and Commercial Law staff from data supplied by the Insurance Services Office (ISO)]

INSURANCE SERVICES OFFICE, INC.
500 12TH STREET N.W. SUITE 1010 WASHINGTON D.C. 20004 (202) 463-1900

MAVIS A. WALTERS
SENIOR VICE PRESIDENT

June 2, 1986

The Honorable Peter W. Rodino, Jr.
Chairman, Committee on the Judiciary
U.S. House of Representatives
Washington, D.C. 20515-6216

Dear Chairman Rodino:

We are pleased to provide additional information to the Subcommittee on Monopolies & Commercial Law of the House Judiciary Committee. In recognition of our role as a statistical agent and a rate service organization for the property/casualty insurance industry, ISO has conducted several studies over the past 15 months dealing with the financial condition of the industry. We believe that we have a responsibility to periodically inform the property/casualty insurance industry, its regulatory authorities and other interested parties about significant problems and difficulties which we may have identified.

Copies of three important studies are being provided for the committee's review. We believe that they provide meaningful insight into the nature of recent problems experienced in the commercial liability insurance market. These studies are as follows:

1) "The Coming Capacity Shortage" - February 1985, an analysis of the available capacity projected for 1985, 1986 and 1987 under a model that used reasonable assumptions (as to inflation, catastrophe, reserve strengthening, et. al.) and found that capacity would probably fall short of demand for property/casualty insurance.

2) "1985: A Critical Year" - May 1985, a joint ISO/NAII study that analyzed the current state of the property/casualty industry in comparison to historical performance and indicated that there was a critical need to restore insurer profitability.

Attachment 11

commissions, taxes, general underwriting expenses - that are typically incurred soon after the policy is written. For some types of coverages, such as fire insurance, most losses are paid out during the policy period in which they were incurred or shortly thereafter. For other coverages, notably the liability coverages, most losses are not paid out until several years after the policy period in which they were incurred. Insurers must set aside income to establish reserves for claims that have not yet been paid. These reserves are liabilities and represent the amount expected to be paid. Insurers establish reserves for known claims and also for claims that have occurred but have not been reported to the insurer (IBNR). These IBNR reserves are particularly significant for the liability lines since many liability claims are not even reported to the insurer until several years after the policy has expired.

Any cash flow analysis considers only the paid losses and ignores the reserves which insurers are legally obligated to pay, and for which the premium has already been collected. To measure profitability then, revenues (underwriting income and investment income) must be compared with all costs associated with that revenue - expenses, paid losses, all loss adjustment expenses and all loss and expense reserves including IBNR.

In order that your Subcommittee might have sufficient information to analyze profitability correctly and to make a valid comparison between premiums and losses, we are supplementing the paid loss data which you have specifically requested with the more complete incurred loss information. These incurred losses represent the best available estimate of the losses and loss adjustment expenses that will be paid for each policy year.

The attached pages contain the detailed responses to the questions raised in your April 23 letter. We should note that these responses contain the latest information to the extent that it is available. Furthermore, ISO does not maintain claim files therefore does not have any detailed information on closed claims beyond the product liability study released in 1977.

Should you or your staff have any questions on this material please contact my office.

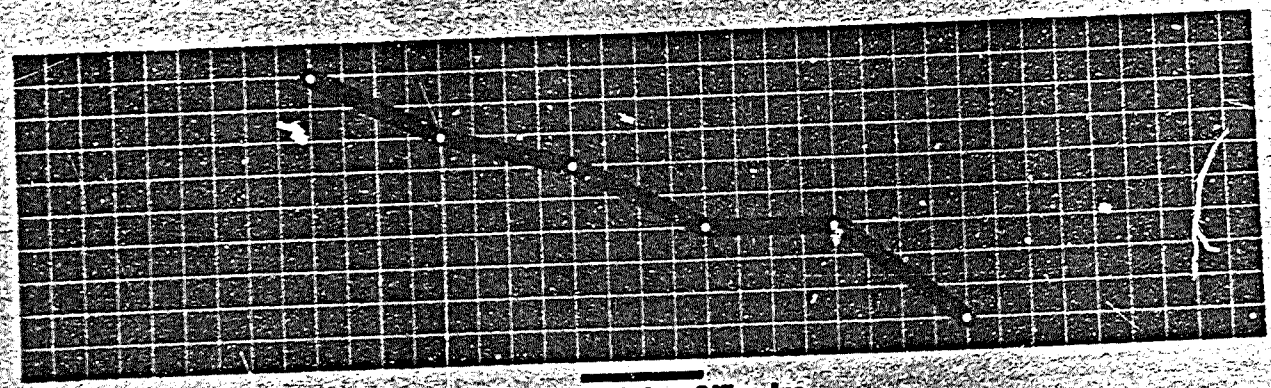
Sincerely,

Mavis A. Walters

Mavis A. Walters
Senior Vice President

INSURER PROFITABILITY— THE FACTS

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



Insurance Services Office, Inc.
February 1986

Attachment
Attendance 20

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

INSURER PROFITABILITY— THE FACTS

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

Insurance Services Office, Inc.
February 1986

3

PURPOSE

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

NOTE: Actual year-end 1985 results for the property/casualty insurance industry will not be compiled until late March 1986. Industrywide [illegible] cited by various analysts and [illegible] 1985 were estimated results [illegible] financial data through the first nine months. In this analysis, ISO references the financial statistics most often cited by critics—those estimates published by A.M. Best Company. This report is being issued prior to the release of year-end 1985 results in order to promptly provide comprehensive information.

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

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

MAJOR CHARGES RAISED BY INDUSTRY CRITICS/17

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

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

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

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

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

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

ACCUSATION: Insurance is too expensive.

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

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EXECUTIVE SUMMARY

A financially sound U.S. property/casualty insurance industry provides a vital service in the form of needed security to individuals and corporations. The cost of insurance affects almost every aspect of American life. Consequently, the economic integrity of this industry, as well as the availability and affordability of insurance, are critical to society.

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

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

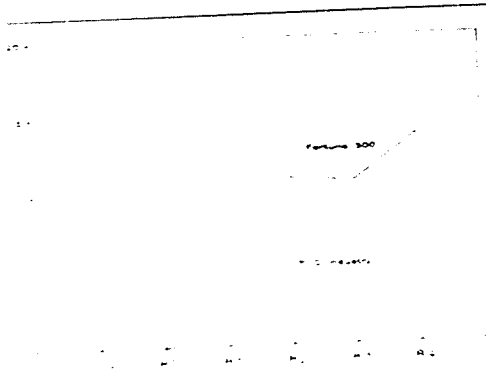
This analysis reviews the current financial state of the industry and refutes, on a point-by-point basis, the critics' charges.

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

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

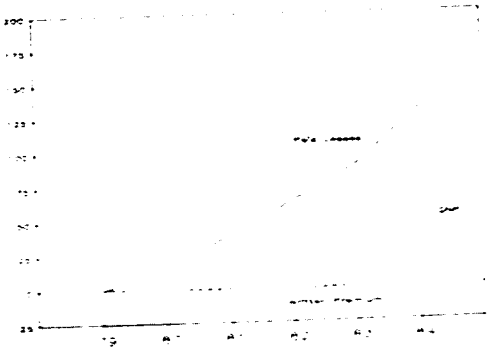
During the 1980's, the return on net worth of the property/casualty industry moved increasingly below the average rate for the Fortune 500 companies. (See chart A.) And results for the first nine months of 1985 indicate no major improvement in profitability. The annualized return on net worth was 4%,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

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



A

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



B

Loss Growth and Premium Growth vs. GNP (Nat. Commercial Liability

ıd accusations. The following paragraphs ımarize these charges and ISO's responses.

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

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

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

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

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

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

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

- **Insurance is too expensive.**

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

Conclusion

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

11

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

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

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

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

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

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

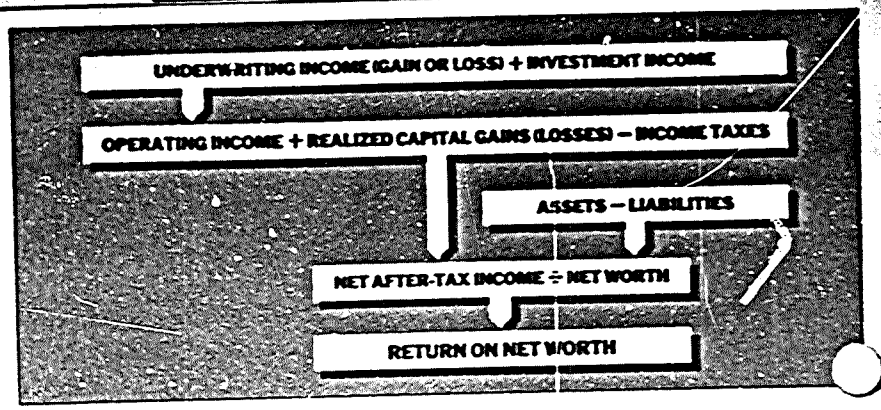
1984 was the worst year to date for the property/casualty insurance industry. The industrywide return on net worth[1] was below 2% in 1984, with total earnings of $1.3 billion. The Fortune 500 companies' median return was 13.6% in 1984, averaged 13.2% over the last ten years, and has never fallen below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

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

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

THE MAJOR COMPONENTS OF INSURER PROFITABILITY

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



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

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

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

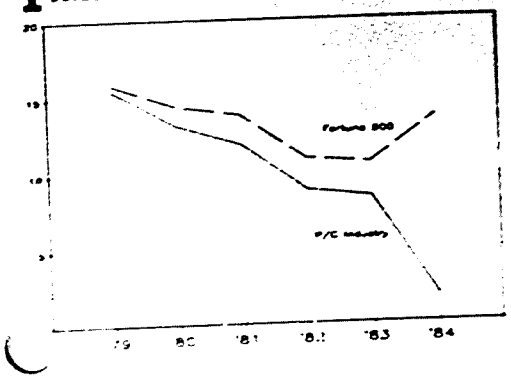
In all but two years of its history, the industry's *investment income* (the interest and dividends received on investments) was enough to offset underwriting losses. (See chart 2.) The first time investment income did not exceed underwriting losses was in 1975, when investment income fell short of the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

Year-end 1985 results will show no significant improvement over 1984, despite substantial premium increases. Figures for the first nine months of 1985 showed slight improvement over the comparable period in 1984, but the annualized 4% return on net worth was still far from acceptable by any business standard. It is unlikely that the full-year 1985 returns on net worth will exceed 4%.

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

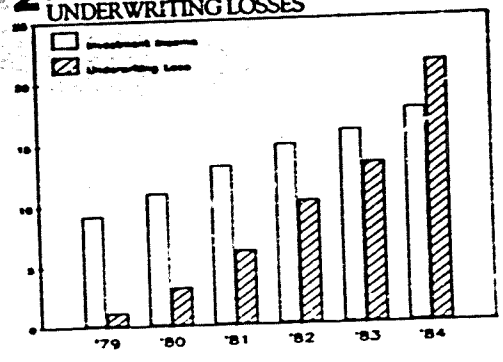
During the first nine months of 1985, investment income fell short of the underwriting loss by $3.5 billion, compared with a

1 PROPERTY/CASUALTY RETURNS HAVE PLUMMETED



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

2 INVESTMENT INCOME NO LONGER OFFSETS UNDERWRITING LOSSES



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

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

The companies that insure our nation's businesses have been particularly hard hit. The degree of deterioration in insurers' claim experience has varied greatly by type of insurance. In general, the results for commercial lines (insurance coverages purchased by businesses) have deteriorated more severely.

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

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

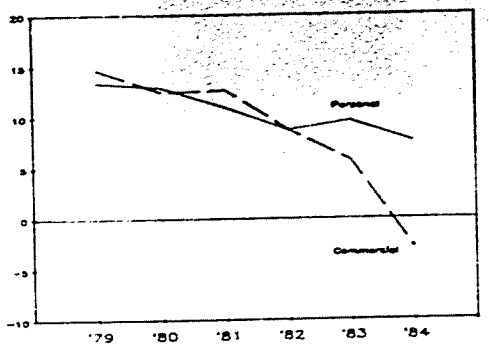
Reinsurers have experienced large financial losses. Insurance companies are in the business of assuming risk, but in many cases the potential claims are too uncertain and too large for any one company to absorb. This is particularly true for liability policies covering government entities and many large corporations, which may require coverage limits of $50 million or more. In response to these expanding liability coverage needs, reinsurers[2] (often described as companies that insure insurance companies) have grown to be an important segment of the property/casualty insurance industry and a crucial link in providing many necessary types of insurance coverages.

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

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

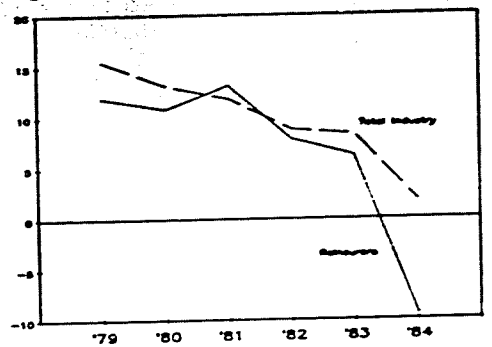
[2]*For a more thorough discussion of reinsurance, see the Appendix.*

3 COMMERCIAL INSURERS LOST MONEY IN 1984



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

4 REINSURERS LOST MONEY IN 1984



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

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

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

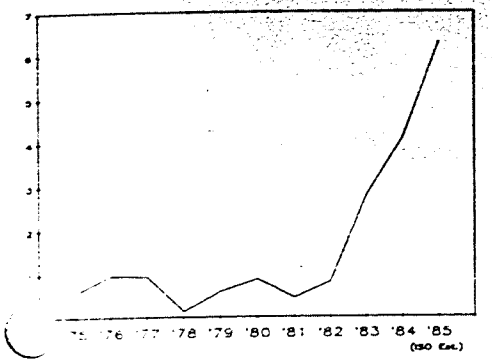
The major components of net income after taxes are operating income (the sum of underwriting income and investment income), realized capital gains and federal income taxes. Although the industry produced an operating loss of $3.8 billion in 1984, this loss was offset by other sources of income. These other sources of income are not predictable or regularly recurring and therefore cannot be depended on to provide similar amounts of additional income in future years.

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

Capital gains may be realized under two sets of circumstances. If the overall stock market performance is relatively flat, offering little if any appreciation in value for shareholders, large investors with a portfolio of both winners and losers may be able to sell the winners—stocks that increased in value since the time of purchase. These investors will have realized a capital gain. But by keeping the losers, they have incurred an offsetting *unrealized* capital loss, since their portfolio account now consists of stocks with depreciated value. These circumstances generally prevailed in 1984.

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

5 REALIZED CAPITAL GAINS AT RECORD LEVELS



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

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

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

A second major source of non-repeatable income for insurers in the last few years is tax credits. Tax credits are available to those businesses that have incurred a pre-tax net loss for a given tax year and paid taxes during a prior profitable period. Tax credits may also be used by a company that is a subsidiary of an otherwise profitable parent. During the last two years, nearly $4 billion in tax credits have been utilized by the property/casualty industry. Clearly, tax credits at these levels cannot be expected to continue.

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

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

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

MAJOR CHARGES RAISED BY INDUSTRY CRITICS

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

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

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

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

ACCUSATION

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

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

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

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

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

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

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

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

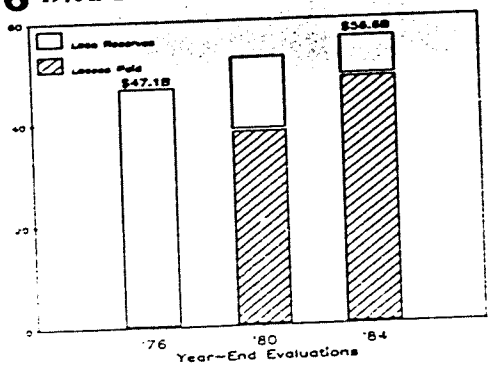
For medical malpractice, the estimate for ultimate claim payments on the policies written through 1976 initially totaled $1.9 billion. The year-end 1984 estimate for those same medical malpractice losses had risen to $2.3 billion, of which $1.9 billion had already been paid. (See chart 8.) This means that, as of year-end 1984, the original 1976 medical malpractice reserve was already *insufficient* by $400 million.

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

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

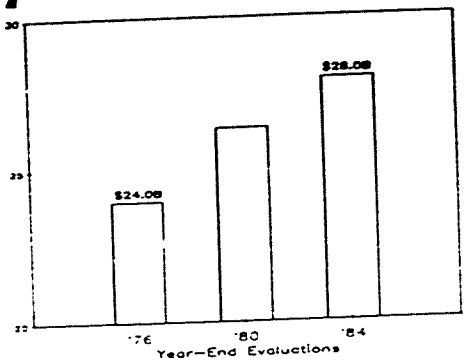
THE FACTS: Policyholder dividends, although not "losses", are price discounts to customers that are legitimate business expenses, deductible from income. This treatment follows that dictated by statutory accounting procedures developed by the National Association of Insurance

6 1976 INDUSTRY RESERVES FELL SHORT



Calendar Year 1976 Loss Reserves ($ Billions) *The reserves set aside at year-end 1976 proved to be nearly $10 billion (20%) short eight years later.*

7 1976 GENERAL LIABILITY RESERVES FELL SHORT



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

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

The charge that policyholder dividends should not be treated as expenses could just as easily—and just as mistakenly—be applied to any price discount a company offers its customers to encourage the purchase of the company's product or service. And that's what policyholder dividends are: a price discount. When manufacturers offer a $10 refund on the price of a coffeemaker or a $500 rebate on the price of a car, they are not distributing profits; rather, they are incurring an expense that is, in effect, a price cut. As with manufacturers offering price discounts, policyholder dividends are appropriately recognized as an insurer expense that reduces profits. Policyholder dividends are not a distribution of profits.

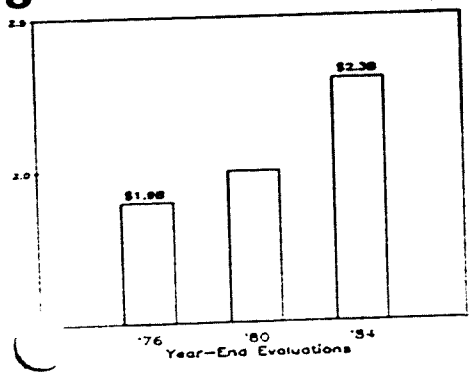
Policyholder dividends are unlike dividends to stockholders. Policyholder dividends represent a portion of gross revenues that a company has designated for return to its policyholders. Many insurer managements pay dividends to policyholders as a competitive tool to retain business. Also, many insurers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

On the other hand, dividends to stockholders of *any* business corporation represent a distribution to its owners of a portion of current or past earnings, based on each owner's total holdings. Unlike policyholder dividends, stockholder dividends do not offset income. They are charged directly to net worth.

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

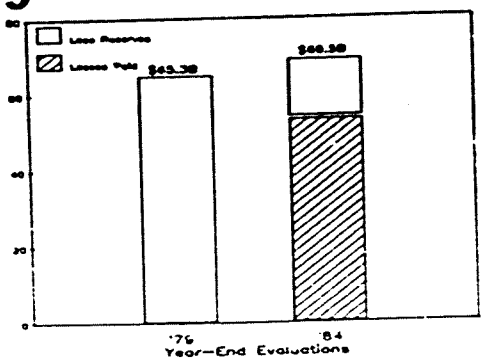
THE FACTS: This charge is false. Every quarter, statistics compiled and released by ISO highlight net after-tax

8 1976 MEDICAL MALPRACTICE RESERVES FELL SHORT



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

9 1979 INDUSTRY RESERVES FELL SHORT



Calendar Year 1979 Liability Loss Reserves ($ Billions) *The reserves set aside at year-end 1979 for liability losses were more than $4 billion (6%) deficient just five years later.*

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

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

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

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

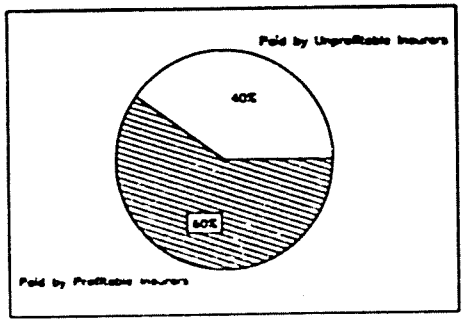
Pre-tax operating income is important to financial analysts, since it is free of the unpredictable and erratic swings exhibited by realized capital gains over a short period. While the total return on net worth (represented by net after-tax income, including realized capital gains) is the more proper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

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

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

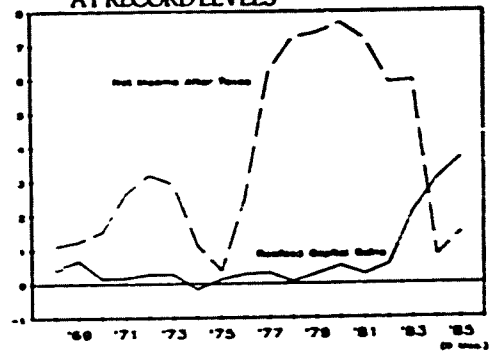
No insurer can guarantee large realized capital gains in a future year. Therefore, operating income has become the common measure for evaluating the success—or lack thereof—of an insurance company's operation.

10 WHO PAID POLICYHOLDER DIVIDENDS IN 1984?



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

11 INSURERS REALIZED CAPITAL GAINS AT RECORD LEVELS



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

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

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

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

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

Dividends to policyholders are premium discounts to customers, rather than a distribution of profits to owners. They are properly considered as a legitimate business expense in the determination of the rate of return on net worth. Removing the effects of policyholder dividends on income is inaccurate. (See page 20.)

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

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

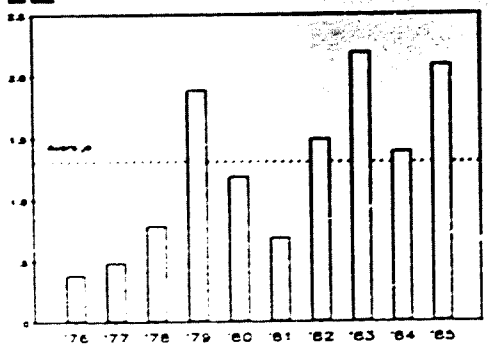
billion or 1.75% of assets—more than three times the 10-year average. (See chart 13.) Substituting the average capital gains for the 1985 amount reduces the return on net worth by 4 points.

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

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

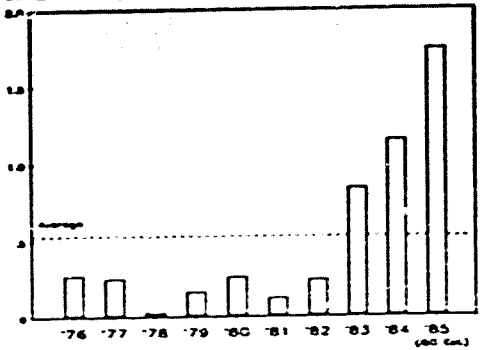
These errors have been partially recognized by critics who, more recently, quoted a revised return on net worth of 6% for 1985—still an overestimate.

12 CATASTROPHE LOSSES CANNOT BE IGNORED



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

13 REALIZED CAPITAL GAINS VARY OVER TIME



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

ACCUSATION

Price increases are excessive. Losses are not the problem.

CHARGE: The insurance industry needed only a 12-15% increase in written premium in 1985 in order to achieve a 13-15% return on net worth in 1986. Given the magnitude of the premium increases in 1985, no additional price increases are needed in 1986.

THE FACTS: No reasonable set of assumptions could support the above statements. It is not plausible that a 12-15% premium increase in 1985 could produce such a high rate of return in 1986. This analysis cannot refute the specific assumptions or calculations underlying the critics' charges since no supporting data have been provided.

Based on an ISO analysis, if industry written premiums had increased only 12-15% in 1985, further increases in excess of 30% would be required in 1986 to achieve a 13% return on net worth. An overall premium increase of this magnitude would be far larger than any ever achieved by the insurance industry.

Given the estimated 20% premium growth that occurred in 1985, ISO forecasts there will be a smaller increase in 1986. Assuming a 17.5% increase for 1986, ISO projects that 1986 industry returns on net worth will rise. Under reasonable assumptions for loss growth, investment income, realized capital gains and taxes, the 1986 return on net worth will be only 8-9%, which is far below the typical returns for most other U.S. industries and below the median result for the Fortune 500 in each of the last 10 years.

