

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

1127 - 11th Street, Suite 550, (916) 445-2125
Sacramento 95814



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Vice-Chairman
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M LESTER OSHEA

ABRAHAM SPIEGEL

RICHARD R. TERZIAN

JEAN KINDY WALKER

PHILLIP D. WYMAN
Assemblyman

ROBERT T. O'NEILL
Executive Director

A REPORT ON

THE LIABILITY INSURANCE CRISIS

IN THE STATE OF CALIFORNIA

JULY 1986

LIABILITY INSURANCE CRISIS
IN THE
STATE OF CALIFORNIA

A Report
of the
COMMISSION ON CALIFORNIA STATE GOVERNMENT
ORGANIZATION AND ECONOMY

July 1986

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July 14, 1986

The Honorable George Deukmejian
Governor of CaliforniaThe Honorable David A. Roberti
President pro Tempore of the Senate
and Members of the SenateThe Honorable James Nielsen
Senate Minority Floor LeaderThe Honorable Willie L. Brown, Jr.
Speaker of the Assembly
and Members of the AssemblyThe Honorable Patrick Nolan
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

The liability insurance crisis has not been remedied in California. Although Proposition 51 registered the public's indignation with the difficulties and costs associated with obtaining liability insurance, and addressed one portion of the problem relating to noneconomic damages, the insurance crisis continues.

Due to the inability of the Administration, the Legislature, the insurance industry, the legal profession, or consumers to work out a solution to the crisis, the Commission on California State Government Organization and Economy initiated a study on the matter more than seven months ago. Our study revealed that there is no single culprit responsible for the problem. Instead, it is the result of multiple, interrelated causes. However, our work revealed startling information. For example, the study showed that:

- o Cost of commercial general liability coverage rose by an average of 81 percent in 1985;
- o 50 percent of California businesses responding to a recent survey have had to raise the price of their goods or services to cover the increased cost of liability insurance coverage;
- o Virtually every city in the State is unable to obtain commercial liability coverage;
- o 54 cents of every total dollar paid by an insurance company goes to cover the sum of the defendant's and the plaintiff's legal costs; and
- o The Insurance Commissioner has held only one public hearing on excessive rates and has never fined an insurance company for excessive rates since 1948.

Moreover, the impact of the crisis has been severely felt by all Californians. For example, the Commission's study showed that:

- o 14 percent of all doctors surveyed who previously delivered babies, no longer do so;
- o 50 percent or 370,000 trucks on the California highways are operating without insurance coverage;
- o In Monterey and Salinas, officials have considered suspending paramedic programs; and
- o In Plymouth, the City disbanded its police department and closed its city playgrounds and pools.

Our research showed that the underlying cause of the crisis is the uncertainty in predicting risk in the insurance industry. While the cause of the uncertainty is widely debated, the Commission identified five major underlying causes, including:

- o Evolution of tort law--during the past 25 years, the basis of liability has been expanded enormously in a series of judicial decisions;
- o Lack of predictability in risk assessment--the process of determining the outcome and settlement amount for a particular policy or group of policies has become more difficult in the past ten years;
- o Unsound rate-setting practices in the insurance industry--the insurance industry has engaged in unsound business practices with respect to the process of establishing adequate rates to cover losses and ensure underwriting profitability;
- o Withdrawal of the reinsurance market--in the last several years there has been a significant increase in both the number and size of the largest liability awards and settlements which have primarily been paid by reinsurers; and
- o The Insurance Commissioner's lack of authority and leadership in the rate-setting process--the Insurance Commissioner does not have authority to control rate increases in California and has not exercised his discretionary powers to control rate increases and make insurance available.

In order to alleviate this crisis, the Commission recommends a comprehensive reform package to address the multiple problems that have created the crisis, including the following recommendations:

- o The Governor and the Legislature should establish a \$500,000 cap with a cost of living allowance on the recovery of compensatory damages in personal injury actions;
- o The Governor and the Legislature should prohibit collusion between plaintiffs and settling defendants typically referred to as "Mary Carter" Agreements;
- o The Governor and the Legislature should establish a much stricter burden of proof for punitive damages;
- o The Governor and the Legislature should prohibit a person from obtaining damages for injuries incurred while in the process of committing a felony;
- o The Governor and the Legislature should place limits on the cost of the civil justice system, including limiting the plaintiff's attorney fees to one-third of recovery, limiting the defendant's attorney fees, and establishing penalties for frivolous claims or defenses;
- o The Governor and the Legislature should modify the collateral source rule to offset plaintiff's recovery by the amount of any public benefits received;
- o The Governor and the Legislature should require periodic payments for all future damages over \$100,000;
- o The Governor and the Legislature should establish a statewide reinsurance pool for public entities;
- o The Governor and the Legislature should consider providing the Insurance Commissioner with authority to compel appropriate insurers to participate in market assistance plans, joint underwriting authorities, or FAIR plans if voluntary participation is inadequate;
- o The Governor and the Legislature should require insurance carriers to take individual prior practices and claims history into account when establishing rates and coverage;
- o A study should be conducted regarding the operations of the Insurance Commissioner's Office and the Department of Insurance aimed at determining whether any barriers exist preventing competition in the marketplace;
- o The Governor and the Legislature should require that insurance companies disclose their loss data for California on a line-by-line and state-by-state basis;

- o The Governor and the Legislature should consider requiring prior approval by the Insurance Commissioner of insurance rate increases in excess of 15 percent;
- o The Governor and the Legislature should increase penalties and fines against the industry for non-compliance;
- o The Governor and the Legislature should consider establishing a bipartisan independent five-member part-time commission to replace the Insurance Commissioner; and
- o The Governor and the Legislature should require the Insurance Commissioner to continue to monitor federal actions regarding product liability.

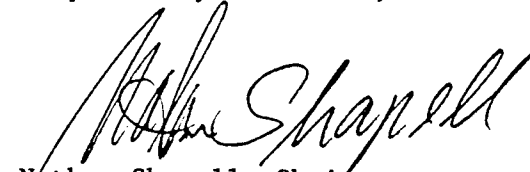
The members of the Commission believe that the liability insurance crisis demands a rapid and effective response from our State Government. The Commission believes that its recommendations will protect individual businesses and public entities that are struggling to obtain or afford insurance, while maintaining the rights of individuals to seek fair compensation. Now is the time for a nonpartisan comprehensive response to the insurance problem that is plaguing our entire State.

Respectfully submitted,



M. Lester Oshea, Chairman
Liability Insurance Crisis
Subcommittee

Haig Mardikian
Mary Anne Chalker



Nathan Shapell, Chairman
James Bouskos, Vice Chairman
Senator Alfred Alquist
Albert Gersten, Jr.
Senator Milton Marks
Assemblywoman Gwen Moore
Abraham Spiegel
Richard Terzian
Jean Kindy Walker
Assemblyman Phillip Wyman

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EXECUTIVE SUMMARY

California and the rest of the nation face a liability insurance crisis unparalleled in economic consequences since the oil shortage of the 1970s. This crisis has struck every type of business and governmental agency with drastic increases in premiums and reductions in coverage. Due to the widespread nature of the crisis, the Commission on California State Government Organization and Economy initiated a study in November 1985 to identify its major causes and to present recommended solutions. The Commission held two public hearings and conducted extensive research into the underlying problem areas. Based on the research, the Commission found that the overriding problem which has driven the current crisis is the uncertainty in predicting risk in the insurance industry. This uncertainty is the result of the following five major interrelated factors:

- o Evolution of tort law--during the past 25 years, the basis of liability has been expanded enormously in a series of judicial decisions;
- o Lack of predictability in risk assessment--the process of determining the outcome and settlement amount for a particular policy or group of policies has become more difficult in the past ten years;
- o Unsound rate-setting practices in the insurance industry--the insurance industry has engaged in unsound business practices with respect to the process of establishing adequate rates to cover losses and ensure underwriting profitability;
- o Withdrawal of the reinsurance market--in the last several years there has been a significant increase in both the number and size of the largest liability awards and settlements which have primarily been paid by reinsurers; and
- o The Insurance Commissioner's lack of authority and leadership in the rate-setting process--the Insurance Commissioner does not have authority to control rate increases in California and has not exercised his discretionary powers to the setting of rates or the availability of insurance.

Although Proposition 51 has addressed a portion of the problem relating to non-economic damages, it will not, in and of itself, solve the problem. Instead, each of these five major interrelated factors must be addressed.

The following sections describe the major findings in each chapter of the report. This is followed by a listing of the recommendations of the Commission to address these problems.

CHAPTER II - EFFECTS OF THE LIABILITY INSURANCE CRISIS

FINDING #1 - Liability Insurance is Unaffordable for Many Groups Resulting in the Denial of Necessary Goods and Services to the People of California. In the last two years, liability premiums for both public and

private entities have increased by as much as 100 to 9000 percent rendering insurance unaffordable for many groups. In addition, many entities cannot obtain insurance, leaving them with the option of either "going bare" or going out of business. In either case, consumers must pay more for purchasing goods or services.

FINDING #2 - Liability Insurance Coverage is Not Available for Many Public Entities. The number of cities, counties, and special districts that are unable to obtain liability insurance is increasing drastically. However, this availability problem for public entities does not appear to be a result of actual claims history over the past several years.

CHAPTER III - EVOLUTION OF TORT LAW

FINDING #3 - The Basis of Liability in Tort Has Expanded and Exposed "Deep Pockets" to New Risks. Over the last 40 years, the judiciary in California has expanded the grounds for holding defendants liable in tort. This progressive expansion of liability has made it increasingly difficult for parties to predict risk and insure against that risk.

FINDING #4 - The Average Size of Jury Awards and Settlements Have Increased Due to "High Stakes" Cases. While the number of lawsuits filed and the great majority of awards have remained relative constant when adjusted for inflation and population increase during the last 25 years, the average size of jury awards has risen dramatically in recent years. This has been due almost exclusively to a fifteen-fold increase in multi-million dollar verdicts. It is also reasonable to infer that this increase has had a similar impact on cases settled prior to trial.

FINDING #5 - The Joint and Several Rule That Was Partially Repealed by Proposition 51 is Unfair to Low-Fault Defendants. The Commission has determined that the operation of the rule of joint and several liability has been inconsistent with the proportionate fault system adopted in California in 1975. As a result, "deep pocket" defendants found either minimally at fault or less at fault than the plaintiff suffer major inequities when they are required to pay more than their proportionate share of the judgement. The recent passage of Proposition 51 addresses part, but not all, of this inequity.

FINDING #6 - The Law Encourages Collusive Settlements at the Expense of Remaining Defendants. The judiciary has consistently refused to credit non-settling defendants with a settling defendant's proportionate share of the fault when the non-settling defendant is found partially at fault. This practice, intended to promote quick settlements with defendants of limited means, is open to abuse on two counts. First, the risk of an undervalued settlement is borne by the defendant who is not a part of the settlement, rather than by the plaintiff. Second, a settlement with one of a number of defendants may be conditioned on that defendant actively aiding the plaintiff (commonly referred to as a "Mary Carter" agreement). This form of agreement can lead to collusion between plaintiffs and settling defendants.

FINDING #7 - The Plaintiff's Burden of Proof is Too Low to Control Increasing Punitive Damage Awards. The current burden of proof required

of the plaintiff to justify an award of punitive damages against a defendant is lower than the burden of proof required in other quasi-criminal cases. The Commission believes that the current burden of proof, among other factors, allows and encourages misapplication and misuse of punitive damages.

FINDING #8 - The Collateral Source Rule Can Result in Double Payments to Plaintiffs. The shift in tort law emphasis from deterrence to the compensation of injured plaintiffs has undermined the doctrinal bases for the collateral source rule. Application of this rule has resulted in double payment of losses to some plaintiffs, particularly with respect to public benefits. While the law should encourage people to carry their own insurance, and not penalize them for doing so, the same policy considerations do not apply to public benefits like social security, Medicare, and welfare benefits.

FINDING #9 - The Cost of Administering the Civil Justice System is Excessive and Creates a Burden to Plaintiffs and Defendants. The cost of administering the civil justice system has reached an intolerable level. The Commission found that nearly 54 cents of every premium dollar paid by an insurance company goes to cover the total of plaintiff's and defendant's legal costs, irrespective of other administrative costs. Moreover, legal costs of the tort system are increasing even faster than the average size of jury verdicts. This increasing legal cost is the result, in part, of the complexity of trials and the use in some cases of wasteful, unnecessary, and frivolous pre-trial motions. These costs have subtracted from plaintiff's recoveries for injuries and placed a great strain on liability carriers.

FINDING #10 - Payment of Lump Sum Awards for Future Damages at the Time of Judgement Hurts Both Parties. Testimony and evidence gathered by the Commission indicate that payment of future damages in a single lump sum at the time of judgement is not in the best interest of either party. Payment of a large future damage award places a heavy burden on the defendant or his insurer and compensates the plaintiff for damages not yet suffered. Periodic payments of future damages would increase the probability that the plaintiff will have funds available to meet future expenses.

CHAPTER IV - POLICIES AND PRACTICES OF THE LIABILITY INSURANCE INDUSTRY

FINDING #11 - The Liability Insurance Industry is Cyclical Which Results in Periodic Affordability and Availability Problems. The liability insurance industry is affected by an interest-sensitive rate-making structure and unique accounting practices. The full cost of liability coverage is borne by a changing combination of customer premiums and interest earned from the investment of those premiums. A number of accounting practices unique to the liability insurance industry, particularly in the definition and calculation of profits and losses, contribute to the cyclical nature of the insurance industry. As a result, there have been and probably will continue to be periodic problems of affordability and availability. Due to forces affecting the industry and the effects of prior unsound underwriting practices, the next cycle may be even more extreme and prolonged.

FINDING #12 - A Significant Number of Reinsurance Underwriters Have Withdrawn from the Market thus Limiting Insurance Availability. One of the major reasons the current crisis is so widespread and acute has been the withdrawal, between January 1984 and December 1985, of approximately 45 percent of the total number of companies offering reinsurance, or "insurance for insurers," from the market. This withdrawal has significantly reduced insuring capacity in many lines, particularly in the area of public entity coverage. There is currently no reliable indicator of when, or even if, this vital part of the industry may recover.

CHAPTER V - THE INSURANCE COMMISSIONER'S ROLE IN PROVIDING
STABILITY IN THE INSURANCE MARKETPLACE

FINDING #13 - The State Insurance Commissioner's Regulatory Powers in California are More Limited Than in Other States. The balance between regulation and the free market in the insurance industry in California is unlike that of any other major industry. The industry is exempt from all federal and state anti-trust laws, and unlike in other states, is not required to either file rates or seek prior approval for them. As a result, the insurance industry has considerably less regulation and accountability than other industries.

FINDING #14 - The Insurance Commissioner Does Not Have the Authority to Collect Adequate Data to Monitor Trends in the Insurance Industry. Although the Commissioner collects adequate data to determine whether a carrier is financially solvent, the Commissioner does not collect, nor does he have the legal authority to collect, adequate data regarding the construction of insurance rates. Data is submitted by insurance carriers on a nationwide basis, rather than on the basis of experience in California. Additionally, no data is presented regarding the cost of legal judgements and settlements, with the exception of product liability and worker's compensation lines. Thus, the Commissioner is unable to carry out his statutorily mandated function to determine if a rate is "excessive, inadequate, or unfairly discriminatory."

FINDING #15 - The Insurance Commissioner Does Not Fully Utilize His Authority to Make Insurance Available. The Commissioner currently has sufficient legal authority to establish voluntary programs to provide insurance to all entities at a more affordable price. However, the Commissioner, except in one instance to date, has chosen not to exercise this power. A request for voluntary solutions from the industry by the Commissioner may result in needed relief. If not, additional authority to mandate solutions may be needed by the Commissioner.

FINDING #16 - The Insurance Commissioner Does Not Have Legal Authority to Control Rates. Liability insurance carriers are not required to gain approval of rates from the Commissioner prior to implementation, nor to file them with the Commissioner. In addition, the Commissioner does not have the authority to mandate that any licensed insurer underwrite a particular classification of risk, with the sole exception of the Automobile Assigned Risk Plan. Finally, the penalties and fines for noncompliance with the authority that the Commissioner does have are so minor that they are not adequate deterrents. In fact, since 1948 the

Commissioner has never imposed a penalty on a carrier for use of excessive or inadequate rates.

CHAPTER VI - CONCLUSIONS AND RECOMMENDATIONS

The Commission has developed a comprehensive set of recommendations to address the findings of its report. These recommendations include:

1. Establish a \$500,000 cap on compensatory damage awards for pain and suffering, with a cost of living adjustment.
2. Prohibit collusion between plaintiffs and settling defendants.
3. Establish a stricter burden of proof as the standard for punitive damage awards.
4. Prohibit a person from obtaining damages for injuries incurred while in the process of committing a felony.
5. Place limitations on the cost of the civil justice system including:
 - o Limit plaintiff's attorney fees to one-third of the recovery.
 - o Develop a mechanism for limiting defendant's attorney fees.
 - o Establish penalties for frivolous claims and defenses.
6. Modify the collateral source rule to offset plaintiff's recovery by the amount of any public benefits received.
7. Require periodic payments for all future damages over \$100,000.
8. Establish a statewide reinsurance pool for carriers writing coverage for public entities.
9. Provide the Insurance Commissioner with the authority to form voluntary market assistance plans, joint underwriting authorities, and FAIR plans. If voluntary participation is inadequate, consider providing the Commissioner with the authority to compel insurers to participate.
10. Require insurance carriers to take individual prior practices and claims history into account when establishing rates and coverage.
11. Conduct a review of the Insurance Commissioner's Office and the Department of Insurance aimed at determining whether barriers exist in California which unnecessarily prevent competition in the marketplace.
12. Require insurance companies to fully disclose loss data on a line-by-line and state-by-state basis.
13. Consider requiring prior approval of rate insurance increases in excess of 15 percent by the Insurance Commissioner.

14. Increase fines and penalties for non-compliance with Insurance Code requirements.
15. Should consider establishing a bipartisan, five-member Insurance Commission to replace the Insurance Commissioner.
16. Require the Insurance Commissioner to continue to monitor federal actions regarding product liability.

The Commission believes that these recommendations address the various interrelated causes of the crisis, and will protect individual businesses and public entities that are struggling to afford or obtain liability insurance, while maintaining the rights of individuals to seek fair compensation for damages.

CHAPTER I

INTRODUCTION

California and the rest of the nation have been besieged by a severe liability insurance crisis during the last two years that is unparalleled in its economic consequences since the oil shortages of the 1970's. The liability insurance crisis has brought with it a dramatic rise in premiums and in the cancellation of general coverage of insurance policies. The problems associated with the affordability and availability of liability insurance have detrimentally affected the quality of life enjoyed by all Californians. Due to the widespread nature of the crisis, no elements of our society have been spared its devastating effects. It has had a negative impact on all major groups in our society, including business people, governmental agencies, consumers, and private citizens of every age.

Recently, other states have acted to help resolve the insurance crisis. The states of West Virginia, Washington, New York, and Florida, among others, have passed legislation to address the problems creating the insurance crisis. (Appendix A provides a summary listing of measures enacted by selected states.) However, California has been stalemated in its efforts to address the crisis in a comprehensive and effective manner. Neither the Governor, the Legislature, the insurance industry, or consumers have been able to mobilize a successful effort to combat this crisis. As a result, insurance premiums have continued to rise, cancellations have increased, and insurance availability has all but evaporated for specific groups that provide fundamental services in our society, such as OB/GYN physicians and nurse midwives, food suppliers, transporters, and providers of general government services.

The recent passage of Proposition 51 by an overwhelming majority of California voters indicates that the citizenry of the State want action to resolve the economic havoc that this crisis is creating. However, Proposition 51, in and of itself, will not solve the crisis. Additional action is needed by the Governor and Legislature working in concert with the insurance industry and consumer groups to restore stability in the marketplace.

Due to the pervasiveness of the insurance crisis and its severe negative impact on the State, the Commission on California State Organization and Economy, also known as the Little Hoover Commission, undertook a major study of the crisis. This report presents the findings of the Commission and recommends actions that need to be taken by the Governor and the Legislature to remedy the problems the State is currently facing with respect to the availability and affordability of insurance.

BACKGROUND

The Commission on California State Government Organization and Economy was established in 1962 to review the management and operations of State funded activities and recommend ways for the State to operate more efficiently and effectively. Throughout its history, the Commission has conducted numerous studies that have ultimately improved the quality of life for millions of

Californians. The Commission initiated the study of the liability insurance crisis because it believed that the problems regarding liability insurance were significantly impairing the activities and functions of many governmental agencies, businesses, and individuals in California.

The Commission's study revealed that there is no single culprit of the insurance crisis, rather there are a number of interrelated problems which have culminated in the present crisis. Because of the multi-faceted nature of the insurance crisis, no single-dimensional solution, such as the recent passage of Proposition 51, will ultimately solve it. Instead, a comprehensive package of reforms is needed to provide a long-term solution to the current problems.

The overriding problem that has spawned the current crisis is the uncertainty in predicting risk in the insurance industry. The cause of this uncertainty is widely debated. The public has heard from the insurance companies that the joint and several rule frequently requires cities and businesses with "deep pockets" to absorb an entire settlement or verdict. Trial lawyers and consumer advocates have argued that the liability insurance crisis is a hoax concocted by the industry to mask a blatant grab for profits and to generate support for a sweeping overhaul of the justice system that will shortchange victims. Finally, some have indicated that poor management practices by insurers and a lack of State regulation have led to financial problems that have greatly contributed to the crisis.

The Commission's review of the underlying causes of uncertainty in the insurance marketplace in California identified five major factors:

- ° Evolution of tort law -- during the past 25 years, the basis of liability has been expanded enormously in a series of judicial decisions.
- ° Lack of predictability in risk assessment -- the process of determining the outcome and settlement amount for a particular policy or group of policies has become more difficult in the past ten years.
- ° Unsound rate setting practices in the insurance industry -- the insurance industry has engaged in unsound business practices with respect to the process of establishing adequate rates to cover losses and ensure underwriting profitability.
- ° Withdrawal of the reinsurance market -- in the last several years there has been a significant increase in both the number and size of the largest liability awards and settlements which have primarily been paid by reinsurers.
- ° The Insurance Commissioner's lack of authority and leadership in the rate setting process -- the Insurance Commissioner does not have legal authority to control rate increases in California and has not exercised his discretionary powers to influence the setting of rates or the availability of insurance.

The Commission believes that each of these five major factors must be addressed in order to eliminate the uncertainty that permeates the insurance

industry in California at the present time and bring long-term stability to the marketplace.

SCOPE AND METHODOLOGY

In November 1985, Chairman Shapell and members of the Commission unanimously initiated a study on the liability insurance crisis. At that time, Chairman Shapell appointed Commissioner Lester Oshea as the Chairman of the Subcommittee responsible for overseeing the detailed study field work. In addition, Commissioners Haig Mardikian and Mary Anne Chalker were appointed as Subcommittee members.