The following facts support the ISO analysis and forecasts.

(1) Recent insurance industry returns on net worth have been low—below 2% for 1984, with modest improvement, at best, in 1985. Roughly a 10-point increase in return on net worth would be required to reach the 13-15% range hypothesized for 1986.

(2) Industry losses have continued to escalate rapidly, rising 15% in the first nine months of 1985. The full-year increase in losses will be at least as high.

The charge that no additional price increases are needed in 1986 is false. If the industry implements no increases in 1986, a return on net worth of only 5% could be expected—and 1987 returns would be even lower. The beginning of another downturn so soon after the longest and most severe downturn in the history of the industry would seriously threaten the industry's ability to make future claim payments.

CHARGE: Insurance premiums are increasing so dramatically today solely because of prior inadequate prices. Increasing losses are not the problem.

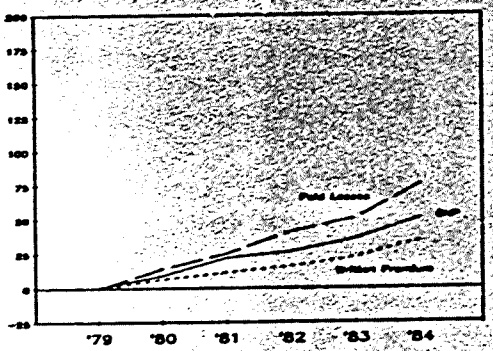
THE FACTS: This charge is incorrect. No one can deny that insurers reduced prices far below the level needed to cover the costs of policies written. However, in the past five years, growth in property/casualty losses has far exceeded the country's economic growth as measured by GNP.

During 1979-1984, GNP grew 50% while written premium increased only 34%, or 2.4 points per year *slower* than the average annual GNP growth rate. On the other hand, paid losses grew 76%, or 3.4 points per year *faster* than GNP. (See chart 14.)

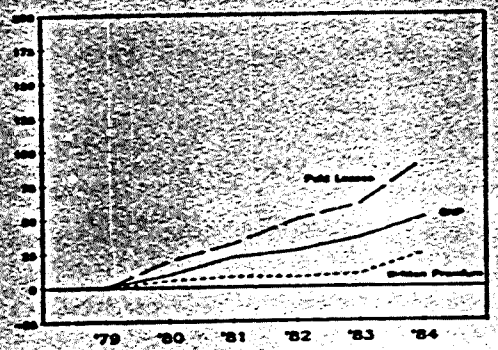
Moreover, the increase in losses was not uniform across all lines of insurance. Commercial lines paid losses grew 92% while personal lines

LOSSES GREW FASTER THAN PREMIUMS, ESPECIALLY FOR COMMERCIAL LIABILITY LINES

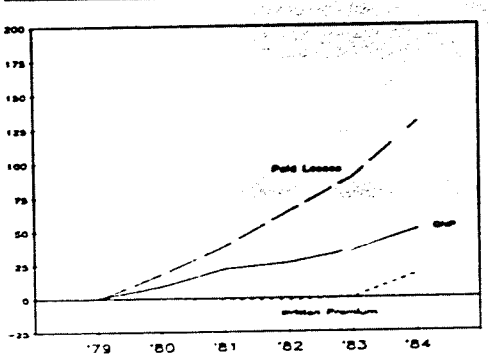
Since 1979, paid losses have grown at a faster rate than either GNP or premiums. The problem is more severe for commercial lines, especially the commercial liability lines.



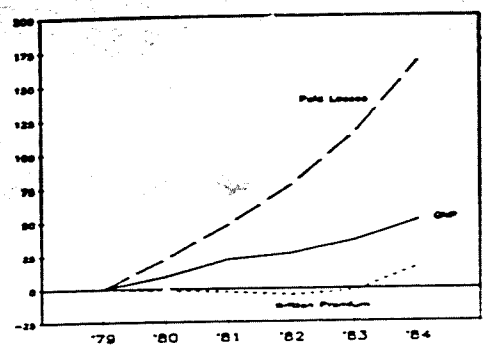
14
Loss Growth and Premium Growth vs. GNP (%): All Lines



15
Loss Growth and Premium Growth vs. GNP (%): Commercial Lines



16
Loss Growth and Premium Growth vs. GNP (%): Commercial Liability



17
Loss Growth and Premium Growth vs. GNP (%): General Liability & Medical Malpractice Combined

losses increased 62%, and commercial liability losses increased 130% during the period—well over double the GNP growth rate. (See charts 15 and 16.)

Finally, general liability and medical professional liability paid losses have grown 167% over the five-year period—more than triple the GNP growth. (See chart 17.) From 1979 to 1984, paid loss growth averaged 22% a year—13 points more than the average annual GNP growth rate. (See chart 18.)

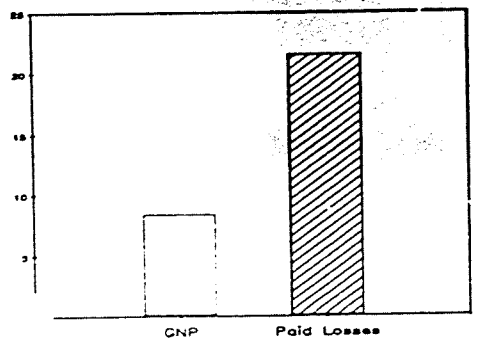
The Administrative Office of U.S. Courts reports that product liability suits filed in U.S. District Courts increased from 1,600 in 1974 to more than 13,500 in 1985—a growth rate of 22% per year. (See chart 19.) Very large awards are becoming much more common. Jury Verdict Research, Inc. reports that the number of million-dollar verdicts in the U.S. has increased each year, from 24 in 1974 to over 400 in 1984. (See chart 20.)

One aspect of the problem of increasing losses is the accompanying litigation costs. The Institute for Civil Justice studied asbestos litigation and found that a disproportionate share of the expenditures on these claims does not reach the victims. Specifically, only 37% of costs in asbestos litigation become net compensation to victims. (See chart 21.)

While current availability and affordability problems are certainly due in part to past price reductions, a major contributor to the problems has been the significant increase in losses. From 1979 to 1984, policyholders had the benefit of low insurance price levels that did not keep pace with losses. But as a result, the insurance industry experienced below-average returns on net worth relative to the Fortune 500 companies in every year since 1979.

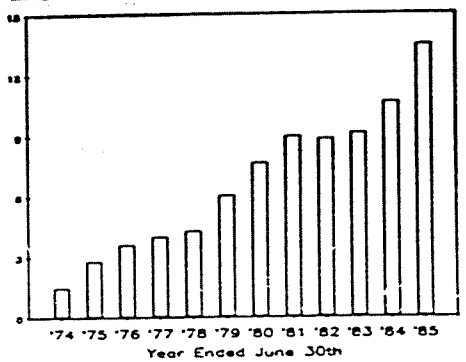
The large premium increases occurring now, particularly for the commercial liability lines, will not recoup past losses nor make up for recent substandard returns. Such increases are needed simply to bring insurance prices in line with the costs of policies written today.

18 LOSS GROWTH OUTPACES ECONOMIC GROWTH



General Liability & Medical Malpractice Losses vs. GNP—1979-84 (Annual % Change) *For the past five years, the average rate of growth in general liability and medical malpractice paid losses was 22% vs. a 9% GNP growth rate, a 13-point annual gap.*

19 LITIGATION EXPLOSION



Product Liability Lawsuits (Thousands) *Since 1974, the number of product liability lawsuits filed in U.S. District Courts has increased more than eight-fold. Source: Administrative Office of U.S. Courts.*

CHARGE: The 1985 written premium increase of 71% for general liability insurance was excessive. If insurers had not slashed liability rates a few years ago, they would have earned handsome profits.

THE FACTS: The 1985 premium increase was not excessive. Even after that increase, current general liability premium levels are still inadequate when compared with current general liability losses.

The 1984 general liability written premium of $6.5 billion was no greater than the 1978 written premium. But from 1978 to 1984, losses and loss adjustment expenses incurred increased 74%, from $4.3 billion to $7.5 billion. (See chart 22.) Even after including the estimated 1985 increase, written premium has grown at an annual rate of only 8% since 1978, while losses have grown at an annual rate of 14%.

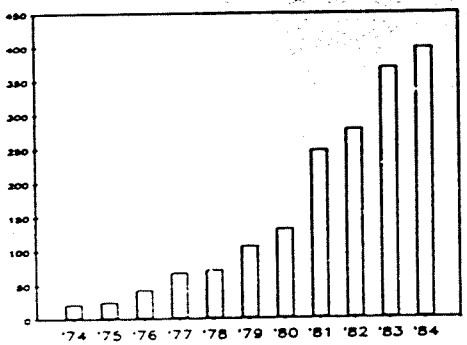
A.M. Best Company estimates the 1985 combined ratio[3] for general liability at 144. At that level, even with a reasonable estimate of anticipated investment income, the general liability lines will lose money. With an estimated annual 8½% interest rate, historical payout patterns for general liability and the A.M. Best combined ratio estimate for 1985, insurers lost 7¢ on every dollar of general liability premium written in 1985. Obviously, the 1985 increase was not sufficient.

One critic has charged that "general liability rates of return on net worth" would have averaged 30% per year from 1976 to 1983, if insurers had not cut premiums. This hypothetical rate of return is flawed by unrealistic assumptions.

- For all lines combined, it assumes that the ratio of earned premium to net worth is 2:1. The actual average for 1976 through 1983 was 1.6:1.
- Further, it assumes that the hypothetical 2:1 earned premium to net worth ratio is

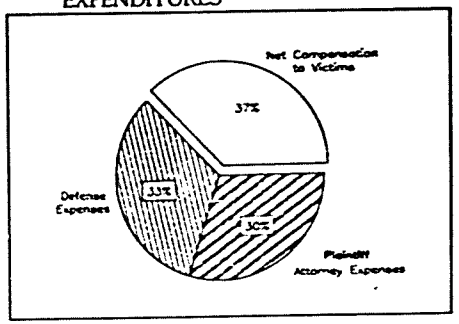
[3]*Combined ratio = incurred losses and loss adjustment expenses divided by net earned premium plus other underwriting expenses divided by net written premium plus dividends to policyholders divided by net earned premium.*

20 NUMBER OF HUGE VERDICTS INCREASING



Million-Dollar Verdicts *From 1974 to 1984, the number of million-dollar verdicts rose dramatically. Source: Jury Verdict Research, Inc., Solon, Ohio.*

21 VICTIMS RECEIVE ONLY 37% OF ASBESTOS CLAIMS EXPENDITURES



Average Expenditures per Tried Asbestos Claim (%) *The Institute for Civil Justice has found that only 37% of asbestos claims expenditures become net compensation to victims.*

the same for general liability as for all lines combined. In a line like general liability, claims remain outstanding for long periods of time while legal standards change; a prudent insurer would therefore require more net worth to support each dollar of general liability premium than for most other lines.

- In rewriting history, the critics assume that, had premiums been greater, *all* the additional premium revenue would have been profit. This assumption ignores the fact that, at a minimum, commissions and premium taxes would be paid and income taxes would rise (or credits decrease).

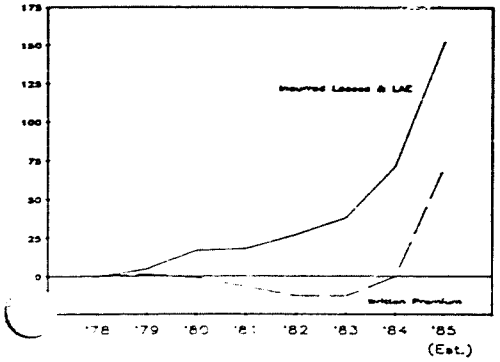
Thus, the conclusion that the "general liability return on net worth" would have been 30% is inaccurate.

CHARGE: Since, for medical malpractice, the industry's paid losses are less than their investment income, this line can be treated on a "pay as you go" basis.

THE FACTS: This charge has two flaws. First, the figures are inaccurate and incomplete; the industry's paid losses alone for medical malpractice are substantially greater than investment income, even without consideration of paid loss adjustment expenses. Second, even if the figures were accurate and complete, the charge is irrelevant. It is inappropriate to consider only actual payments without recognizing future liabilities for injuries that have already occurred but for which the related claims are not yet settled. For long-tail lines like medical malpractice, these claims take many years to settle.

For 1984, A.M. Best reported $970 million in medical malpractice paid losses and $440 million in paid loss adjustment expenses (monies expended in the investigation and settlement of claims), for a total of $1.4 billion.

22 1985 GENERAL LIABILITY PREMIUM GROWTH NOT ENOUGH TO CATCH LOSSES



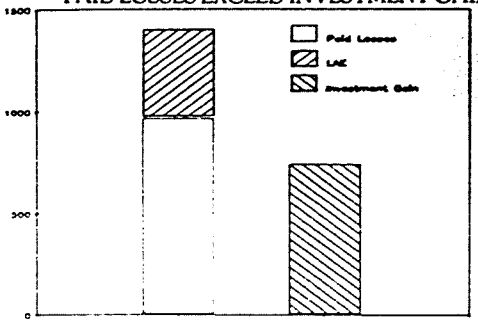
General Liability Premium Growth vs. Loss Growth (%) *1985's large premium growth for general liability was not enough to bring premiums in line with 1985 general liability losses and loss adjustment expenses. And, since 1978, the rate of growth in losses is nearly double that of premiums.*

This compares with only $750 million of net investment gain. (See chart 23.) In addition, underwriting expenses and policyholder dividends of $300 million were paid in 1984.

Even if 1984 paid losses had been less than investment income, comparing the two is naive. An analogy can be made to a pension plan with the vast majority of participants in their 30's and 40's. For many years, premiums paid into the plan will far exceed benefits paid out, but it is quite obvious that the liability for future benefit payments is growing each year and must be funded.

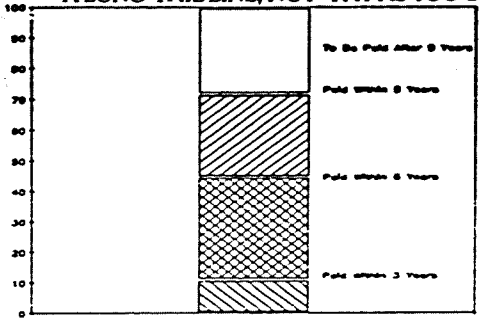
Similarly, medical malpractice claims often take years to emerge and additional years to be litigated. Claims paid out the first year are miniscule, and even after several years, only a small percent of ultimate losses are paid out. For 1976, the year for which the most complete and mature data is available, only 1% of total estimated losses were paid in the first year, only 11% in the first three years and only 72% even after nine years. (See chart 24.) The percentages are similar for other years examined. To conclude anything about the profitability of this line on the basis of paid losses is like saying that the Social Security system is properly funded simply because more money was collected this year than was paid out this year.

23 CRITICS' CHARGES FALSE: MEDICAL MALPRACTICE PAID LOSSES EXCEED INVESTMENT GAIN



Medical Malpractice Insurers' Paid Loss & Loss Adjustment Expense vs. Investment Gain ($ Millions)
For 1984, investment gain for medical malpractice insurance is significantly lower than loss and loss adjustment expenses paid. Critics falsely contended the opposite.

24 MEDICAL MALPRACTICE INSURANCE: A LONG-TAIL LINE, NOT "PAY AS YOU GO"



1976 Medical Malpractice Claims: Percent of Ultimate Losses Paid
After nine years, only 72% of 1976 medical malpractice losses were paid. Claims often take years to emerge and additional years to litigate.

ACCUSATION

...ing
...profitability. This ...ical
downturn.

CHARGE: The stock index of property/casualty insurers rose by 50% during 1985, almost double the rise of the general stock market. This is hardly indicative of a troubled industry.

THE FACTS: The fact that property/casualty stock prices, as measured by the A.M. Best Company's property/casualty stock index, outperformed the rest of the stock market is no indication that this industry is profitable. Investors expect improvements in rates of return for property/casualty insurers, but investor expectations are merely that—*expectations*. They do not guarantee results.

Signs of a firming in insurance premiums (especially for commercial lines) began to emerge at the end of 1984. This price strengthening continued throughout 1985 and shows no sign of abatement in 1986. It is clear that sophisticated institutional investors believe that insurers have regained control of their financial destinies and that earnings will improve. But investor expectations do not guarantee future results, and investor behavior does not ...ssarily correlate with future earnings of ...ndustry.

CHARGE: Property/casualty insurers had net income of $75 billion over the last 10 years. This is a huge amount of money to make. And they paid no taxes.

Note: The $75 billion figure in the critics' charge is based on a fact sheet prepared for the House Ways and Means Committee by the General Accounting Office. The GAO produced a chart that contained the following figures for the property/casualty insurance industry.

1975-1984 (in billions)

Underwriting Gains (Loss)	($ 45.8)
Investment Gains	121.0
Net Gains	$ 75.2

THE FACTS: The $75 billion figure is not net income. It *excludes* policyholder dividends paid and *includes* unrealized capital gains. Net income after taxes averaged $5.1 billion per year, for an average return on net worth of 10.9%. The 10.9% figure is lower than that of the Fortune 500 companies. And insurers' tax credits are based on underwriting losses and the tax status of their investments.

Some critics have used the GAO's figures to reach erroneous conclusions. The underwriting loss shown excludes policyholder dividends paid, and since policyholder dividends are a cost of doing business, they must be deducted from income. (See page 20.)

Investment gains, as shown, include unrealized as well as realized capital gains. Unrealized capital gains flow directly to surplus and do not affect income until realized. A restatement of the 1975-84 totals, with the proper adjustments for policyholder dividends and unrealized capital gains, follows:

PROPERTY/CASUALTY INSURANCE INDUSTRY INCOME, 1975-1984 (in billions)

Underwriting Gain (Loss) After Policyholder Dividends	($ 60.0)
Investment Income	103.7
Operating Income	$ 43.7
Realized Capital Gains	7.7
Net Income (Before Federal Income Tax)	$ 51.4

Property/casualty insurers received a total of $125 million in federal income tax credits during 1975-1984. Thus, industrywide net income after tax for the 10-year period averaged $5.1 billion per year, not an excessive return. Over the 10-year period 1975-1984, returns on net worth ranged from 1.7% to 19.0%, averaging 10.9%. A comparison with other industries follows:

RETURNS ON NET WORTH, 1975-1984

	P/C Insurance	Diversified Financial	Banks	Fortune 500
Low:	1.7%	8.3%	11.5%	10.7%
High:	19.0	17.5	14.1	15.9
Range:	17.3	9.2	2.6	5.2
Average:	10.9	12.8	12.6	13.2

The property/casualty insurance industry has had the lowest average return, while experiencing the greatest variability of all the industries listed. (See chart 25.) This occurs despite the economic theory that increased variability should be rewarded with greater average returns.

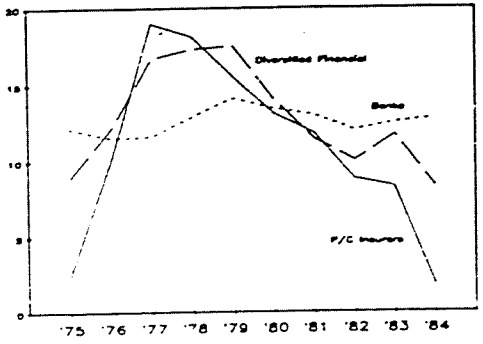
While some critics have argued that the property/casualty insurance industry is a low-to-average risk business, the Majority Report of the Advisory Committee to the NAIC Task Force on Profitability and Investment Income (January 1983) concluded that "the property-casualty insurance business is riskier than the average business in the American economy."

Although property/casualty insurers received a total of $125 million in federal income tax credits during 1975-1984, they paid $21 billion in state and local taxes, licenses, and fees other than payroll taxes. The 1985 federal income tax credit is estimated at under $2 billion while state and local taxes paid are estimated at over $3 billion.

Net federal income tax credits have accumulated for several reasons. In eight of the past 10 years, the industry posted underwriting losses. Since the 10-year underwriting loss was $60 billion, the positive net income of $51 billion came from investment gains. In achieving this income, property/casualty insurers, like other businesses, benefited from various incentives provided by the federal tax system to help the country achieve certain economic objectives.

For example, to help state and local governments raise money through the sale of bonds, Congress has determined that interest

25 INDUSTRY RETURNS ARE VOLATILE OVER TIME



Return on Net Worth: Property/Casualty Insurers vs. Other Industries (%) *Returns on net worth for property/casualty insurers are much more variable than those for other industries. Over the past 10 years, the average rate of return for property/casualty insurers (10.9%) has been below that of the Fortune 500 companies (13.2%), while exhibiting much more variation.*

such bonds is exempt from federal taxes. This ...bles such bonds to be sold with interest rates below the market rate, reducing interest costs ultimately paid by state and local taxpayers. Insurers could have earned higher interest income (on taxable bonds) and paid taxes on that interest income, inflating their federal tax bills but leaving state and local governments without a source of low-cost financing.

Over the last six years, 40% of the industry's net investment income has come from non-taxable bonds. Favorable tax treatment also exists for dividends on equities held by insurers, which have accounted for 20% of the industry's net investment income. In addition, property/casualty insurers (like all investors) benefited from reduced tax rates on realized capital gains.

It is inappropriate to criticize insurers for acting in compliance with tax laws and public policy.

CHARGE: This is a typical cycle. The property/casualty industry will recover quickly, just as it has in past cycles.

THE FACTS: This cycle is clearly not typical. The results of the recent past demonstrate that the industry is experiencing anything but a "typical" cyclical period. Underwriting losses, operating losses, combined ratios, the number of insolvencies and the number of companies targeted for immediate regulatory attention were all at record highs in 1984, while the industrywide return on net worth was at an all-time low. And reinsurers, on whom insurers depend as never before, have been seriously weakened.

The 1984 underwriting loss was $21.5 billion. Prior to this cycle, the record underwriting loss was $4.2 billion in 1975. (See chart 26.) The 1984 operating loss was $3.8 billion. The previous record was $0.3 billion in 1975. (See chart 27.) The 1984 combined ratio was 118.0. Prior to this cycle, the record was 107.9, again in 1975. (See chart 28.)

In 1969, the National Committee on Insurance Guaranty Funds began to collect data on insolvencies that trigger state guaranty funds. Until last year, the record number of insolvencies in any two-year period was 25. During 1984-85, there were 40 insolvencies; and the books on 1985 insolvencies are not yet closed. (See chart 29.)

The National Association of Insurance Commissioners (NAIC) developed an early warning system to alert regulators to potential insolvencies. In discussing the 1985 test results, Iowa Insurance Commissioner Bruce W. Foudree, former President of the NAIC, said that 215 property/casualty insurers had been targeted as being in need of immediate regulatory attention under the NAIC early warning system—"the most ever and a 73% increase over last year."

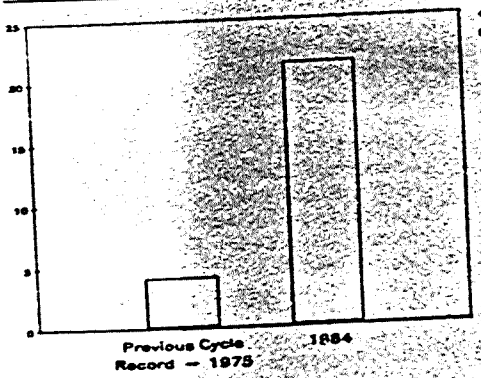
On the basis of bottom-line results, the 1984 return on net worth was 1.7%, despite a record $4.8 billion of realized capital gains and tax credits. The previous low return on net worth of 2.4% occurred in 1975, when the sum of tax credits and realized capital gains was only $0.7 billion.

One of the most important differences between this down cycle and all previous ones is its length. This time, the combined ratio worsened for seven consecutive years beginning in 1978. Previously, the longest continuous

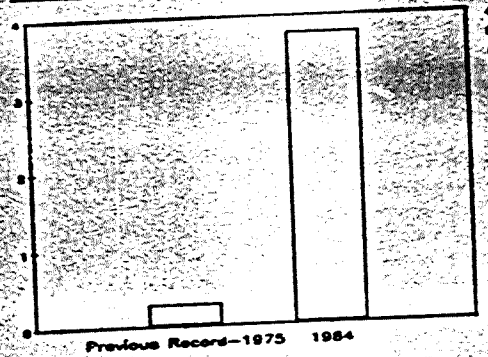
A TYPICAL CYCLE?

By several measures — underwriting loss, operating loss, combined ratio, and insolvencies — it is clear that the cycle that bottomed in 1984 was far more severe than any previous one.