The intent of the study was to focus on the multitude of interrelated causes of the liability insurance crisis in an effort to develop a comprehensive solution to the problem. Because of the complexity of tort law, the Commission retained an independent consultant technically qualified in tort law to assist in the analysis of specific provisions of tort law and in the review of statutes and regulations governing the insurance industry. Mr. Howard Dickstein, partner in the Sacramento firm of Kanter, Williams, Merin & Dickstein, was selected to assist the Commission.

As part of the study, the Commission held two public hearings, on February 28, 1986 and on April 29, 1986, and received testimony from business, government, academic officials, and members of the public relating to the causes and impacts of the insurance crisis. These public hearings were supplemented by research conducted by the Commission staff, including meetings with businesses and trade groups in the insurance industry, interviews with representatives of consumer groups, discussions with the Insurance Commissioner's office, and contacts with various other concerned groups and individuals. In addition, Commission staff and members of the Commission's Liability Insurance Crisis Subcommittee attended a two-day insurance symposium sponsored by the Center for Law and Politics held in May.

REPORT FORMAT

The remainder of the report focuses on identifying the magnitude of the insurance crisis in California and on analyzing the major problems which have contributed to the crisis. Chapter II discusses the effects of the liability insurance crisis, while Chapter III presents the changes that have occurred in tort law during the last three decades. Chapter IV talks about the business practices of the insurance and reinsurance industries and Chapter V reviews the role of the Insurance Commissioner. Finally, Chapter VI provides the Commission's conclusions and recommendations for resolving the problems that have contributed to the insurance crisis in California.

CHAPTER II

EFFECTS OF THE LIABILITY INSURANCE CRISIS

In the last two years California businesses, professionals and public entities have had to face a severe liability insurance crisis. Liability insurance costs have risen so significantly that this type of insurance is not affordable for some groups and in many more cases, particularly for public entities, liability insurance is not available at any price. This has had a detrimental impact of the availability and cost of essential goods and services for the people of California.

Liability insurance itself is necessary to compensate persons injured in some way by the party insured. Evolving social emphasis and judicial actions on the compensation of parties injured by others have made liability insurance a necessity for all segments of the economy. If the cost of protection increases so rapidly that entities cannot afford insurance, or if protection is not available at any cost, goods and services which our society relies upon are restricted or jeopardized. As direct purchasers of insurance, as taxpayers, and as purchasers of goods and services, all Californians are significantly affected by the present crisis.

Finding #1 - Liability Insurance is Unaffordable for Many Groups Resulting in the Denial of Necessary Goods and Services to the People of California

Liability insurance rates and premiums have increased over the last two years, rendering insurance unaffordable for many groups. In addition, many entities cannot obtain insurance at any price, leaving them with the option of either "going bare" or going out of business. In either case, consumers must pay more for purchasing goods and services.

Since mid-1984, private and public entities alike have faced liability premium increases from 100 to 9000%, or in many cases, an inability to obtain coverage at any price. A.M. Best & Co., the insurance industry's leading compiler and publisher of statistics and information, indicates that premiums for commercial general liability coverage rose by an average of 81 percent in 1985. Numerous claims-free businesses have experienced drastic increases in premiums. These premium increases have been justified by the liability carriers on the grounds that a particular type of business, as a class, has an increased potential for loss. A survey of California Chamber of Commerce's members indicated that in late 1985 "approximately one out of every eight members is operating without any liability insurance coverage at all, and many others are operating with a significantly reduced level of coverage."

The impact of this phenomenon is twofold. First, if a company can afford insurance coverage, it pays the higher premium with funds that would otherwise be used to directly provide goods and services to the public. For example, a survey of member businesses by the United States Chamber of Commerce shows that 50 percent of the businesses surveyed had raised the price of their goods or services to cover the increased cost of liability insurance coverage. Second,

insurance for certain activities may simply not be affordable or available. Thus, individuals or businesses are faced with the choice of "going bare" or ceasing operations. When entities operate without adequate insurance, the risk is transferred to other segments of the community. In California during the past two years, our review showed that:

- ° According to a recent member survey completed by the California Medical Association, 14 percent of all physicians surveyed who previously delivered babies no longer do so, and eight percent have substantially reduced their maternity caseload. Another 27 percent are considering reduction or elimination of their maternity caseload.
- ° The state's 300 primary care non-profit health clinics, serving approximately three million to four million of California's working poor, will either severely curtail services or close entirely by the end of 1986. This is due to the withdrawal from this market by two of the three insurance carriers and the restricted underwriting practices of the third carrier.
- ° The Easter Seal Society in San Francisco was forced to shut down a therapy program for handicapped children for several weeks because it was unable to locate any professional malpractice insurance. When coverage was finally located, the premium increased 1300 percent over the previous year.
- ° A survey and other data collected by the Highway Carrier Association indicates that perhaps 50% of the approximately 370,000 trucks on the highways in California are operating without insurance coverage.
- ° A survey of apartment owners in the Los Angeles area by the Los Angeles Chamber of Commerce indicates that a majority of the owners surveyed had a 100-200% rise in liability premiums in the last year. This has resulted in either higher rents charged to tenants or postponed or deferred maintenance of structures.

These are just a few examples of the severity of the insurance crisis throughout California. The ultimate result of the liability insurance crisis is the denial of necessary and vital goods and services to the people of California. This restriction of essential commodities is impairing the public safety, health and overall quality of life in the State.

Finding #2 - Liability Insurance Coverage is Not Available for Many Public Entities

The number of cities in California that are unable to obtain liability insurance is increasing drastically. Further, the County Supervisors' Association reports that there are no insurance companies willing to write coverage for counties. With premium rate increases and the withdrawal of insurance companies from certain markets, public entities are having to discontinue or limit many of their activities.

The League of California Cities reported in February that 43 cities were involuntarily uninsured and an additional 25 cities were badly underinsured with coverage of less than \$1 million. By June, the League of Cities indicated

that virtually every city in the State was unable to obtain commercial liability insurance.

Some California cities were unable to secure quotes from any insurance companies, whereas others found insurance to be unaffordable. The lack of insurance has caused operational problems such as the closure of fire stations, public restrooms, police departments and parks. Moreover, in a number of small cities, members of the city councils have either resigned from office or chosen not to run for office because of fear of personal liability. As shown in the following examples, the problem is widespread:

- ° Point Arena -- a town of 450 in Northern California was quoted an insurance premium which was several times its annual city budget.
- ° Twain Harte -- all five directors of the local park district resigned in March because the liability insurance policy expired. The directors feared that without insurance they could be held personally liable for accidents in the park district.
- ° Monterey and Salinas -- officials have considered suspending paramedic programs due to unacceptable increases in the cost of liability coverage.
- ° Plymouth -- the city disbanded its police department and planning commission in late 1985 because no liability coverage could be obtained. City playgrounds and pools have been closed. Two members of the city council have resigned, citing the lack of public officials' liability coverage as the reason.
- ° South Lake Tahoe -- due to a 300 percent proposed increase in liability insurance premiums, the city closed the public transit system and contracted transportation services to a private firm composed of former city employees.

In a survey prepared by the League of California Cities in which 357 of the 441 cities polled responded, the League found that the amount of money paid in joint and several liability cases had decreased from \$18.4 million in 1982-83 to \$16.9 million in 1984-85, and the number of cities involved in both judgements and settlements decreased by 20 percent over the same three-year period. Joint and several liability cases involve cases in which a defendant may be held fully or partially liable for damage to another party and the true degree of liability can be transferred from one party to another. Therefore, since payouts for joint and several liability cases have decreased over the last two years, claims history alone does not explain the current crisis.

A report prepared by the County Supervisors Association in August 1985 documented unprecedented increases in premiums and deductible limits and corresponding decreases in coverages. Specifically, the Association found that between 1984 and 1985 insurance premiums increased by an average of 62 percent and coverage decreased by an average of 35 percent. Thus, in 1985, counties were able to buy \$209 of insurance with every premium dollar. Now, in 1986, the same dollar buys only \$47 of insurance, a 77 percent reduction in insurance coverage.

Further, the report indicates that since last year the market for county liability insurance has experienced another change. What was primarily a crisis of affordability last August is now an availability crisis. There are currently no insurance companies willing to write policies for counties.

During our review, the Commission found that all public entities are feeling the effects of the liability insurance crisis. However, the Commission also found that insurance claim payments on behalf of cities had not increased. Therefore, the inability to obtain insurance coverage does not necessarily result from increased payments by insurance companies.

CHAPTER III

EVOLUTION OF TORT LAW

The evolution of the law of tort can be divided into three phases: the pre-industrial revolution, the industrial revolution, and the post-World War II periods. During each of these phases, events occurred that have shaped today's tort law.

In the first stage, which lasted for five hundred years until the turn of the 19th Century, the task of tort law was not controversial. Judges and juries determined, in response to the concrete facts in a particular lawsuit, whether a loss sustained by one party, the plaintiff, should be left to lie where it fell or be shifted to the other party, the defendant. During this era, in which personal hardship and adversity were accepted without question and only the wealthy had access to the legal system, nothing short of the most reprehensible intentional conduct, like an assault or battery, warranted the drastic intervention of the legal system to transfer a loss from the plaintiff to the defendant. Further adjustment of the loss to other entities or society as a whole, would not have been possible in an age when liability insurance and "deep pocket" defendants were unknown. The function of tort law during this phase was primarily vengeance and deterrence, which provided an alternative to violent retaliation in the form of monetary compensation to the victim. Any shifting of the loss to an entity other than the defendant would have undercut this purpose.

Tort law entered the second phase of its evolution near the turn of the 19th century, when the birth of the industrial revolution, migration of the population to the cities, the coming of the railroads, and the general acceleration of commercial activity confronted society with an accident problem of unprecedented proportion. Over the next century and a half, there was a vast expansion of the categories of liability and a probing of the frontiers of protection against accidental harm. In imposing these new rules, the judicial system recognized that the activities being subjected to these controls, hazardous as they were, were precisely those enterprises, like industry, mining, construction and the railroads, on which it was thought all human progress was dependent.

The result of the interplay of these countervailing considerations during this second period was the creation of negligence as an independent tort. This created a duty on the part of the defendant to take reasonable care to avoid injuring another, but was balanced carefully by the defenses of contributory negligence and assumption of risk. Contributory negligence precluded a plaintiff from prevailing if it could be shown that his own negligence contributed in the slightest degree to his injury. It also involved the assumption of risk under which the plaintiff was precluded from recovering if he had engaged in an activity with any awareness of the risks that later gave rise to the injury. Nor could the plaintiff recover in negligence if the type of injury he suffered was not a direct and foreseeable result of the defendant's wrongful act. If the plaintiff was injured by a defective product, he could only sue the person from whom he bought it directly. During this period, the Courts also revived the medieval doctrine of sovereign immunity to

insulate defendants acting in a public capacity, including governmental and charitable institutions.

Tort law entered a third phase, from which it has yet to emerge, beginning in the mid-20th Century. This occurred at a time when a veritable explosion in technology gave rise to dangerous new machinery, power tools, wonder drugs, consumer items and new forms of transportation, creating new possibilities for serious injury.