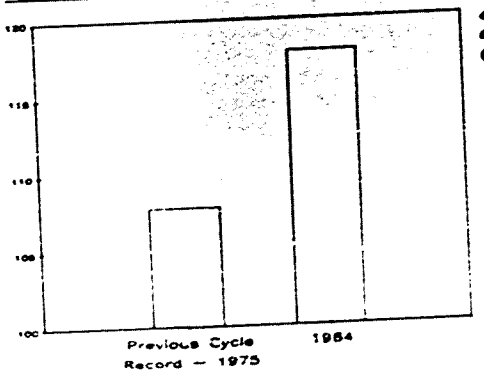
26
Underwriting Losses ($ billions)



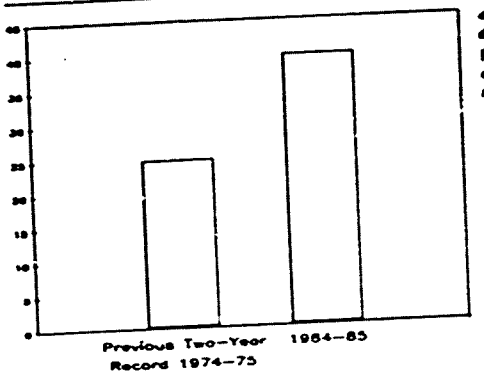
27
Operating Losses ($ billions)



28
Combined Ratios



29
Insolvencies Covered by State Guaranty Funds



eriod of deteriorating combined ratios was for the .ve years 1960 through 1964. During that period, however, the combined ratio worsened by only five points; in this cycle, it deteriorated by 21 points.

Another indicator of the depth of this cycle is the number of insurers receiving reductions in any year from their A.M. Best rating of A+. That number increased from 23 in 1982, to 61 in 1983, to 80 in 1984 and finally to 149 in 1985. (See chart 30.) In 1985, only 24% of the companies rated received an A+, compared with an average of 39% in 1976 and 1977 following the last adverse underwriting cycle.

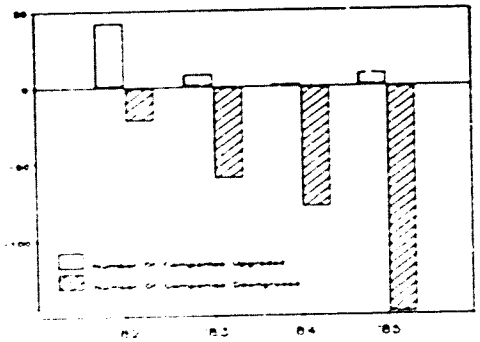
The property/casualty insurance industry is now more dependent on the reinsurance mechanism* than ever before. During 1979-1984, reinsurance recoverable (monies owed to insurers by their reinsurers) more than doubled, while surplus grew 5[illegible] (See chart 31.) For reinsurers themselves, the amount recoverable from their reinsurers more than tripled during this period, while their surplus grew 73%. (See chart 32.) During this period, premiums for the industry increased 30%, while reinsurance premiums increased 54%. At the same time as dependence on reinsurance rapidly increased, reinsurers' financial condition seriously eroded. The 1984 return on net worth for the entire insurance industry was nearly 2%, while it was negative 10% for reinsurers. In 1985, A.M. Best lowered the ratings of half the reinsurers rated.

For the past two decades, reinsurers' combined ratios have closely paralleled those of the property/casualty industry with the gap never exceeding 4½ points, except for the 6-point gap in 1965, the year of Hurricane Betsy. (See chart 33.) As recently as 1982, the two combined ratios were only one-tenth of a point apart. The gap grew to 6 points in 1983 and then to 13 points in 1984. Although this gap has begun to narrow in 1985, reinsurer combined ratios are still substantially worse than those for the entire property/casualty industry.

Historically, personal and commercial lines results have been similar. Between 1967 and 1982, the difference between the combined ratios never exceeded 6 points. (See chart 34.) As recently as 1981, the ratios were only 2 points

*For a more thorough discussion of reinsurance, see the Appendix

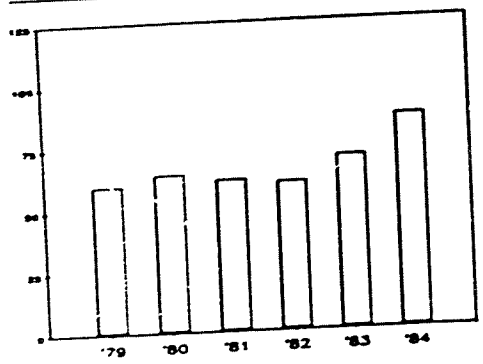
30 INSURERS' FINANCIAL RATINGS DOWNGRADED



A.M. Best's A+ Rating Reductions
A.M. Best's highest rating is an A+, which it gives to companies that it considers to be the most financially secure. In the last two years, A.M. Best has removed 239 companies from this category, while upgrading only 11

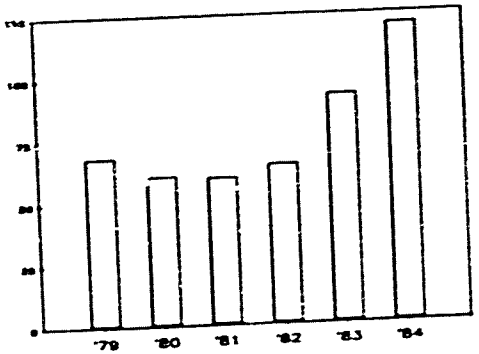
REINSURANCE RECOVERABLES GROWING

The entire property/casualty industry and reinsurers themselves have become more dependent on reinsurance. For the industry, reinsurance recoverable represented 85% of surplus in 1984, doubling in value from $26 billion in 1979 to $55 billion in 1984. For reinsurers, recoverables represented 123% of surplus in 1984, tripling in dollar value since 1979.



31

Industry Reinsurance Recoverable (% of Surplus)

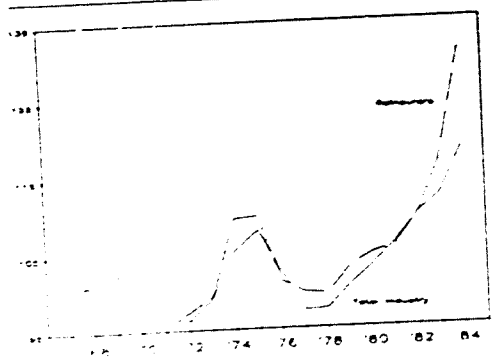


32

Reinsurers' Reinsurance Recoverable (% of Surplus)

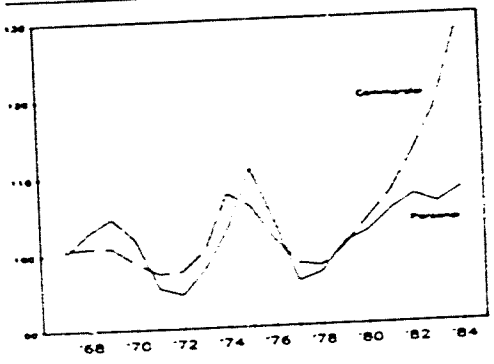
DETERIORATION GREATEST IN COMMERCIAL LINES AND REINSURANCE

Reinsurers have experienced significantly more severe combined ratios than the industry as a whole since 1983, a marked contrast to past cycles. Likewise, commercial lines combined ratios have skyrocketed recently, while those for the personal lines have been more stable.



33

Combined Ratios: Reinsurers vs. Total Property/Casualty Industry



34

Combined Ratios: Personal Lines vs. Commercial Lines

art. Then in 1983, the gap grew to 12.5 points. 1984, when it grew to over 20 points, those insurers writing predominantly commercial lines had a negative return on net worth. In 1985, the gap began narrowing but still stood at nearly 15 points for the year ended September 30, 1985.

An even greater concern for commercial lines insurers and reinsurers is that their combined ratios may be understated due to reserve inadequacy. Because of this, the combined ratios for these insurers could be worse than the record highs recorded.

Richard E. Stewart, former Superintendent of Insurance of the State of New York, discusses the current cycle in a December 1985 Marsh & McLennan *Commentary* article. In it, he writes, "...this is not just a routine turn in the underwriting cycle. It has structural as well as cyclical causes." He further notes, "Whereas economic inflation drove the casualty insurance crises of the mid-seventies, the current one is driven by terrible events and by changes in liability law." And he adds, "Insurance has met liability problems before. These are liability disasters. No exclusion is reliable, no excess level out of reach."

All these elements strongly support the conclusion that this is not just a "typical cycle" for the property/casualty insurance industry. Because reinsurers and commercial lines insurers have been hit harder, premium increases will fall unevenly, with some commercial liability policyholders experiencing very large increases. Because the industry's downturn lasted longer than ever before and because the depth of the downturn was worse than ever before, the recovery must be longer and stronger in order to achieve an adequate level of profitability for the industry.

ACCUSATION

Insurance is too expensive.

CHARGE: The total insurance bill in the U.S. will rise from 11.1% to more than 12% of disposable income in 1985—more than $300 billion—displacing personal federal income taxes as the third largest expense in the nation's budget. Only food and housing cost Americans more than insurance.

THE FACTS: These statistics are misleading. The $300 billion figure includes life, health, and accident insurance premiums as well as all property/casualty insurance premiums. The costs of life, health and accident insurance do not belong in a discussion of property/casualty insurance. Moreover, the inclusion of business insurance expenses is inappropriate when making comparisons to disposable income, which is a measure of personal income only.

Personal lines insurance premiums (for private passenger automobile and homeowners insurance) are estimated to be $64 billion in 1985, which would represent 2.3% of disposable income, the amount of 1985 personal income after taxes.

Insurance is not even the largest expense associated with owning either a car or house. In 1984, the Federal Highway Administration conducted a study on the cost of owning and operating typical vehicles in suburban Baltimore, Maryland. The study concluded that insurance was the third largest cost—behind vehicle cost depreciation, and gas and oil for most cars. For large and compact cars, it ranked fourth—behind vehicle cost depreciation, gas and oil, and also maintenance, accessories, parts and tires.

A 1983 countrywide study by the U.S. League of Savings Associations showed that the cost of insurance represents less than 3% of the monthly housing expenses faced by home purchasers in the United States. Insurance costs came in fourth—behind mortgage payments, real estate taxes and utilities.

There are many items that cost Americans more than insurance. One way to analyze relative costs is to examine the components of the nation's personal consumption expenditures, which are included in GNP. According to the Department of Commerce, personal consumption expenditures represent the market value of purchases of goods and services by individuals and non-profit institutions and the value of food, clothing, housing, and financial services received by them. Therefore, the components of personal consumption should be compared with personal lines premiums as follows:

1985 AMOUNT SPENT ($ BILLIONS)	
PERSONAL CONSUMPTION COMPONENT	
Food & Beverages	474
Housing	403
Motor Vehicles & Parts	168
Clothing & Shoes	156
Furniture & Appliances	129
Gasoline & Oil	92
INSURANCE PREMIUMS	
Personal lines insurance premiums[3]	64
Total property/casualty insurance premiums	142

The table indicates six components which are a greater proportion of consumer spending than property/casualty personal lines premiums.

[3]It should be noted that personal lines insurance premiums do not include premiums written on non-profit institutions. However, inclusion of premiums written on non-profit institutions with personal lines premiums would have a minor impact and would not raise the total above any of the six personal consumption items listed above.

CHARGE: Property/casualty insurance premiums written rose by $24.6 billion in 1985, from $117.7 to $142.3 billion, while coverage decreased substantially. This works out to an increase of $105 per person for substantially less coverage.

THE FACTS: These figures are misleading. A.M. Best's estimate of the $24.6 billion increase is for all property/casualty premiums, not just personal lines premiums.

Personal lines premium (for the coverages purchased by individuals to protect their autos and homes) increased $6.7 billion, or 11.7% in 1985, an increase of $28 per person, not $105. The 11.7% increase in personal lines premiums in 1985 approximated the 13% increase in personal lines losses. ISO estimates that personal lines paid losses and loss adjustment expenses increased $5.5 billion in 1985, equivalent to an average $23 payment per person. After all losses and expenses, insurer underwriting loss for personal lines was over $1 billion more in 1985 than in 1984.

There do not appear to be significant marketplace problems in the personal lines. Large premium increases are the exception rather than the rule, and restrictions in coverage have been rare.

Most of the 1985 written premium increase was in commercial lines, which increased $17.8 billion or 30%, as the industry reacted to the growth in losses for these lines.

These increases in commercial insurance loss costs are a matter of concern, since they are outpacing the costs of other goods and services. It is precisely this point that has led industry leaders, businesspersons, legislators, regulators and consumers to investigate methods of reducing the upward spiral in insured losses.

APPENDIX
DISCUSSION OF REINSURANCE

Reinsurance is essentially an insurance transaction whereby the reinsurer, for a premium, agrees to indemnify the ceding insurer or reinsured against all or part of the loss which the latter may sustain under its policies of insurance. It is often described as the insurance of insurance companies because it provides reimbursement for an insurer's losses under policies covered by the reinsurance contract. Reinsurance is purchased by the primary or excess ceding insurer for its own benefit so that it can spread its risks and limit its own liability from large or catastrophic losses. The usual reinsurance contract does not involve the policyholder, who looks only to its insurer for defense and indemnity against loss.

Reinsurance was developed to provide capacity essential to the continued growth of the direct insurance industry. In addition to capacity, reinsurance is purchased by a primary insurer to (1) reduce exposure to liability on particular risks, (2) protect against accumulations of losses arising out of catastrophes, (3) reduce total liabilities to a level appropriate to its premium volume and capital, (4) reduce exposure to certain and possibly more hazardous lines of business or alter its "mix" of business, (5) help stabilize operating results, and (6) obtain assistance with new concepts and lines of insurance.

Reinsurance contracts are shaped to meet the specific needs of the ceding insurer . . . There are no standard reinsurance contracts; there are two basic types which are used and adapted to accommodate the buyer's business. A reinsurance *treaty* is a broad and often automatic agreement that covers some portion of a particular class or classes of business, i.e., the ceding insurer's entire workers' compensation or property book of business. In contrast, a *facultative* agreement covers a specific risk of the ceding insurer and requires the insurer and reinsurer to agree on terms and conditions on a contract-by-contract basis. Both treaties and facultative agreements may be based on a *pro-rata* distribution where the two parties share proportionately in premiums and losses. The agreements may also be written on an excess basis, where only the losses of the insurer in excess of a predetermined amount, known as the "retention", are reinsured.

Reinsurance Association of America statement before the House Subcommittee on Commerce, Transportation and Tourism, September 19, 1985.

Coopers
&Lybrand

certified public accountants

1251 Avenue of the Americas
New York, New York 10020

telephone (212) 536-2000

a principal areas of the world

February 12, 1986

Insurance Services Office Inc.
125 Maiden Lane
New York, NY 10038

Gentlemen:

You have requested our opinion on the appropriate accounting by property and liability insurance companies for (1) dividends to policyholders and (2) realized gains and losses on investments. Our opinions expressed herein do not relate to assessment enterprises or fraternal benefit societies which may employ different accounting principles.

Generally accepted accounting principles for property and liability insurance companies are set forth in the Statement of Financial Accounting Standards No. 60 (the Statement), "Accounting and Reporting by Insurance Companies". The Statement contains the guidance for our views on the transactions set forth above which are:

Dividends to Policyholders

In our opinion, generally accepted accounting principles for property and casualty insurance companies require that dividends to policyholders be charged to operations.

Realized Gains and Losses on Investments

In our opinion, generally accepted accounting principles for property and casualty insurance companies require that realized gains and losses on all investments (including, but not limited to, stocks, bonds, mortgage loans, real estate and joint ventures) be reported in the income statement below operating income and net of applicable income taxes.

Very truly yours,

Coopers & Lybrand

or additional copies of this analysis, contact:
Insurance Services Office, Inc.
Corporate Communications Department
160 Water Street
New York, New York 10038

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UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

FOR RELEASE ON DELIVERY
Expected about 9:00 a.m.
Monday, April 28, 1986

STATEMENT OF

JOHNNY C. FINCH, SENIOR ASSOCIATE DIRECTOR

GENERAL GOVERNMENT DIVISION

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ON

PROFITABILITY OF THE PROPERTY/CASUALTY

INSURANCE INDUSTRY

Attachment 21

Mr. Chairman and Members of the Subcommittee:

We are pleased to appear before the Subcommittee again to assist it in its deliberations on the subject of the insurance industry. At your request, we will address our remarks today to (1) the property/casualty industry's pricing strategies, particularly as they are affected by "cash flow underwriting"; (2) industry profitability; (3) the cyclical nature of that profitability; (4) the financial outlook for the industry; and (5) the current difficulties in the property/casualty industry, specifically as they relate to the medical malpractice and general liability insurance lines.

In addressing these issues, we will make the following points. Property/casualty companies have used a pricing strategy which sacrificed underwriting profit margins in order to generate cash for investment purposes. As a result of this strategy, the property/casualty industry has made, depending upon whose estimates are used, between $50 and $75 billion in net gains over the last 10 years. Furthermore, like many other businesses, property/casualty underwriting is subject to profitability cycles. While underwriting losses have mounted since 1980, estimated data for 1985 indicates that the underwriting cycle has turned and is now moving in a positive direction. Indeed, the industry itself is projecting substantial net gains over the next 5 years.

The current difficulties in liability insurance are found principally in certain liability insurance lines. Two lines frequently mentioned by the media within a crisis context are general liability and medical malpractice. These lines, however, represent a small portion, less than 10 percent, of the total property/casualty business. Furthermore, as compared to some reported premium increases, our computations show that, with smaller increases in earned premium revenues, these lines could break even.

I will now discuss these points in greater detail. In doing so, I will explain the sources of our data and the scope of our work.

PROPERTY/CASUALTY COMPANY PRICING STRATEGIES

A property/casualty company derives its income from two principal areas: underwriting gains, which are the excess of premiums over claims and expenses, and investment gains. Because of investment gains, a property/casualty company can have net income even though its premium revenues alone are not large enough to cover claims and expenses.

Thus, the ability to offset underwriting losses with investment income plays an important role in a company's pricing strategy--that is, the amount it charges for the insurance that it offers. For a number of years, many companies have employed a pricing strategy known as cash flow underwriting. Basically,

companies have been willing to accept lower premiums for certain insurance lines in order to encourage sales and obtain funds for investment. In essence, the strategy has been to sacrifice underwriting gains for investment gains. For example, in 1984, claims, expenses, and policyholder dividends exceeded premium revenues by almost 18 percent.

The companies, however, have taken this risk because they expected to make up the premium shortfall through investment income. Through the increased volume of premiums resulting from this pricing approach, companies were able to generate a larger amount of net cash flow which they could then invest to earn additional investment income. For instance, over the 5-year period 1980-1984, when the industry's claims and expenses exceeded premiums by about 9 percent, its underwriting loss was about $45 billion. Even so, the industry had $82 billion in investment gain which, when offset against its underwriting losses, resulted in a net gain of about $37 billion. The investment gain was made possible, at least in part, by the industry's pricing strategy which generated about $66 billion in net cash flow. The industry was then able to invest these funds at favorable rates.

From 1975 to 1983, investment gains, in the aggregate, have exceeded underwriting losses by a fairly wide margin. However, this situation changed in 1984, when underwriting losses for the industry were $19.4 billion while investment gains were $17.9 billion. Reacting to this result, some companies have sharply raised premiums.

PROFITABILITY OF THE PROPERTY/CASUALTY INDUSTRY

We developed a financial overview of the property/casualty insurance industry using financial data for the 10-year period 1976 through 1985. We obtained the 1976-1984 data from Best's Aggregates and Averages and the 985 data from Best's Insurance Management Reports, dated December 30, 1985. The 1985 data were estimated by Best's since final 985 operating results were not, and are still not, available. While Best's reports omit figures for many small or new companies, we believe that the data are representative of the overall financial results of the property/casualty industry.

In the table below, we show sources of property/casualty income broken out by underwriting gains, investment gains, and total gains. This table clearly illustrates the results of the industry's pricing strategy to obtain investment income at the expense of underwriting income. While property/casualty companies had about $65 billion in underwriting losses, they also earned about $140 billion from their investments during this 10-year period. Overall, the industry had a net gain of about $75 billion.

All Companies -- Consolidated Basis
1976 through 1985
($ in billions)

Underwriting gains/(losses)	Investment gains	Net gains
($65.2)	$140.2	$75.0

We would like to make two points about our figures which may differentiate them from figures developed by others. First, the investment gains include net investment income and both realized and unrealized capital gains. We recognize that unrealized gains are just that, unrealized, and therefore, are subject to investment risks which could result in lower or higher amounts. However, we have chosen to include unrealized gains in our figure because it is within a company's control to manage its investment portfolio so as to realize these gains while the investments are profitable.

Second, the underwriting losses do not reflect policyholder dividends. We consider these dividends to be voluntary, not mandatory, distributions by the companies. Since the companies are not required to make these distributions, we have chosen to exclude them from our underwriting loss figure.

Even if we adjusted our figures to exclude unrealized gains and to include policyholder dividends (the approach used by the industry for its calculation), the industry's net gain for this 10-year period would still be $51 billion. In either case, it is within management's discretion to realize investment gains or to not pay policyholders' dividends.

CYCLICAL NATURE OF INDUSTRY PROFITABILITY

While it is important to look at the figures for the most recent years, it should be noted that over the longer period the property/casualty industry has demonstrated profit and loss cycles. We believe that data covering longer periods give a more complete picture of the industry's profitability.

Unlike most other industries, the property/casualty insurance industry is flexible with respect to capacity or supply. During profitable periods insurance companies can increase their capacity, take varied and greater risks, and generally lower their premium rates to achieve a greater market share. Such actions result in price competition as other firms lower their prices to retain their market share. Price competition results in a change from favorable premium profit margins to unfavorable margins, resulting in the underwriting profit and loss cycles.

Attachments I and II illustrate the cyclical nature of the property/casualty industry profitability. Attachment I shows the year-by-year underwriting and investment results for the 12-year period from 1974 through 1985. Column 2 in that attachment, underwriting gains and losses, illustrates the cyclical nature of the industry. The earlier cycle bottomed out in 1975 with a $3.65 billion loss and peaked in 1978 with a $2.55 billion gain. Since 1980, underwriting losses have mounted again. However, estimates indicate that the loss cycle bottomed out in 1985 and that the cycle has now turned upward.

Attachment II illustrates the cyclical nature of property/casualty stock companies over the past 40 years. For purposes of illustration, we used the combined ratio concept, a ratio of claims and expenses to premium income. The attachment reflects the industry's underwriting results and premium pricing strategy; it does not include investment results. As can be seen, stock companies have had several underwriting cycles since 1945.

FINANCIAL OUTLOOK FOR THE INDUSTRY APPEARS FAVORABLE

From all indications, it appears that the trend towards larger underwriting losses has peaked. Available industry estimates show that over the next 5 years the industry expects substantial net gains. Our calculations, made from the industry estimates, indicate an expected net gain before taxes of more than $90 billion over the years 1986-1990.

Analysts of the industry also generally predict favorable industry prospects. For example, an August 1985 study by Salomon Brothers, Inc.,[1] forecast that premiums written will grow at a 12 percent annual rate over the 1985-1989 period. The same study forecasts a 10 percent growth rate for incurred losses over the period. The study forecasts further that total industry profits will rise annually at a rate of 25 percent over the same period. More recently, the Best's Insurance Management

[1]Salomon Brothers, Inc., Property/Casualty Insurance Organizations, Five-Year Review and Outlook, 1985 edition, August 1985.

Reports, dated December 30, 1985, estimated that net premiums written in 1985 would increase by 21 percent over net premiums written in 1984.

PROBLEMS IN MEDICAL MALPRACTICE AND GENERAL LIABILITY LINES

Although the financial outlook for the industry as a whole appears favorable, the current difficulties in liability insurance are more pronounced in certain lines. Two insurance lines often mentioned in the context of high premiums and lack of availability are medical malpractice and general liability. General liability insurance includes coverage of items like day care centers, [redacted]. The following examples are illustrative of some reported difficulties individuals and businesses have encountered recently:

--In February, the government's interagency Tort Policy Working Group reported on a survey of day care providers which found that insurance policies had been cancelled or not renewed for 40 percent of the respondents and the majority of those with continuing coverage had experienced premium increases of between 200 and 300 percent.

--In March, the American Medical Association testified before this Subcommittee that malpractice insurance rates for obstetricians in Maryland increased by 130 percent last summer.