Besides the technological reasons for this reorientation, significant though largely unspoken social and economic factors played a decisive role. First, there was the growing realization that tort law could perform the function not merely of shifting the loss between the parties to a lawsuit, but also of spreading that loss imperceptibly throughout the community. A "deep pocket" defendant such as public utility, industrial corporation, governmental entity or commercial enterprise, could subsume the loss as a cost of doing business, usually through raising rates, prices, taxes and purchasing liability insurance. The assumption was that these "deep pockets" could spread their losses so widely that no one person or entity would suffer undue hardship and plaintiffs would be fully compensated. Other factors in this further evolution included a new political emphasis upon the compensation function of tort law in a society increasingly sensitive to social welfare concerns, a recognition that imposing substantial liability on industrial enterprises could deter hazardous behavior and prevent losses from occurring in the first instance, and the assumption that industry was now so well established that new tort rules could not threaten its vitality. Not only did this reorientation result in the creation of new plaintiff oriented tort doctrines, but it also gave new significance to traditional doctrines, like joint and several liability, the collateral source rule and punitive damages, which are discussed below in the Commission's findings.

Each of these three phases have reflected their prevailing social and economic trends. As a result of the current liability insurance crisis, the validity of the assumptions underlying tort doctrine in its present phase have been widely questioned. The Commission has considered this evolutionary development of the law, the social and economic underpinnings of the present period, and its impact on the cost and availability of liability insurance in developing its findings.

Finding #3 - The Basis of Liability in Tort Has Expanded and Exposed "Deep Pockets" to New Risks

Over the last 40 years California Courts have expanded the grounds for holding defendants liable in tort, exposing insurance companies, public entities and other deep-pocket defendants to new and frequently unpredictable risks. As a result, it has become increasingly difficult for defendants to predict their risks and insure against them.

Beginning in 1944, when the California Supreme Court first held in Escola v. Coca Cola Bottling Company that a manufacturer was responsible to an ultimate consumer for injury caused by a defect in its product, even though there was no contractual relationship between them, the Courts in California have handed down a series of decisions, many of which were later codified by

the Legislature, extending liability in new directions while narrowing or eliminating traditional common law defenses.

In the 1960's in Greenman v. Yuba Power Products, the Court established a regime of strict liability without fault for defects in the manufacture or design of products causing injury to a plaintiff. It imposed an obligation on physicians to inform their patients of material risks inherent in a particular treatment before caring for them in Cobbs v. Grant. With the Legislature's subsequent ratification, the court limited significant governmental immunities in Muscopf v. Corning Hospital District, and, in Klein v. Klein, decided in 1962, the Court abolished interspousal immunities.

Injuries that had previously gone uncompensated, like negligent infliction of mental distress to parties who had not suffered any physical injury, became available for the first time in California following the 1968 decision in Dillion v. Legg. Loss of marital consortium became compensable by a spouse in Rodriguez v. Bethlehem Steel, soon thereafter. Even trespassers became entitled to recover from property owners if they were injured by an unreasonably dangerous condition on the property after the Court's 1968 decision in Rowland v. Christianson. And the traditional immunity prohibiting passengers who were guests in a car from suing the driver was struck down in 1973 by the Supreme Court in Merlo v. Brown.

Claims policies of insurance companies themselves did not escape attention. In 1974, in the Royal Globe case, the California Supreme Court imposed a duty "of good faith and fair dealing" requiring carriers to act in good faith with both their own insureds and third party claimants by paying valid claims promptly, accepting reasonable settlement offers and avoiding conflicts of interest.

And in 1975, in Li v. Yellow Cab with emphasis upon loss spreading at its zenith, the bar of contributory negligence and assumption of risk were replaced by the Supreme Court with a comparative fault or proportionate liability system, in which a partially blameworthy plaintiff could still recover a proportion of his damages to the extent that the defendant was also partially negligent in causing those damages. Instead of extending this concept to cases involving multiple defendants, so that each one would be liable only for its proportionate share of the fault, the Supreme Court in the 1978 American Motorcycle case chose to retain the existing doctrine of joint and several liability. This left the prevailing plaintiff free to collect his entire judgement from any defendant.

During this period of liability expansion, it became increasingly difficult for defendants to predict their risks and to insure against them. Moreover, the one sided nature of these changes, and occasional but well publicized extreme examples of their application by lower courts, as when a would-be burglar was held to have standing to sue a school district for his injuries when he fell through a disguised skylight, undercut the credibility of the judicial system in the view of significant sectors of the population.

Finding #4 - The Average Size of Jury Awards and Settlements Has Increased Due to "High Stakes" Cases

While the number of lawsuits filed and the great majority of awards have remained relatively constant during the past 25 years, the average size of jury awards has risen dramatically in recent years due almost exclusively to a fifteen-fold increase in multi-million dollar verdicts. Moreover, it is reasonable to infer that this increase has had a similar impact on cases settled before trial.

According to the Rand Corporation's Institute for Civil Justice¹ and the National Center for State Courts,² the size of the great majority of jury awards, and the number of lawsuits filed, have for the most part remained unchanged during the past 25 years after correction for inflation and the increase in population. Juries still find for defendants about as often as they find for plaintiffs. The average size of a jury award, however, has more than quadrupled over the same time period. This seeming anomaly appears to be due almost exclusively to a fifteen-fold increase in the limited number (about 400 nationwide) of million dollar verdicts per year. The liberalized rules governing liability have thus had a material impact only in "high stakes" cases.

While there are no reliable statistical indicators to confirm this, testimony to the Commission from California public entities indicated that the lion's share of these increases were in the non-economic categories of damages, such as pain, suffering, emotional distress and punitive damages, for which the law has developed no objective standards to support or criteria to measure. In addition, the courts do not require the opinion of any witness as to the reasonableness of non-economic damage awards. The Commission also heard testimony that, perhaps because of this element of subjectivity, juries tend to award substantially higher damages, as much as 50 percent higher, against "deep pocket" defendants, such as governmental entities, insurance companies and large corporations, than they do against other defendants in substantially similar cases.

There is reason to believe that this increase in the size of million dollar verdicts has influenced the value of the remaining 95 percent of the cases filed that are settled before trial. Although there is no data to quantify the impact these few large jury verdicts have on the valuation of smaller cases for settlement purposes, it is logical to conclude that the parties are influenced in their settlement valuations by the size of jury awards in similar cases. Therefore, if the number of multi-million dollar verdicts were substantially reduced, it is reasonable to predict that this related phenomenon would be similarly affected.

In response to the increased size of million dollar verdicts, proposed caps on compensatory damages for pain and suffering have been enacted recently,

¹Comparative Justice: Civil Jury Verdicts in San Francisco and Cook Counties, 1959-1980, Michael G. Shanley and Mark A. Peterson

²National Center for State Courts: A Preliminary Examination of Available Civil and Criminal Trend Data in State Trial Courts for 1978, 1981, and 1984, (1986).

or are now pending in other states. Exhibit III-1, on the next page, provides a summary of some other states that have recently enacted caps on compensatory damages. This exhibit shows that currently adopted caps on compensatory damages for pain and suffering range from \$200,000 in Ohio to \$573,000 in Washington. While California has a \$250,000 limit on medical malpractice claims under the Medical Injury Compensation Reform Act (MICRA), California has not adopted a uniform cap for non-economic damages.

Finding #5 - The Joint and Several Rule That Was Partially Repealed by Proposition 51 is Unfair to Low-Fault Defendants

The operation of the common law rule of joint and several liability has been inconsistent with the proportionate fault system in California. As a result, deep-pocket defendants have been subjected to major inequities when juries have found deep-pocket defendants either minimally at fault or less at fault than the plaintiff. The recent passage of Proposition 51, which eliminated joint liability for non-economic damages, should address this inequity to some extent. However, Proposition 51 does not address cases against low-fault defendants and contributorily negligent plaintiffs.

Until the recent passage of Proposition 51, California followed the traditional version of the joint and several liability rule. Under this rule, a plaintiff who was adjudged to have been injured by multiple defendants was permitted to recover full payment of the judgement by any of the defendants regardless of the share of the fault the jury assigned to that defendant. The plaintiff could do this only once, so that double payment could not occur, and the defendant who paid had the right to require other defendants to reimburse him in shares equal to their respective adjudged fault under a related common law rule called contribution. The problem arose if any one of these co-defendants was insolvent, as is frequently the case, because under the joint and several rule the "deep pocket" defendant then must bear the entire brunt of the judgement.

The rationale of the joint and several rule has always been that as between a partially culpable defendant and an innocent plaintiff, that defendant should properly bear the risk of another defendant's insolvency. At the time this rule was developed in the Middle Ages, however, no plaintiff could recover damages if the jury found that his or her own negligence had contributed in any degree to bringing about the injury. This rule effectively discouraged plaintiffs with a minor degree of fault from drawing the jury's attention to this fact by suing defendants who also were at fault to a minor degree.

This model of innocent plaintiff/guilty defendant became outmoded overnight, however, in 1975, when the California Supreme Court replaced the rule of contributory negligence with comparative fault, so that even a plaintiff who had contributed to his own injury could recover damages to the extent that the fault assigned to the defendant(s) also contributed. The disincentive to name "deep pocket" low fault defendants was removed, giving the plaintiff a powerful incentive to include low-fault defendants in a lawsuit as the plaintiff's only practical hope for recovering any substantial compensation.

Exhibit III-1

SUMMARY OF CAPS ON NON-ECONOMIC
DAMAGES ADOPTED BY SELECTED STATES

STATE	CAPS ON NON-ECONOMIC DAMAGES
California	\$250,000 for medical malpractice cases only
Washington	Ranges from \$117,500 to \$573,000 based on a sliding scale; average annual wage x life expectancy x 0.43
Florida	\$450,000 for all tort cases
Ohio	\$250,000 in all cases other than wrongful death actions; \$200,000 in medical malpractice cases other than wrongful death actions.
Massachusetts	\$100,000 per occurrence for cases involving public entities only

Source: National Association of Insurance Commissioners

That one of several defendants may have to assume an often grossly disproportionate share of the total liability became the target of increasing concern and objection by those most directly affected, the "deep pocket" defendants who had to pay more than their proportionate share of a judgement if the other defendants were insolvent. In addition, as the number of very large damage awards has increased, the operation of this rule became increasingly burdensome. Its effects undoubtedly influenced the outcome of settlements in which low fault defendants, such as public entities like Caltrans, are sued because they are responsible for the design and maintenance of highways on which automobile accidents occur. Public entities are oftentimes encouraged to settle lawsuits despite their tangential involvement if their co-defendants are uninsured or insolvent. This largely invisible low-fault/high pay dynamic, now utilized routinely, according to testimony, in the settlement of high stakes lawsuits with public entities, was perhaps the most glaring inequity in the entire "deep pocket" phenomenon.

There is clear merit in a rule that ensures that a prevailing plaintiff will not go completely uncompensated. This is particularly true where he is less at fault than the defendant, and his damages are economic and can be objectively determined. However, the Commission finds that the common law system failed to work an equitable compromise between the rights of the plaintiff, the rights of defendant, and the needs of society as a whole. The data clearly shows that the rule's principal weakness and primary cost was only in cases against low-fault defendants and contributorily negligent plaintiffs.

Finding #6 - The Law Encourages Collusive Settlements at the Expense of Remaining Defendants

The Courts' refusal to credit a non-settling defendant with a settling defendant's proportionate share of the fault, when the non-settling defendant is found partially at fault, is inconsistent with comparative negligence principles and encourages collusion between plaintiffs and settling defendants.

Under the rule of law now applied in California, if a plaintiff settles his claim against one defendant, but goes to trial against another defendant and wins, the jury may deduct from the verdict against the non-settling defendant only such amount as the settling defendant paid the plaintiff. This is true even if the jury finds the settling defendant to be 80 percent at fault and the non-settling defendant to be 20 percent at fault. Instead of deducting the settling defendant's proportionate share, the jury can deduct only the actual dollar amount the settling defendant paid the plaintiff. Thus, the risk of an undervalued settlement is not borne by the plaintiff, but by the remaining defendants who were not privy to the settlement.

Not only does this practice promote quick settlements with defendants of limited means, but such settlements are often conditioned upon the so-called "Mary Carter" agreements, in which the settling defendant agrees to cooperate with the plaintiff in prosecuting the plaintiff's claim against the remaining defendants. Testimony indicated that some such agreements also provide that the amount due under the settlement will decrease on a sliding scale if the plaintiff recovers judgement against the remaining defendants. For example, a representative from the California Department of Transportation discussed an accident on a state freeway where the freeway shoulder had been converted to an

operational lane to alleviate congestion. A vehicle was disabled and parked in the lane that had formally been the shoulder. The vehicle was hit by a drunk driver seriously injuring the person in the disabled vehicle. The drunk driver, Caltrans and the bar that served the liquor to the driver were all named as defendants in the suit. Just before trial the bar entered into a "Mary Carter" agreement guaranteeing \$3 million. In return, the plaintiff agreed to pursue the trial against Caltrans and if the plaintiff was successful in recovering any substantial amount of money from Caltrans the agreement provided that the amount to be paid by the bar under the guarantee settlement agreement would decline to as little as \$50,000. As the testimony from public entities amply established, the very threat of such a "Mary Carter" agreement is a potent inducement for deep-pocket defendants to agree to a settlement themselves, a practice one witness referred to as "benign blackmail."

The Commission considers that while the original purpose of this rule, to promote settlements, may have been a laudable one, in the present environment in which 95 percent of cases settle anyway, the rule serves primarily to encourage fraudulent practices.

Finding #7 - The Plaintiff's Burden of Proof is Too Low to Control Increasing Punitive Damage Awards

The burden of proof required of the plaintiff to justify a jury award of punitive damages against a defendant is lower than the burden of proof in other quasi-criminal cases. Among other factors, the current burden of proof encourages misuse of punitive damages.

In addition to recovering his medical bills, earnings, losses and compensatory damages for pain and suffering, both physical and emotional, the common law rule provides that a successful plaintiff can recover, in a limited number of cases, damages that the law frankly describes as "punitive." Such damages are available if the jury finds, by a preponderance of the evidence, that a defendant is guilty of oppression, fraud or malice in his conduct. Malice means conduct which is carried on with a conscious disregard of plaintiff's rights; oppression means subjecting a plaintiff to cruel and unusual punishment; and fraud means an intentional misrepresentation, deceit or concealment of a material fact known to the defendant. While the law does not fix any standard for the amount of the award of punitive damages, it must bear a reasonable relationship to the conduct and be in an amount which will have a deterrent effect in light of the defendant's financial condition.

One witness before the Commission observed that "punitive damages are in the air, are on the move." Further,³ research undertaken by the Rand Corporation's Institute for Civil Justice³ confirms this observation. In San Francisco, over a 25 year period, both the number and the amount of punitive damage awards have increased sharply.

³Comparative Justice: Civil Jury Verdicts in San Francisco and Cook Counties, 1959-1980 by Michael G. Shanley and Mark A. Peterson

The Commission is concerned that punitive damage awards, which are more in the nature of criminal penalties than civil compensation, are available against a "deep pocket" in an unlimited amount whenever a jury determines that its conduct was "oppressive." In contrast, a criminal prosecution is initiated only when a public official concludes that the prosecution promotes the public interest, and is limited by carefully prescribed statutory limitations on penalties. However, a plaintiff can initiate a punitive damage claim merely to secure a strategic advantage. In addition, in a criminal case, a jury would have to find a defendant guilty beyond a reasonable doubt. To award punitive damages, a jury need only make a finding of guilt based on the "preponderance of the evidence," which means that the evidence on one side is slightly "more convincing" than the evidence on the other.

In disciplinary hearings before the State Bar, on the other hand, in which a lawyer's license is at stake, or in a Board of Medical Quality Assurance hearing to revoke or suspend a physician's license, the highest civil standard of "clear and convincing proof to a reasonable certainty" is utilized. Thus, the lower burden of proof required for punitive damages in tort cases is inconsistent with this trend.

Finding #8 - The Collateral Source Rule Can Result in Double Payments to Plaintiffs

The shift in emphasis in tort law from deterring culpable defendants to making injured plaintiffs whole has undermined the doctrinal bases for the collateral source rule. As a result, the collateral source rule can now result in double payment to plaintiffs.

The collateral source rule provides that damages awarded to a successful plaintiff will not be reduced by any sums which the plaintiff has received or is scheduled to receive from another or "collateral" source for the same injury. It operates both as a rule of evidence preventing the defendant from presenting evidence of collateral payments to the jury and as a rule of damages, providing that, with the exception of worker's compensation awards, the award against defendant at trial will not be reduced by reason of collateral payments.

At common law, the high barriers to liability, the fact that few plaintiffs had collateral sources of compensation in any case and the law's emphasis on penalizing culpable actors, meant that the collateral source rule was both little used and furthered the law's function of deterring wrongdoers. The Commission finds, however, that with the shift in emphasis in the law from deterrence to compensation, once the plaintiff has been made whole, extra compensation is more difficult to justify, particularly with respect to public benefits, as opposed to private benefits, like insurance policies, for which the plaintiff has paid a premium. While the law should encourage people to carry their own insurance, and not penalize them for doing so, the same policy considerations do not apply to public benefits like social security, Medicare, Medi-Cal and welfare payments, for which the taxpayer bears the burden.

Under MICRA and proposals in both New York and Washington, the collateral source problem is attacked by allowing the jury to consider such payments in deciding awards. In addition, the Tort Policy Working Group, an interagency

task force of ten federal agencies and the White House, recommended earlier this year with regard to publicly provided collateral sources of compensation that there should be an automatic offset against plaintiff's recovery of tort damages for the same injury.

Finding # 9 - The Cost of Administering the Civil Justice System is Excessive and Creates a Burden to Plaintiffs and Defendants

The costs of administering the civil justice system have reached an intolerable level. The expense of litigation, taking both sides attorneys' fees into account, eats into plaintiffs' recoveries and adds to the strain on liability carriers.

Based on information provided by the Rand Corporation, the Commission established that nearly 54 cents of every premium dollar paid by an insurance company goes to cover the sum of the defendant's and plaintiff's legal costs. In addition, the increased complexity of trials and multiplication of the parties, caused in part by abrogation of the contributory negligence rule and retaining the joint and several rule, have exacerbated the problem. A Rand Corporation study⁴ of the Civil Justice System nationwide concluded that \$320 million was spent in 1982 as the public cost incurred by the State and Federal courts in administering personal injury litigation.

The Commission understands that, while the prevailing contingency fee is 33 1/3 percent of plaintiff's recovery, and insurance defense attorneys normally charge \$65 to \$100 per hour, some plaintiff's attorneys take a higher contingency fee for cases with less merit and some "deep pocket" defense lawyers command a much higher hourly rate.

While the Commission recognizes that litigation costs are essential to the operation of the tort system, and that only through the mechanism of the contingency fee can many plaintiffs afford to litigate their claims at all, the Commission has heard testimony that attorney fees for both sides are increasing at a rate even faster than the size of jury verdicts and that attorneys for both sides engage in wasteful, unnecessary and even frivolous pre-trial motions.

Finding #10 - Payment of Lump Sum Awards for Future Damages at the Time of Judgement Hurts Both Parties

The current judicial practice of awarding the prevailing plaintiff all of his future damages, including medical bills, loss of earnings, pain, suffering and emotional distress, in a lump sum discounted for present value upon entry of judgement is not in the interest of either party.

⁴Costs of the Civil Justice System: Court Expenditures for Processing Tort Cases by James S. Kahalil and Abby E. Robyn

The payment of a large award for future damages at the end of a trial places a heavy burden on a defendant or its insurer and compensates the plaintiff for damages he has not yet suffered. Currently, 18 states have adopted some form of periodic payment legislation to authorize future damage awards to be stretched out over a period of years to reduce that burden. The periodic payment provision in MICRA may be one of the reasons the rate of increase in medical malpractice premiums in California is only half that of the national average.

From the plaintiff's perspective, many of his damages, like future wage losses and medical bills, have not yet occurred, and periodic payments enhance the probability that the plaintiff will have money available for those damages when they do occur.

As long as the award of future damages is not made assignable or discounted for present value, a reasonable rate of return during the period of the payments is provided for, and the economic portion of plaintiff's loss remains payable to plaintiff's dependents or estate if he dies while periodic payments are still due, there are no compelling reasons for not adopting a periodic payment plan in large damages cases.

Possible damages and inequities for the plaintiff of a periodic payments schedule include the following: (1) unless a substantial amount of the award is paid at judgement the plaintiff could be forced to sell his future damages award at a discount in a secondary market just to pay expenses; (2) the defendant could receive an unfair double windfall if the plaintiff is not given a reasonable rate of return during the period of the payments; and (3) the defendant could receive a triple windfall if the plaintiff dies while a substantial number of payments are still due.

CHAPTER IV

POLICIES AND PRACTICES OF THE LIABILITY INSURANCE INDUSTRY

The recent poor financial condition of the liability insurance industry largely reflects self-inflicted wounds over the last several years resulting from the industry's marketing and pricing practices during the past decade. Insurers use premiums to generate investment income. When interest rates and investment income are high, as they were during the late 1970's and early 1980's, insurers are able to utilize the income to subsidize underwriting operations. From the consumers perspective this subsidy is beneficial because it produces declining commercial insurance prices. However, the scale that so carefully balances investment income and premiums was tipped out of balance during the early 1980's because of unsound pricing and underwriting practices by the insurance industry. In SMARTS Insurance Bulletin, an industry trade paper published in early 1986, the editor stated:

The insurers and reinsurers created their own brutal price war over the past five years. No one other than they themselves forced any underwriters to cut prices, meet or beat a quote, throw in coverage after coverage with no charge, or throw away the underwriting book.

Therefore, the current problems can be partially understood by looking at both the unique issues of the early 1980's and the long-term "insurance cycle" including the accounting, casualty underwriting, and reinsurance processes.

FINDING #11 - The Liability Insurance Industry is Cyclical Which Results in Periodic Affordability and Availability Problems

The liability insurance industry is affected by an interest-sensitive rate-making structure and unique accounting practices. This makes the industry cyclical in nature. Without intervention in the current insurance crisis, the industry will probably recover. However, the next cycle may even be more extreme and prolonged due to forces affecting the insurance industry.

The liability insurance industry is highly cyclical. This is due to a combination of factors including the interest-sensitive ratemaking structure and some unusual aspects of insurance accounting practices. However, the current cycle within the insurance industry is deeper and more debilitating than any other cycle in the past. Therefore, without any action to soften the cycle, the next cycle may be more severe and prolonged. The fluctuations of the liability insurance industry have long been known, at least within the industry, to constitute an ongoing cycle of both profitability and availability. Exhibit IV-1, on the next page, displays the combined underwriting ratios for liability stock companies during a 36-year period beginning in 1950.

As shown in Exhibit IV-1, the insurance industry had underwriting gains in 1977, 1978 and 1979 followed by underwriting losses beginning in 1980.

However, it should be noted that the graph is only a partial picture of the industry's profitability since investment income, the other major source of revenue, is not included.

When a policy is written, premiums received are invested to produce additional revenue. This invested income is used to offset administrative costs and pay losses. The actual cost of insurance is therefore paid by a combination of premiums and investment income. When investment income is high, as it was from 1976 through 1983, insurance premiums constitute a smaller portion of underwriting costs. Conversely, when interest rates drop, premiums must be increased to cover anticipated or actual losses.