--The March 24, 1986, issue of Time reported the story of one asbestos removal company whose policy increased in cost from $9,361 to over $450,000, an increase of almost 5,000 percent, despite never having been sued.

The medical malpractice and general liability lines, however, do not represent a major portion of the total property/casualty insurance business. Attachment III shows, for 1985, the relationship of these two lines to other property/casualty lines. The data were estimated by Best's which reports on 27 insurance line categories. For our purposes, we have grouped certain lines into one category; for example, personal and commercial automobile liability is shown as automobile liability.

The figures in this attachment show that the medical malpractice and general liability lines represent a relatively small portion of the industry. Medical malpractice premiums accounted for less than 2 percent of all property/casualty premiums written for 1985 and general liability premiums accounted for less than 8 percent. However, underwriting losses attributable to these lines accounted for almost a quarter of

all underwriting losses; medical malpractice being 5.6 percent and general liability being 18.3 percent. It should be noted, Mr. Chairman, that for certain companies that specialize in these liability lines, the proportion of the losses will likely be higher.

Despite the relatively large proportion of underwriting losses that the medical malpractice and general liability lines represent, attachments IV and V show that in 1984 these two lines could have broken even with smaller increases in premium rates than the rate increases presently being reported in the media. Attachment IV, for example, shows that for the medical malpractice line, a premium rate increase of 20 percent would have put this line at a break even point. Similarly, attachment V shows that for the general liability line, an approximate 30 percent increase in premium rates would have been sufficient to break even. (1984 is the most recent year for which we are able to make such estimates; the necessary data is not yet available for 1985.)

CONCLUSION

In conclusion, Mr. Chairman, available financial information for a recent 10-year period indicates that the profitability of the property/casualty industry has been cyclical in nature. The data further indicate that over this period the industry has been generally profitable. The industry's profitability has been lower in recent years;

however, the industry projects increasing premium volumes and more favorable prospects for the next few years. The data also show that while medical malpractice and general liability insurance have received considerable attention recently, they represent a relatively small portion of the industry overall. Finally, our calculations show that, for 1984, these lines could have broken even with smaller increases in premium rates than some premium rate increases currently being reported in the media.

That concludes my statement, Mr. Chairman. We would be pleased to respond to questions.

ATTACHMENT I

ATTACHMENT I

UNDERWRITING GAINS, INVESTMENT GAINS, COMBINED UNDERWRITING AND INVESTMENT GAINS: ALL COMPANIES -- CONSOLIDATED BASIS[a] YEARLY 1974-1985 ($ in millions)

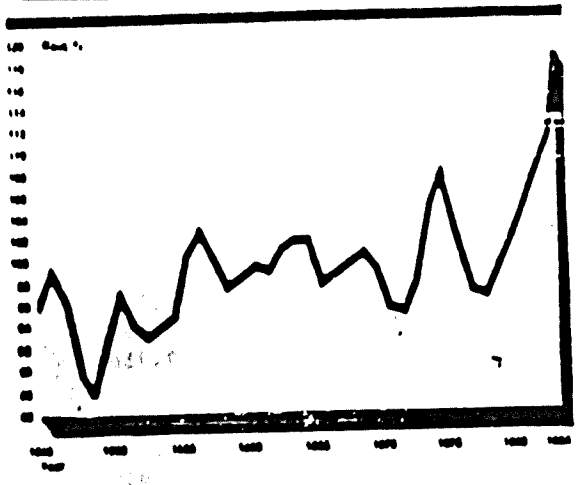
Year	Underwriting gains/(losses)	Investment gains/(losses)	Total
1974	(1,974)	(2,443)	(4,417)
1975	(3,653)	7,009	3,356
1976	(1,726)	7,173	5,447
1977	1,926	5,063	6,989
1978	2,548	7,758	10,306
1979	24	11,610	11,634
1980	(1,712)	15,870	14,158
1981	(4,464)	10,858	6,394
1982	(8,303)	18,387	10,084
1983	(11,088)	19,441	8,353
1984	(19,379)	17,875	(1,504)
1985 Est.	(23,100)	26,200	3,100

[a]Consolidated totals eliminate double counting by excluding intercompany transactions between parent and subsidiary companies.

ATTACHMENT II

ATTACHMENT II

Combined Underwriting Ratios for Property/Casualty Stock Companies for the Years 1945-84[a]



Year	Ratio %	Year	Ratio %
1945	95.8	1965	101.9
1946	98.8	1966	98.1
1947	96.3	1967	98.9
1948	91.2	1968	100.0
1949	87.6	1969	100.6
1950	93.0	1970	99.3
1951	97.1	1971	95.8
1952	94.4	1972	95.4
1953	93.1	1973	98.2
1954	93.6	1974	105.0
1955	94.9	1975	107.5
1956	100.5	1976	102.0
1957	102.9	1977	97.0
1958	100.0	1978	96.6
1959	97.8	1979	99.6
1960	98.4	1980	102.4
1961	99.4	1981	104.9
1962	99.0	1982	108.7
1963	101.0	1983	111.8
1964	101.9	1984	119.0

[a]A combined ratio is a ratio of claims and expenses to premium income. Ratios below 100 represent underwriting gains and ratios above 100 represent losses.

ATTACHMENT III

Net Premiums Written and Underwriting Gains/Losses Estimated for All Insurance Lines for 1985 ($ in billions)

Selected long-tailed insurance lines[a]	Net premiums written	Premiums as a percent of all lines	Underwriting gains/(losses) after dividends	Underwriting gains/(losses) as a percent of all lines
Automobile liability	$35.7	25.1%	($7.3)	29.0%
Workers compensation	16.8	11.8	(3.7)	14.7
General liability	11.1	7.8	(4.6)	18.3
Medical malpractice	2.6	1.8	(1.4)	5.6
Subtotal	66.2	46.5	(17.0)	67.6
Selected short-tailed insurance lines[a]				
Automobile physical damage	24.9	17.5	(0.3)	1.2
Homeowners multiple peril	15.0	10.5	(1.8)	7.1
Commercial multiple peril	11.7	8.2	(3.0)	11.9
Subtotal	51.6	36.2	(5.1)	20.2
All others[b]	24.5	17.2	(3.1)	12.3
Total all lines	$142.3	100%[c]	($25.2)	100%[c]

[a]Long-tailed insurance lines are lines characterized by third-party involvement (an injured party other than the insured) and by settlements that will occur in an unknown future time period. Short-tailed lines, on the other hand, typically involve only two parties (the insurer and the insured) and settlements that will take place within a relatively short time frame (generally a year or two) following a claim.

[b]Includes such long-tailed lines as reinsurance and group accident and health, as well as such short-tailed lines as burglary and theft, and aircraft.

[c]Does not add due to rounding.

ATTACHMENT IV

ATTACHMENT IV

Break Even Analysis for the Medical Malpractice Line in 1984 ($ in millions)

Computation of Additional Earned Premiums Needed to Break Even:

Premiums earned	$1,707	
Net investment gains[a]	750	
Total Revenues		$2,457
Less:		
Net losses incurred	$1,913	
Expenses and dividends	868	
Total Outlays		2,781
Net income/(loss) before taxes		($323)[b]
Sales commissions on additional premiums ($323 / (1-.052) - $323)[c]		18
Additional earned premiums needed to break even before commission		$341
Percent additional earned premiums needed to break even ($341 / $1,707) x 100)		20.0%

[a]Does not include unrealized gains.

[b]Does not add due to rounding.

[c]Commissions paid on this line averaged 5.2 percent of premiums written.

ATTACHMENT V

ATTACHMENT V

Break Even Analysis for the General Liability Line in 1984
($ in millions)

Premiums earned	$6,251	
Net investment gains[a]	1,665	
Total Revenues		$7,916
Less:		
Net losses incurred	$5,456	
Expenses and dividends	4,100	
Total Outlays		9,556
Net income/(loss) before taxes		($1,640)

Computation of Additional Earned Premiums Needed to Break Even:

Sales commissions on additional premiums ($1,640 / (1-.121) - $1,640)[b]	226
Additional earned premiums needed to break even after commission	$1,866
Percent additional earned premiums needed to break even ($1,866 / $6,251) x 100)	29.8%

[a]Does not include unrealized gains.

[b]Commissions paid in this line averaged 12.1 percent of premiums written.

The manufactured crisis

Liability-insurance companies have created a crisis and dumped it on you.

March 23, 1980, was a bright, beautiful spring day in Gillette, Wyo. So Alta Means thought she would do some cleaning in a cottage she owned. Her granddaughter, nine-year-old Dustina Rhodes, lazily tagged along. Suddenly, the tiny cabin exploded into an orange fireball, engulfing Means in flames and blowing Dustina out the door. The grandmother died a couple of weeks later from massive burns; the granddaughter survived but suffered severe burns.

A spark had ignited a cottage bloated with propane gas—gas that leaked through a *Honeywell V8280* valve on the cottage's room heater. That type of valve, the Consumer Product Safety Commission subsequently said, tended to jam open because of a defect in design and manufacture. The valve was recalled by Honeywell in 1985. Dustina Rhodes and Alta Means' estate sued Honeywell for their losses. They eventually settled for more than $1-million.

Now the insurance industry and manufacturers are trying to pass legislation that could make it more difficult to adequately compensate victims like Dustina Rhodes for their injuries. The push for so-called "tort reform" is on at both the state and Federal levels.

Insurers say legislation is needed to fix a "crisis" that has made many types of liability insurance costly—or even impossible to get. The insurance industry has launched a $8.5-million advertising campaign and an intense lobbying and public-relations effort to lay the blame for its financial problems on people who are injured, juries, or lawyers.

The insurance crisis

The current liability-insurance crisis began a little more than a year ago with skyrocketing premiums and cancellations of policies.

- In New Haven, Conn., a chain of seven day-care centers affiliated with Yale University saw its liability insurance premium jump from $400 in 1984 to $2400 last year.
- In Brooksville, Fla., a general vascular surgeon paid $5000 for malpractice insurance in 1984. In 1985, the rate tripled to $15,000, and this year he is paying $38,000. The doctor is thankful he doesn't practice in Miami, where his rates would top $70,000 a year.
- In Hammondsport, N.Y., the Bully Hill Winery has sharply curtailed its free wine-tasting because its insurance premiums have gone from $3000 for $1-million in coverage in 1985 to $8000 for $500,000 in coverage in 1986.
- Aetna Life and Casualty has recently dropped some 400 municipalities from its liability-insurance rolls.

The increasing cost and declining availability of liability insurance affects everyone. Police departments cancel patrols and cities dismantle playgrounds for lack of municipal liability insurance. Many obstetricians are leaving their field. The number of nurse-midwives could shrink as they, too, find it increasingly difficult—if not impossible—to obtain malpractice insurance. Doctors' escalating insurance costs are bound to show up in their bills to patients. Day-care centers could become less affordable as their insurance rate hikes are passed on to working parents. The cost of owning a condominium rises with every bump up in liability-insurance premiums.

How it happened

In its advertising and in most statements to the press and the public, the insurance industry lays blame for the crisis on lawyers, juries, or victims whose alleged carelessness brought on their own problems. Lawyers use the civil justice system "to right every imagined wrong," cries the Insurance Information Institute, an industry trade group.

A more objective analysis suggests that the "crisis" is of the insurance industry's own making. A Washington state task force concluded last year that the crisis "is mostly a result of poor management practices by the [insurance] companies." In New York, a report of the Governor's Advisory Commission on Liability Insurance said that "the industry's poor recent financial condition largely reflects self-inflicted wounds."

Insurance companies have two major sources of money to cover claims and make profits—the premiums policyholders pay, and the interest the companies can earn on money that isn't immediately needed to pay claims. When interest rates are high, insurance companies try to get as many customers as possible to bring in the premium dollars they want to invest. In the early 1980s, when interest rates topped 20 percent, insurance companies slashed premiums to sell as many policies as they could.

"The insurance companies did anything they could to get money to put into the money markets," says Dennis Jones, a spokesman for the Professional Insurance Agents trade association. "They did not underwrite the business as well as they should have. [Underwriting is the science of assessing risk and setting an appropriate premium to cover the risk.] But it's very tempting to get the money in today to earn 21 percent interest and worry about the losses later."

In 1981, the property-and-casualty industry suffered a record $6.3-billion in underwriting losses (premiums collected minus expenses and claims paid). Yet there was no "liability crisis." Investment gains of $13.2-billion the same year still created plush net profits.

The "crisis" came when interest rates dropped, slowing the rise of investment income. By 1984, the profit/loss picture had reversed itself. Underwriting losses of $21.5-billion exceeded investment income of $17.7-billion. Even so, the industry managed to show a small profit—in large part as a result of the tax benefits described on page 547.

In 1985, underwriting losses were $24.7-billion, and investment income was $19.5-billion. Because of tax benefits, the industry again came out slightly ahead, but profits were weak.

To right itself, the industry has taken two major steps. First, it has jacked up rates for all liability-insurance buyers to levels that not only cover current losses but, some critics charge, recoup losses from mismanagement in previous years. Second, companies have dropped lines of business designated as "high risk."

When pressed, some insurance executives

Attachment 23

representatives concede that the effect of the business cycle on interest rates is a major factor in the present crisis. "The fact that premiums are going up at high rates is purely due to the cycle," says Sean Mooney, senior vice president at the Insurance Information Institute. He nevertheless maintains that the "lawsuit crisis" is the reason that some parties can't get liability insurance at all.

An orchestrated campaign

The insurance industry is trying to turn its crisis into an opportunity—a chance to press for one of its favorite objectives, "tort reform." In plain words, the industry's version of tort reform means placing limits on the rights of injured people to sue for and recover damages.

The latest round in the industry's long-standing campaign began in early 1985. At that time, insurance-industry leaders already knew that a cycle-borne crisis that would necessitate jarring premium increases was brewing. The industry launched an advertising program aimed at U.S. opinion leaders—politicians, business leaders, executives, and journalists.

In June, 1985, John Byrne, then chairman of the board of Geico, a major insurance company, told the Casualty Actuaries of New York that "the insurance industry should quit covering doctors, chemical manufacturers, and corporate officers and directors." Byrne also said, "It is right for the industry to withdraw and let pressure for [tort] reform build in the courts and in the state legislatures."

By summer of 1985, insurance rates indeed started rising. As the varied group of liability-insurance consumers began to feel the squeeze, they started to complain. Through the second half of last year, a grass-roots coalition of doctors, municipalities, nurse-midwives, manufacturers, day-care centers, and others with insurance problems came together. Many of them believed what the insurance industry was telling them: that greedy lawyers and excessive jury verdicts were to blame for the increasing insurance rates.

In early 1986, the Journal of American Insurance pointed to the tort-reform movement as a superb example of coalition-building by the insurance industry.

This March, the Insurance Information Institute announced a $6.5-million advertising campaign to sell "the lawsuit crisis." This second campaign, still in progress, is aimed at the general public.

Print and television commercials talk about the possible demise of high-school football and other sports programs and suggest you write to the Insurance Information Institute. If you do write, you get advice on how to influence legislators. Voters, the insurance people hope, will pass the message of panic on to their state and Federal representatives.

Those 'high' awards

Insurance-industry leaders say that the average award in product-liability cases is now more than $1-million.

That figure—and many others used by the industry—is based on statistics compiled by Jury Verdict Research, a firm in Solon, Ohio, that keeps track of such things. The Jury Verdict Research statistics, however, don't reflect reality very well.

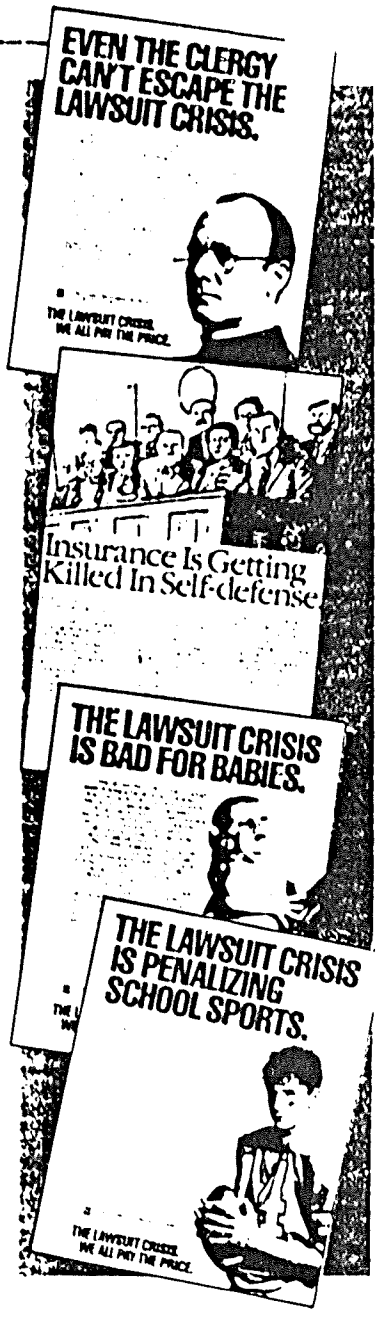
The statistics are raw data on initial awards by a jury, and that's usually not the last word in litigation. Cases are often appealed, and the appeals court may reduce the award or overturn the verdict, resulting in an award of zero. To avoid the uncertainty and added expense of an appeal, some plaintiffs and defendants agree to an immediate post-trial settlement, which can be significantly lower than what the jury awarded.

Trial judges also reduce jury awards. Indeed, the very first multimillion-dollar award on record ($3.5-million in damages won by actor John Henry Faulk in 1962 for being blacklisted for his political views in the 1950s) was reduced to $450,000 by the judge. According to one study, done by the Rand Corporation's Institute for Civil Justice, half of the initial jury awards surveyed were reduced after the trial. The largest awards were the ones most likely to be reduced and subject to the biggest reductions.

There are other important reasons why the average verdict numbers are, statistically speaking, extremely "soft." The Jury Verdict R statistics include only verdicts in favor of the plaintiff. Cases that the defendant wins and that result in an award of zero are not counted. Cases settled before trial aren't counted either.

One unusually large verdict can skew the numbers by pulling the annual average way up. Such was the case in 1978, when a jury awarded more than $127-million to a man who was seriously burned when a gasoline tank exploded in an accident involving a Ford *Pinto*. As a result of that one verdict, the average product-liability award in 1978, according to the Jury Verdict Research, hit $1.7-million—up an astounding 285 percent over the previous year's average. But the trial judge later reduced the *Pinto* award to $6.7-million. Had the statistics accurately reflected

Insurers are spending millions of dollars—including $6.5-million through the Insurance Information Institute—to sell the idea of a "lawsuit crisis."



that, they would have shown the average award in 1978 to be just 19.5 percent over the previous year, not 285 percent.

It's best to look at median awards rather than average awards. To be sure, the average would provide the best gauge of the industry's costs—if the figures were trustworthy. But, as we've seen, average awards are disproportionately influenced by a few large verdicts—the very ones most apt to be reduced post-trial. Furthermore, it's the median, not the average, that shows how the typical injured person is compensated.

Between 1975 and 1984, according to Jury Verdict Research, the growth in the median initial medical-malpractice award has been less than the rise in inflation. In product-liability cases, the growth rate for median initial awards has exceeded the inflation rate, but not by much.

The Rand Corporation's Institute for Civil Justice has tracked tort action in San Francisco and in Cook County, Ill., which includes Chicago, since 1960. It has found that the median initial award, adjusted for inflation, stayed virtually level.

The phantom explosion

The explosion that claimed the life of Alta Means was real. The so-called "litigation explosion" repeatedly cited by advocates of tort reform is essentially a myth. Under close scrutiny, many of the facts and figures cited by tort-reform advocates do not hold up:

Assertion: The U.S. is in the midst of a "litigation explosion."

Fact: Last year, the National Center for State Courts (a nonprofit group funded largely by the courts themselves) analyzed data on tort litigation in 20 state courts for the years 1978, 1981, and 1984. Careful examination of the data "provides no evidence to support the existence of a national 'litigation explosion' in state trial courts during the 1981-84 time period," said Dr. Robert Roper, a project director at the center.

The center's data show that the annual number of tort filings in 17 states studied rose 9 percent between 1978 and 1984. Meanwhile, population in those states rose 8 percent. While court filings in 20 states did rise 14 percent between 1978 and 1981, they fell 4 percent between 1981 and 1984.

The number of liability cases filed in Federal courts has increased significantly. But a single type of suit—damage claims related to asbestos—accounts for much of the increase. Last year, 4239 of the 13,554 product-liability cases filed in Federal courts—31 percent—were asbestosis cases. That's not surprising. Asbestosis and asbestos-induced cancer result from many years of exposure; only in recent years have the consequences of long-term exposure become evident in debilitating illness and death. In CR's opinion, people who are suffering from asbestosis or asbestos-induced cancer (and the families of those who have died) deserve compensation.

Assertion: Plaintiffs win million-dollar verdicts regardless of merit.

Fact: Stories told to prove this point are, at most, isolated incidents, and are often exaggerated to the point of myth. Insurers like to cite their favorite horror stories—about large awards given to a woman who said she lost her psychic powers after a hospital CAT scan, or to a man who injured himself using a lawn mower to trim a hedge, or to a California vandal who injured himself falling through a school-building skylight.

Such anecdotes typically lose some important details and gain a few embellishments in the telling. Take the case of the psychic. Both United Press International and Associated Press made much of the fact that Judith Haimes was awarded close to $1-million by a Philadelphia jury last March after she said that a CAT scan at Temple University Hospital made her lose her psychic abilities. That's what made the headlines.

Buried at the bottom of both wire-service stories was the fact that Judge Leon Katz told the jury to disregard that issue, and to base the verdict on whether the hospital was negligent in administering a contrast dye into her brain. The procedure allegedly caused Haimes to suffer breathing difficulties, intense headaches, nausea, and incontinence. What the jury really decided was that the hospital had negligently caused Haimes's adverse physical reaction, not that she had lost her psychic powers.

A Crum & Forster ad in 1977 referred to the man who used a lawn mower to trim a hedge, hurt himself, sued the manufacturer, and won. The tale has been repeated dozens of times in support of the notion that consumers injure themselves foolishly and then seek out greedy lawyers to bring groundless lawsuits. But the story was purely apocryphal. Crum & Forster admitted that it had no reliable source for the alleged incident.

And that vandal who fell through the skylight? There's some truth to that one. But the incident isn't as absurd as it first sounds. The skylight was painted the same color as the school's roof. The school district knew that situation was hazardous because a young girl had already been killed falling through a similar skylight at another school six months before.

When a plaintiff receives a large award, it's usually for a very good reason. Jurors

Verdict Research has on file 2094 cases in which initial verdicts equalled or exceeded $1-million during the period from 1962 to 1985. Of those, 71 percent were for such damages as paralysis, permanent brain damage, wrongful death, amputations, and burns.

What insurers want

Several proposals have been put forth by the insurance industry and its supporters in state legislatures.

Limits on awards for pain and suffering. Most industry-backed tort-reform proposals do not attempt to limit the amount of recovery for economic losses such as lost wages and medical costs. However, limits are being proposed on compensating victims for the pain and suffering that results from an injury. CU believes that while those harms are difficult to quantify, they are nonetheless real and should not be subject to a fixed, preset limit. A man confined to a wheelchair as a result of someone's negligence but still able to keep working at his regular desk job might suffer no lost wages, but certainly his quality of life would be affected.

Limits on punitive damages. Punitive damages, as the name implies, are imposed to punish a defendant for acting irresponsibly or with disregard for safety. CU believes punitive damages must be maintained in full force to help deter manufacturers and others from irresponsible behavior.

Elimination of joint and several liability. The legal doctrine of joint and several liability applies when more than one defendant is responsible for causing an injury. If one defendant cannot pay, the burden of payment is transferred to the other parties found to be at fault.

Critics of the doctrine say that it encourages plaintiffs to sue multiple defendants, especially those with "deep pockets," such as large corporations, municipalities, and people who carry a lot of insurance. Why, they ask, should a wealthy defendant that bears only, say, 5 percent of the responsibility for a mishap have to pay for most or all of the damages, simply because the other defendants cannot pay?

The question is a valid one, and the issue a complex one. But CU does not believe the doctrine should be abolished. Without it, there would be no mechanism to make sure victims can recover a fair amount for damages. If the doctrine of joint and several liability were eliminated, victims would be left holding the bag when those defendants able to pay succeed in shifting the blame to those who can't.