From the consumer's perspective, the drop in premiums during the late 1970's and early 1980's was beneficial, since purchasers of liability insurance were able to take advantage of both the industry's reliance upon investment income from the premium dollar to offset part of the cost of claim losses, as well as benefit from the insurer's price war. However, with the decline in the interest rate in 1983, and with the increase in losses and administrative expenses which began in 1980, this particular portion of the cycle came to an abrupt end. The insurance companies stated that, in order to cover their rising expenditures, they would have to raise premiums to cover both lost investment income and also the rise in the actual "losses" caused by faulty underwriting.

Different Methods Exist for Determining Profitability in the Insurance Industry

The property casualty insurers have stated that they are currently earning a return on net worth well under that of the Fortune 500, are becoming insolvent in record numbers, and generally are in dire financial conditions. However, some experts believe that the term "losses" used within the insurance industry is not synonymous with the term "losses" in other industries. These experts state that the Best Property Casualty Index rose by 50 percent in 1985, almost doubling the rise of the Dow Industrial Average, and has risen another 26 percent during the first quarter of 1986, again, almost double the Dow. Since 1975, the insurance stock index has risen more than 500 percent, more than 5 times the rise of the Dow.

Mr. Robert Hunter, President of the National Insurance Consumer Organization has an explanation for the discrepancy. Specifically, he states in his paper "And Now The Real Facts; A Response to the Insurance Services Office-Insurer Profitability -- The Facts" that, "The key to understanding the performance of the insurance industry and the performance of the insurance industry stocks is the way the industry does its accounting." The report goes on to state that "in 1985, the property casualty industry took in about \$142 billion in premiums, paid out about \$130 billion in claims and expenses, and yet declared about a \$25 billion underwriting loss." The reason is that State Insurance Commissioners require that insurance companies report their profit or loss each year based on "worst case" assumptions. Specifically, they require insurance companies to "assume that after the end of the year, (1) all policies are cancelled so that all policy holders receive that part of the premium that the insurer has not earned, and (2) all claims known and unknown will be paid at full value."

To test the solvency of insurers in this manner makes sense, but to add profits or losses arrived at based on these assumptions and to report them as a measure of the industry's profitability is misleading. First, in order to pay out a dollar in 10 years, one needs to set aside much less than a dollar today, since money set aside will earn interest. However, insurers set up a reserve which they carry as a liability for the full amount they estimate they will eventually pay out in the future. This practice, which has been strongly criticized by the Federal General Accounting Office, is the major reason why liability insurers consistently earn substantial profits but pay no Federal income tax. Between 1975 and 1984, for example, according to a recent GAO study, the industry had net gains of \$75 billion, yet paid no Federal income tax and actually received a tax refund of \$125 million.⁵ Secondly, the amount of unearned premium that policy holders are assumed to receive back from the insurer at the end of the year is overstated, since the insurer would also receive a part of the commission from the agent and a part of its premium taxes from the State. If these adjustments were made, Mr. Hunter estimates that the property casualty industry would show an underwriting loss of \$19.5 billion rather than \$25 billion in 1985. In addition, in 1985 the industry had investment income of \$19.7 billion, realized capital gains of \$5.3 billion, and federal tax credits of \$1.9 billion. Thus, the property casualty industry's total profit could be estimated in 1985 to be \$7.4 billion, a net return of approximately 11 percent.

Insurance Industry Has Not Always Used Sound Underwriting Practices

An understanding of the process used to calculate premiums, or the "underwriting" process, is also necessary to fully comprehend the current crisis. Liability insurance premiums are calculated using a number of different factors. Among these factors are the professional judgements by actuaries regarding the anticipated probability of payment for claims made against a policy, and the anticipated cost of those claims, known as risk assessment. The primary process of risk assessment and evaluation is usually handled jointly by all liability insurance companies through the auspices of a separate industry funded organization, the Insurance Services Office (ISO). ISO's purpose is to construct base rates for liability insurance and to gather the statistics and other information necessary to construct those rates, the "benchmark" for most lines of insurance.

To assess risk for a particular line of insurance, actuaries will take into account the prior histories of all claims filed and paid, on a regional basis, usually going back over a period of two to five years. The actuaries also attempt to determine, based upon statistical models, the length of time during which it is likely claims may or will be filed and paid against the policy. This period of time is known as the "claims tail" and may vary from as little as 6-9 months in the case of auto liability insurance to 7-8 years in medical malpractice insurance, and in some areas such as product liability, as long as 20-25 years. The actuary will also make a determination of the size of future claims losses based upon the relevant legal doctrines currently in

⁵U.S. General Accounting Office, Tax Administration: Information on How the Property/Casualty Insurance Industry is Taxed (October, 1985)

place. The actuary then makes a determination as to the presumed investment return available over the life of the policy which would allow portions of the premium to be invested. This amount is then discounted depending upon the amount of money and the period of time in the "claims tail" necessary to make all loss payments. Finally, the actuary will add administrative and brokerage costs, taxes and a profit factor. In California, these additional factors total approximately 46% of the "benchmark" rate.

Once the ISO rate is developed, it is provided to the subscribers and members of the ISO, who at this time write approximately 80% of the liability premiums in California. These primary insurers may modify the benchmark rate based upon their own assumptions, including the risk assessment factors used to reflect a "better than average" risk client, assumptions regarding the administrative cost and brokerage fees which reflect their own experience, and possibly entirely different judgements regarding the anticipated income to be made from the premiums charged. The individual companies will also, of course, be aware of the competition of other companies for the same clients, and may, as previously noted, reduce premiums in order to retain their share of the market. The result of such "modification" or "adjustment" can be a premium rate which is as little as 20 percent to 30 percent of the ISO rate. Such rates were not uncommon during the period from 1977 through 1983, and are reflective of the liability carriers' actuarially unsound pricing practices.

Left to itself, the liability insurance industry will presumably right itself and, at some future point, begin the cycle all over again. However, in the absence of any attempt to dampen the extremes of fluctuation, it is entirely possible that the current stage of the cycle will be more prolonged than usual, and recovery to the next stage much slower. The Commission believes that this may mean that many more liability carriers, both primary insurers and reinsurers, will be irreversibly damaged and may withdraw from the marketplace, so that many more businesses and public entities will curtail functions, or will cease functioning entirely.

FINDING #12 - A Significant Number of Reinsurance Underwriters Have Withdrawn from the Reinsurance Market thus Limiting Insurance Availability

Almost one half of the reinsurance underwriters in the nation have partially or entirely withdrawn from the reinsurance market because of the uncertainty and unpredictability that exists in the marketplace. Since the reinsurance market acts as a safety net for the industry by expanding the available insurance capacity, the withdrawal of reinsurance underwriters from the market has severely restricted the availability and affordability of insurance.

One of the major reasons the current crisis has been so devastating has been the almost complete disappearance of one of the most vital, and yet least understood parts of the liability underwriting process. This is reinsurance, or "insurance for the insurers." The reinsurance market acts as a "backstop" or "safety net" for the entire liability insurance market.

Reinsurance is basically a transaction wherein a secondary insuring company will, for a fee or secondary premium, agree to indemnify the primary carrier for part of the loss incurred. It is used to expand coverage capacity

of the primary insurers. The liability underwriter's risk assumptions are limited by a number of factors, including the need for his company to achieve diversity in a particular line, the adequacy of pricing and return on investment, and the amount of surplus capacity available to write new business or to offer higher limits of coverage on old business. In order to protect the consumer and public, insurance regulatory practices have restricted the leverage an insurance company may use to expand capacity. Traditionally, a two to one (2:1) ratio of premiums to retained surplus is desirable, and a three to one (3:1) ratio may be acceptable. An insurer who is more highly leveraged may be ordered to cease assuming additional risks and to write no new coverage until his ratio returns to an acceptable level.

One method of expanding capacity and thus bringing in more premiums for investment is to transfer a portion of the risk to another insurer by entering into a reinsurance contract. This allows the primary carrier to expand its capacity by passing a portion of the risk along, stabilize operating costs, reduce exposure in certain risky areas, and develop new business opportunities. Reinsurers usually assume the risk for the "high end" portion of a policy coverage written by the primary insurers. This is particularly important to corporations and public entities who may need or require coverage limits in the millions or tens of millions of dollars. It has been common practice for primary carriers to pass through a large portion of the assumed risk, in some cases up to 90 or 95 percent, through a reinsurer if such reinsurance could be obtained. From the late 1970's through 1983, the reinsurance market was extremely active due to the high rate of interest obtainable on invested premiums and the relatively low losses. Particularly because of the high interest rates available, much of the reinsurance was undertaken on only a marginal and inadequate portion of the primary insurers premium. Those premiums, as already noted, were inadequate to cover losses during that period, and the process of reinsurance only passed the more drastic effects along to the reinsurer.

As an example, the primary carrier would write a policy for \$1 million in liability coverage with the premium charged totaling \$10,000. In an attempt to spread the risk the primary carrier would request that a reinsurer assume one half of the liability on the policy in return for \$4,000 or 40 percent of the original premium, since the likelihood of the settlement cost breaching the reinsurance limits is low. However, given that the original premium charged by the primary carrier is not adequate by itself to cover anticipated claims on the policy, the reinsurer is in essence accepting an unrealistic liability potential for the amount of premium received.

In the last several years, according to several studies by the Institute for Civil Justice of the Rand Corporation,⁶ there has been a significant increase in both the number and size of the largest liability awards and

⁶Comparative Justice: Civil Jury Verdicts in San Francisco and Cook Counties, 1959-1980, Michael G. Shanley and Mark A. Peterson

The Civil Jury: Trends in Trials and Verdicts, Cook County Illinois, 1960-1979, Mark A. Peterson and George L. Priest

settlements. Thus, when the loss surge began to result in larger awards, which were passed through to the reinsurer by the primary carrier, the losses to the reinsurance companies quickly began to outstrip both the reinsurers fees and interest earned.

The Reinsurance Association of America has indicated that, in 1984, its member companies reported a decrease in aggregate surplus of \$400 million due to paid losses. Although there was an increase in aggregate surplus in 1985, they state that it was due almost entirely to an infusion of funds from the reinsurer's parent and holding companies, done as an effort to shore up the secondary market. These losses, and the problems associated with risk assessment of reinsurance agreements, which were primarily written on "long tail" lines and in many cases on high risk industries such as toxic materials or pharmaceuticals, have compelled reinsurers to either raise their premiums to a level which could not be afforded by the primary carriers or to withdraw entirely from the reinsurance marketplace.

From January 1984 to December 1985, 90 reinsurance underwriters, or approximately 45 percent of the total number of companies offering reinsurance in the nation had partially or entirely withdrawn from the market. This constriction of the secondary market for liability insurance has had the direct effect of denying coverage to many businesses and public entities. Since most primary insurers are not willing to write policies and retain the total risk at necessary levels of coverage, they are often not willing to write any coverage at all, causing the crisis of availability.

There is little indication at this point of when or under what conditions this vital portion of the market may reconstitute itself. It is entirely possible that, due to prior losses and the continued perception of rising losses by reinsurers, there may be no significant degree of return by reinsurers to the United States market for several years. This lack of reinsurance availability may cause the primary market to remain extremely restricted at any level of premium, regardless of any tort reform, and may result in a nonexistent market for perceived "high risks," such as public entities.

CHAPTER V

THE INSURANCE COMMISSIONER'S ROLE IN PROVIDING STABILITY IN THE INSURANCE MARKETPLACE

The California Department of Insurance was established to protect insurance policy holders in the State. To accomplish this objective, the Department conducts examinations of insurance companies and producers to ensure that operations are consistent with State law. Specifically, the examinations and reviews by the Department of Insurance are used to regulate insurance companies to ensure that losses to policy holders, beneficiaries or the public due to insolvency of the insurers are prevented; to ensure that the industry's practices are not unlawful or fraudulent; and to ensure that the general public and policyholders are not discriminated against with regard to the sale of insurance.