Limiting contingency fees. Lawyers who take on a liability or malpractice case typically work on a contingency-fee basis: They get a percentage of the damage award, typically about 30 percent of the damages paid. If they lose the case, they get nothing. Such a system allows victims who aren't wealthy to obtain legal representation at little or no initial cost. At the same time, because attorneys are "investing" their own time and money in the case, they have an incentive to weed out frivolous or weak cases. Furthermore, it would create an imbalance if lawyers for injured consumers were subject to a form of price control while corporations and other large defendants were not limited in their legal budget. All in all, CU thinks the contingency-fee arrangement is an acceptable one.

The wrong cure

Clearly, however, the insurance companies' message is getting through. State and Federal legislators have passed or are considering a number of industry-backed tort-reform proposals, most of which would limit compensation to victims.

Maryland, for example, has put a $350,000 cap on pain and suffering damages in personal-injury cases. Missouri set the same limit for pain and suffering awards in malpractice cases.

In June, the New Jersey Assembly passed and sent to the state Senate a bill that would limit pain-and-suffering damages to $5000 for minor injuries, $300,000 for catastrophic injuries. The bill also sets a $500,000 lid on the amount a person could collect from a public entity, such as a county or municipality.

In California, voters recently passed Proposition 51, which eliminated the legal doctrine of joint-and-several liability for pain-and-suffering damages. And the Florida legislature this June passed a bill to limit awards for pain and suffering to a maximum of $450,000. (The Florida legislature, tied the measure to a 40 percent rollback in liability-insurance prenuums. Within two days, six insurance companies had announced that they would no longer write new commercial liability insurance in the Sunshine State.)

In New York, the Governor's commission recommended some changes in the tort system, such as modifying the doctrine of joint and several liability. CU's Executive Director, Rhoda Karpatkin, served on the commission and filed a dissent. Nonetheless, a bill incorporating some tort-system changes—undesirable ones, in our opinion—was about to be signed into law as this issue went to press.

The Reagan Administration has proposed a sweeping package that could cover product-liability claims against corporations, Government contractors, and the U.S. Government itself. The Reagan

Why insurers love the tax code

Between 1975 and 1984, the property-and-casualty insurance industry's assets more than tripled, to $265-billion. Industry surpluses—assets left after liabilities are deducted—are at near-record levels of $64-billion. Both assets and surpluses have shown a nearly unbroken record of growth through the recent so-called crisis years. Over those same years, the industry has also enjoyed substantial profits. Part of the reason has to do with the industry's favored tax status. Here's how the system works:

When a policyholder files a claim, the insurance company estimates what its ultimate payment will be and sets that money aside into a "loss reserve." The money may not actually be paid out for years, especially if damage disputes are dragged through the courts. But for tax purposes that money is deducted as an expense. Using this privilege, companies salt away billions of dollars.

Meanwhile, the insurance company invests the loss reserve in bonds, real estate, or the stock market, and garners a profit. (The profit is taxable, unless it flows from a tax-exempt investment such as municipal bonds.)

"As a result of certain tax advantages, many property/casualty companies have not paid federal income taxes for a number of years and, in fact, have qualified for refunds," said Natwar M. Gandhi of the U.S. General Accounting Office. "While property and casualty companies had about $46-billion in underwriting losses from 1975 through 1984, they had about $121-billion in investment gains during this period, resulting in a net gain of about $75-billion for those years. From 1975 through 1984, federal income taxes were a negative $125-million, a rate of minus 0.2 percent of the net gain."

The tax-revision proposals currently being considered by Congress would make little dent in the insurance industry's tax privileges; they would, however, impose a minimum tax on insurance companies.

plan, which Attorney General Edwin Meese called a response to "the crisis in tort liability" would impose caps of $100,000 on awards for noneconomic damages such as pain and suffering. Punitive damages would also be capped at $100,000. In addition, the Reagan bill would limit fees that lawyers could charge in product-liability cases.

Such tort-reform measures will not solve the insurance crisis. Indeed, similar measures have been tried in various places—with little if any effect on insurance rates or availability. In Ontario, Canada, lawyers' contingency fees are not allowed and awards for pain and suffering are capped. Nonetheless, liability-insurance rates in Ontario are skyrocketing and the insurance is hard to get—just as in the U.S.

In hearings before state legislatures, insurance-industry representatives have declined to promise that the tort-reform measures they advocate would result in lower insurance premiums. Even if they ended the industry's self-inflicted crisis, however, such measures would still be repressive and undesirable, in our view. Adequate compensation for injured parties is a part of our system of justice.

The right cure

The lawsuit crisis may be phony, but the insurance crisis is real. Towns, doctors, day-care centers, and others face urgent problems of insurance availability and affordability. What is needed to alleviate the problem is not tort reform but better regulation of the insurance industry. The Governor's Advisory Commission on Liability Insurance in New York has put forward several worthwhile recommendations for strengthening the regulatory system:

☐ **Price regulation.** Insurance regulators should do more to keep prices on an even keel, discouraging both excessive and artificial cyclical price cuts that endanger the health of insurance companies and excessive price hikes that create hardships for consumers.

The Commission suggested that a state insurance department can achieve this goal in part by setting upper and lower limits on permissible prices that insurers may charge. That practice would help to avoid wild swings, while still giving insurers some flexibility. As in any price-regulated industry, insurance companies could request changes in the permitted price bands from time to time.

☐ **Limiting cancellations.** The recent crisis atmosphere was created partly because of abrupt cancellations or nonrenewal of coverage by insurers. The Commission proposed that insurance companies be permitted to cancel or

...se to renew coverage only in certain clearly defined circumstances, such as nonpayment of premiums or fraud on the part of the insured. A "major change in the scale of risk" assumed by the insurer would be a valid cause for cancellation or non-renewal. But presumably the insurer would have to demonstrate to regulators that the risk level had indeed become unreasonable.

■ **Providing more resources.** The insurance industry is regulated almost exclusively by the 50 states, even though the industry has been nationwide in scope for decades. State insurance regulators are typically understaffed operations that are responsible for more work than they can capably handle.

Federal oversight is needed. But so long as the states have the responsibility, the state insurance departments need more staff, more money, and in many cases more legal authority.

■ **Appointing a consumer advocate.** The Commission recommended that an individual be appointed to work full time representing the interests of consumers before the New York State Insurance Department. In light of the strong lobbying presence of the insurance industry in every state, the suggestion is a sensible one for all states to consider.

■ **Letting municipalities pool risks.** The Commission suggested creating a structure whereby municipalities and other government bodies could share the risks of liability claims. Since one large claim could severely damage a small town, county, or government body, that suggestion makes sense. It's also consistent with the theory of insurance, in which many parties share the risk of an event that will probably happen only to a few.

In addition to those recommendations, CU also advocates three more.

First, the insurance industry should be subject to both Federal and state antitrust laws (the laws that ban price-fixing), as most industries are. Under the McCarran-Ferguson Act, which Congress passed in 1945, insurance companies are all but exempt from Federal antitrust rules. That makes it harder to stop companies if they act in concert to raise prices for a particular line of insurance.

Second, conflict-of-interest policies for insurance regulators should be made stiffer, in light of a U.S. General Accounting Office study finding that half of state insurance regulators either came from the insurance industry or found employment in it after leaving office.

Third, state regulators should encourage insurance companies to offer economic incentives to corporations and municipalities that follow good safety and risk-management practices. ■

MEMORANDUM

August 13, 1986

TO: Special Committee on Tort Reform and Insurance Liability

FROM: Kansas Legislative Research Department

RE: Major "Tort Reform" Changes Implemented by the Kansas Legislature Over the Past 12 Years

The following is a list by year of the major "tort reform" items of legislation adopted by the Kansas Legislature since 1974 which have had or could have a substantial impact on the tort system.

1974

The Kansas Automobile Reparations Act (the Kansas no-fault law) was recodified after its initial passage in 1973 and a district court decision had held the original law was unconstitutional. This modified no-fault law requires insurance with specified coverages, provides personal injury protection benefits, and limits recovery of pain and suffering and other nonpecuniary damages to cases that meet a dollar threshold or other specified criteria.

The Kansas Workers Compensation Act was amended to substantially expand coverage, upgrade benefits, and codify certain key terms including the test for work disability such as "permanent total disability," which occurs when the worker is unable to return to any type of substantial and gainful employment. If the worker is unable to return to work of the same type and character the disability is a permanent partial disability. The latter test had been used prior to 1974 for permanent total disability.

The comparative negligence statute was enacted which abolished the doctrine of contributory negligence as a bar to recovery. If the injured party's negligence was 49 percent or less, recovery is possible. The rule on joint and several liability likewise was abolished so that when more than one party is found to be negligent, each party is responsible only for that portion of the negligence attributed to them.

1975

Legislation amended the wrongful death statute to eliminate a $50,000 cap on damages for pecuniary loss but imposed a $25,000 cap on nonpecuniary damages.

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1976

A major legislative package passed dealing with medical malpractice liability and insurance. This package included:

1. a shortened "discovery period" (statute of limitations) for the injury from ten to four years for medical malpractice actions;
2. admission of evidence of certain collateral sources in medical malpractice actions;
3. permissive screening panels;
4. attorney fees approval by the court;
5. mandatory reporting by insurers of medical malpractice claims to the Insurance Commissioner;
6. civil immunity for reporting malpractice to licensing boards;
7. expanded powers for the Board of Healing Arts;
8. continuing education requirements for health care providers;
9. permissive payment of damages in installments; and
10. mandatory insurance coverage by health care providers, creation of a state administered excess insurance fund (Health Care Stabilization Fund) with unlimited dollar coverage and a statutory joint underwriting association (JUA) to provide insurance coverage for providers unable to purchase insurance from a private insurer.

1979

The Kansas Tort Claims Act was passed providing liability for negligent acts of the state and its local units of government unless a specific exemption from liability applies. The Act prohibits punitive damage awards against public bodies but permits their award against employees who have acted with actual fraud or malice. The Act limits damages to $500,000 per occurrence or the amount of insurance coverage if this is higher.

1980

The interest rate on judgments was raised from 8 percent to 12 percent.

1981

The Kansas Products Liability Act was enacted. The Act includes a provision that a product seller's liability terminates once the product's useful safe life has expired and a rebuttable presumption is created that this safe life expires after ten years. The Act provides that if the injury causing aspect of the product complied with regulatory standards at the time of manufacture, then the product shall not be deemed defective.

Two further exemptions from liability were added to the Kansas Tort Claims Act relating to employees covered by Firemen's Relief and for injuries resulting from maintenance of abandoned cemeteries.

1982

A law was passed permitting recovery of attorneys fees in automobile negligence cases by the prevailing party if the amount involved is less than $3,000 in damages.

The interest rate or judgement was raised from 12 to 15 percent.

Frivolous litigation penalties were enacted. If a claim or defense is asserted or the truth of a statement in a pleading or during discovery is denied without a reasonable basis and not in good faith, the court shall assess added costs, expenses, and attorney fees against the party and the party's attorney may be jointly and severely liable for these costs.

1983

The Kansas Tort Claims Act was expanded to cover civil rights actions.

1984

A law was enacted permitting insurance coverage for punitive damages where a person might be vicariously liable for the acts of another.

The wrongful death statute was amended to raise the nonpecuniary damage limit from $25,000 to $100,000.

The amount of mandatory insurance coverage for health care providers was doubled; a $10 million cap on the balance of the Health Care Stabilization Fund was removed; a $3 million cap per claim was placed on the Fund; a Board of Governors for the Fund was established; a statutory privilege protecting health care provider peer review records and reports was established; and a disciplinary administrator for the Health Care Stabilization Fund was established.

1985

A cap of $3 million or 25 percent of the annual gross income of health care providers was enacted. The collateral source rule exemption for health care providers was recodified and expanded.

Kansas antitrust laws were amended to grant municipalities immunity from damage awards but permitted the right of a party to seek injunctive relief.

1986

A major revision of tort and insurance law was enacted dealing with medical malpractice actions. The legislation places a $1 million cap on damage awards and a $250,000 subcap on nonpecuniary damages subject to a "pinhole" for future medical costs; requires mandatory settlement conferences; establishes qualifications for expert witnesses; makes screening panel findings admissible into evidence; expands the membership and powers of the Board of Healing Arts; mandates risk management programs for medical care facilities; and expands reporting requirements regarding medical malpractice.

The post judgement interest rate was amended to tie this rate to 4 percent above the discount rate.

A products liability amendment was passed. The amendment prohibits the admission of evidence of advancements or changes in technology after a product was designed and sold unless offered to impeach a witness.

Expanded sanctions against a party or the party's attorney were established. These included:

1. requiring "every motion and other paper," not just pleadings be signed certifying that reasonable inquiry has been made or there is a good faith argument for position taken;

2. requiring good faith participation in pretrial conferences; and

3. requiring discovery requests, responses, or objections to be signed certifying good faith.

V86-194/MH/db

ABA Journal August 86

Punitive Damages:

BY STEPHEN DANIELS

The preliminary findings of the American Bar Foundation's research indicate that punitive damage awards are not routine. They are not, typically, given in amounts that boggle the mind. Table 1 reports some of the preliminary findings. It presents the total number of reported verdicts and the number and percentage of cases in which the plaintiff won money. It also shows the number and percentage of verdicts in which a money award included a punitive award.

In none of the jurisdictions studied did even one-quarter of the cases in which the plaintiff was successful include an award for punitive damages. In the 33 sites reported on Table 1, the percentage of verdicts with money awards that included punitive damages ranged from 0 percent in four sites to 21.6 percent in Cobb County, Ga. (near Atlanta). For two-thirds of the sites, less than 10 percent of the awards included punitive damages.

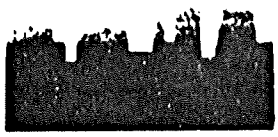
The highest percentages of punitive awards were in Fulton, DeKalb and Cobb counties (metropolitan Atlanta); Maricopa County (Phoenix, Ariz.); Harris County (Houston); and Brown County (Green Bay, Wis.). More than 13 percent of the money awards in each of these jurisdictions included a punitive award.

Four other sites had percentages higher than 10 percent: Dane (Madison) and Racine counties in Wisconsin; and Alameda (Oakland) and Sacramento counties in California. Interestingly, the punitive damages percentages for the jurisdictions with the three largest cities in the country were relatively low: 1.6 percent in New York City, 2.2 percent in Cook County, Ill., and 8.6 percent in Los Angeles County, Calif.

CAUSES OF ACTION

A more important question deals with the incidence of punitive damages in different causes of action. As a part of the research now underway, a detailed analysis has been done on seven of the sites: Cook County, New York City, Los Angeles County, San Diego County, Fulton County, Harris County and Maricopa County.

Among other things, this analysis shows that product liability and medical malpractice, which figure so prominently in discussions of the crisis, did not make up particularly large proportions of the reported verdicts at any of



Stephen Daniels is a project director for the American Bar Foundation. He has a doctorate in political science.

Attachment 24

$25,000, and only two were higher than $20,000: New York City ($25,000) and Harris County ($24,100). The remaining two sites had medians below $20,000: Maricopa County ($16,200) and Fulton County ($16,000).

Generally speaking, huge jury awards are not a single, ominous storm engulfing the entire country. The variation in medians, however, suggests that there may be some inclement weather on the map—around New York City for awards generally but not for punitive awards specifically, and around Los Angeles for awards generally and for punitive awards.

But in other sites, particularly Cook, Harris, Fulton and Maricopa counties, the medians for all dollar awards as well as for punitive awards certainly were not of the magnitude that boggles the mind. Interestingly, the three sites with the highest percentages of punitive damage awards—Harris, Fulton and Maricopa counties—had three of the four lowest medians for punitive awards, and all were below $25,000.

PATTERNS

As different types of cases had different patterns with regard to the incidence of punitive awards, they also had different patterns with regard to the size of punitive awards. For instance, product liability cases were not, relatively speaking, that likely to lead to punitive awards.

In fact, plaintiffs were not likely to win at all in these cases (in only one site, New York City, did plaintiffs win even half of these cases—60.3 percent). But when a plaintiff did win and received a punitive damage award, he or she was likely to win a large amount of money.

In the seven sites there were a total of 11 reported product liability cases with punitive damage awards, and eight had total awards (compensatory, punitive and specials) of $1 million or more. A similar pattern was found with medical malpractice. In none of the seven sites did even half of the medical malpractice plaintiffs win, and those who did rarely received punitive damages. When punitive damages were awarded, however, half had total awards of $1 million or more.

Fraud cases, on the other hand, tended to have high percentages of reported verdicts in which plaintiffs won. As might be expected, they also resulted in a much higher percentage of punitive awards. But these cases were not likely to receive very high awards. Overall, fraud cases represented the largest total number of punitive damage cases in the seven sites. There were 66, but only eight (12.3 percent) had awards of $1 million or more.

This suggests that the kinds of cases drawing the most attention because of the size of their awards did not constitute large percentages of all reported verdicts. They were less likely to result in awards for plaintiffs, and they were less likely to include punitive awards. The causes of action that were likely to see higher percentages of plaintiffs' verdicts or higher percentages of punitive awards also were more likely to have fewer big awards and lower awards generally. Hence they draw less attention.

In other words, there may be two punitive damage systems at work. One for the few highly visible mega-cases in areas like malpractice or product liability, and another for the more common and less visible areas that are more likely to see plaintiffs win money and receive punitive awards, but in much lower amounts.

Much discussion, of course, has been based on the highly visible but highly unusual mega-cases rather than on the more typical cases. Consequently, that discussion has been somewhat distorted, and we should be skeptical of the demands for sweeping reforms emanating from it.

The material presented here is from a large-scale research project still very much in progress. Nonetheless, these preliminary findings are sufficient to call into question many of the claims about the incidence and magnitude of punitive damages. Punitive damages are not, at least in the sites examined, routine. Nor are they awarded in amounts that boggle the mind. Higher percentages of verdicts with punitive awards appeared in only a few sites, and even there the median punitive awards were relatively low.

Punitive damages appear to be clustered in certain types of cases, as might be expected given the purposes of and requirements for punitive damages. Extremely high awards do not appear to be the norm, and the few high awards that do occur tend to appear in only a handful of causes of action in which plaintiffs are not likely to be successful.

When we think of problems in the civil justice system, it is perhaps more sensible to think not of a single, massive storm about to engulf the entire country, but of a weather map depicting different climatic conditions and meteorological events. Some conditions may be inclement, but others may be quite comfortable. If there are problems, they are likely to be in particular types of cases in particular locales, and any reforms or changes in the civil system should reflect this. ■

Table 2: Median Awards for Seven State Sites

COUNTY	
COOK, IL	
NEW YORK CITY, NY	
SAN DIEGO, CA	

W. RYAN
FOR
BA/ GARRETT,
ASSOCIATE DIRECTOR
EDMUND G. AMPENS,
CHIEF FISCAL ANALYST

STATE OF KANSAS

STAFF
LEGISLATIVE COORDINAT UNCIL
INTERIM COMMITTEES
STANDING COMMITTEES
LEGISLATIVE INQUIRIES

THE LEGISLATIVE RESEARCH DEPARTMENT
ROOM 545-N STATEHOUSE
PHONE (913) 296-3181
TOPEKA, KANSAS 66612

July 30, 1986

Mr. Jan Pacey
Forrest T. Jones and Company
3130 Broadway
P.O. Box 131
Kansas City, Missouri 64141

Dear Mr. Pacey:

On behalf of the 1986 Special Committee on Tort Reform and Insurance Liability, I would like to invite you to appear before the Committee on Friday, August 15. The meeting will be held in Room 313-S, Statehouse, Topeka. You have been scheduled to appear at 9:00 a.m.

The purpose of the meeting is to hear from insurers of local units of governments, various types of professionals such as certified public accountants, engineers, architects and lawyers, directors and officers, day care centers, and similar lines. Basically, the Committee would like a report on the affordability and availability of these lines of insurance, recent premiums and claims history, and suggestions for changes needed in the tort and liability insurance system.

The following are some more specific ideas which would be helpful for you to address in your remarks if possible:

1. What factors are considered in making the rates for the professions or lines of insurance that you offer to Kansas insureds? To what extent is Kansas claims experience utilized versus national experience? What effect does national experience have on Kansas rates?

2. What has been your experience regarding premiums earned and actual losses paid including defense costs in Kansas and nationwide for the lines or line of insurance over the past ten years? Of the losses paid, how much of this amount represents payments to claimants, defense costs, or other expenses?

3. What has been the frequency of claims experience in Kansas and nationwide over the past ten years in the line or lines of insurance you offe-?

Attachment 25

4. Please describe the standard policy for the line or lines you offer in Kansas noting the deductible amount, the dollar amount of coverage, other pertinent features and whether defense costs are included or excluded from the policy limits. How have the rates and policy provisions varied or changed in the past ten years?

5. Has your company cancelled or nonrenewed policies recently? If so, what factors are considered in making these decisions? Does your company work with insureds in an attempt to reduce risks and to insure continued coverage?

6. What can the Kansas Legislature do to help stabilize or reduce liability insurance rates and insure availability of coverages for insureds in regard to the tort system or in the area of insurance regulation?

If you need clarification of any of the questions, do not hesitate to call. Also please do not feel bound to limit your remarks only to the issues raised in the above questions.

I am enclosing a copy of the Committee's study charge and a list of the Committee's members for your information. Thank you for your cooperation and assistance in this matter.

Sincerely,

Mike Heim
Principal Analyst

MH/jsf

P.S. If the 12 questions cannot be completed within the time period with ease —

Parley

LAWYERS PROFESSIONAL LIABILITY

St. Paul Fire & Marine

Kansas Experience
as of July 1, 1986

Year	Number Insureds	Number Claims	Earned Premium	Paid Loss	Paid Expense	Reserved Loss	Reserved Expense	Total Loss Ratio
1981	1,391	30	352,061	125,748	150,123	-0-	-0-	78.4
1982*	1,842	46	375,038	504,951	418,427	21,503	28	204.0
1983*	1,987	87	465,798	407,834	365,067	864,880	98,103	265.3
1984*	2,615	120	665,093	371,287	714,086	968,250	261,303	325.5
1985	3,217	97	1,661,178	109,376	196,076	1,232,500	648,742	131.6
1986	3,000(App.)	N/A	1,521,517	7,767	10,387	571,350	325,314	60.1

* Years in which Paid Loss and Paid Expense exceeds Earned Premium.

National vs Kansas
Loss Ratio

Year	National	Kansas
1981	87.7	78.4
1982*	144.7	204.0
1983*	184.6	265.3
1984	174.5	325.5
1985	155.0	131.6
1986	70.2	60.1

Attachment 26

Rate History

Kansas Lawyers

St. Paul Fire & Marine

Coverage Level - $100,000 per claim/$300,000 Annual Aggregate
Deductible - $1,000 per claim
Experience Level - Lawyers in practice 8 years or more

	Annual Rate	Prior Year's Loss Ratio
1981	$ 266	85.2
1982	$ 298	78.4
1983	$ 303	204.0
1984	$ 518	265.3
1985	$1,528	325.5
1986	$2,021	131.6

Parker

School Board Legal Liability Insurance

Kansas

National Union Fire Insurance Company

Year	Number Insureds	Number Claims	Earned Premium	Paid Loss	Paid Expense	Reserved Loss	Total Loss Ratio
1982	63	18	47,502	1,000	11,128	1,220	28.1
1983	94	21	195,898	10,000	36,185	13,200	30.4
1984	96	12	206,342	-0-	47,521	15,000	31.2
1985	135	30	286,579	2,500	9,844	125,500	48.1
1986	164	33	166,952	-0-	4,683	31,400	21.6

School Board Legal Liability

Loss Ratios

Year	National	Kansas
1982	78.1	28.1
1983	92.3	30.4
1984	59.4	31.2
1985	13.8	48.1
1986	N/A	21.6

Attachment 27

PROPOSAL # 29
TORT REFORM AND LIABILITY INSURANCE
KANSAS LEGISLATURE

Attachment 28

PROPOSAL #29 - TORT REFORM AND LIABILITY INSURANCE
KANSAS LEGISLATURE

STATEMENT OF THOMAS X. WRIGHT, SENIOR VICE PRESIDENT OF EMPLOYERS MUTUAL CASUALTY BEFORE THE SPECIAL COMMITTEE ON TORT REFORM AND LIABILITY INSURANCE ON FRIDAY, AUGUST 15, 1986, STATEHOUSE, TOPEKA, KANSAS.

EMPLOYERS MUTUAL CASUALTY COMPANY

I am Thomas X. Wright, Senior Vice President of Employers Mutual Casualty Company, Des Moines, Iowa. This is the parent company of Employers Mutual Companies (EMC) and is affiliated with American Liberty Insurance Company, Dakota Fire, EMC Reinsurance Company, EMCASCO Insurance Company, Farm and City Insurance Company, Illinois EMCASCO Insurance Company, and Union Mutual Insurance Company of Providence. Placing the position of our companies in perspective, our net worth, currently, is probably in excess of $140 Million as compared to the net worth of the property and casualty insurance industry, which is somewhere in the neighborhood of $75 Billion. We write about $300 Million in premium as compared to an industry writing about $150 Billion annually.

Although premiums are written in every state of the union, our business is principally conducted in 18 branch offices, one of which is located in Wichita. We write a respectable volume of general liability insurance (approximately $6½ Million in the past five years) within the State of Kansas, and which includes some professional liability. Attached to this presentation, there is marked Exhibit A (General Liability - Wichita over a 5 year period) and Exhibit B (Kansas Municipal Utilities over a 5 year period), and Exhibit C (Special Lines-Linebacker).

VALIDITY OF STATISTICS

I hope the attached statistics will be of help to you. These are pure loss ratios. Some demonstrate incurred loss to earned premium as low as 4% in some years, and 358% in other years. This raises the question of what insurance underwriters characterize as the "tail". To these figures should be added the following which is a notation on each exhibit:

(1) Underwriting expenses, commissions and other acquisition costs, premium taxes and so forth. (2) Other losses which have been incurred but not reported (IBNR). (3) Allocated and unallocated loss adjustment expenses (investigation, expert analysis, attorney fees, etc.).

It is estimated that defense costs of claims reported in 1983 and 1984 for general liability will approach 50% of loss payments, and this is true "for all types of risks whether large or small in all areas of the country" according to Insurance Services Office (ISO). It is my understanding that your committee has received presentations from Insurance Services Office, the Institute for Civil Justice and others, and you are therefore able to take these statistics and place them into proper perspective. A simple example may demonstrate the point. Approximately ten years ago, we wrote a general liability policy on a hospital to protect the policyholder from liability in excess of the primary limits then carried. The premium was approximately $10,000. Since losses did not surface for ten years, some, being disengenuous, would conclude that the company made a killing in the years 1975, 1976, 1977, etc. Ten years later, we are confronted with several cases seeking millions of dollars damages. These allegations involve newly born

children, afflicted with retardation and blindness, allegedly the result of negligence many years ago. This demonstrates the "tail" about which underwriters are concerned. We are asked "how much premium did you receive and how much did you pay"? If this simplistic approach became the sole criteria under which the casualty industry wrote business, there would be far more than the 40 insolvencies demonstrated in the past two years.

I sympathize with the challenge presented to this special committee by the legislature, especially in your efforts to determine "the impact, if any, of tort reform and insurance reform measures on the availability and affordability of liability insurance". I wish I had a simple answer to your $64 questions: Mr. Wright, when the law of joint and several liability is changed, as well as the laws on contribution and indemnity between joint tort feasors, how much should premiums be reduced for municipalities? For daycare centers? For football helmet manufacturers? Mr. Wright, when we modify the laws of comparative negligence (or comparative fault) what percentage of reductions may be expected? Etc. Etc.

I do not have these specific answers. I do have a suggestion. I have in front of me a literal "pile" of forms required by the National Association of Insurance Commissioners. This includes the Annual Statement of our company and almost every imaginable statistic derived from the research of 50 independent Insurance Commissioners. You will want to acquaint yourself with the requirement of the insurance expense exhibits mandated by the NAIC, the product liability supplements, the Schedule P - Medical Malpractice Reserve Developments, etc., and a host of other forms designed to demonstrate that measure of "truth" which we all seek in response to these problems.

Knowledge about the "transfer of risk" will help a great deal. Hundreds of insurance companies have sought answers to these questions for different reasons. We are <u>competitors</u> operating in a free enterprise market. Our company, for instance, is not a utility, and therefore, should not be viewed in that light. There is no public authority which has designated a geographical territory within which our company (or any company) may have the exclusive right to solicit business. There is no geographical area within which such business, if solicited, is guaranteed to bring to the company any particular return on its investment. I repeat, these guarantees of no competition, and a particular return on investment, indigenous to a utility, has no application to any of the hundreds of insurance companies competing for business. We have a right to seek a profit. We also have an exposure to the risk of insolvency. We are not a utility.

In our search for "truth", I was reminded of a discussion sometime back within a particular conference of the American Bar Association as we sought to organize a "Symposium" on standards of professional conduct imposed upon lawyers, their obligation to an insurance carrier which has written a contract designed to pay loss, and protect the policyholder from liability. We originally sought to follow a model which the lawyer members of this conference had established in a previous symposium on science wherein such matters as the "acceptance of voice spectograms by the legal and scientific communities" would be discussed. Why do I suggest

the analogy? Science is dealing with ultimate truth. The laws of nature, when discovered, will demonstrate that truth. Can we, in any way, suggest that our Civil Justice System and the rules and regulations under which it is governed is sufficiently scientific that we may ultimately find "truth" in any statistic?

The problem of the underwriter in accepting transfer of risk for a price is not entirely unlike the judgment exercised by a lawyer in determining the value of his case. Some members of this committee may be lawyers, and I am sure you can identify with the problem that exists when one undertakes to place a specific value on a particular injury when considering the multi-faceted variables which go into its determination: conflicting facts, conflicting laws of liability, disparity in the abilities of the opposing lawyers, a different demeanor and attitude among various judges, a profound variance in the makeup and values of juries even within the same community, inflation, the size of the defendant (whether corporate or individual) etc. etc. Where is truth? Some years ago, one could gather together some experts (legally trained people on either the plaintiff or defense side) and develop their conclusions on value which could eventually be demonstrated as a "bell curve" on a graph. Today it is suggested that the variables in some lines are so profound that we get "spikes" which defy any rational evaluation. Some work has been done in this area by the Institute for Civil Justice, and I would quote the following:

> (From the dissertation "Deep Pockets, Empty Pockets") It is stated "litigants characteristics influence the outcomes of their trials... our findings are consistent with expectations that deep pocket defendants will generally be assessed larger damage awards, particularly when sued by plaintiffs claiming severe injuries..."
>
> (From the dissertation "Compensation of Injuries") It is stated "the findings raise concerns about how injuries evaluate cases and about the equity of juries decisions. Even after taking into account plaintiff's economic loss and severity of their injuries, plaintiffs with similar injuries receive markedly different awards in different types of lawsuits. A plaintiff injured in an auto accident was likely to receive only one-third as much as a plaintiff who suffered a similar injury in a work place incident. Disparities increased in recent years as compensation increased for malpractice, product liability and street hazard cases".

One may legitimately question the analogy of underwriting judgment and its relationship to the transfer of risk which may include a large number of injuries, with that of a lawyer seeking to resolve the dilemma of whether a case is worth $10,000, or $150,000. Nevertheless, the point remains that the concept of achieving "truth" through the development of statistics in an area which is anything but scientific cannot help but result in frustration and contradiction. Some have likened our Civil Justice System to a "lottery". Underwriters make a distinction between "gambling" and "insurance" but the two become analogous when certain principals are overlooked. The underwriter states that "losses which are bound to happen are uninsurable", and that the "law of large numbers" is imperative before one may seek to price the transfer of that risk. In addition, they speak of the necessity that only losses be covered which are "fortuitous". When the principals are applied, it is easy to see that flood insurance is not universally written, that vaccines for particular diseases generate such a high incidence of loss that they are no longer available, that we have very few engaged

in the manufacture of football helmets.

In an address to the National Association of Insurance Commissioners in Kansas City June 10, 1985, Sir Peter North sought to explain the position of Lloyds of London and the world insurance industry stating:

> "The present legal system in the United States makes it impossible for the liability or casualty insuror to operate certainly to the extent necessary to satisfy the insuring needs of the public; the reason for this is the total uncertainty facing an insuror as to how the U.S. Courts will interpret various policy wordings".

Some years ago, Dr. Emmet J. Vaughan, Professor of Insurance at the University of Iowa, appeared before a similar committee in the Iowa Legislature. The issue was quite similar. The legislature was concerned with the high cost of medical malpractice insurance, product liability, and municipal liability. He suggested that the legislature could do one of four things:

1. A fund could be established by the State to satisfy the buyers of insurance who complain about high premiums. He concluded, however "the only way that this could be done apart from a change in the amount of claims would be through a tax subsidy".

2. Compel insurors to write insurance for distressed classes of policyholders. He then concluded that this would result in loss being "passed on to other policyholders in the form of higher automobile rates, higher homeowners rates, and higher rates in other lines".

3. Reject the prior suggestions, designed to subsidize policyholders in professional lines, manufacturers, etc., and instead require that they pass on "the high cost of their insurance to consumers of their goods and services".

4. He suggested a fourth approach, namely, "reducing the amount flowing out of the other end of the conduit". This was described as "tort reform".

We should not leave this subject relating to the validity of statistics without some comment on reserves. Here again, we are discussing a subject which is related to the "tail" about which underwriters are concerned. Critics of the industry like to ask two questions: (1) How much is your written premium? (2) How much did you pay last year? This simplistic approach is easily demonstrated to be fraught with the ultimate in mis-information. Going back 10 years, Insurance Services Office concludes that 1976 industry reserves were not adequate to dispose of those identical losses by the year 1984. The conclusion is that the reserves were under estimated by 20%!

Why are reserves important? A simple illustration will demonstrate the point.

> Let us assume a company with $300 Million in reserves and $100 Million in net worth. Assuming that the reserves for claims and losses are under stated by 20% what then is the net worth of the company? Obviously an under-statement of 20% (20% X $300 Million) would reduce the net worth by $60 Million.

The above illustration and the problems demonstrated are exacerbated when one considers the necessity of not writing more insurance than is warranted by a company's net worth. If the above company were writing $300 Million in business on the basis of $100 Million of net worth (ratio of 3 to 1) an inadequacy of reserves by 20% would demonstrate that this company, in fact, was writing business with a ratio of 7.5 to 1. As Chairman of the Iowa Insurance Guaranty Association, and somewhat acquainted with the problems of Iowa National Insurance Company, Carriers Insurance Company, Excalibur, Ideal Mutual, etc., it is apparent that reserve inadequacy, coupled with the acceptance of a particular volume of business not warranted by a company's net worth, is a major problem. Some years ago, insurance companies, in response to the exhortation that "investment income should be included in rate making" wrote a quality and volume of business which was not warranted. An arbitrary, simplistic answer, of mandating underwriting restrictions to "smooth out the cycle" is not only simplistic, but exacerbates the problem. Artificial solutions, which negate competition, as well as principals of underwriting, create the very problem which we seek to avoid as respects availability and affordability.

The so-called "bed pan mutuals" are a case in point. They arose in response to the availability and affordability problem and yet have demonstrated losses which are as bad, if not worse, than those of commercial liability insurers. The movement toward self-insurance, although viable as respects a giant policyholder, has been severely strained. Their reliance upon the tremendous capacity developed in the reinsurance market in previous years, and which has now been withdrawn exposed the weakness of this endeavor. Many question the ability of Bermuda based insurers to perform.

A study of the Joint Underwriting Associations established a few years ago in response to what some felt was an "insurance problem", while others characterized it as a "Civil Justice problem" is rather interesting. Many of the largest joint underwriting associations for medical malpractice are characterized with loss ratios well in excess of 100% and what is of greater concern a net worth (surplus) which is insufficient to pay outstanding losses:

JUA	Statement Date	Deficit Surplus
Massachusetts	12-83	$ -308,987,000
New York	12-83	-248,993,000
New Jersey	12-82	- 40,049,000
New Hampshire	12-82	- 35,188,000
Rhode Island	12-82	- 26,828,000
South Carolina	12-83	- 12,898,000

STATISTICS -VS- UNCOMMON SENSE

Perhaps the most irresponsible statement pertaining to the present problem of our Civil Justice System is the insurance "conspiracy theory". The Nader group contends that "the insurance industry" is responsible for "manufacturing a crisis". I suppose one may conjure up a vision of five automobile manufacturers in a smoke filled room "cooking up" some kind of a deal. There are about

2500 insurance companies. I would imagine several hundred do business in this state. Is it conceivable that hundreds of insurance companies could gather together, perhaps in a smoke filled room (more likely an auditorium) and "manufacture a crisis"? The scenario would probably run something like this: "Boys, let's arrange to have a $25 Billion underwriting loss in 1985". At the same time, they would be told that "we would expect everyone to hold down their investment income in such a fashion that we could generate a $5 Billion operating loss". Is not this fantasy? Sounds like a pretty expensive advertising campaign to me. How would this "conspiracy" find volunteers who would go bankrupt. There have been about 40 insolvencies over the past two years.

I suppose one of the problems is the propensity for too many in characterizing the business of insurance as "the industry". Assuming 1500 companies doing regular business, with an average of 10 members on the Boards of Directors, we are looking at decision making involving approximately 15,000 people, and then only on the question of overall broad policy. I come from a farming state similar to Kansas. Depending upon one's definition of "farmer", and how one would compile the "net worth" of that particular industry, some rather mischievous ratios and statistics could be developed. I believe we should think in terms not only of a large industry, but the individual companies in a fiercly competitive business providing a public service, and seeking to generate a profit within our free enterprise system. The directors on each board look at the Chief Executive Officer with a jaundiced eye characterized best by an exhortation "don't place in jeopardy the financial well being of this company!"

What statistics should we seek? I would suggest that the answer lies in the voluminous statistics and reports which now reside within the Insurance Department in 50 states, coupled with the Boards and Bureaus (Insurance Services Office) which have disseminated various exhibits to this committee. The most meaningful statistic to an insurance executive is the bottom line. In the year 1985 when it cost $115 for every $100 of premium, the statistic is meaningful. One may suggest to an underwriter that "this state has never had a punitive damage award in a particular type of case, or a large award involving child molestation". This may not at all be significant to the underwriter. He looks at the bottom line and determines the combined loss and expense ratio. Premiums written and losses paid may or may not be relevant to the bottom line. The number of lawsuits filed may not be relevant if one excludes the total loss and expenses in a particular line of business.

CONCLUSION

Who is to blame? This is a simplistic approach. We have demonstrated that the so called "conspiracy theory" of the "insurance industry" is irresponsible. I do not blame lawyers. We have an adversary system. Each lawyer is bound to vigorously pursue the cause of his client and extract every dime to which he is entitled under our Civil Justice System. He is mandated to discredit and preclude evidence helpful to the other side. Our judiciary has created a revolution as respects rights and remedies. It is incumbent upon the lawyer as an officer of the court to be knowledgeable and pursue these rights and remedies. The large number of lawyers are simply a response to the old economic maxim as respects supply and demand.

In the longrun, John Q. Public must make the decision as respects the amount which he is willing to pay for our Civil Justice System. Commercial policyholders understandably confusedwith the plethora of technical niceties articulated by the judiciary are relegated to a protest as respects the one statistic which they can understand. High insurance premiums. I am here on behalf of our policyholders, and members of the public in an expression of concern over the revolution in our Civil Justice System in the past 25 years. Some feel that the cost is too high. The horror stories, which we need not repeat here, demonstrate the excesses and the faults of that system.

Some say that the insurance industry "makes book" on the transfer of risk and should therefore not be concerned as respects the substantive laws of liability. Although one may take exception to the analogy with gambling, it is nevertheless true that our principal concern is the integrity of insurance as an Institution. This being true, it is necessary that principals of underwriting be maintained, rather than an effort to gain a "quick fix" to "smooth out the cycle". The free enterprise system with hundreds of insurance carriers, competing with each other and applying sound underwriting principals, does not need revision. The companies must be free to (1) reject risks which are uninsurable because loss is bound to happen. (2) Utilize and rely on the law of large numbers to develop an appropriate price. (3) Require that loss be "fortuitous".

As legislators you have a choice. It is not an easy one. Subsidies with a tax is not an answer. Transfer of costs from commercial to personal lines policyholders is likewise no answer. A fine tuning and refinement of our Civil Justice System to find an acceptable level of fairness and equity which can be supported by the public is the proper path. The free enterprise system stands willing to compete, and accept the transfer of risk so long as insurance principals are permitted to operate, as distinguished from those which are more indigenous to "gambling".

I do have one suggestion. If there is one characteristic which stands out in the revolution of our Civil Justice System, it is the emphasis (or de-emphasis) on burden of proof. We were outraged several years ago as respects the major revolution in China when "adversaries" were dragged to the middle of the square and subjected to a great deal of finger pointing. As the shouting reached a crescendo, the "defendant" was taken away and hanged. We, of course, have a system far removed from such a crude exercise of "proof". At the same time, any member of the Bar can testify that our judges no longer "participate" in making decisions as respects the burden of proof required comparable to the system which existed 25-30 years ago. Supreme Courts throughout the country have universally mandated a requirement that practically all factual issues go to a jury. A decision on the facts "if reasonable minds would not differ" was formerly the prerogative of the judge and not the jury. "You make goo. Goo causes cancer. You owe me for my cancer". This simplistic approach, although indeed an overstatement, demonstrates the problem. I am not blaming district court judges, for they frequently have little choice because directed verdicts and summary judgments seem to be routinely reversed by Supreme Courts. Thus, legislators may want to consider whether the old rule as respects burden of proof by a "preponderance of the evidence" should be evaluated. A "preponderance" does not mean that truth is established.

It merely means that the existence of a fact (causal connection) is more probable than its non-existence. Thus, we find the foundation for much injustice. Some suggest, that punitive damages, being indigenous to the criminal justice system should be proved "beyond a reasonable doubt" rather than by a "preponderance". Some lawyers refer to "pain and suffering" as "blue sky damages". Would it be feasible to require that these be proven by "clear and convincing evidence". The United States Supreme Court recently did something of this nature in a libel case imposing upon the plaintiff an obligation to prove "malice" by clear and convincing proof, the failure of which warranted a summary judgment. This may be worthy of consideration to bring back members of the bench at the trial level in a greater participation of the decision making relative to the existence or non-existence of facts as the basis for proof.

Thomas X. Wright
Senior Vice President

Employers Mutual Casualty Company
717 Mulberry
Des Moines, Iowa 50309

GENERAL LIABILITY
WICHITA

Exhibit A

Year	Earned	Incurred	Ratio
5 Yr. Total-All Lines			
1985	1,668,528	1,549,134	92.8
1984	1,252,183	455,089	36.3
1983	1,178,279	384,893	32.7
1982	1,307,972	450,279	34.4
1981	1,347,129	514,599	38.2
5 Yr. Total	6,754,091	3,353,994	49.7
M & C			
1985	787,129	551,136	70.0
1984	663,149	195,062	29.4
1983	544,527	230,078	42.3
1982	601,950	122,198	20.3
1981	610,959	130,355	21.3
5 Yr. Total	3,207,714	1,228,829	38.3
O L & T			
1985	716,126	439,464	61.4
1984	409,006	230,003	56.2
1983	463,298	220,499	N/A
1982	499,161	337,407	67.6
1981	518,589	280,471	54.0
5 Yr. Total	2,606,180	1,507,844	57.9
O & C			
1985	6,541	4,900	74.9
1984	5,337	2,909	54.5
1983	9,227	0	N/A
1982	9,394	636	6.8
1981	10,684	500	4.6
5 Yr. Total	41,183	8,945	21.7
CONTRACTORS			
1985	832	0	N/A
1984	1,379	0	N/A
1983	1,347	0	N/A
1982	17,692	0	N/A
1981	14,274	0	N/A
5 Yr. Total	35,524	0	N/A

To these figures should be added:

1. Underwriting expenses, commissions, other acquisition costs, premium taxes, etc.
2. Other losses which have been incurred but not reported (IBNR).
3. Allocated and unallocated loss adjustment expenses (investigation, expert analysis, attorney fees, etc.).

Exhibit A

	Year	Earned	Incurred	Ratio
PRODUCTS				
	1985	154,502	553,634	358.3
	1984	170,339	27,063	15.9
	1983	157,844	65,684(cr)	N/A
	1982	178,579	9,962(cr)	N/A
	1981	191,441	103,273	53.9
	5 Yr. Total	852,705	608,324	71.3
NURSES				
	1985	0	0	N/A
	1984	0	0	N/A
	1983	30	0	N/A
	1982	39	0	N/A
	1981	0	0	N/A
	5 Yr. Total	69	0	N/A
DRUGGIST'S LIABILITY				
	1985	1,922	0	N/A
	1984	1,596	0	N/A
	1983	1,545	0	N/A
	1982	1,157	0	N/A
	1981	1,082	0	N/A
	5 Yr. Total	7,302	0	N/A
CDP-CPL				
	1985	1,476	0	N/A
	1984	1,377	52	3.8
	1983	461	0	N/A
	1982	0	0	N/A
	1981	0	0	N/A
	5 Yr. Total	3,314	52	1.6

Employers Mutual Companies

Exhibit B

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PRODUCTION AND EXPERIENCE REPORT
OF DECEMBER 1984

To these figures should be added:
1. Underwriting expenses, commissions, other acquisition costs, premium taxes, etc.
2. Other losses which have been incurred but not reported (IBNR).
3. Allocated and unallocated loss adjustment expenses (investigation, expert analysis, attorney fees, etc.).