Since the federal government neither regulates nor monitors the insurance industry, and since private individuals cannot sue insurance companies for price fixing under the anti-trust laws, the only entities with authority to control insurance company practices within the United States are the state Insurance Commissioners or the Departments of Insurance. But the willingness and ability of the state Insurance Commissioners to meaningfully regulate the industry has been questioned.

In 1979, for example, the General Accounting Office (GAO) conducted a study and found that "there are serious shortcomings in state laws and regulatory activities with respect to protecting the interest of insurance consumers in the United States." They specifically found that "most states do not have specialized examiners, and few states have the capacity to do computerized audits." Further, they determined that "the degree of scrutiny given important premium increase requests was not adequately reviewed and that insurance regulation is not characterized by an arms-length relationship between the regulators and the regulated."⁷ The Commission has found that California is no exception. The California Insurance Commissioner's role in the regulation of insurance regarding the rating process is extremely limited.

FINDING #13 - The State Insurance Commissioner's Regulatory Powers in California are More Limited Than in Other States

The balance between regulation and the free market in the insurance industry is unlike that of any other major industry. While there are distinctions between the insurance industry and other regulated industries, the consumer does not have the same form of protection mechanisms in insurance as he does in other regulated industries. Specifically, other industries that are

⁷U.S. General Accounting Office: "Issues and Needed Improvement in State Regulation of the Insurance Business," October 1979.

exempted from restraint of trade and anti-monopoly provisions of anti-trust laws have regulated rates. The insurance industry is a hybrid with the benefits of both species. Unlike a public utility, its rate process is not controlled by the State, and unlike all other major industries, it is exempted from federal and State anti-trust laws. As a result, the insurance industry has considerably less regulation than other industries which potentially exposes the consumer to problems.

The framework for regulating the insurance industry is unlike that of any other major industry. In 1945, Congress passed the McCarran-Ferguson Act, in which it subordinated its authority to impose controls of any significant kind on the industry to the states. It expressly exempted the business of insurance from the operation of most of the federal anti-trust laws, including the Sherman Act, the Clayton Act and the Federal Trade Commission Act, so long as such business was regulated by the states. Shortly thereafter, in 1948, in response to the McCarran Act and in an effort to attract insurance companies who were then badly under-represented in the State, California enacted the McBride-Grunsky Act. Its purpose was to regulate insurance rates "to the end that they shall not be excessive, inadequate or unfairly discriminatory," to authorize the use by insurance companies of rating organizations, and to authorize cooperation between insurers in rate making and related matters.

The McBride Act did not empower the Insurance Commissioner to set rates, approve rates or even file rates. On the contrary, it expressly authorized insurers to act in concert among themselves or with the aid of rating and advisory organizations, to establish rates, policy forms and underwriting rules, and to share any statistical information designed to achieve those objectives.

What sets this method of operation apart from other industries which have similarly been exempted from anti-trust laws and authorized to form cartels, such as utilities and the communications industry, is the Department of Insurance's lack of control over the rate process. Most state statutes require insurance companies to seek prior approval before setting or changing their rates. Some states only require companies to file their rates; however, California is the only State in which insurance companies have no such obligations. Instead, the Act requires only that insurers and rating organizations maintain certain statistical data to record their losses and expense experience on a nationwide basis and make such records available to the Commission on an annual basis.

Thus, the insurance industry is benefiting from the free market unlike a public utility and is exempted from the anti-trust laws similar to a public utility. Therefore, to a considerable extent, the insurance industry, unlike any other major industry, has the "best of both worlds" and accountability is extremely limited. As a result, the consumer does not have the regulatory protections that exist in other industries.

FINDING #14 - The Insurance Commissioner Does Not Have the Authority to Collect Adequate Data to Monitor Trends in the Insurance Industry

Although the Insurance Commissioner collects adequate data to determine whether a company is solvent or not, the Commissioner does not collect, nor

have the authority to collect, adequate information regarding insurance rates. As a result, the Commissioner cannot comply with his mandate and determine whether a rate is "excessive, inadequate or unfairly discriminatory."

The Department of Insurance collects financial data for each of the 1,544 licensed insurers participating in California. The financial status of each is presented in the annual statement prepared by each company on a nationwide basis. While the 65-page document provides a good basis for determining the overall solvency of a corporation, it doesn't provide adequate data to determine the company's actual payouts, how much they actually take in on a year-by-year, line-by-line, and state-by-state basis. Specifically, the information doesn't provide the amount insurance companies pay each year for jury verdicts, settlements or related attorney fees. The lack of Statewide information makes it difficult, if not impossible, to determine whether a rate is excessive or inadequate for a given line of insurance.

Additionally, the information accumulated and compiled by the Department of Insurance does not provide for the determination of how victims fare under the present legal system. In evaluating the appropriateness of no-fault automobile insurance, for example, the Federal administration found that under the tort system claimants with small economic losses collected five times their economic damages on the average, while those with substantial losses collected only half their economic damages. In these instances, caps on awards would have been inappropriate since they would lower payments to the seriously injured who were already being under-compensated. On the other hand, an alternative system in which people with limited damages give up their traditional right to sue, but in exchange, receive a right to a limited recovery without having to prove fault, made sense.

Currently the only aggregate rate information is collected by Insurance Services Organization (ISO), the association which collects insurance industry trade data. The information collected by ISO is provided on a voluntary basis and therefore only represents a percentage of the Statewide insurance history.

In one area the Department does require additional information. Current reporting requirements for products liability state that insurers issuing a policy of products liability insurance in this State are required to transmit the following information to the department each year in an annual report: (1) premiums written; (2) premiums earned; (3) unearned premiums; (4) the dollar amount of claims paid; (5) the amount of outstanding claims; (6) net loss reserves for outstanding claims excluding claims incurred but not reported; (7) net loss reserves for claims incurred but not reported; (8) losses incurred as a percentage of premiums earned; (9) net investment gain or loss and other income or gain or loss allocated to products liability lines; (10) net income for Federal and foreign income taxes; and (11) expenses incurred including the loss adjustment expense commission and brokerage expense, other acquisition expenses and general expense. This type of reporting information for each State provides a true picture of the insurance coverage and the cost of that coverage by specific line of insurance and would be very beneficial for all other liability categories.

Another data collection option would be to obtain general liability information similar to that currently obtained for State workers' compensation insurance. Specifically, the State currently collects data on the workers

compensation system through the Workers Compensation Insurance Rating Bureau, a non-profit corporation. All companies writing workers compensation insurance are required by law to submit all policies written for review by the Bureau, as well as submitting periodic statistical reports. These reports, submitted at 18-month intervals, must include premium and loss information for each policy, a listing of losses by job classification and type of injury, and the current status of any outstanding claims.

Without good information, sound decision making is difficult. The Insurance Commissioner must have appropriate information available before the excessiveness or adequacy of rates within California can be fully ascertained. Without adequate information, the role of the Insurance Commissioner can only be reactive.

FINDING #15 - The Insurance Commissioner Does Not Fully Utilize His Authority to Make Insurance Available

The Insurance Commissioner has sufficient authority to establish voluntary programs to provide insurance to all entities at an affordable price. However, the Insurance Commissioner has not fully exercised this authority. As a result, currently public entities, nurse midwives and free standing birthing centers can not obtain insurance at any price. Therefore alternative programs should be fully explored.

The authority and responsibility of the Department of Insurance in responding to an insurance crisis is controlled by applicable statutes and is quite restrictive in nature. The Insurance Commissioner has no statutory authority to compel any licensed insurer to underwrite a particular risk or any particular classification of risk which it does not choose to underwrite. There is one exception, the California Automobile Assigned Risk Plan, which provides the equitable apportionment among insurers admitted to transact liability insurance of those applicants for automobile bodily injury and property damage liability insurance who are in good faith entitled to, but unable to procure through ordinary methods, insurance in the marketplace.

However, the Insurance Commissioner does have the authority to request that insurance companies participate in voluntary plans. For example, in late 1985, an affordability and availability crisis for licensed day care providers developed. The Department of Insurance established a market assistance program (MAP) to provide a marketplace for these risks at affordable levels. This program is a voluntary effort by insurers, agents and brokers working under the leadership of the Department to match insurance demand with insurance supply. The MAP for day care providers has been in operation for a few months, and has attracted about 20 insurer participants who individually underwrite each risk submitted. The California Market Assistant Program received 434 completed applications during its first 7 months of operation. Of this amount, 340 were completed and distributed to insurance companies for quotes. As of the May 15, 1986, 254 day care centers have received at least one quote and 83 have secured new insurance.

The State of New York recently organized a MAP for governmental entities and a separate one for day care providers. It reports that as of mid-February, the public entity MAP, also after 4 months of operation, had received 164

completed applications and that all of these applicants had either secured new insurance or had received extensions from their existing carriers. In New York State, no public entity that had applied to the MAP was known to be bare of coverage.

Since these voluntary programs have been successful for day care providers in California and public entities and day care providers in New York, the Department could potentially explore a similar program for cities, counties, nurse midwives, free-standing birth centers and other groups that are also suffering from a liability insurance crisis.

Another area that could be more fully explored is joint underwriting associations. Joint underwriting associations already exist for medical malpractice insurance, automobile liability coverage and for some forms of fire insurance. Specifically, the Insurance Commissioner is not empowered to mandate, but could request that within the California liability insurance market, all insurers write all lines of insurance. This would reflect the premise that insurance for entire communities is a function of vital concern to the public interest. Given that general liability lines, the major "crisis" area in California, and the nation, represent a relatively small portion of the industry, accounting for less than eight percent of all the premiums written, a program of this nature would be possible if the risk was equally shared among all carriers.

Although the explicit authority to mandate these programs is not available to the Insurance Commissioner, a request by the Commissioner given his stature in the community may result in voluntary solutions to the crisis. If not, additional authority to mandate these solutions may be warranted.

FINDING #16 - The Insurance Commissioner Does Not Have Legal Authority to Control Rates

The Insurance Commissioner does not have sufficient authority to regulate the rates and availability of insurance. While the Commissioner does have authority in some areas, the penalties and fines that exist for noncompliance are insufficient and therefore do not act as an adequate deterrent. Moreover, since the enactment of the statute in 1948 the Insurance Commissioner has never fined an insurance company for excessive rates.

In California, the role of the Commissioner with regard to the liability insurance crisis is very limited. As previously discussed, the Insurance Commissioner has no statutory authority to compel a license insurer to underwrite a particular risk on any particular classification of risk which it does not voluntarily choose to underwrite. The Commissioner is authorized to inspect records periodically in order to determine whether a particular rate or rating system complies with the requirements of prohibiting excessive, inadequate, or discriminatory rates.

In defining rates that are excessive or inadequate, the State law specifically indicates:

no rate shall be held to be excessive unless: (1) such rate is unreasonably high for the insurance provided; and, (2) a reasonable

degree of competition does not exist in the area with respect to the classification to which such rate is applicable. No rate shall be held to be inadequate unless: (1) such rate is unreasonably low for insurance provided and (2) the continued use of such rate endangers the solvency of the insurer the rate, or unless (3) such rate is unreasonably low for the insurance provided and the use of such rate by the insurer using same has, or if continued will have, the effect of destroying competition or creating a monopoly.