EMC WICHITA KANSAS MUNICIPAL UTILITIES

DESCRIPTION	WRITTEN PREMIUM	PERCENT CHANGE PRIOR YEAR	EARNED PREMIUM	INCURRED LOSSES	RATIO	NEW COUNT	PERCENT CHANGE PRIOR YEAR	RENEWAL COUNT	PERCENT CHANGE PRIOR YEAR
TOTAL PERSONAL	00	N/A	00	00	N/A	00	N/A	00	N/A
PCT. TOTAL WRITTEN	N/A								
BP TOTAL	1,425,111	31.5	1,343,131	567,328	42.2	35	-28.6	281	116.2
AUTO	322,071	43.9	296,227	52,401	17.7				
LIAB.	350,393	43.2	326,209	170,800	52.3				
FIRE	462,459	67.0	424,352	129,108	30.4				
W.C.	288,937	14.4-	294,569	215,018	73.0				
OTHER	1,270	59.1	1,173	00	N/A				
TOTAL COMMERCIAL	1,425,111	31.5	1,343,131	567,328	42.2	35	-28.6	281	116.2
PCT. TOTAL WRITTEN	100.0								
TOTAL 1984	1,425,111	31.5	1,343,131	567,328	42.2	35	-28.6	281	116.2
TOTAL 1983	1,083,886	999.9	850,866	441,621	51.9	49	600.0	130	999.9
TOTAL 1982	94,673	999.9	47,222	2,949	6.2	07	N/A	04	100.0
TOTAL 1982-1984	2,603,673		2,241,222	1,011,899	45.1	92		416	
TOTAL 1980-1984	2,613,757		2,251,194	1,011,899	44.9	92		420	
* * * * * * * *	PREMIUM	* * *	COMMISSION	DIVIDEND					
CURRENT TOTALS									
ALL LINES	1,425,111	31.5	296,011	54,007					
IRM	00	N/A	00	00					
OCEAN MARINE	00	N/A	00	00					

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Employers Mutual Companies

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PRODUCTION AND EXPERIENCE REPORT
OF DECEMBER 1984

EMCASCO WICHITA KANSAS MUNICIPAL UTILITIES

DESCRIPTION	WRITTEN PREMIUM	PERCENT CHANGE PRIOR YEAR	EARNED PREMIUM	INCURRED LOSSES	RATIO	NEW COUNT	PERCENT CHANGE PRIOR YEAR	RENEWAL COUNT	PERCENT CHANGE PRIOR YEAR
TOTAL PERSONAL	00	N/A	00	00	N/A	00	N/A	00	N/A
PCT. TOTAL WRITTEN	N/A								
BF TOTAL	00	N/A	00	35	N/A	00	N/A	00	N/A
W.C.	00	N/A	00	35	N/A				
TOTAL COMMERCIAL	00	N/A	00	35	N/A	00	N/A	00	N/A
PCT. TOTAL WRITTEN	N/A								
TOTAL 1984	00	N/A	00	35	N/A	00	N/A	00	N/A
TOTAL 1983	00	N/A	00	00	N/A	00	N/A	00	N/A
TOTAL 1982	00	N/A	00	00	N/A	00	N/A	00	N/A
TOTAL 1981-1980	00		00	35	N/A	00		00	
TOTAL 1980-1984	00		00	35	N/A	00		00	

* * * * * * *	PREMIUM	* * *	COMMISSION	DIVIDEND
CURRENT TOTAL				
ALL LINE	00	N/A	00	00
IAM	00	N/A	00	00
OCEAN MARINE	00	N/A	00	00

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Employers Mutual Companies

Exhibit B

PRO[illegible] AND EXPERIENCE REPORT
AS OF DECEMBER 1984

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UNION MUTUAL WICHITA KANSAS MUNICIPAL UTILITIES

DESCRIPTION	WRITTEN PREMIUM	PERCENT CHANGE PRIOR YEAR	EARNED PREMIUM	INCURRED LOSSES	RATIO	NEW COUNT	PERCENT CHANGE PRIOR YEAR	RENEWAL COUNT	PERCENT CHANGE PRIOR YEAR
TOTAL PERSONAL PCT. TOTAL WRITTEN	0 N/A	N/A	0	0	N/A	0	N/A	0	N/A
SP TOTAL W.C.	324,707 324,707	177.3 177.3	336,423 336,423	368,524 368,524	109.5 109.5	01	50.0-	05	N/A
TOTAL COMMERCIAL PCT. TOTAL WRITTEN	324,707 100.0	177.3	336,423	368,524	109.5	01	50.0-	05	N/A
TOTAL [illegible] TOTAL [illegible] TOTAL [illegible] TOTAL [illegible] TOTAL [illegible]	324,707 198,749 0 523,456 523,456	177.3 N/A N/A	336,423 89,821 0 426,244 426,244	368,524 53,211 00 421,736 421,736	109.5 59.3 N/A 98.8 98.8	01 04 00 03 03	50.0- N/A N/A	05 00 00 05 05	N/A N/A N/A
* * * * * * *	PREMIUM	* * *	COMMISSION	DIVIDEND					
CURRENT TOTAL ALL [illegible] [illegible] [illegible]	324,707 0 0	177.3 N/A N/A	17,779 0 0	00 0 00					

[illegible] 0235 SI Rev. 1-82

Employers Mutual Companies

Exhibit B

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ALL COMPANIES KANSAS KANSAS MUNICIPAL UTILITIES

DESCRIPTION	WRITTEN PREMIUM	PERCENT CHANGE PRIOR YEAR	EARNED PREMIUM	INCURRED LOSSES	RATIO	NEW COUNT	PERCENT CHANGE PRIOR YEAR	RENEWAL COUNT	PERCENT CH PRIOR YEAR
TOTAL PERSONAL	00	N/A	00	00	N/A	00	N/A	00	N/A
PCT. TOTAL WRITTEN	N/A								
BP TOTAL	1,809,818	N/A	1,679,525	935,883	55.7	26	N/A	286	N/A
AUTO	522,071	N/A	496,717	52,401	17.7				
LIAB.	350,293	N/A	336,309	170,800	52.3				
FIRE	462,439	N/A	464,352	125,108	30.4				
W.C.	673,644	N/A	650,703	583,577	92.5				
OTHER	1,270	N/A	1,173	00	N/A				
TOTAL COMMERCIAL	1,809,818	48.0	1,679,525	935,883	55.7	36	29.4-	286	120.
PCT. TOTAL WRITTEN	100.0								
TOTAL 1984	1,809,818	N/A	1,679,525	935,883	55.7	36	N/A	286	N/A
TOTAL 1983	1,222,624	999.9	741,390	494,833	52.6	51	628.6	130	999.
TOTAL 1982	94,073	999.9	47,113	2,949	6.2	07	N/A	04	100.
TOTAL 1982-1984	3,127,125		2,468,028	1,433,671	53.7	95		421	
TOTAL 1980-1984	3,137,209		2,478,059	1,433,671	53.5	95		425	
* * * * * * *	PREMIUM	* * *	COMMISSION	DIVIDEND					
CURRENT TOTALS									
ALL LINES	1,809,818	48.0	121,907	54,007					
FAM	00	N/A	00	00					
OCEAN MARINE	00	N/A	00	00					

Exh 0275 SI Rev 1 82

Exhibit C

KANSAS

SPECIAL LINES - LINEBACKER

SCHOOLS	DOCUMENTS	YEAR	WRITTEN PREMIUM	INCURRED	I/W RATIO
	27	85	26,433	6,542	24.7
	27	84	21,808	19,481	89.3
	28	83	15,734	2,154	13.7
	30	82	22,735	98,624	433.8
	38	81	21,776	6,638	30.5
		5 Year	108,486	133,439	123.0
MUNICIPALITIES					
	163	85	121,230	57,654	47.6
	143	84	82,534	44,691	54.1
	117	83	64,756	17,362(cr)	N/A
	59	82	45,675	40,004	87.6
	41	81	36,226	603	1.7
		5 Year	350,421	125,590	35.8
TOWNSHIPS					
	34	85	16,559	0	N/A
	22	84	10,084	0	N/A
	19	83	9,382	0	N/A
	17	82	11,538	0	N/A
	15	81	14,674	0	N/A
		5 Year	62,237	0	N/A
COUNTIES					
	41	85	89,980	3,415	3.8
	35	84	48,922	62,384(cr)	N/A
	35	83	46,077	87,733	190.4
	37	82	40,724	63,362	155.6
	33	81	50,277	93,224	185.4
		5 Year	275,980	185,350	67.2
TOTAL LINEBACKER					
	265	85	254,202	67,610	26.6
	227	84	163,348	1,788	1.1
	199	83	135,949	75,526	53.3
	143	82	120,672	201,991	167.4
	117	81	122,953	100,465	81.7
		5 Year	797,124	444,380	55.7

To these figures should be added: 1. Underwriting expenses, commissions, other acquisition costs, premium taxes, etc. 2. Other losses which have been incurred but not reported (IBNR). 3. Allocated an unallocated loss adjustment expenses (investigation, expert analysis, attorney fees, etc.).

Exhibit D

SPECIAL COMMITTEE ON TORT REFORM
AND LIABILITY INSURANCE
August 15, 1986

Employers Mutual Companies
Wichita Operations

Except for our Errors & Omissions policy (Linebacker) we use ISO rates subject to our company's deviation based on our company experience in Kansas. Our rates for the Linebacker policy would also be based on our Kansas experience. We write a Town Liability coverage on the smaller towns and rates for this coverage are determined by our own company experience.

Our General Liability policy is a standard ISO form which generally is written without a deductible. The Linebacker policy, which we write on towns, counties, townships and schools, has a deductible provision varying from $500 to $3,000 depending on the population or number of students. The dollar amount of coverage is determined by the insured with limits of liability available up to $500,000. Defense costs are not included in the policy limits.

We have uncovered only three instances in the past two years where a county or town risk was non-renewed. One county risk was non-renewed due to poor loss experience and two towns were also non-renewed due to claims. In addition, there were non-renewals on Directors & Officer's policies in 1985 on risk connected with the medical profession.

Exhibit E

A good safety program should fit your organization like a custom-tailored suit.

..LET EMC SHOW YOU!

EMC HAS ALWAYS BEEN COMMITTED TO ASSISTING POLICYHOLDERS IN MINIMIZING THEIR LOSSES DUE TO ACCIDENT, AND TO THE DEVELOPMENT OF CUSTOM-TAILORED SAFETY PROGRAMS. EMC'S ROLE IS TO ACT AS A CONSULTANT TO YOUR MANAGEMENT GROUP TO PROVIDE INFORMATION AND ASSISTANCE. EMC CANNOT RUN YOUR SAFETY PROGRAM SINCE ONLY YOU KNOW YOUR SPECIFIC NEEDS, AND YOU CONTROL THE RESOURCES TO SATISFY THESE NEEDS.

IT IS IMPORTANT TO NOTE THAT ALL RISK IMPROVEMENT SERVICES ARE PROVIDED AT NO ADDITIONAL COST TO ALL EMC POLICYHOLDERS. THIS "NO ADDED CHARGE" POLICY IS NOT TYPICAL OF ALL INSURANCE COMPANIES.

THE FIRST RISK IMPROVEMENT CONTACT WILL BE A SURVEY TO ASSESS YOUR OPERATIONAL EXPOSURES, TO IDENTIFY MAJOR VISIBLE HAZARDS, AND TO COLLECT BUILDING COST ESTIMATING INFORMATION WHEN EMC PROVIDES PROPERTY COVERAGE. RECOMMENDATIONS TO CONTROL THESE HAZARDS DETECTED, WILL BE PROVIDED. A BRIEF AUDIT OF YOUR SAFETY ACTIVITIES WILL ALSO BE MADE.

ASSISTANCE IN DEVELOPING A COMPREHENSIVE SAFETY PROGRAM WILL BE AT YOUR REQUEST, AND THE PROGRAM WILL BE TAILORED TO YOUR NEEDS AND RESOURCES. INITIALLY, THE PROGRAM WILL BE BASED ON LOSS ANALYSIS OF SIMILAR OPERATIONS BY USING EMC'S LARGE COMPUTERIZED LOSS DATA SYSTEM.

ALL SAFETY PROGRAMMING WILL INVOLVE MANAGEMENT AND EMPLOYEES IN ACTIVITIES THAT MAINTAIN INDIVIDUAL SAFETY INTERESTS, AND HAVE PROVEN LOSS REDUCTION RESULTS. WHERE APPLICABLE, EMC CAN UTILIZE PROGRAMS THAT ASSESS BOTH MANAGEMENT'S AND EMPLOYEE'S SAFETY ATTITUDES AND COMMITMENT.

PRE-HOSPITAL TRAINING

EVEN WITH THE MOST EFFECTIVE SAFETY PROGRAM FEASIBLE, ALL OPERATIONS EVENTUALLY EXPERIENCE INJURY ACCIDENTS. IT IS THEREFORE IMPERATIVE THAT YOUR PERSONNEL BE ADEQUATELY TRAINED IN EMERGENCY FIRST AID PRACTICES BEFORE THAT ACCIDENT OCCURS. EMC CAN ASSIST IN PROVIDING THIS TRAINING FOR OUR POLICYHOLDERS.

THESE TRAINING SESSIONS CAN BE SCHEDULED BY OUR RISK IMPROVEMENT REPRESENTATIVE, OR CONTACTING THE AREA EMC BRANCH OFFICE. IN ADDITION TO THE PROGRAMS LISTED BELOW, SPECIAL PROGRAMS CAN OFTEN BE DEVELOPED IF SUFFICIENT LEAD TIME IS PROVIDED.

PRE-HOSPITAL INSTRUCTIONAL PROGRAMS

1. CPR INSTRUCTION
   AMERICAN HEART ASSOCIATION CLASSES
   HEARTSAVER - 4 HRS
   BASIC RESCUER - 8 HRS
   CPR INSTRUCTOR - 12-16 HRS

2. FIRST AID
   AMERICAN RED CROSS
   MULTI-MEDIA FIRST AID 8 HRS.
   MULTI-MEDIA FIRST AID INSTRUCTOR - 4 HRS

3. "THE BURN SHOW" - 1-1/2 HOUR - 2 HOUR SLIDE PRESENTATION ON THE PATHOPHYSIOLOGY OF BURNS.

4. THE PSYCHOSOCIAL EFFECTS OF BURNS - 1 - 1-1/2 HOUR SLIDE SHOW ON THE CARE GIVEN TO ELECTRICAL BURN.

5. HYPOTHERMIA - 1 - 1-1/2 HOUR SLIDE SHOW ON THE EFFECTS OF EXPOSURE TO COLD.

TRAINING OF YOUR PERSONNEL IS A MAJOR TASK FOR ALL POLICYHOLDERS, AND EMC CAN ASSIST IN MANY AREAS. JUST A FEW INCLUDE:

1. MACHINE GUARDING
2. HAZARD RECOGNITION
3. ACCIDENT INVESTIGATION
4. FIRE PREVENTION & FIRE PROTECTION
5. PRE-HOSPITAL EMERGENCIES
6. SLIPS & FALLS
7. BACK INJURIES
8. OFF-THE-JOB SAFETY
9. MATERIAL HANDLING
10. FOREMAN & SUPERVISOR SAFETY ORIENTATION
11. DRIVER SAFETY
12. ENVIRONMENTAL HEALTH SURVEYS
13. POLLUTION ABATEMENT

ON THE TOPIC OF DRIVING SAFETY ALONE, EMC UTILIZES FOUR DIFFERENT TRAINING SYSTEMS AND COMBINES THE BEST OF EACH TO DEVELOP AN EFFECTIVE PROGRAM. THOSE INCLUDE AAA, SMITH SYSTEM, NATIONAL SAFETY COUNCIL'S DEFENSIVE DRIVING, AND EVASIVE DRIVING TECHNIQUES. ALL PROGRAMS ARE CUSTOM TAILORED FOR YOUR SPECIFIC NEEDS AND EXPOSURES.

MANAGEMENT OF YOUR SAFETY PROGRAM IS CRITICAL, AND CAN NOT BE DELEGATED TO EMC. WE CAN ASSIST, THOUGH, IN AREAS SUCH AS MBO (MANAGEMENT BY OBJECTIVE) AND THE DEVELOPMENT OF EMPLOYEE PARTICIPATION GROUPS. WE CAN ASSIST YOU TO DEVELOP METHODS TO MEASURE THE EFFECTIVENESS OF YOUR PROGRAM, AND TO OBTAIN FEEDBACK TO MAINTAIN AND IMPROVE IT'S EFFECTIVENESS. WITH AN EFFECTIVE PROGRAM TAILORED TO YOUR NEEDS, IT'S SUCCESS WILL PROVIDE THE NOURISHMENT FOR IT'S CONTINUED GROWTH AND DEVELOPMENT.

6. HYPERTHERMIA 1-1.5 HR. SLIDE PRESENTATION ON THE EFFECTS OF EXPOSURE TO HEAT.

7. SAVE YOUR PARTNER 1/2 HR. PRESENTATION OUTLINING THE IMPORTANCE OF INFORMING YOUR PARTNER OF MEDICAL CONDITIONS THAT CAN KILL WITHIN 5 MINUTES.

8. HOW TO DEAL WITH A PESTICIDE FIRE 3 HR PRESENTATION USING SLIDES, 16 MM FILM, AUDIO TAPE AND OVERHEAD PROJECTION TRANSPARENCIES SHOWING THE HAZARDS AND LEGAL REQUIREMENTS OF PESTICIDE INCIDENTS. PRIMARILY FOR FIRE AND RESCUE PERSONNEL.

9. PCBs VOLUME 1 3/4 HR VIDEOTAPE DETAILING THE HEALTH EFFECTS OF PCBs ON HUMANS. DIRECTED TOWARD MANAGEMENT.

10. PCBs VOLUME 2 3/4 HR VIDEOTAPE DETAILING THE REGULATIONS AND RECORD KEEPING CONCERNING USE AND STORAGE OF PCBs.

11. CPR/FIRST AID INSTRUCTORS AN INTENSIVE WEEK LONG CLASS GIVEN AT EMC DESIGNED TO TEACH INDIVIDUALS TO BE BOTH AMERICAN HEART ASSOCIATION CERTIFIED CPR INSTRUCTORS AND RED CROSS MULTI-MEDIA FIRST AID INSTRUCTORS.

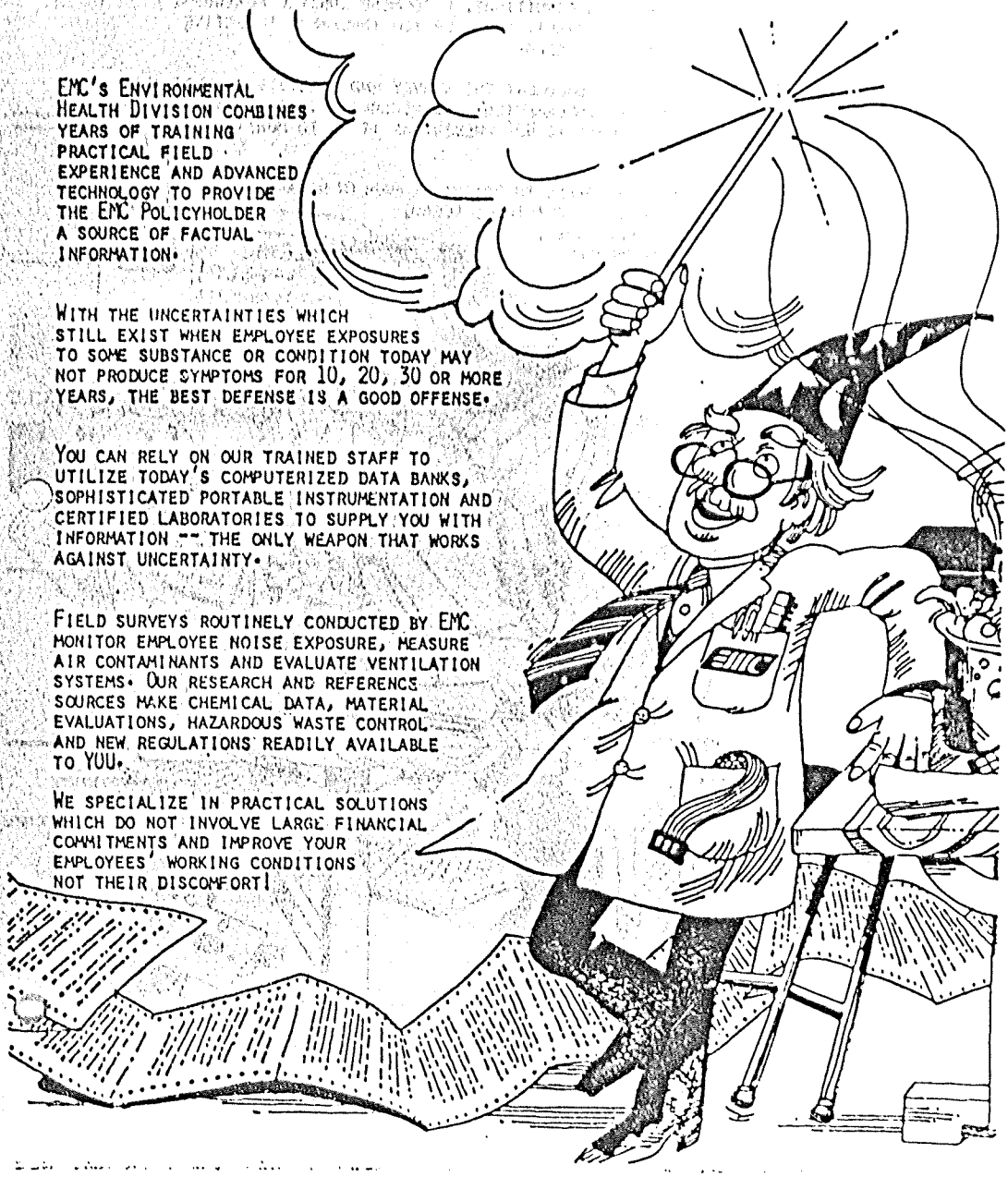
12. THE BACK PROBLEM VOLUME 1 2 HR SLIDE PRESENTATION EXPLAINING THE PATHOPHYSIOLOGY OF CERVICAL BACK INJURY AND LOWER BACK PAIN. EXPLAINS WHY EVEN AFTER ENGINEERING CONTROLS HAVE BEEN INSTITUTED, A COMPANY SPONSORED EXERCISE PROGRAM MAY BE REQUIRED TO REDUCE THE FREQUENCY AND SEVERITY OF BACK PAIN.

13. THE BACK PROBLEM VOLUME 2 1/2 HR SUMMARY OF VOLUME 1 INTENDED AS AN INITIAL PRESENTATION TO MANAGEMENT.

14. OCCUPATIONAL NURSING PROGRAMS CONSULTATION WITH COMPANIES INTERESTED IN ESTABLISHING OCCUPATIONAL NURSING DEPARTMENTS.

Exhibit C

ENVIRONMENTAL HEALTH SERVICES



EMC's Environmental Health Division combines years of training practical field experience and advanced technology to provide the EMC Policyholder a source of factual information.

With the uncertainties which still exist when employee exposures to some substance or condition today may not produce symptoms for 10, 20, 30 or more years, the best defense is a good offense.

You can rely on our trained staff to utilize today's computerized data banks, sophisticated portable instrumentation and certified laboratories to supply you with information -- the only weapon that works against uncertainty.

Field surveys routinely conducted by EMC monitor employee noise exposure, measure air contaminants and evaluate ventilation systems. Our research and references sources make chemical data, material evaluations, hazardous waste control and new regulations readily available to YUU.

We specialize in practical solutions which do not involve large financial commitments and improve your employees' working conditions not their discomfort!

BASED ON YOUR SPECIFIC NEEDS, PROBLEMS AND LOCATIONS, WE WILL WORK WITH YOU TO PROVIDE DOCUMENTATION OF EXISTING CONDITIONS, RECOMMEND CONTROL MEASURES, ASSIST IN DEVELOPING TRAINING PROGRAMS, AND HELP YOU IMPLEMENT EFFECTIVE PERSONAL PROTECTION PROGRAMS, AS NEEDED.

COMPLETE REPORTS ARE PROVIDED TO DOCUMENT THE SURVEY AND ANALYSIS RESULTS AND TO MONITOR CHANGES WHICH MAY BE IMPLEMENTED. WE RECOGNIZE THAT SOMETIMES IT IS JUST AS IMPORTANT TO DOCUMENT WHAT IS NOT PRESENT AS IT IS TO MONITOR AN OBVIOUS HAZARD.

WHEN YOUR OPERATION EXPOSES EMPLOYEES TO POTENTIAL HEALTH HAZARDS--WHETHER NOISE, CONFINED SPACES, OR CHEMICALS (LEAD, ASBESTOS, CARBON MONOXIDE, WELD FUMES, SOLVENTS, ETC)--EMC'S ENVIRONMENTAL HEALTH DIVISION IS AVAILABLE TO YOU, AS AN EMC POLICYHOLDER, AT NO ADDED EXPENSE!

LEAGUE OF KANSAS MUNICIPALITIES

INSURANCE MARKET ANALYSIS

April, 1986

(Revised June 1986)

Prepared by:
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Attachment 29

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APPENDICES

(See separate document - Insurance Market Analysis Appendices)

INTRODUCTION AND STUDY METHODS

The League of Kansas Municipalities retained Tillinghast, Nelson & Warren, Inc. (Tillinghast) in January, 1986 to determine the insurance market conditions facing Kansas municipalities. The League desired an opinion on whether or not the private insurance market will be able to meet municipal insurance needs in 1986 and in the future.

In order to meet these objectives, Tillinghast staff undertook the following activities:

- Developed a survey questionnaire to gather information on exposures to loss and insurance programs in place among the municipalities.
- Tabulated the results of a survey questionnaire and produced exhibits summarizing the information.
- Identified key insurance agents, brokers and underwriters who are familiar with the municipal insurance market conditions.
- Interviewed the identified agents, brokers and underwriters by telephone.
- Developed observations, conclusions and recommendations from the survey questionnaires and the interviews, and incorporated these into a final report.

For readers unfamiliar with Tillinghast, the firm is the world's largest risk management and actuarial consulting firm. We do not sell or underwrite insurance.

I. RESULTS OF SURVEY QUESTIONNAIRE

This chapter presents the results of the survey questionnaire that was distributed in February, 1986. A copy of the 13 page survey document is found in Appendix A.

Respondent Profile

The survey was sent to approximately 500 of the 627 municipalities in Kansas. Some cities of less than 500 population and many of those of less than 300 were not sent a questionnaire. Responses were received from 160 municipalities. Of the 160 responses, 111 responses were complete and 49 were incomplete. The information from the incomplete surveys was used to the extent possible, but all exhibits showing historical exposure and premium data is from complete surveys only.

Complete surveys are from municipalities representing 40% of the state's municipal population. They represent 52% of the population if Wichita and Kansas City (non-respondents) are excluded. Complete surveys were received from a wide range of population sizes, including a good sample from the very largest municipalities as well as responses from the very smallest municipalities. Therefore, we believe that the responding municipalities can serve to represent all municipalities in Kansas. Appendix B lists all municipalities in Kansas and shows which municipalities responded to the survey and which municipalities submitted complete responses.

Indicators of Market Conditions

Several questions on the survey capture information on current

insurance market conditions. Exhibit I shows the extent of difficulty that municipal officials have had in purchasing general liability or umbrella liability insurance in the last 24 months. It is interesting to note that 70% of the respondents said that they have had no difficulty. Only 15% of the respondents said that they have had serious difficulty in obtaining liability insurance.

These results are in dramatic contrast to results obtained from similar surveys that Tillinghast has undertaken in other states. Clearly, municipal officials in Kansas are experiencing less difficulty in purchasing liability insurance than their counterparts in other states.

Exhibit II displays the number of policy cancellations or refused renewals in the last 24 months. The results seem to indicate that there has not been any wholesale cancellation of policies. There have been some cancellations of the liability lines, particularly general liability and public officials' liability. As in other states and in the market in general, there seems to be little difficulty with respect to property and workers' compensation insurance.

Exhibit III shows the number of insurance bids that were received by municipalities during their last bidding process. Not all municipalities bid their insurance and, therefore, these numbers do not necessarily include all municipalities. For those municipalities that do bid their insurance, most of them are receiving very few bids. For example, more than 70% of the respondents to this question received two bids or less during their last bidding process. Six of the respondents received no bids. To some extent, the dearth of bidders is due to poor insurance market conditions. However, we suspect that in many of the smaller municipalities, there may not be

very many eligible agents available to bid. In other words, these same municipalities may have received very few bids even during more favorable insurance market conditions. Nevertheless, the competitive bidding process does not seem to be working at the present time in Kansas.

EXHIBIT I

DIFFICULTY IN PURCHASING GENERAL LIABILITY OR UMBRELLA LIABILITY INSURANCE IN THE LAST 24 MONTHS

None	101
Moderate	21
Serious	23
No Response	14

EXHIBIT II

POLICY CANCELLATIONS OR REFUSED RENEWALS
IN THE LAST 24 MONTHS

No policies cancelled or renewals refused*	60
General liability	24
Auto liability	15
Umbrella and excess liability	12
Public officials' liability	22
Police professional liability	3
Other liability	10
Property	13
Boiler and machinery	0
Contractors' equipment	5
EDP and valuable papers	1
Workers' compensation	14

* Plus 38 with no response, which probably means no cancellations.

EXHIBIT III

NUMBER OF INSURANCE BIDS RECEI
DURING LAST BIDDING PROCESS

No bids	6
One bid	11
Two bids	24
Three bids	14
Four bids	2
More than four bids	1
No response	30

From the first three exhibits, we conclude the following:

- Insurance market conditions for local governments are not as severe in Kansas as they are in many other states;

- Only a small number of municipalities in Kansas are experiencing severe difficulty in purchasing liability insurance; and

- As expected, municipalities are experiencing more difficulty in purchasing liability insurance than in purchasing property and workers' compensation insurance.

Premium Volume

Exhibit IV summarizes four years of premium information by line of coverage for those municipalities that submitted complete surveys (111). Please note that this exhibit includes information only from municipalities that provided premium information for three policy years. This was done so that conclusions can be drawn from trends in premium from one year to the next.

General liability premiums increased dramatically from 1984-85 to 1985-86. The increase over this period was 115%.* This

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* The 1984-85 to 1985-86 growth rate is based on 112 respondents that provided premium data for at least those two years. The growth rates from earlier years are based on 86 respondents that provided premium data for at least three years.

followed on the heels of a 50% increase from the 1983-84 year to the 1984-85 year. The premium increase was much more modest (11%) for the earlier years. Thus, although we concluded in the previous section that there was not a severe insurance availability problem, Exhibit IV demonstrates that there is an affordability problem. Kansas municipalities are paying a high price for continued coverage.

EXHIBIT IV

PREMIUM HISTORY
RESPONDING MUNICIPALITIES

	Policy Year: 4/01/85 4/01/86	4/01/84 4/01/85	4/01/83 4/01/84	4/01/82 4/01/83
1. Primary General Liability	$1,362,627	$596,917	$397,409	$354,537
2. Auto Liability	$1,090,144	$552,388	$340,408	$443,743
3. Public Officials Liability	$169,520	$120,445	$81,940	$71,879
4. Police Professional	$386,957	$209,588	$102,194	$135,419
5. Other Liability	$70,959	$47,132	$31,875	$33,407
6. Umbrella/Excess Liability	$314,412	$167,192	$126,443	$75,468
7. Property	$957,544	$700,575	$480,331	$424,807
8. Boiler Machinery	$99,997	$87,919	$78,863	$78,170
9. Contractors Equipment	$87,273	$61,422	$40,542	$28,833
10. EDP & Valuable Papers	$18,851	$11,977	$7,834	$7,167
11. Workers Compensation	$1,433,756	$1,076,698	$990,612	$1,014,773
TOTALS - General Liability	$1,747,998	$811,241	$555,727	$453,413
Auto Liability	$1,090,144	$552,388	$340,408	$443,743
Professional Liability	$556,477	$330,033	$184,134	$197,312
Property	$1,163,665	$861,893	$607,570	$538,977
Workers Compensation	$1,433,756	$1,076,698	$990,612	$1,014,773

The premium increases for other lines of coverage are much more modest. For example, property insurance premiums have increased by 30-40% for each of the last two years and workers' compensation premiums increased 30% from 1984-85 to 1985-86 and 8.6% from 1983-84 to 1984-85. It is interesting to note that workers' compensation premiums actually declined from 1982-83 to 1983-84, which was the last year of the "soft market."

Exposure Summary

Exhibit V summarizes for the last four years several measures of loss exposure for Kansas municipalities. The exhibit shows that there have been gradual and steady increases in the number of motor vehicles, average annual employment, and total operating budgets. Thus, the dramatic increases in premium shown in Exhibit IV above cannot be attributed to sharp increases in loss exposures.

Limits and Deductibles

We collected information on the limits of coverage being purchased by municipalities and the extent to which they are self-insuring, including deductible amounts.

For primary general liability, the vast majority of respondents are buying policies with a $500,000 bodily injury limit per occurrence. Only 17 respondents are buying coverage with a $1 million limit. Only a small number of municipalities are purchasing coverage at lower limits.

These limits are consistent with the limits being carried by other municipalities, based on Tillinghast's experience. For the most part, smaller municipalities in the United States carry limits of $500,000 for primary general liability.

EXHIBIT V

EXPOSURE HISTORY
RESPONDING MUNICIPALITIES

	BUDGET 1986	ESTIM. 1985	FISCAL YEAR, ACTUAL 1984	ACTUAL 1983
1. Total Operating Budget *	$350,138,457	$301,862,858	$278,387,821	$243,173,349
2. Average Annual Employment**				
A. Police Officers only	1049.85	984.85	946.35	786.85
B. Full-Time Firemen	689	679	613	36;
C. Public Works and Utilities	1836.21	1816.7	1698.795	1313.23
D. All Other Employees	2378.675	2293.535	2225.515	1593.275
E. Total Employment	5666.425	5604.875	5211.6	3761.725
F. Number Volunteer Firemen	1862	1862	1849	1841
3. Number of Motor Vehicles				
A. Passenger autos-owned	678	734	572	562
B. Trucks and other vehicles	1923	1858	1491	1447
C. Mobile equipment (e.g. graders, tractors)	959	957	814	784

* This figure includes all expenditures including utilities and other enterprises

** Average of full and part-time employees who worked during the indicated year.

Exhibit VI shows the primary general liability limits and deductibles. We were surprised to learn that the large majority of respondents (74%) have no deductible on their general liability policies. All but two of the remaining respondents had deductibles of $1,000 or less. Thus, we can conclude that municipalities in Kansas are risk-averse. The propensity to purchase first-dollar coverage is probably one of the principal reasons for the very sharp increases in liability premiums over the last two years. Some of these sharp premium increases could have been mitigated if the municipalities had increased their deductibles.

Seven of the respondents indicated that they were self-insured or uninsured for primary general liability.

EXHIBIT VI

PRIMARY GENERAL LIABILITY
LIMITS AND DEDUCTIBLES

Bodily Injury Limit Per Occurrence	
$1,000,000	17
500,000	114
300,000	2
250,000	3
100,000	4
25,000	1
10,000	1
Deductible	
$ 0	104
100	8
250	18
500	6
1,000	4
25,000	2
Self-Insured or Uninsured	7

Umbrella Liability Limits

Exhibit VII shows the limits of coverage being purchased for excess liability. At least 89 respondents are buying no umbrella liability coverage (an additional 67 municipalities provided no information, and we believe that many of these municipalities probably also have no umbrella liability coverage). Those municipalities that are buying umbrella policies are buying very modest limits - in most cases $1 million. Three municipalities are buying umbrellas of $1.5-$3 million, and only two municipalities are purchasing a $10 million umbrella.

From this we conclude that Kansas municipalities have been buying relatively small amounts of liability coverage, when compared to municipalities in other states.

The Kansas Tort Claims Act limits the liability for claims to $500,000 for any number of claims arising out of a single occurrence. This cap does not apply if the municipality has purchased insurance with a limit higher than $500,000. Thus, there is a disincentive to buy coverage above $500,000.

Premium and Exposure Summaries for Individual Municipalities

We have prepared individual premium and exposure summaries for each respondent. These individual exhibits are found in Appendix C and D to the report.

EXHIBIT VII

UMBRELLA LIABILITY LIMITS

No coverage*	89
$1 million	12
$1.5-$3 million	3
$10 million	2

* An additional 67 municipalities provided no information; many of these municipalities probably have no excess liability coverage.

Claims Volume

Several questions on the survey collected information on the claims experience of the respondents. We did not ask for detailed loss experience information, but rather for general data on numbers of claims filed and numbers of claims paid.

Exhibit VIII shows the number of claims filed against the city or its officers and employees under the Kansas Tort Liability Act since it took effect on July 1, 1979. Sixty percent of the respondents said that they have had no claims filed. Thirty-one respondents said that they have had five or less claims filed, and 14 respondents had more than five claims filed. It is difficult to draw and conclusions about this information without knowing the dollar amount claimed and the nature of the claim.

Exhibit IX shows the number of paid claims under the Kansas Tort Liability Act since July 1, 1979. The vast majority of respondents have not paid any claims over the seven-year period. Nineteen municipalities have paid five or fewer claims and 14 have paid more than five claims.

Although we do not know the amounts of the claims payments, it is apparent that Kansas municipalities have not experienced a frequency problem on tort liability claims. Therefore, the very sharp increases in premium charged by the insurers over the last two years is probably not caused by actual Kansas municipal loss experience, but rather by the overall poor loss ratios experienced by the insurance industry and perhaps by the poor loss experience experienced by public entities in other states.

EXHIBIT VIII

NUMBER OF CLAIMS FILED AGAINST THE CITY OR ITS OFFICERS AND EMPLOYEES UNDER THE KANSAS TORT LIABILITY ACT SINCE IT TOOK EFFECT ON JULY 1, 1979

Filed Claims	No. of Municipalities
None	53
Five or less	31
More than five	14
No response	9

EXHIBIT IX

NUMBER OF PAID CLAIMS UNDER THE
KANSAS TORT LIABILITY ACT
SINCE JULY 1, 1979

Claims Paid	No. of Municipalities
None	118
Five or less	19
More than five	14
No response	4

Exhibit X shows the number of claims filed for alleged violations of state or federal civil rights laws from 1980 through 1985. The vast majority of respondents (82%) have not experienced any filed claims. Civil rights claims are an emerging area of loss exposure for municipalities nationwide. This is a particular problem in those states where there are caps on judgments in the state statutes. These caps do not apply to cases brought in federal court.

Professional Liability

Exhibit XI shows the limits and deductibles for public officials' liability policies. A relatively small number of municipalities are purchasing public officials' liability coverage. The predominant limits of coverage are $500,000 to $1 million.

Thirty-seven respondents indicated that they are self-insured or uninsured for public officials' liability.

Insurers usually require insureds to carry higher deductibles for professional liability. This is reflected in Exhibit XI. Most of the municipalities have deductibles of at least $1,000 and as high as $2,500 for this coverage.

Exhibit XII shows a similar pattern for police professional liability coverage. The limits and deductibles are generally the same, although more municipalities have no deductible for police professional liability.

EXHIBIT X

NUMBER OF FILED CLAIMS FOR ALLEGED VIOLATIONS
OF STATE OR FEDERAL CIVIL RIGHTS LAWS
FROM 1980 THROUGH 1985

Filed Claims	No. of Municipalities
None	126
Five or less	27
More than five	2
No response	2

EXHIBIT XI

PUBLIC OFFICIALS' LIABILITY
LIMITS AND DEDUCTIBLES

Limit Per Occurrence		Deductible	
$5,000,000	3	$ 0	8
2,000,000	3	100	3
1,000,000	39	500	9
500,000	29	1,000	21
250,000	3	1,500	8
100,000	2	2,000	6
25,000	2	2,500	13
5,000	5		
Self-Insured or Uninsured	37		

EXHIBIT XII

POLICE PROFESSIONAL LIABILITY
LIMITS AND DEDUCTIBLES

Limit Per Occurrence		Deductible	
$5,000,000	3	$ 0	17
2,000,000	3	100	3
1,000,000	37	250	2
500,000	33	500	4
250,000	1	1,000	6
100,000	2	1,500	4
25,000	2	2,000	2
		2,500	4
		5,000	3
		10,000	2
Self-Insured or Uninsured	38		

Property Deductibles

Exhibit XIII shows the predominant property deductible on the property policies. This exhibit again confirms that Kansas municipalities are risk-averse. Ninety two percent of the respondents have property deductibles of $1,000 or less.

EXHIBIT XIII

PREDOMINANT PROPERTY DEDUCTIBLE

Deductible Amount	No. of Municipalities
$ 0	11
100	49
500	22
1,000	16
3,000	1
5,000	3
10,000	4

II. RESULTS OF INTERVIEWS WITH INSURANCE AGENTS, BROKERS AND UNDERWRITERS

Introduction

From the survey questionnaires, Tillinghast was able to identify insurance agencies that are writing municipal insurance. We tried to identify agencies from various locations within the state and agencies that service more than one municipality. However, it became clear that there is a vast proliferation of local insurance agents in Kansas, most of which are located within a small municipality. Through telephone calls to some of the survey respondents, we were able to get names and phone numbers of the account executives. We then contacted these agents and brokers and asked them a series of questions to get their impressions and observations on current market conditions and their outlook on the short and long-term future.

We also asked the agents and brokers for the names of underwriters at insurance companies that are writing municipal business. We then contacted these underwriters and asked them the same questions.

We also contacted the person who is administering the state market assistance program to get information on which municipalities have applied for assistance and which municipalities have gotten coverage.

Appendix E is a list of the interviewees.

Insurance Agents and Brokers

The following is a summary of the observations of the insurance agents and brokers:

- Generally speaking, the agents that we talked with did not have a very broad perspective. Also, they did not have a sophisticated long-term outlook or view of insurance market conditions.

- There are many fewer insurance companies willing to write municipal business than there were two years ago. All of the agents and brokers listed at least two or three insurers who used to write municipal business but will no longer entertain submissions. The agents say that they are working much harder, and must now make direct presentations to underwriters. Many of the agents said that municipal business is the most frustrating to work with.

- For the most part, renewals are being secured, but at much higher premiums.

- Municipalities are being forced to take higher deductibles.

- There was a general consensus that the market will remain unchanged or become tighter during the next six months. Some agents thought that the market would begin to turn as early as the middle of 1987. However, most agents see think the turnaround will come later, possibly as late as 1990.

- PENCo is mentioned by several agents as a possible source of municipal insurance.

- Employers' Mutual was also mentioned frequently, although there was a consensus that Employers' Mutual will not write much new business in the near future.

Insurance Underwriters

Employers' Mutual: Mr. Robert Gufe of Employers' Mutual said that EMC currently writes approximately 140 municipalities and 50 counties in Kansas. For certain lines of coverage, they will look at new business. However, they are closed for new applications for public officials' liability and police professional liability. One important criterion for new business is the existing relationship that EMC has with a particular agent. The agents must already have a certain minimum premium volume with EMC before they can get attention from EMC's underwriters. Also, EMC requires supporting coverage business.

As a rule, EMC will only write business for cities under 15,000 in population. EMC will not use the new commercial general liability policy form until September, 1986. This means that municipalities with April 1, 1986 anniversary dates* will be given renewals using the old comprehensive general liability policy form.

Tillinghast recently contacted the President of Employers' Mutual Company, who indicated that EMC had a 1986 goal of no net increase in public entity premium nationwide.

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* The survey showed 168 policies with an April 1 anniversary date. There is a wide range of policy anniversary dates, with January 1 (124) being the second most frequent date.

INA: Our contact at INA said that INA is still writing municipal business, but on a very selective basis. INA has a capacity problem and thus is concerned about increasing premium volume. INA is working only through agents who already have a certain minimum level of premium volume with INA. INA is not yet using the new CGL policy form, and they do not know when they may implement the new form.

Cleveland Group: A representative from the Cleveland Group told us that their insurer, Great American Insurance Company, will write only cities under 70,000 in population. They are not yet using the new CGL policy form either.

Allied Group: The Allied Group will write insurance for municipalities with populations under 2,000. They are currently entertaining applications from all public entities of that size. They are not yet using the new CGL policy form.

Kansas Farm Bureau: According to the managing underwriter, this insurer has recently been writing more municipal business. This is partly the result of the loss of some municipal business during the soft market, because Kansas Farm Bureau did not cut its prices as drastically as its competitors. They will not be using the ISO claims-made form but will be using the ISO CGL occurrence form starting January 1, 1987.

PENCo/Hartford Insurance Group: PENCo is the managing general agent with exclusive rights on placing municipalities with The Hartford Insurance Group in Kansas. Currently, The Hartford has only been writing the medium to larger size municipalities, according to our PENCo contact. Due to staffing problems, PENCo has never viewed the Kansas market as a priority.

In addition to placing municipalities with The Hartford, PENCo can also provide larger municipalities with an all-lines aggregate program. This program is essentially a protected self-insurance plan. They just recently offered the all-lines aggregate program to Johnson County, Kansas.

When PENCo provides proposals to Kansas municipalities, it is almost always with Nutmeg Insurance Company, which is a non-admitted carrier and a member of The Hartford Insurance Group. Nutmeg can provide coverage for all-lines including public officials liability and law enforcement liability.

The policy form being used by Nutmeg is even more restrictive than the ISO commercial general liability form. The limitations include:

- An extended tail provision limited to three years and not automatic;
- A high cost for the three year tail of 125% to 200% of premium;
- No provision in the policy for coverage to be triggered by a verbal statement from the insured;
- No reinstatement of aggregate limits with the purchase of the tail coverage; and
- No criteria for establishing the retroactive date (there are four criteria specified on the ISO form).

The Hartford wants to be able to provide coverage through an admitted carrier. Thus, they are attempting to have Twin Cities Insurance Company become admitted. Twin Cities has

filed a non-ISO form for department approval, which is identical to the form currently being used by Nutmeg. Because of the limitations outlined above in the policy form, the department has not approved the form and The Hartford is refusing to make any changes to the form. According to a representative from the department, they are concerned that insureds will not be well informed as to the potential gaps in coverage. The department has asked The Hartford to add a disclosure form to the policy, which would explain the scope of coverage. This would be consistent with the disclosure form that ISO has agreed to add to its policy at the department's request. So far, The Hartford has refused to provide the disclosure form. It appears that unless The Hartford adds the disclosure form and/or modifies its policy form, it will still be forced to offer coverage only through a non-admitted carrier.

It is also interesting to note that only admitted carriers have to pay the 4% insurance tax. Thus, if Twin Cities were to become admitted, presumably their premium would be 4% higher than the premium being charged by Nutmeg.

Market Assistance Program

The Kansas market assistance program has been in existence since January 1. A total of 145 organizations have requested assistance. Of the total, 22 are public entities. These public entities include cities, townships and counties.

In order to obtain assistance, an entity must have received two to three declinations for coverage. Therefore, if a quote is received, no matter how high the price, the entity is ineligible for the market assistance program. However, some entities that are ineligible for the program often receive informal assistance.

To date, 22 cities, counties and townships have received assistance from the program. Sixteen of those public entities have obtained coverage and six still have no coverage.

III. CONCLUSIONS AND RECOMMENDATIONS

The results of the survey questionnaire and Tillinghast's interviews of Kansas insurance professionals indicate that a relatively small number of municipalities are finding it difficult to obtain liability insurance; the remaining municipalities are able to renew their liability policies, but at sharply increased premiums. These market conditions exist in other states. However, in many other states, particularly on the West and East coasts, the conditions are much more severe. For example, in California a large percentage of municipalities cannot buy liability insurance at any price. Tillinghast's experience in recent public sector work leads us to believe that Midwestern states have not been hit as hard as other parts of the country.

From these observations, we conclude that there is no urgent need for the League of Kansas Municipalities to form a group self-insurance program, especially since League management is not naturally inclined to again "get into the insurance business." The possibility of a limited municipal pool program is discussed below.

We also conclude that insurance market conditions for municipalities in Kansas will not improve during 1986. Most 1986 renewals will probably be accomplished successfully, but at much higher premiums, with higher deductibles and additional exclusions. However, these renewals will also probably use the old comprehensive general liability policy form, which is more advantageous than the new policy form being forced on municipalities in many other states.

Clearly, insurance market conditions in Kansas will be influenced by national trends. The problems of affordability and availability of insurance for public entities have affected different states differently. We believe that the short-term trends will also vary from state to state. There has already been some return of insurers into the property market. However, conditions are still worsening in some states with respect to general liability, excess liability, and professional liability coverages. Workers' compensation coverage will probably not be too much of a problem in the short-term. We believe that national conditions will not markedly change before July, 1987. While it is hard to make any forecasts, we believe that conditions may improve for liability coverages sometime late in 1987. Even when conditions do start to improve, the changes in the general liability policy form, as well as changes that are likely in the professional liability policy forms, will mean that conditions probably will never "return to normal." Generally speaking, public entities will be forced to take more aggressive risk retention postures to focus more on risk assessment and risk control. We believe that the commercial insurance market will not be a principal source of risk financing for the most difficult municipal exposures, including public officials' liability, law enforcement liability and environmental impairment liability.

The League could take several steps requiring a modest level of effort to ease the problems faced by its members (in lieu of developing a pool program). Rather than focusing on a risk financing program, the League should provide risk management technical assistance to municipal officials, focused on assisting municipalities to make decisions on reasonable self-insured retentions. In most cases, this will mean

educating municipalities to take higher deductibles and assisting them in planning for payment of self-insured losses within the deductibles.

Assistance and guidelines should also be provided to municipal officials to help them determine reasonable limits of coverage, in light of the Tort Claims Act and according to each municipality's size and exposures. Because some insurers may introduce the new ISO policy form, the League should provide information and helpful hints to municipal officials on the differences between the old and new policy forms. This will focus on (1) claims-made versus occurrence coverage, (2) the importance of the anniversary date, (3) the importance of the retroactive date, and (4) the issues associated with purchasing tail coverage.

Many municipal officials will be interested in seeing the summary results of the questionnaire. For example, municipal officials will be interested in the deductibles and limits carried by other municipalities. This may assist them to make decisions regarding their own insurance purchasing.

You have asked for Tillinghast's comment on the feasibility of regional pools[a] being established in Kansas. It has been our experience that regional pools are most successful in those major industrial states which have a number of large and diverse public entities. For example, those states with the most number of regional pools are California and Illinois and most recently New Jersey.

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[a] By "regional pool," we mean a pool that is not designed to be the only pool in that state and which may be appealing to only a relatively small group of municipalities.

Given the relative homogeneity of public exposures in Kansas, we do not believe that the League should encourage the proliferation of regional pools. It would be difficult to general sufficient premium volume among several different pools to support the administrative burden that pools must support.

It is also interesting to note that the Arthur J. Gallagher Company and PENCo have each established pooling products that are available to groups of small to medium sized public entities. Both of these packaged programs are supported, in large part, by domestic and foreign insurers and provide all lines aggregate protection above a relatively modest pool self-insured retention. In order to obtain access to the Gallagher or PENCo excess insurance package, a pool is required to use the Gallagher or PENCo service organization for claims management information services. These programs are essentially a hybrid of group self-insurance and insurance. There is usually very little risk taking on the part of the pool because the modest aggregate self-insured retention is usually fully funded.

An additional area where the League can provide low-level technical assistance is in the area of insurance procurement and agent/broker selection. There is a tremendous number of insurers and agents in Kansas - more so than we have seen in any other state. Related to this is the wide variation in insurance policy anniversary dates. Some of the problems in insurance procurement may be alleviated by improving and standardizing the process that is being used by cities to select agents and brokers. Competitive bidding is probably being used in most cases, as is indicated on the survey results. More appropriate in the current market would be a process to pre-qualify agents and brokers, and to select a

single agent or broker to represent the municipality. This single agent should then be given access to all insurance markets, and should negotiate on behalf of the municipality.