But given the vagueness of the guidelines, the Commission was unable to find a single formal determination made by the Department in the past 25 years that a rate is excessive. However, the Department indicates that it has successfully requested rate reductions informally. Given the vagueness in the law and the limited authority and information available to the Commissioner, a formal determination that a rate is excessive would be very difficult to ascertain. And even if a determination could be made, the enforcement powers of the Commissioner "when the department's own inspection demonstrates non-compliance or if an individual aggrieved by any rate charged files a complaint," are weak. Specifically, the law states that if there is good cause to believe that the insurer has not complied with the requirements, the Commissioner may within ten days, serve the insurer with a notice of non-compliance. If there is no agreement to correct the non-compliance, the next step is the levying of sanctions.

However, sanctions or penalties available to the Insurance Commissioner are unrealistically low and therefore prove to be ineffective. For example, if the insurer ignores the Commissioner's order to reduce a given rate, State law provides for a penalty of "not to exceed \$1,000 for each day such person or organization fails to comply with the provisions for such Order. Such penalties shall not exceed in aggregate the sum of \$30,000." The other "major" penalty that the Commissioner can enforce, as delineated in Section 1859 of the Insurance Code, states that "any person or organization that fails to comply with a final order of the Commissioner shall be liable to the State in the amount of \$50."

As previously discussed, the McBride Act empowers the Commissioner to gather information from insurers, initiate investigation into their rating practices, hold hearings to determine if rates are excessive, inadequate or discriminatory, and penalize insurers who are found to be in violation of the Act. None of the Commissioner's power, however, impose an affirmative duty on the Commissioner to perform any of these functions. They are largely discretionary in practice, and some of these functions have never been performed. For example, since the enactment of the statute in 1948, the Insurance Commissioner has only held one public hearing and has never fined an insurance company for excessive rates.

Penalties for violations, which range from \$50 for failure to comply with the Commissioner's order, to an absolute maximum of \$30,000 for non-compliance with rating standards, are also inadequate. Considering the size of the insurance industry, the current penalties do not appear to be sufficient to deter insurers from charging inappropriate rates.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSION

Over the past two years the cost of liability insurance coverage for different groups in California has increased from 100 to 9000 percent. In addition, other major groups, including public entities, have been unable to secure insurance coverage. The soaring cost and worsening shortage of liability insurance is taking its toll on businesses, individuals and governmental agencies throughout the State. This crisis is affecting the daily lives of all Californians with the closure of parks, day care centers, and small businesses, and the reduction in essential services, such as police and fire protection. Further it has compromised the very goal of liability insurance which is to provide public safety and ensure the availability of goods and services.

In general, the Commission believes that there are a multitude of interrelated causes of the crisis and all involved parties must share the responsibility for the excessive price and unavailability of insurance. Specifically, the Commission found that the liability crisis has resulted from uncertainty in the insurance industry which is primarily due to the following problems:

- ° The evolution of tort law has expanded the bases of liability exposing insurance companies, public entities and other "deep-pocket" defendants to new and unpredictable risks.
- ° The lack of predictability in risk assessment has made it difficult to forecast the size of claims for a particular exposure.
- ° Unsound pricing practices of the insurance industry as demonstrated by the price war of the late 1970's and early 1980's.
- ° The withdrawal of the reinsurance market which has significantly limited the available insurance capacity.
- ° The limited authority of the Insurance Commissioner in the rate-setting process.

The Commission's study found that the insurance crisis is threatening the quality of life enjoyed by all Californians by reducing the availability of goods and services and increasing costs.

RECOMMENDATIONS

The Commission recommends a comprehensive reform package for solving the insurance crisis to address the multiple problems that have created the crisis. The Commission believes that its recommendations will protect individual businesses and public entities that are struggling to afford insurance while

maintaining the rights of individuals to seek fair compensation for damages. Therefore, the Commission submits the following recommendations:

1. Establish a Cap on the Recovery of Compensatory Damages

- ° The Governor and the Legislature should, except in the case of intentional torts, and excluding economic damages, adopt legislation that limits recovery for compensatory damages in personal injury action to \$500,000 with a cost of living adjustment.

2. Prohibit Collusion between Plaintiff and Settling Defendants

- ° The Governor and the Legislature should modify State law to prohibit agreements between a plaintiff and a settling defendant to cooperate in prosecuting plaintiff's claim against the remaining defendants in consideration for a reduction in the settlement amount. When one defendant settles with a plaintiff, who subsequently prevails at trial, the remaining defendants should be liable only for their proportionate share of the liability.

3. Establish a Stricter Burden of Proof for Punitive Damages

- ° The Governor and the Legislature should modify State law to require juries to be instructed that in order to award punitive damages against a defendant, except in the case of intentional torts, the plaintiff must establish by clear and convincing proof that the defendant was guilty of oppression, fraud, or malice and acted in conscious disregard of the plaintiff's rights.

4. Limit Damages Incurred While in the Process of Committing a Felony

The Governor and the Legislature should enact legislation that stipulates that a person has no cause of action for damages for injuries incurred while in the process of committing a felony.

5. Place Limitations on the Cost of the Civil Justice System

The Governor and the Legislature should establish limits on the cost of litigation in the following areas:

- ° Plaintiffs' attorney fees should be limited to the prevailing rate of one-third of plaintiffs recovery.
- ° A mechanism should be developed in consultation with affected parties to place reasonable limits on defendants' attorney fees that are comparable with the limitation on plaintiffs' attorney fees.

- ° Penalties should be imposed against plaintiffs and defendants for asserting frivolous claims and defenses by awarding the prevailing party costs and reasonable attorney fees not exceeding \$10,000 for such frivolous claims or defenses. For a claim or defense to be considered frivolous, it would have to be: (1) made in bad faith, either for the purpose of delaying or prolonging the resolution of the litigation and to harass another; or (2) without any reasonable basis in law or fact and lacking any good faith argument for an extension, modification, or reversal of existing law.

6. Modify the Collateral Source Rule

- ° The Governor and the Legislature should modify the collateral source rule to provide that following a jury verdict for a plaintiff, the plaintiff's recovery should be offset by the amount of any public benefits that the plaintiff has been or is scheduled to receive from collateral sources.

7. Establish Requirements for Periodic Payments

- ° The Governor and the Legislature should enact legislation that allows for periodic payments by insurance companies. Specifically, when the future damages awarded by the jury to the plaintiff in a personal injury case exceeds the sum of \$100,000, that portion of the award over \$100,000 should be paid in unassignable periodic installments with a reasonable rate of return to the plaintiff, unless the parties agree otherwise. If a plaintiff dies while periodic payments are still due, the payments should terminate, except that the portion of damages attributable to loss of future earnings should remain payable to the plaintiffs' dependents, if any, or his estate.

8. Establish a Reinsurance Pool for Public Entities

- ° The Governor and Legislature should establish a Statewide reinsurance pool to offer reinsurance to primary carriers writing liability coverage for public entities. Provisions of the pool should include:
 - ° A specified deductible amount;
 - ° A requirement that the primary insurer will retain a significant portion of the total liability coverage; and
 - ° A requirement that the pool is to be funded by a bond issue and the creation of a reinsurance authority under the control of the State Treasurer. The fund would be guaranteed by the revenues it earned only. Specifically, there would be no use of State funds or the use of the State's credit.

9. Undertake Market Assistance Plans and Joint Underwriting Authorities or FAIR Plans

- ° The Governor and the Legislature should consider providing the Insurance Commissioner with sufficient legal authority to form voluntary market assistance programs and joint underwriting authorities or FAIR plans.
- ° If voluntary industry participation is deemed inadequate, the Governor and Legislature should consider providing the Commissioner with the authority to compel appropriate insurers to participate.

10. Develop Insurance Rates Based on Experience

- ° The Governor and the Legislature should require insurance companies to consider prior practices and claims history when establishing rates or denying coverage. Because insurance companies today often lump all insureds in a category together, regardless of how often any individual has been sued, good risks subsidize bad risks. Experience rating would bring down premiums for day care centers, non-profit organizations and other insureds in which experience is virtually non-existent.

11. Conduct a Review of the Insurance Commissioner's Office and of the Department of Insurance

- ° An independent study should be conducted regarding the operations of the Insurance Commissioner's Office and the Department of Insurance aimed at determining whether any barriers exist in California which unnecessarily prevent competition in the marketplace.

12. Require Disclosure of Loss Data by Insurance Companies

- ° The Governor and the Legislature should require that insurance companies disclose their loss data for California on a line-by-line and state-by-state basis similar to the current requirements for product liability. Given that California is the largest insurance market in the nation, a data collection and statistical information base should be designed to monitor California's underwriting experience.

13. Consider Requiring Prior Approval of Insurance Rate Increases

- ° The Governor and the Legislature should consider enacting legislation requiring prior approval by the Insurance Commissioner of insurance rate increases in excess of 15 percent. In addition, such legislation should require the Insurance Commissioner to act upon these requests within 60 days.

14. Increase Penalties and Fines in the Insurance Industry

- ° The Governor and the Legislature should increase penalties and fines against the industry for non-compliance. Most of the various penalties and fines promulgated in the Insurance Code have not changed since their enactment.

15. Consider Establishing an Insurance Commission

- ° The Governor and the Legislature should consider establishing a bipartisan independent five-member part-time commission, with staggered terms to replace the Insurance Commissioner.

16. Continue to Monitor Product Liability

- ° The State Insurance Commissioner should continue to monitor Federal actions in the area of product liability.

APPENDIX A

LIABILITY INSURANCE
PERTINENT TORT LAW PROVISIONS*

Provisions	California Except MICRA	California MICRA**	New Hampshire	Ohio	Massachusetts	New York	Washington	Florida
1. Joint and Several Liability	Liability is several for non-economic damages only; all others are joint	Liability is several for non-economic damages only; all others are joint	Joint and Several liability abolished	Liability is joint in certain cases	If plaintiff is at least 51% at fault no award; if less, award is reduced by percentage then joint and several	Liability is joint	Eliminated when plaintiff at fault; except toxics, business torts and some product liability	Minor limitations for public entities
2. Cap on non-economic damages	None	Maximum of \$250,000	Maximum of \$850,000	Maximum of \$250,000 for government agencies except in wrongful death cases	None	Limits in worker's compensation and automobile cash	Sliding scale; ranging \$117,500 to \$573,000;	Maximum of \$450,000
3. Collateral source rule	Evidence may not be introduced	May be introduced	Evidence may not be introduced	Must be subtracted from judgement in public entity cases	May be introduced at the discretion of the trial judge	Evidence may not be introduced	Evidence may not be introduced	May not be introduced, except in automobile accident cases
4. Periodic payments	No provision	Mandatory for future economic damages over \$50,000	No provision	Optional	No provision	No provision	Mandatory if future economic losses \$100,000 or more	Optional by agreement of parties
5. Attorney's contingent fee limits	No limit	Sliding scale ranging from 10% to 40%	No limit	No limit	No limit	No limit	Court review for reasonableness	No limit
6. Statute of Limitations	1 year from date of incident	3 years from date of incident or reasonable knowledge	3 years from date of incident or reasonable knowledge	1 year from date of incident or reasonable knowledge	3 years from date of incident	1 to 4 years depending on cause	8 years for medical malpractice only	4 years from incident in negligence cases only
7. Punitive Awards	No limit	No limit	No punitive damages awarded	No limit	No punitive damages awarded	No limit	No limit	No limit
8. Sovereign Immunity	No general immunity	No general immunity	Cap of \$500,000 on civil liability	Immunity for limited cases only	Cap of \$100,000 per claim for public entities	No provision	Sovereign immunity except in cases of gross negligence	Cap of \$100,000 per claim, per person for public entities

* This chart summarizes only the primary provisions of the relevant statutes, most of which contain significant exceptions.

** MICRA - Medical Injury Compensation Reform Act of 1975

SOURCES - National Association of Insurance Commissioners
National Conference of State Legislatures